

The Mosenthal Spine Clinic
199 Heater Road Lebanon, NH 03766

Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Birth date _____ Home Phone _____
Employer _____ Work Phone _____
Doctor's name and office location _____
How did you happen to choose this office? PCP Referral ___ Personal Referral ___
Yellow Pages ___ Office Sign ___ Other (please list) _____
If Primary Care Physician or personal, could you please give us his/her name(s) as we would like to send them a thank-you card _____
Email (if you would like to receive our digital newsletter) _____

FINANCIAL POLICY

A. INSURANCE

If your insurance has been verified by our office and your deductible has been met, your responsibility will be to pay for that portion or percentage of your care not covered by your insurance at the time services are rendered. If your deductible has not been met or your insurance cannot be verified by our office, payment is due at the time services are rendered. We would ask you to remember that we do not have a contract with your insurance company....you do and that payment for our service to you is your responsibility.

B. AUTO/PERSONAL INJURY

Most auto insurances cover our services to you 100%. If you are in an accident, we will render care provided you have an attorney or proper auto insurance coverage. However, if for any reason your visits are not paid for you will be responsible for them.

C. WORK-RELATED INJURY

Our services for on-the-job injuries are normally covered 100% by insurance. Providing you and your employer have met the requirements of the Industrial Commission, we will render care and direct bill the insurance company.

D. NON-INSURANCE

For those patients who do not have insurance coverage for our services, you may pay by cash, check, VISA or MasterCard. All fees for services rendered are expected to be paid at the time of service.

If you have any questions about our financial policy, please ask before services are rendered. Thank You!

Agreement to Pay/Assignment of Benefits/Medical Release/Consent to Treat Minor Child

I understand and agree that all fees for professional services rendered in my behalf are my personal responsibility and are due and payable at the time services are performed unless otherwise stipulated as above. I hereby authorize and direct my insurance carrier to pay all benefits which may be due me according to my policy directly to Mosenthal Spine Clinic in order to be applied to my account. I hereby authorize and direct the Mosenthal Spine Clinic to release all medical information necessary to process this claim. I hereby authorize this office to administer medical treatment deemed necessary to myself. I hereby request and consent to the performance of medical treatment on the patient named below, for whom I am legally responsible, by the medical doctor or physician assistant working at the clinic or office. I understand and am informed that, as in the practice of medicine there are some risks to treatment. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. I have read or have read to me, the above consent and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

Signature _____ Date _____