North Colorado Spine & Orthopaedics

6200 W 9th St
Greeley, CO 80634

Demographic Information

Date: _____

Full Name	
Social Security #	
Date of Birth	
Age	
Male/Female	
Street Address	
City, State, Zip Code	
Home Phone	
Work Phone	
Cell Phone	
e-mail address	

Employer	
Employer's Address	
City, State, Zip Code	

Primary Care M.D.		Phone #	
Referring Physician		Phone #	
Other Referral Source			

If you are under 18 years of age:

Guardian's Name	
Guardian's Address	
City, State, Zip Code	

Who may we contact if we cannot reach you?

Name	
Relationship	
Address	
City, State, Zip Code	
Phone Number(s)	

Body Part being Treated (right/left/both)	
Date of Injury (if applicable)	
Is this injury work related?	
Is this injury auto related?	

If this injury is work related/auto related, please answer the following:

Work Comp/Auto Insurance Company	
Claim Number	
Telephone Number	
Work Comp Doctor/Auto Adjuster?	

Insurance Information (Shaded information is required)

	Primary Insurance	Secondary Insurance
Insurance Company		
Effective Date		
Policy #		
Group #		
Policy Holder's Name		
Relationship		
Policy Holder's Birthday		
Policy Holder's SSN		
Insured Policy Holder's Address (if diff.)		

**** Account balances over 30 days old will be charged $10 per month or accrue interest at the rate of 18% annually, whichever is greater. ****

CONSENT FOR CARE: I give my consent to all health care services performed by North Colorado Spine and Orthopaedics' medical staff and/or employees, including diagnostic procedures, medications, injections and other procedures or services given as ordered by our physicians. I understand that NCSO participates in training programs for health care personnel. Some patient services may be provided by persons in training under the supervision and instructions of our physicians or employees.

I understand and acknowledge that my insurance coverage is a contract between my insurance company and me and that **I am personally responsible for all medical expenses incurred during evaluation and treatment at North Colorado Spine and Orthopaedics**. I understand that as a courtesy my primary insurance will be billed; however, it is my responsibility to follow up on delinquent claims.

If I am a member of a PPO or HMO I am required to make my co-pay and co-insurance payments at the time of service, and I am responsible for keeping my primary care referrals current. I understand that I am responsible for paying any charges which insurance does not pay as a result of my not obtaining a referral from my primary care physician.

Account balances older than 60 days will be sent to collections. **If your account is sent to collections, it is your responsibility to have your medical care transferred to another medical practice.**

I assign all benefits from said claim to North Colorado Spine & Orthopaedics. I further agree that a photocopy of this agreement shall be valid as the original.

I authorize North Colorado Spine & Orthopaedics to release all necessary medical information to the PCP and referring physician listed on the front of this form and to my insurance carrier for processing my claims. _____ (Initial)

_____ _____

Patient or Responsible Party's Signature Date