PERFORMANCE SPINE & SPORTS PHYSICIANS, P.C.

PATIENT RESPONSIBILITY AGREEMENT FORM

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

Address: _____

Telephone: _____ Date of Birth: _____

Social Security Number: _____ Employment: _____

Sex M / F Emergency Contact: _____ Relationship: _____

Phone #: _____

We request that you assist us with the following:

INSURANCE INFORMATION

It is in your best interest to know and understand your insurance plan benefits and your responsibility for any deductibles, co-insurance or co-payment amounts prior to any visit. **Copayment is due at the time of your visit or your visit may need to be rescheduled.** If you fail to provide timely or accurate insurance information that results in non-payment for services or your insurance denies coverage, you will be responsible for payment. I authorize Performance Spine & Sports to release all medical information to all of my insurance carriers or other third party payers as may be required or requested for the processing of claims.

APPOINTMENTS

We ask that if you must cancel or change an appointment you provide at least 24 hours notification to our office. Missed appointments or arriving late for an appointment is very costly to everyone as we staff based on schedule needs and we can't see other patients who may need or want a visit at that time. Abuse of this policy may result in your discharge from the practice.

DEMOGRAPHIC INFORMATION

It is your responsibility to provide accurate and up-to-date personal information to our office and to notify us of any address or telephone number changes.

FORMS

Please check with our office for our form policy.

PAST-DUE ACCOUNTS

It is your responsibility to keep your account current. Should your account remain unpaid, you will not be able to schedule appointments until arrangements have been made to clear your outstanding balance. If payment arrangements are not made, your account will be turned over to our collection agency.

This is to certify that, I understand, consent to examination and treatment. This information and any photography may be used for scientific and educational purposes. I hereby authorize Performance Spine & Sports Physicians, P.C. to furnish information to my insurance carrier, employer, referring physician, or other physician concerning my treatment and/or illness. I transfer assignment of all insurance benefits to Performance Spine & Sports Physicians, P.C. for services, treatment, supplies or surgeries provided by physicians or staff. I understand that **I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE.**

_____ _____

Patient Signature Date