INSURANCE INFORMATION
Please read the following sections carefully

As a courtesy, we will bill your insurance company. In some cases, unless you are insured under worker's compensation, you may be responsible for up to the full amount of the charges incurred during your visit. If the provider you are seeing is not a contracted provider under your insurance plan, you may wish to discuss your financial responsibility with the member services department at you insurance company.

I understand that I may be responsible for paying for services rendered, including responsible attorney's fees and cost incurred in the event of any default. **The information that is provided on this form is complete and accurate to the best of my knowledge.**

Signature: _____ Date: _____

Primary Insurance Company: _____ Phone: _____

Name of insured: _____Social Security Number: _____

Insurance Address: _____

Policy #: _____ Group #: _____

Does your insurance require pre-authorization for visits to a doctor? [ ] Yes [ ] No

Do you have a co-payment for each doctor's visit? If so what is the co-payment amount? _____
Co-payments must be made at the time of service or your visit will be rescheduled.

Secondary Insurance Company: _____ Phone: _____

Name of Insured: _____ Social Security Number: _____

Insurance Address: _____

Policy #: _____ Group #: _____

MEDICARE/MEDICAID PATIENTS ONLY:
I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Coeur d'Alene Spine and Brain, PLLC** for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, formally the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature: _____ Date: _____

I hereby authorize my provider(s) at Coeur d'Alene Spine and Brain, PLLC to release any information obtained in the course of my examination that my insurance company may request. I also authorize assignment of my medical benefits to my provider(s) at Coeur d'Alene Spine and Brain, PLLC. This assignment of benefits allows our office to collect directly from your insurance company. **Without this release, you will be required to pay for your visit at the time that services are rendered.**

Signature: _____ Date: _____

In case of a medical emergency, who would you like us to notify?

Name: _____ Phone #: _____

Address: _____ Relationship to patient: _____

Worker's Compensation Information:

Carriers Name: _____ Claim #: _____

Claim Office Address: _____

Adjuster, (Claims Manager): _____ Phone #: _____

Date of Injury: _____ Employer: _____

Employers Address: _____

Are you represented by an attorney? [ ] Yes [ ] No

If yes, what is the attorney's name: _____ Phone #: _____