

## Delaware Spine Institute General Information Sheet

1673 South State Street  
Suite B  
Dover, DE 19901  
302-674-8444

100 South Main Street  
Second floor Suite 200  
Smyrna, DE 19977  
302-659-4460

An appointment has been made for you with Delaware Spine Institute. We emphasize the team approach to the diagnosis, treatment and rehabilitation of patients with back and neck pain. Our physicians have completed residencies and certification in spine care. They share a common philosophy, which is the importance of establishing the cause or source of spinal and extremity pain before a precise, tailored management plan can be provided. The specific methods of diagnosis and treatment will be well explained along with the rational and scientific basis for any intervention. No diagnostic test or treatment intervention will be undertaken without your active involvement in the decision making process.

Likely, another physician has referred you to us. To insure a complete assessment of your problem, it is critical that you bring with you:

- All medical records related to your pain that we will be treating you for.
- X-ray films (plain films, CAT scan, MRI myelograms, Bone Scans) NO CD's Actual films.
- Medication list

Referring physician's office should assist you in obtaining your x-rays and medical records. This will make your visitation time with the physician much more valuable and productive.

In order to minimize the time you may spend waiting to see the physician, we ask that you take the first important step in being actively involved in your care. That is you need to read and fill out the following forms prior to coming to our office or your appointment may be rescheduled:

- Patient registration sheet
- History Form
- Notice of Privacy Practice policy

Filling out these materials enables our team to better care for you and will shorten your time in the office while increasing your direct Physician time. If you have any question regarding these forms or your appointment, please call us at 302-674-8444.

Our payment policy requires patients to pay their co-payments prior to their evaluation or payment in full for those without insurance coverage. We will verify insurance coverage prior to your appointment date: however it is not our responsibility to provide a referral if your insurance carrier requires this.

We look forward to seeing you and invite you to call with any questions office phone 302-674-8444.

Sincerely,  
Ronald Lieberman, DO and the Delaware Spine Institute Staff

**Delaware Spine Institute Patient Registration Sheet**

Patient Name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Home Phone(\_\_\_\_) \_\_\_\_\_ Work/alternate phone(\_\_\_\_) \_\_\_\_\_

May we contact you at home? \_\_\_\_\_ Email Address \_\_\_\_\_

Marital Status (circle one) S/M/D/W Gender: Male/Female Social Security# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Mailing Address (If different from above) \_\_\_\_\_

Referring Physicians name \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

If a doctor did not refer you to our practice, how did you hear about us? \_\_\_\_\_

**Insurance Information**

Primary Insurance (please check one)

\_\_\_\_\_ Health Insurance \_\_\_\_\_ Auto Insurance \_\_\_\_\_ Worker's Comp \_\_\_\_\_ Other

Company Name \_\_\_\_\_

Address \_\_\_\_\_

Adjuster \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_

Policy# \_\_\_\_\_ Claim# \_\_\_\_\_

Insured Name and DOB (if different from patient) \_\_\_\_\_

Secondary Insurance (please check one)

\_\_\_\_\_ Health Insurance \_\_\_\_\_ Auto Insurance \_\_\_\_\_ Worker's Comp \_\_\_\_\_ Other

Company Name \_\_\_\_\_

Address \_\_\_\_\_

Adjuster \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_

Policy# \_\_\_\_\_ Claim# \_\_\_\_\_

Insured Name and DOB (if different from patient) \_\_\_\_\_

Date of Injury \_\_\_\_\_ Do you have an Attorney? \_\_\_\_\_ if so,

Attorney Name \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

**Worker's Comp Authorization**

I authorize the release of medical information regarding my work injury sustained on \_\_\_\_\_ to my employer \_\_\_\_\_

Patient Signature \_\_\_\_\_

**DELAWARE INTERVENTIONAL SPINE ASSOCIATES**  
**HISTORY & PHYSICAL (PRE-PROCEDURE EVALUATION)**

To help assure that you are provided the highest quality of care possible, we would appreciate your completing this questionnaire and bringing it with you to your appointment.

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex: M / F Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Which is your dominant hand? (circle one) Right / Left / Ambidextrous

Your referring doctor (and address if known) \_\_\_\_\_

Your primary physician (and address if known) \_\_\_\_\_

1. When did your present pain begin? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

2. Where is your present pain? \_\_\_\_\_

3. How did your present pain begin? (circle the best answers)

- 1 = unknown
- 2 = occurred while sitting
- 3 = occurred while lifting
- 4 = occurred while bending
- 5 = occurred while walking
- 6 = occurred during an athletic activity
- 7 = occurred as a result of a fall
- 8 = occurred as a result of an auto accident
- 9 = occurred as a result of trauma
- 10 = occurred as a result of injury at work
- 11 = other, describe: \_\_\_\_\_

3. Have your symptoms changed since they began, and if so, how?  Yes  No

4. Check the following words which best describe your symptoms:

- Constant  Intermittent  Sharp  Dull  Electrical  Burning
- Tingling  Numbness  Skin Sensitivity  Spasm  Aching

5. I have weakness (not related to pain):  All the time  Sometimes  Never

If yes, when and where? \_\_\_\_\_

**PRE-PROCEDURE SCREENING/EVAL WORK-UP CONTINUED:**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Date:** \_\_\_\_\_

5. When is your pain worse? Night Day Does it ever awaken you? Yes No

6. If you have back or leg pain, what makes it worse? What makes your pain better?

	Worsens Pain	Relieves Pain	No effect on pain
Sitting	_____	_____	_____
Standing	_____	_____	_____
Rising from sitting	_____	_____	_____
Leaning forward	_____	_____	_____
Walking	_____	_____	_____
Lying on your:			
Side	_____	_____	_____
Back	_____	_____	_____
Stomach	_____	_____	_____
Driving	_____	_____	_____
Coughing/Sneezing	_____	_____	_____
Bending forward	_____	_____	_____
Extending backwards	_____	_____	_____
Bowel movements	_____	_____	_____
Sexual activity	_____	_____	_____
Ice	_____	_____	_____
Heat	_____	_____	_____
Pain medications	_____	_____	_____
Other (describe):	_____	_____	_____

7. If you have head, shoulder, neck or arm pain, what makes it worse? What makes you pain better?

	Worsens Pain	Relieves Pain	No effect on pain
Looking up	_____	_____	_____
Looking down	_____	_____	_____
Turning head	_____	_____	_____
Coughing/Sneezing	_____	_____	_____
Laying down	_____	_____	_____
Ice	_____	_____	_____
Heat	_____	_____	_____
Pain medications	_____	_____	_____
Other (describe):	_____	_____	_____



**PRE-PROCEDURE SCREENING/EVAL WORK-UP CONTINUED:**

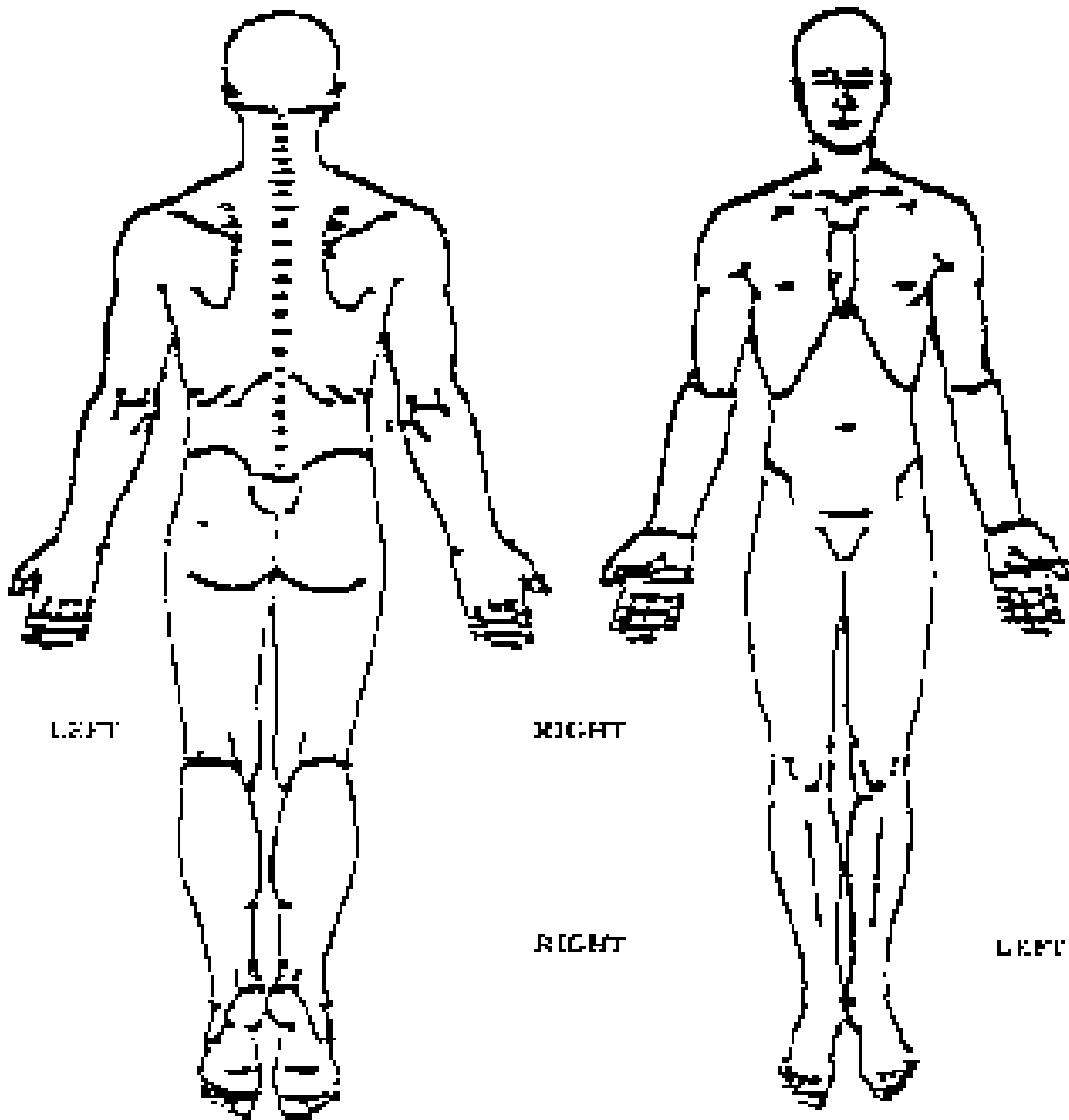
**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PLEASE SHADE IN YOUR PAINFUL AREAS ON THE PAIN MAP BELOW USING THE FOLLOWING COLOR(S) THAT BEST DESCRIBES THEIR CHARACTER:**

ACHES-----YELLOW  
PINS AND NEEDLES-----GREEN  
STABBING-----RED

BURNING-----BLUE  
NUMBNESS-----BLACK

**\*COLORED PENS PROVIDED AT APPOINTMENT**



**PROCEDURE SCREENING / EVALUATION WORK-UP CONTINUED:**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Please list all your current medications (including Pain medication) and dose if known:  
(continue on back if necessary)

MEDICATION	DOSE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

10. Please check the following illnesses you have had or have now:

- |  |                                     |  |   |
|--|-------------------------------------|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pneumonia  | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Asthma        | <input type="checkbox"/> Thyroid    | <input type="checkbox"/> Bleeding too Easily | <input type="checkbox"/> Osteoarthritis       |
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Epilepsy   | <input type="checkbox"/> Colon Disease       | <input type="checkbox"/> Stomach Ulcers       |
| <input type="checkbox"/> Stroke        | <input type="checkbox"/> HIV/AIDS   | <input type="checkbox"/> Vascular disease    | <input type="checkbox"/> Kidney trouble       |
| <input type="checkbox"/> Anxiety       | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Bladder trouble      |
| <input type="checkbox"/> Anemia        | <input type="checkbox"/> Fractures  | <input type="checkbox"/> Migraine Headaches  | <input type="checkbox"/> Genetic disorder     |

Cancer (Specify): \_\_\_\_\_

Other (Specify): \_\_\_\_\_

**ARE YOU ALLERGIC TO:**

	YES	NO
CONTRAST DYE	<input type="checkbox"/>	<input type="checkbox"/>
IODINE / SHELL FISH	<input type="checkbox"/>	<input type="checkbox"/>
LOCAL ANESTHETICS	<input type="checkbox"/>	<input type="checkbox"/>
STEROIDS	<input type="checkbox"/>	<input type="checkbox"/>
VERSED	<input type="checkbox"/>	<input type="checkbox"/>
LATEX	<input type="checkbox"/>	<input type="checkbox"/>

OTHER: \_\_\_\_\_ :

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

**CURRENT ILLNESSES:**

	YES	NO
TAKING ANTIBIOTICS IN THE PAST MONTH?	<input type="checkbox"/>	<input type="checkbox"/>
ANY INVASIVE PROCEDURES IN THE LAST MONTH? (EX: ROOT CANAL, D&C, TOOTH EXTRACTION) COMMENT: _____	<input type="checkbox"/>	<input type="checkbox"/>
ANY URINARY TRACT INFECTION, STOMACH INFECTION, LUNG INFECTION IN THE PAST MONTH? COMMENT: _____	<input type="checkbox"/>	<input type="checkbox"/>

**PREVIOUS NON-SPINAL SURGERY:** Please check the box next to any surgical procedures you have had:

- Angioplasty  Appendectomy  Gallbladder surgery  Colon resection  Coronary artery bypass
- Fracture repair  Hemorrhoid surgery  Hernia repair  Hysterectomy,  Kidney surgery  Lumpectomy
- Mastectomy  Prostatectomy  Tonsillectomy Other \_\_\_\_\_

**Have you had Neck (Cervical) spine surgery?**  Yes  No

If yes, Date \_\_\_\_\_, Surgeon & type of surgery: \_\_\_\_\_

For what symptoms? \_\_\_\_\_

Results:  WORSE  SAME  BETTER

**Other Neck surgery:**

Date \_\_\_\_\_, Surgeon & type of surgery: \_\_\_\_\_

Results:  WORSE  SAME  BETTER

Date \_\_\_\_\_, Surgeon & type of surgery: \_\_\_\_\_

Results:  WORSE  SAME  BETTER

**Have you had Low back (Lumbar) spine surgery?**  Yes  No

If yes, Date \_\_\_\_\_, Surgeon & type of surgery: \_\_\_\_\_

For what symptoms? \_\_\_\_\_

Results:  WORSE  SAME  BETTER

**Other Low back surgery:**

Date \_\_\_\_\_, Surgeon & type of surgery: \_\_\_\_\_

Results:  WORSE  SAME  BETTER

Date \_\_\_\_\_, Surgeon & type of surgery: \_\_\_\_\_

Results:  WORSE  SAME  BETTER

Patient Name: \_\_\_\_\_  
 Date: \_\_\_\_\_ DOB: \_\_\_\_\_

Please check any of the following problems you have had:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Unexplained fever            | <input type="checkbox"/> Blurred vision  | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Weight loss more than 10 lbs | <input type="checkbox"/> Red, itchy eyes | <input type="checkbox"/> Difficulty hearing    |
| <input type="checkbox"/> Weight gain more than 10 lbs |  | <input type="checkbox"/> Sinus trouble         |
| <input type="checkbox"/> Generally feel ill           |  | <input type="checkbox"/> Sore throat           |

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Angina (chest pain) | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Loss of appetite    |
| <input type="checkbox"/> Leg swelling        | <input type="checkbox"/> Chronic cough       | <input type="checkbox"/> Trouble with bowels |
| <input type="checkbox"/> Racing heart rhythm | <input type="checkbox"/> Wheezing            | <input type="checkbox"/> Black tarry stools  |
|  | <input type="checkbox"/> Pleurisy            | <input type="checkbox"/> Ulcer pain          |

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Blood in urine                     | <input type="checkbox"/> Joint stiffness           | <input type="checkbox"/> New skin sores            |
| <input type="checkbox"/> Burning during urination           | <input type="checkbox"/> Joint swelling            | <input type="checkbox"/> New skin lumps            |
| <input type="checkbox"/> Trouble urination                  | <input type="checkbox"/> Warm, red joints          | <input type="checkbox"/> Skin discolorations       |
| <input type="checkbox"/> Difficulty with balance/walking    | <input type="checkbox"/> Anxiety                   | <input type="checkbox"/> Abnormal bleeding         |
| <input type="checkbox"/> Easily confused                    | <input type="checkbox"/> Depression                | <input type="checkbox"/> Easy bruising or bleeding |
| <input type="checkbox"/> Headaches                          | <input type="checkbox"/> Unusual stress at home    | <input type="checkbox"/> Night sweats or chills    |
| <input type="checkbox"/> Difficulty starting arm/leg motion |  | <input type="checkbox"/> Day sweats or chills      |
|   |  | <input type="checkbox"/> Swollen lymph nodes       |
| <input type="checkbox"/> Excessive thirst                   | <input type="checkbox"/> Change in menstrual cycle |  |
| <input type="checkbox"/> Cannot relax                       | <input type="checkbox"/> Unusual vaginal bleeding  |  |
| <input type="checkbox"/> Extreme fatigue                    |  |  |

11. Please check the box next to any disease diagnosed in your blood relatives:  Arthritis  Bleeding disorders  
 Diabetes  Epilepsy  Heart disease  Stroke  High blood pressure  Spine pain

12. Do you now, or did you ever smoke?  No  Yes  Quit (when): \_\_\_\_\_  
 How many packs per day? \_\_\_\_\_ How many years total? \_\_\_\_\_

13. Do you drink alcohol?  No  Yes \_\_\_\_\_ drinks/week.

14. Do you now, or have you ever had a drug or alcohol problem?  No  Yes  
 Please explain: \_\_\_\_\_

15. Marital Status:  Single  Married  Divorced  Widowed

16. How many children do you have? \_\_\_\_\_ How far did you go in school? \_\_\_\_\_

17. Work:  Employed Full Time  Employed Part time  Retired  
 Regular Duty  Light Duty  Disability

Employer: \_\_\_\_\_  
 Job Description: \_\_\_\_\_  
 Years at current job: \_\_\_\_\_

18. My hobbies include: \_\_\_\_\_

Name: \_\_\_\_\_  
Date: \_\_\_\_\_ DOB: \_\_\_\_\_

Please read: This questionnaire has been designed to give your health care provider information as to how your pain affects your daily activities. Be sure that these are your answers. Do not ask someone else to complete this questionnaire for you. Please mark an "X" along the line that expresses your thoughts from 0-100 in each section.

**Section I: Pain and Intensity**

To what degree do you rely on pain medications or pain relieving substances for you to be comfortable?

None \_\_\_\_\_ Some \_\_\_\_\_ All the time \_\_\_\_\_  
0% (\_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_) 100%

**Section II: Personal Care**

How much does pain interfere with your personal care (getting out of bed, teeth brushing, dressing, etc)?

None(no pain) \_\_\_\_\_ Some \_\_\_\_\_ I can't get out of bed \_\_\_\_\_  
0% (\_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_) 100%

**Section III: Lifting**

How much limitation do you notice in lifting?

None \_\_\_\_\_ Some \_\_\_\_\_ I can't lift anything \_\_\_\_\_  
0% (\_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_) 100%

**Section IV: Walking**

Compared to how far you could walk before your injury or back trouble, how much does pain restrict walking now?

The same \_\_\_\_\_ Almost the same \_\_\_\_\_ Very little \_\_\_\_\_ I cannot walk \_\_\_\_\_  
0% (\_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_) 100%

**Section V: Sitting**

Back pain limits my sitting in a chair to:

None \_\_\_\_\_ Some \_\_\_\_\_ I can't sit at all \_\_\_\_\_  
0% (\_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_) 100%

**Section VI: Standing**

How much does pain interfere with your tolerance to stand for long periods?

None(same as before) \_\_\_\_\_ Some \_\_\_\_\_ I can't stand \_\_\_\_\_  
0% (\_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_) 100%

**Section VII: Sleeping**

How much does pain interfere with your sleeping?

None(same as before) \_\_\_\_\_ Some \_\_\_\_\_ I can't sleep at all \_\_\_\_\_  
0% (\_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_) 100%

**Section VIII: Social Life**

How much does pain interfere with your social life (dancing, games, going out, eating with friends, etc.)?

None \_\_\_\_\_ Some \_\_\_\_\_ No activities \_\_\_\_\_  
Same as before \_\_\_\_\_ total loss \_\_\_\_\_  
0% (\_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_) 100%

**Section IX: Traveling**

How much does pain interfere with traveling in a car?

None \_\_\_\_\_ Some \_\_\_\_\_ I can't travel \_\_\_\_\_  
0% (\_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_) 100%

**Section X: Vocational**

How much does pain interfere with your job?

None \_\_\_\_\_ Some \_\_\_\_\_ I can't work \_\_\_\_\_  
0% (\_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_) 100%

**Section XI: Anxiety/Mood**

How much control do you feel that you have over demands made on you?

Total (no change) \_\_\_\_\_ Some \_\_\_\_\_ None \_\_\_\_\_  
0% (\_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_) 100%

**Section XII: Emotional Control**

How much control do you feel you have over your emotions?

Total (no change) \_\_\_\_\_ Some \_\_\_\_\_ None \_\_\_\_\_  
0% (\_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_) 100%

**Section XIII: Depression**

How depressed have you been since the onset of pain?

Not depressed \_\_\_\_\_ Overwhelmed by \_\_\_\_\_  
significantly \_\_\_\_\_ depression \_\_\_\_\_  
0% (\_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_) 100%

**Section XIV: Interpersonal Relationships**

How much do you think your pain has changed your relationships with others?

Not changed \_\_\_\_\_ Drastically changed \_\_\_\_\_  
0% (\_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_) 100%

**Section XV: Social Support**

How much support do you need from others to help you during this onset of pain (taking over chores, meals, etc)?

None needed \_\_\_\_\_ All the time \_\_\_\_\_  
0% (\_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_) 100%

**Section XVI: Punishing Response**

How much do you think others express irritation, frustration or anger toward you because of your pain?

None \_\_\_\_\_ Some \_\_\_\_\_ All the time \_\_\_\_\_  
0% (\_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_) 100%

Patient Name: \_\_\_\_\_  
Date: \_\_\_\_\_ DOB: \_\_\_\_\_

**Rate each of the 13 items as to how it applied to you over the past week by checking one of the four phrases for each statement. Please answer every statement.**

	<b>Not <u>At all</u></b>	<b>A little/ <u>slightly</u></b>	<b>A great deal/ <u>quite a bit</u></b>	<b>Extremely/could <u>not have been worse</u></b>
Feeling hot all over	_____	_____	_____	_____
Sweating all over	_____	_____	_____	_____
Dizziness	_____	_____	_____	_____
Blurring of vision	_____	_____	_____	_____
Feeling faint	_____	_____	_____	_____
Nausea	_____	_____	_____	_____
Pain or ache in stomach	_____	_____	_____	_____
Stomach churning	_____	_____	_____	_____
Mouth becoming dry	_____	_____	_____	_____
Muscles in neck aching	_____	_____	_____	_____
Legs feeling weak	_____	_____	_____	_____
Muscles twitching and jumping	_____	_____	_____	_____
Tense feeling across forehead	_____	_____	_____	_____

\_\_\_\_\_  
Signature of person completing these forms

\_\_\_\_\_  
Date

### **Delaware Spine Institute Financial Policy**

Thank you for choosing Delaware Spine Institute as your health care provider. The following is our financial policy. If you have any questions or concerns about our payment policies please do not hesitate to ask our business office personnel. We ask that all patients read and sign our financial policy as well as complete our patient information forms prior to seeing the doctor.

Patient's portion of payment is due at the time of service are rendered unless prior arrangements have been made with the business office manager.

We accept assignment with most major insurance companies and participating provider plans. However you must understand that:

- Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you not your insurance carrier.
- ALL charges are your responsibility weather your insurance company pays or not.
- Fees for service, along with unpaid deductibles and co-payments, are due at the time of treatment.
- If the insurance company does not pay your balance in full within 30days we ask that you contact the carrier to request prompt payment. Please inform our office of the carrier's response.
- Returned checks will be subject to \$30.00 collection charge. We will notify you by certified letter. If the check is not picked up within 10 days, the check will be turned over to law enforcement.
- Unpaid balances over 90 days are subject to collections via small claims court, attorney, and/or collection agency with applicable collection fee. Collection fees are the responsibility of the patient.

We understand that temporary financial problems may affect timely payments of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Authorization to Release and Assign Insurance Benefits: I authorize release of any information required to act on any insurance claim and permit photographic or other facsimile reproduction of this authorization to be used in place of the original assignment. I here by assign to Delaware Spine Institute the medical and /or surgical benefits I am entitled from my insurance company and/or Medicare.

This authorization is in effect for all future claims until I choose to revoke it in writing.

The undersigned understand and agree to the above financial policy. I understand that I am financially responsible for all charges incurred for my medical treatment.

\_\_\_\_\_  
Patient Signature (or authorized signee)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient

\_\_\_\_\_  
Relationship to patient if not patient

\_\_\_\_\_  
Patient Date of birth

\_\_\_\_\_  
Authorized witness