

Northern California Spine & Rehabilitation Associates
 2801 K St #410 Sacramento, CA 95816
 916-733-8277 916-733-8226

INSURANCE UPDATE FORM

Patient Name:	
Gender:	DOB:
Address:	SSN#:
City, State Zip:	Marital Status:
Employer/Occupation:	Home Phone #:
Work Phone:	Referring MD:
Spouse or Emergency Contact:	

BILLING INFORMATION

1st Insurance or Work Comp Carrier:	2nd Insurance or Work Comp Carrier:
Address:	Address:
Address2:	Address2:
Phone:	Phone:
ID# or CLAIM#:	ID# or CLAIM#:
Group#:	Group#:
Insured Name:	Insured Name:
Relationship to Insured:	Relationship to Insured:
If work related, name of employer at time of injury:	

HIPAA

(Health Insurance Portability and Accountability Act)

PLEASE LIST ANY PERSON(S) IN THE BOX BELOW WHOM MAY REQUEST INFORMATION ON YOUR BEHALF.
 IF NONE, PLEASE STATE "NONE."

1:
2:
3:

ASSIGNMENT OF BENEFITS CONSENT FOR TREATMENT, RELEASE OF INFORMATION

I hereby assign all medical and/or surgical benefits, to which I am entitled, including private insurance and any other plan, to Northern California Spine and Rehabilitation Associates (NCSRA). This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid for by said insurance. I hereby authorize NCSRA or its representatives to release all information necessary to secure payment. I hereby authorize NCSRA to perform any medical treatment as deemed necessary. I hereby authorize the release of medical records to NCSRA as needed for any medical treatment.

SIGNED: _____

DATE: _____