Patient Processing and Release Form

❑ Insurance ❑ Auto/Insurance ❑ WC ❑ Attorney Lien

Referring Physician: _____

Patient Name: _____ SS #: _____
Address: _____
Street / City / State / Zip: _____
Home Phone: _____ Work Phone: _____
DOB: _____ Sex: ❑M ❑F Marital Status: ❑ S ❑M ❑D ❑W
Employer: _____
Address: _____
Street / City / State / Zip: _____
Email: _____

Primary Insurance: _____
Insured Name (if not patient)_____ SS#: _____
Insured's DOB: _____
Mailing Address: _____
Telephone: _____
Policy: _____ Group #: _____
Date of Accident: _____ Claim#: _____
Secondary Insurance: _____
Mailing Address: _____
Telephone: _____
Policy: _____ Group #: _____

Acknowledgement of Notice of Privacy Practices

I understand that Delta Spine & Sportcare maintains a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. The most recent version of this notice is displayed in the waiting room area. I understand that Delta Spine & Sportcare reserves the right to change this notice and its practices as needed and will make a reasonable attempt to inform me of any changes. I understand that I can request an additional copy of this notice at any time. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent, and
- The right to request restrictions as to how my health information may be used or disclosed.

I have had the opportunity to receive and review the *Notice of Privacy Practices* of Delta Spine & Sportcare

_____
Printed Name of Person Signing

_____
Patient Signature Date

NOTE: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.