

Pro Sports/Pro Spine

(PLEASE CHECK WHICH ONE APPLIES TO YOU)

IS WHAT YOU ARE BEING SEEN FOR TODAY RELATED TO:

1. _____ WORKER'S 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. _____ LAW SUIT 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, interest on account and collection costs in the event of default to payment of my charges. The collection fees are 30% or 50% if charges are greater than one year.
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