

(PLEASE CHECK WHICH ONE APPLIES TO YOU)

**IS WHAT YOU ARE BEING SEEN FOR TODAY RELATED TO:**

1.  WORKERS' COMPENSATION      DATE OF INJURY: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Patient brought Notice of Injury  
 Received referral authorization from M.D.  
Describe type and location of injury: \_\_\_\_\_  
\_\_\_\_\_
2.  AUTO ACCIDENT      DATE OF INJURY: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Describe type and location of injury: \_\_\_\_\_  
\_\_\_\_\_
3.  LAWSUIT      NAME OF ATTORNEY: \_\_\_\_\_  
Describe type and location of injury: \_\_\_\_\_  
\_\_\_\_\_
4.  OTHER ACCIDENT OR INJURY      DATE OF INJURY: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Describe type and location of injury: \_\_\_\_\_  
\_\_\_\_\_
5.  **NONE OF THE ABOVE:**  
Describe problem: \_\_\_\_\_  
\_\_\_\_\_

**PATIENT/INSURANCE AUTHORIZATION**  
**MEDICARE AND ALL OTHER INSURANCE**

I consent to treatment necessary for the care of the below-named patient.  
I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.  
I allow fax transmittal of my medical records, if necessary.  
I acknowledge full financial responsibility for services rendered by *Pro Sports/Pro Spine*.  
I understand that payment of the charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.  
I agree to pay all reasonable attorney fees and collection costs in the event of default to payment of my charges.  
I further authorize and request that insurance payments be made directly to *Pro Sports/Pro Spine* should I not make full payment at the time of service.  
I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Signature