SPINE SURGERY OF IDAHO
A PIONEER AND LEADER IN EFFECTIVE TREATMENTS

STEPHEN MARANO, M.D. JAMES COOK PA-C

PATIENT NAME _____
(LAST) (FIRST) (MIDDLE INITIAL)

MAILING ADDRESS _____
(NUMBER/STREET) (APT #) (CITY) (STATE) (ZIP)

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

OCCUPATION _____ EMPLOYER _____

SOCIAL SECURITY # _____ E-MAIL _____

☐MALE ☐FEMALE MARITAL STATUS _____ DATE OF BIRTH _____ AGE _____
(SINGLE; MARRIED; DIVORCED; WIDOWED)

SPOUSE'S NAME _____ DATE OF BIRTH _____
(LAST) (FIRST) (MIDDLE INITIAL)

SOCIAL SECURITY # _____ CELL PHONE _____ WORK PHONE _____

OCCUPATION _____ EMPLOYER _____

PARENT (if minor)**/PERSON RESPONSIBLE FOR PAYMENT** _____

RELATIONSHIP TO PATIENT _____ SOCIAL SECURITY # _____ DATE OF BIRTH _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

OCCUPATION _____ EMPLOYER _____

NEAREST RELATIVE/FRIEND NOT LIVING WITH PATIENT _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

PRIMARY CARE/FAMILY DOCTOR _____

REFERRING/REQUESTING DOCTOR _____

INSURANCE INFORMATION

PRIMARY INS. COMPANY _____ SECONDARY INS. COMPANY _____

POLICY/CLAIM # _____ POLICY/CLAIM # _____

GROUP # _____ GROUP # _____

PHONE # _____ PHONE # _____

PRIMARY POLICY HOLDER _____ PRIMARY POLICY HOLDER _____

INS. CONTACT PERSON _____ INS. CONTACT PERSON _____

IF INJURY: ☐WORK RELATED ☐AUTOMOBILE ACCIDENT ☐OTHER

DATE OF INJURY: _____

OVER ➡

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Financial Policy and Agreement

(This must be read and signed prior to seeing the doctor)

We are committed to providing you with the best possible medical care. To do so, we will need your cooperation and understanding of our payment policy. Payment for services is due at the time the service is rendered, unless payment arrangements have been approved in advance. We accept cash, check, Care Credit, MasterCard Visa, and Discover. We will file to your insurance; however, all charges are the patient's or guarantor's responsibility. Co-pay percentages not paid by your insurance company are your responsibility and monthly payment plans are available. We will give you 60 days after your insurance pays to pay your balance. There will be an 18% interest charged on any unpaid balance after this time. Special financial arrangements may be considered for patients left with a large balance after surgical procedures. Such arrangements must be worked out and approved by the front office in advance.

You are liable for all costs and reasonable attorney's fees incurred in collecting any balance due that has not been paid as agreed.

If you have any questions about our office policy or any uncertainty regarding insurance coverage, please do not hesitate to call and ask. *We are here to help you!*

I understand and accept all terms outlined in this agreement.

_____ _____

Signature of responsible party Date

Assignment of my rights and benefits

For services provided by Stephen R. Marano M.D., I authorize and instruct Centers of Medicare and Medicaid, formerly The Healthcare Finance Administration, to pay my claim for medical benefits directly to Stephen R. Marano M.D., or if my health insurance policy prohibits direct payment to the doctor, mail the checks(s) to me in care of: Stephen R. Marano M.D.

Information release

I authorize Stephen R. Marano M.D. to release any information acquired in the course of my treatment to health insurance providers, physicians, or Centers of Medicare and Medicaid involved in this case.

I authorize any physician, hospital, or medical care facility to provide all information on my medical history and treatment to Stephen R. Marano M.D.

_____ _____

Signature of responsible party Date