

Spinal Balance
Vincent Romviel, R.P.T., M.T.

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TODAYS DATE	REFERRED BY	S	M	W	D	SEP
PATIENT'S NAME						
ADDRESS					ZIP CODE	
HOME PHONE	SOCIAL SECURITY #	BIRTH DATE		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
PATIENT'S EMPLOYER		BUSINESS ADDRESS				
OCCUPATION					BUSINESS PHONE	
NAME OF SPOUSE			SPOUSE'S EMPLOYER			
BUSINESS ADDRESS		OCCUPATION		BUSINESS PHONE		
PERSON TO NOTIFY IN CASE OF EMERGENCY		RELATIONSHIP		PHONE #		
KNOWN ALLERGIES TO MEDICATION						

Primary Insurance:	Subscriber:
ID#:	Grp #:
Address:	
Other insurance:	Subscriber:
ID#:	Grp #:
Address:	
Liability: (auto accident) Yes _____ No _____	Date of injury:

WE DO NOT RECOGNIZE THIRD PARTY LIABILITY: THEREFORE, IF YOU WERE INJURED IN AN ACCIDENT AND EXPECT TO COLLECT DAMAGES FROM A NEGLIGENT PARTY, YOU WILL BE EXPECTED TO PAY YOUR BILL IN FULL AT TIME OF TREATMENT.

WORKMAN'S COMPENSATION	DATE OF ACCIDENT	CLAIM NUMBER	EMPLOYER NOTIFIED?
INJUERD ON JOB? Yes _____ No _____			Yes _____ No _____
COMPENSATION CARRIER		ADDRESS OF CARRIER	

Patient Authorization and Insurance Authorization Assignment

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office.

I hereby authorize Vincent Romviel to furnish information to insurance carriers concerning my illness and treatments and and I hereby assign the physical therapist all payments for medical services rendered to me or my dependants. I understand that I am responsible for any balance not covered.

Signature: _____

Date: _____