

Mosenthal Spine Clinic

Todd Mosenthal, DC Lorie Greenwood, DC Cathy Perryman, PT
37 Spencer St. Lebanon, NH 03766 / 607 Tenney Mt. Hwy, Plymouth, NH 03264

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____ Female Male
Last First Middle

Mailing Address: _____ Phone: _____
Street City/Town State Zip

Social Security Number: _____ Marital Status: M S D W

Email Address: _____ Cell Phone: _____

School: _____ Grade: _____ OR Not a Student: _____ (check)

Employer: _____ Phone: _____ Occupation: _____

Referred By: _____ Work: _____

Physician: _____ Physician's Phone: _____

FINANCIALLY RESPONSIBLE PERSON (Parents of Student or Minor)

Name: _____ Name: _____

Relationship to Patient: _____ Relationship to Patient: _____

Social Security #: _____ DOB: ___/___/___ Social Security #: _____ DOB: ___/___/___

Address (if different): _____ Address (if different): _____

Home / Cell Phone: _____ Home / Cell Phone: _____

Email: _____ Email: _____

Employer: _____ Phone: _____ Employer: _____ Phone: _____

INSURANCE INFORMATION Need copies of Insurance Cards

Primary Insurance Company Name: _____ Employer: _____
Insurance

Policyholder's Name: _____ DOB: ___/___/___ Relation to Patient: _____

Secondary Insurance Company Name: _____ Employer: _____
Insurance

Policyholder's Name: _____ DOB: ___/___/___ Relation to Patient: _____

OTHER Insurance Company Name: _____ Employer: _____
Work Comp
Auto Insurance Company Address: _____ Phone: _____

Adjusters Name: _____

Claim #: _____

Patient or Authorized Person's Signature: I authorize the release of any medical information necessary to process insurance claims and also certify that the above information is correct. I authorize payment of insurance benefits to Todd Mosenthal, DC Lorie Greenwood, DC Cathy Perryman, PT

Payment is expected upon completion of service. Balances unpaid after 30 days are subject to a late payment of 1.5% per month or 18% per annum.

Patient or Authorized Person

Date

Mosenthal Spine Clinic

Financial Policy

Thank you for choosing The Mosenthal Spine Clinic. We are committed to providing the best care for our patients and making your experience a positive one in every way we can.

Payment Policy: We ask that you read through the financial policy and sign at the bottom prior to treatment. Full payment is due at the time of service unless prior arrangements have been made with our office. We accept CASH, CHECKS, or CREDIT CARDS.

Regarding Insurance: We participate with a number of medical insurance plans that we will contact to verify eligibility and benefits, and you are encouraged to call your insurance to obtain benefit information.

Insurance Referrals: If your plan requires a referral from your Primary Care Physician, it is your responsibility to obtain it before seeking treatment from us. If a claim is denied due to a lack of referral you will be responsible for the charges.

Interest: Interest at the rate of 1.5% per month or 18% per annum will be charged on balances unpaid after 30 days.

Missed Appointments: We do expect 24 hours notice of cancellation, as a courtesy to the Doctors, Staff and Other Patients.

Minor Patients: Parents or guardians are responsible for all charges for minor children.

Please let us know if you have any questions regarding our Financial Policy.

I have read the Financial Policy; I understand and agree to this Financial Policy.

Person Financially Responsible Signature

Please PRINT Name

Date