Patient Name:_____
Date of Birth:_____
Date of Service:_____

WELCOME TO OUR PRACTICE

For over thirty years, we have been treating pediatric and adult patients with scoliosis and other spinal deformities and disorders. We pride ourselves on providing the highest level of care to our patients in a compassionate environment. Our physicians and staff are professionals who use the latest technologies and treatment options. However, we never lose sight of our first priority to care for our patients. We treat our patients as we would treat our own family.

Notice of Financial Obligations: Your office visit today generates a bill for services rendered. It is your responsibility to pay for or arrange for the payment of all services rendered during the course of this office visit. Your insurance company may pay for all or part of the bill. It is your responsibility to know what benefits are specifically covered by your insurance company. If Dr. Lonner or Dr. Murthy is a participating physician with your insurance company please be aware that your specific plan may or may not cover all services rendered. All services not paid for by your insurance company are considered "non-covered benefits" and they are solely your responsibility. If your insurance company requires referrals or preauthorization from your personal physician or other specific requirements, it is your responsibility to know these rules and obtain all proper referrals and documentation necessary for payment. If you do not adhere to your insurance plans requirements, which result in non-payment of fees to the doctors or reduced payment, you understand that you are responsible to pay the full amount of the bill. You are responsible to pay for all services that your insurance company deems as "not medically necessary," "non-covered benefits," "included as part of other services rendered," or "not cleared by insurance company to be done by the doctors." This includes but is not restricted to: the fee for today's consult whether or not any type of procedure was performed, all xrays and injections. If you are a member of Medicare, you are responsible for all financial obligations of that program, which include your yearly deductible and the 20% patient responsibility.

I have received, read, and understand the above information and agree to all the provisions.

I have reviewed the "NOTICE OF PRIVACY PRACTICES" and agree with its provisions.

Patient, Parent or Guardian's Signature_____ Date_____