

BERGEY SPINE INSTITUTE
900 E. Washington St. Suite 200
Colton, CA 92324
Phone: 909-824-2422 Fax: 909-824-8234

PATIENT CONSENT FORM

Authorization for treatment and release of information:

- 1 I consent for this provider to render the treatment set forth as ordered by my physician
- 2 I give authorization for treatment to be provided in areas not totally isolated from other patients and personnel.
- 3 This authorization, or photocopy of same, authorizes the release of any medical information necessary for treatment and/or to process claims for services rendered by this provider

Signature of Patient/Guardian _____ Date: _____
Guardian Name (Please Print) _____ Relationship: _____

Reimbursement Coverage

I request and authorize my insurance and/or Medicare to make payments for benefits on my behalf to Bergey Spine Institute.

Signature of Patient/Guardian _____ Date: _____

If policyholder is other than the patient, please complete the following. I, the policyholder, request and authorize my insurance company and or Medicare to make payments for benefits on behalf of this patient to Bergey Spine Institute.

Signature of Policyholder _____ Date: _____

PLEASE PROVIDE PROOF OF INSURANCE COVERAGE UPON COMPLETION OF THIS FORM

Assignment and Authorization: I authorize the release of any medical information necessary to process insurance claims on my behalf. I authorize payment of medical benefits directly to Bergey Spine Institute for services and supplies provided to me. A copy of this authorization shall be considered as valid as the original and valid for the duration of my care. I understand I am liable for all charges incurred should my insurance not pay for these services (Except for Workers Compensation).

Signature _____ Date: _____
Please Print Name _____