PATIENT DEMOGRAPHICS:

NAME: ______________________________

ADDRESS: ______________________________

CITY: ____________ STATE: ______ ZIP: ______

HOME PHONE # ____________ DATE OF BIRTH: ____________

SOCIAL SECURITY # ______________ AGE: ______

SEX: ____________ MARITAL STATUS: S M W D

DO YOU OWN OR RENT YOUR OWN HOME? ____________
EMPLOYER NAME: ______________________
EMPLOYER TELEPHOHE # ______________________
ADDRESS: ____________ ____________
CITY: ____________ STATE: ______ ZIP: ______
IN CASE OF EMERGENCY CONTACT: ____________
____

INSURANCE INFORMATION:
NAME: ______________________
POLICY # ______________ ______
POLICY HOLDER'S NAME: ____________ EXP. DATE: ______

FINANCIAL GUARANTEE AND ASSIGNMENT OF BENEFITS

THE FOLLOWING FINANCIAL GUARANTEE AND ASSIGNMENT OF BENEFITS MUST BE SIGNED BEFORE ANY TYPE OF INSURANCE MAY BE PROCESSED. I AGREE TO ACCEPT AND PAY THE ESTABLISHED CHARGES OF THE CLEVELAND BACK AND PAIN MANAGEMENT CNETER (CBPMC). I HEREBY AUTHORIZE AND REQUEST THAT BENEFITS UNDER ANY APPLICABLE INSURANCE OR PAYOR WILL BE PAID DIRECTLY TO CBPMC ON MY BEHALF. I HEREBY AUTHORIZE CBPMC TO PROVIDE MY INSURANCE CO. OR PROVIDER WITH ANY AND ALL INFORMATION REQUESTED ON MY BEHALF. I AGREE, UNDERSTAND AND ACCEPT THAT ALL BILLS NOT PAID BY MY INSURANCE CO. OR PAYOR ARE MY RESPONSIBILITY FOR PAYMENT OF ALL CHARGES NOT COVERED BY MY INSURANCE.

I CERTIFY THAT ALL INFORMATION GIVEN ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE AND ALL INSURANCE POLICIES ARE CURRENT AND ACTIVE. I CERTIFY THAT I HAVE DISCUSSED WITH DR. NICKELS ANY QUESTIONS THAT I MIGHT HAVE ABOUT ANY BILLING OR INSURANCE ISSUES I HAVE.

______________________ ______________
PATIENT SIGNATURE DATE

WITNESS: ______________________