

**Northern California Spine & Rehabilitation**

PATIENT NAME _____		DOB & AGE _____	
SEX _____	SS# _____	MARITAL STATUS _____	HOME # _____
ADDRESS _____			
CITY _____		STATE _____	ZIP _____
EMPLOYER/OCCUPATION _____		WORK # _____	
SPOUSE OR EMERGENCY CONTACT _____		PHONE _____	
REFERRING PHYSICIAN _____			

**\*\*\*\*BILLING INFORMATION\*\*\*\***

1 <sup>ST</sup> INSURANCE OR WORK COMP CARRIER _____ ADDRESS _____ ADDRESS _____ ADJUSTER NAME _____ PHONE # _____ ID# OR CLAIM # _____ GROUP # _____ INSURED NAME _____ RELATIONSHIP TO INSURED _____	2ND INSURANCE _____ ADDRESS _____ ADDRESS _____ ID # _____ GROUP # _____ INSURED NAME _____ RELATIONSHIP TO INSURED _____
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IF WORK RELATED: EMPLOYER AT TIME OF INJ: _____ DOI: _____
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**\*\*\*\*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." HIPPA INFORMATION PROVIDED UPON REQUEST.**

1. _____ 2. _____ 3. _____
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**\*\*\*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 \_\_\_\_\_