NORTHWEST BRAIN & SPINE

2115 NE Wyatt Court, #201 • Bend, OR 97701 • 541-585-2400

Primary Insurance Company_____ Secondary Insurance Company_____

Social Security #: _____ Email:_____

Last name:_____ First: _____ Middle:_____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (___) _____ Cell Phone: (___) _____ Birth Date: _____

Status: ☐ Married ☐ Widow ☐ Single Gender: ☐ Male ☐ Female

Employer: _____ Primary Care Physician: _____

Emergency Name and Phone: _____ (___) _____

Different than above

Is this appointment due to an on-the-job accident? ☐ YES ☐ NO Date of injury: _____
If yes, an 827 form will need to be filled out at your first visit.

Is this appointment due to a motor vehicle accident? ☐ YES ☐ NO Date of injury: _____
If yes, an MVA form will need to be filled out at your first visit.

AGREEMENT AND CONSENT

My signature acknowledges having read the following regarding my services at NW Brain & Spine:

- I authorize the release of my personal health information according to the Notice of Privacy Practices presented me.
- I assign to NW Brain & Spine my insurance company benefit payments for services received.
- To provide correct personal information prior to service or be financially responsible for insurance benefit denial.
- To pay for services received that my insurance company considers a non-covered benefit.
- To pay for services deemed by my insurance company as medically unnecessary.
- Insurance Co-payments at the time of service. Appointments will be rescheduled until Co-payment can be made at the time of service.
- I will pay Insurance Deductibles determined by my insurance company as patient responsibility or make payment plan arrangements prior to receiving services.
- To pay for forms, letters or paperwork requests prior to receiving requested documents.
- Repeated no-show or cancellations may result in no future appointments.
- I agree to be enabled for access to electronic medical record Patient Portal

_____

Signature Date