



Columbia University  
Medical Center

THE SPINE CENTER  
Neurological Institute  
710 West 168<sup>th</sup> Street, 5<sup>th</sup> Floor  
New York, NY 10032  
Telephone: (212) 305-9625 Fax: (212) 342-1540

Date: \_\_\_\_\_

**PATIENT INFORMATION SHEET**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

D.O.B.: \_\_\_\_\_ S.S.#: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone #:(home) \_\_\_\_\_ (work/mobile) \_\_\_\_\_

Mother's Maiden Name: \_\_\_\_\_ Father's Full Name: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Tele: \_\_\_\_\_

Notes: \_\_\_\_\_

**CLINICAL**

How did you hear about the Spine Center? \_\_\_\_\_

Referring Physician \_\_\_\_\_ Tele.# \_\_\_\_\_

PCP Physician: \_\_\_\_\_ Tele.# \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Surgery Date (if applicable): \_\_\_\_\_

**ASSIGNMENT OF BENEFITS for Physical Therapy:** I hereby authorize assignment of payment directly to *Neurosurgical Associates, P.C.* at the Spine Center. If my current policy prohibits direct payment to the providers I will forward a check to the above address. I understand that I am financially responsible for charges that are not covered by my insurance. *I understand that if I do not have a referral from a physician, dentist, podiatrist, or nurse practitioner there is a possibility that treatment may not be covered by my health care plan or insurer and that my treatment may be a covered expense if rendered pursuant to such referral.*

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Treating P.T. Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**I am aware that Physical Therapy does not participate with my Commercial Insurance.**

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_