



12189 W 64th Ave. Ste 102

Arvada, CO

303-424-9549

arvadasportandspine.com

Legal Name: First _____ Middle Initial: ____ Last: _____ Preferred Name: _____
Address: _____ City: _____ State: ____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Date of Birth: _____ Sex: ____ Email: _____
Social Security Number: _____ Marital Status: _____ Spouse Name: _____
Emergency Contact Name: _____ Emergency Contact Phone: _____
____ Employed ____ FT Student ____ PT Student ____ Other Employer: _____ Type of Work: _____

How did you hear about Arvada Sport and Spine Group? Please circle all that apply: Insurance Website Newsletter
If the following we want to thank them: Family/Friend: _____ Provider: _____ Other: _____

IF A MINOR: Parent's Legal Name: First: _____ Middle Initial: ____ Last: _____
Parent's DOB: _____ Parent's Employer: _____ Parent's Work Phone: _____
Parent's Home Phone: _____ Parent's Cell Phone: _____
I the undersigned parent of legal guardian of _____, a minor, do hereby authorize and
consent to treatment by Arvada Sport and Spine Group. _____ (parent or guardian signature)

A card on file is required when scheduling an appointment. At least **24 business hours'** notice is required to cancel or reschedule without a fee. Cancellations or rescheduling with less than 24 business hours' notice, as well as missed appointments, are subject to a **\$50 fee per provider** scheduled, which will be charged to the card on file. Appointments may be subject to cancellation if payment cannot be secured.

As a courtesy, we perform a **complimentary insurance benefits verification** and collect copays, deductibles, coinsurance, or other estimated patient responsibility based on the information provided by your insurance company at the time of service. **Please note that benefit information is not a guarantee of payment or coverage.** Insurance coverage is ultimately a contract between you and your insurance carrier, and the final patient responsibility may differ once claims are processed. By signing our consent and financial forms, you acknowledge that you are financially responsible for any balance determined by your insurance carrier according to your plan benefits.

Patient Policies Acknowledgment:

I acknowledge that I have read and understand the following office policies and consent forms:

- Patient Financial Responsibility Statement
- Appointment Cancellation Policy
- Additional Office Policies & Acknowledgments

By signing below, I acknowledge that I have received, reviewed, and understand these policies and agree to follow them.

Patient/Parent/Guardian Signature: _____ Date: _____