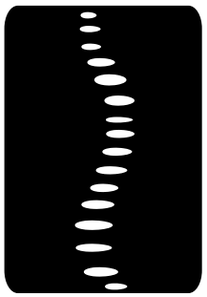

LUBBOCK
SPINE
INSTITUTE

COMPREHENSIVE SPINE TREATMENT

Welcome to Lubbock Spine Institute

Thank you for entrusting us with your healthcare needs.
Enclosed you will find patient information forms that need to be completed.
If you have any questions, please do not hesitate to contact our office.

3419 22nd Street Lubbock, TX 79410 P: 806-796-3000 F: 806-796-3006

PATIENT INFORMATION

Patient Name (Last, First, Middle) | Social Security Number

Date of Birth | Age | Sex | Marital Status

Race: □American Indian □ Asian □Black/African American □Other Pacific Islander □Caucasian □Hispanic

Ethnicity: □Hispanic/ Latino □Non-Hispanic or Latino

Mailing Address **(City, State and Zip)** | Phone Number

Residing Address (If Different) | Cell Phone Number

Email Address

Employer

Employer's Address (City, State and Zip) | Employer's Phone Number

Guarantor/Responsible Party | Social Security Number | Relationship

Guarantor/Responsible Party's Mailing Address | Phone Number

Guarantor/Responsible Party's Employer

Guarantor/Responsible Party's Employers Address (City, State and Zip) | Employer's Phone Number

Person to Contact in an Emergency (Who Does Not Live with You)

Address (City, State and Zip) | Phone Number

INSURANCE INFORMATION

Primary Insurance Carrier | Policy Owner/s Name | Social Security Number | Date of Birth

Insurance ID Number | Group Number | Group Name

Mailing Address (City, State and Zip)

Secondary Insurance Carrier | Policy Owner's Name | Social Security Number | Date of Birth

Insurance ID Number | Group Number | Social Security Number | Date of Birth

Mailing Address (City, State and Zip)

IS THIS A WORK-RELATED INJURY? □YES □NO If "YES", Please Provide the Information Below.

Date of Injury | Date Reported to Employer | Supervisors Name

Employer | Employer Address | Telephone Number

Employer's Workers Compensation Insurance Company | File/Claim Number

 LSC USE ONLY: Date of Surgery_____ Physician _____Med Record #_____Date of Pre-Registration _____

LUBBOCK
SPINE
INSTITUTE
COMPREHENSIVE SPINE TREATMENT

HIPAA (Health Information Portability & Accountability Act)

I understand that at any time I may contact LSI to obtain a current copy of the Notice of Privacy Practices as it pertains to my treatment with LSI & its physicians & midlevels.

1) I authorize my doctor and his clinic staff to release my private medical information to: (Example: Family members, attorney, friends, or social security administration.)

Name Relationship

_____

_____

_____

_____

2) I authorize my doctor and his clinic staff & third party entities contracted with NSA to leave messages with myself or others on recording devices at the following numbers:

YOUR Primary Phone Number: _____

YOUR Secondary Phone Number: _____

I authorize my doctor and his clinic staff to release my private medical information to all medical sources involved in my care, including insurance health plans, physicians, health care professionals, hospitals, clinics, laboratories, pharmacies, medical facilities, third party entities contracted with LSI or other healthcare providers that have provided payment, treatment or services to me or on my behalf.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or the healthcare operations of LSI. LSI is required to agree to any restrictions that I may request. If, however, LSI agrees to any restriction requested by me, such restriction shall be binding on LSI and it's physicians and midlevels. I further understand that I have the right to revoke this consent, in writing, at any time, except to the extent that LSI and it's physicians and midlevels has taken action in reliance on this consent.

☐ I consent to the terms of this agreement.

☐ I do not consent to the terms of this agreement.

Signature: _____ Date: _____

Printed Name: _____ Witness: _____

Patient Financial Contract

I, _____ (Patient's Name) agree to the terms of this financial contract. I agree that if I do not meet the payment guidelines LSI can refer me with or without notice to the collection bureau of his choice. By signing below I am acknowledging receipt of this document and therefore giving my permission to send my account to collections if I do not adhere to the payment guidelines.

Payment guidelines are as follows:

1. I will be responsible for any and all balances left to patient responsibility by my insurance company.
2. I will be responsible for any patient balances due to deductible, co-insurance, co-pay, termed insurance or non-covered services.
3. I will agree to pay 25% of the entire balance monthly, or $250 a month, whichever is greater.
4. I agree that my account may be sent to collections if I do not make a monthly payment when owed.
5. This applies to any and all balances incurred with LSI, LLP.

This is a financial contract between LSI and the patient. By violating this agreement the patient agrees to be sent to collections and can be dismissed from LSI.

Assignment of Benefits

I herby give lifetime authorization for payment of insurance benefits to made directly to LSI and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of a default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Effective June 11, 2018
I agree to pay 25% of the entire balance monthly, or $250 a month, whichever is greater.

Patient Name: _____

Patient Signature: _____ Date: _____

Due to a Federal Government mandate,we are now required to send you an e-mail offering you the opportunity to communicate with us via an online patient portal.

Please note: you will only receive one e-mail from us inviting you to join this portal. Once you get this email, you can either elect to join or decline the offer.

Thank you in advance for helping us comply with this federal mandate by suppling us with your email address.

Name: _____

Email: _____