

South Windsor Neck and Back, LLC

PATIENT INFORMATION

PERSON RESPONSIBLE FOR PAYMENT

Name:	Name:
Address:	Address:
City:	City:
State: Zip:	State: Zip:
Home Phone:	Home Phone:
Date of Birth:	Date of Birth:
Employer:	Employer:
Employer Address:	Employer Address:
Work Phone:	Work Phone:
Soc. Sec. #: <input type="checkbox"/> <input type="checkbox"/>	Relationship to Patient: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Occupation:	
Male: Female:	Single , Married , Divorced , Widowed
Spouse's Name:	
Emergency Contact:	Primary Care Physician:
Phone Number:	Address:
	Phone Number:

PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE

I understand that my insurance company may require a referral for care. If I do not have a valid referral, my insurance company could refuse to pay for my care. If my insurance company requires referrals and I fail to obtain a valid referral, I agree to assume responsibility for payment of my charges.

I hereby give South Windsor Neck and Back, LLC permission to release my records to my other doctors and to my health insurance company, including psychiatric, substance abuse and AIDS related information. Further, I hereby acknowledge that I have been given access to, and reviewed, a copy of the practice PRIVACY POLICY and I understand that I may contact the office manager if I have further questions or complaints and that I am entitled to receive a written copy of these policies at my request. I also understand that I am entitled to receive updates upon request if the PRIVACY POLICY is amended or changed in a material way.

Signature: _____ *Date:* _____

1330 Sullivan Avenue
South Windsor, CT 06074

Tel. (860) 644-2437
Fax (860) 644-8590