



PATIENT REGISTRATION

PATIENT INFORMATION

Last Name _____ First Name _____ Middle _____

Street Address _____ Apt _____

City _____ State _____ Zip _____ Social Security # _____

Home Phone () _____ Cell Phone () _____ Date of Birth _____

Email _____

May we contact you via email/text for appointment reminders and other communications? Y N

EMERGENCY CONTACT INFORMATION

Emergency Contact _____ Relationship _____ Phone () _____

INSURANCE INFORMATION

Primary Insurance _____ Policy Holder's Name _____

Address _____ City _____ State _____ Zip _____

Insured ID# _____ Group # _____ Phone () _____

Work Comp Insurance _____ Adjuster's Name _____

Address _____ City _____ State _____ Zip _____

Claim # _____ DOI _____ Phone () _____

Release of Information: I authorize the release of my medical records to any insurance company, adjuster, examiner or attorney requesting information regarding my treatments. A photocopy of this release shall be considered effective and as valid as the original.

Signature of Patient/ Guarantor/ Guardian _____ Date _____

Assignment of Benefits: I authorize payment of medical benefits directly to **Pain Management Associates** and/or its affiliate facilities **Interventional Spine Center** for services rendered.

Signature of Patient/Guarantor/Guardian _____ Date _____

Responsible Party's Name _____ Relationship to Patient _____

Payment in full maybe required at the time of service. For your convenience, we accept personal checks, credit/debit cards, and cash. Any Medical Insurance, which you may have, is intended to protect you against financial loss and payment in full for your care is your responsibility regardless of insurance coverage.

Treatment Authorization: I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient, authorized to furnish the information requested. I have read the above paragraph regarding payment of fees, and I understand that I am solely responsible for all charges incurred, regardless of insurance coverage or the liability of another party. I will make sure that my claims are paid promptly.

Signature Patient/Guarantor/Guardian _____ Date _____



PATIENT PRIVACY PRACTICE

The privacy of your health information is very important to us. We want you to understand how we use and disclose your information and your rights to this information. We ask you to review our Notice of Privacy Practice that describes the legal duties with respect to your healthcare information.

HOW WE USE HEALTHCARE INFORMATION:

We use information regarding you to provide treatment, insure appropriate payment for the treatment(s) we provide, and monitor the quality of our operation.

WHEN WE MAY DISCLOSE INFORMATION:

In certain limited cases, we are permitted to disclose healthcare information. Example, when there is a serious threat to your health and or safety, for Workers' Compensation, to reduce public health risks, or when concerned with law enforcement. In addition, we may disclose information to tell you about related services and alternate treatment and to discuss health related research with your permission.

INFORMATION RIGHTS:

- You will have the right to know how we use your healthcare information, who we can give it to and your rights to this information.
- You have the right to ask us to restrict our uses and disclosures where we believe such restrictions will not harm you and where it is possible for us to do so.

You have the right for a confidential communication of your healthcare information. For
- example, you can ask for a conversation to be held in private or for your billing to go to another address.
- You have the right to look or copy information in your chart, unless the doctor feels this would be harmful to you or someone else.
- You have the right to request that we amend your records, if we agree it is inaccurate or incomplete.
- You have the right to ask us for information regarding who we have disclosed your healthcare information to, someone other than those treating you, handling your bills, for our internal operation, or when you have authorized release of information.

Please sign below that you have reviewed our Notice of Privacy Practices. If you have any questions, please feel free to speak to your Physician or our Office Manager.

Signature: _____

Date: _____

PAYMENT POLICY

Thank you for choosing **Pain Management Associates and Interventional Spine Center** for your pain management needs. It is our goal to provide you with the best quality of care. Below you will find our payment policy. Please read it and feel free to ask us any questions so that we can resolve any financial concerns you may have prior to the onset of your treatment with us. Please sign at the bottom in the space provided.

Proof of Insurance: All patients must provide us with a valid insurance card and a valid government issued photo identification at the time of service. This is a CMS requirement as well as a protective measure for you. Should you have any changes with your insurance please contact us immediately to ensure your information is properly updated prior to your appointment(s). Failure to provide us with correct information in a timely manner may result in your being financially responsible for any and all charges denied by your insurance.

Deductible, Co-Payment, Co-Insurance: Your health insurance is an agreement between you and the carrier providing coverage for you. Your policy requires us to collect all deductibles, co-pays and co-insurance amounts that are listed as your responsibility. Your cost share amounts are due at the time of service. As a courtesy, we verify your benefits prior to your visit and do our best, based on the information provided, to estimate your responsibility. You should be aware all insurance companies provide a disclaimer that verification of coverage is not a guarantee of payment and all claims are subject to policy benefits, limitations and exclusions in effect during the adjudication process. The amount we collect on the day of your visit may be adjusted up or down after your claim is processed and finalized by your insurance company.

Claims Submission: As a courtesy, we submit your claims and assist you in any way we reasonably can to get your claims paid by the insurance company. However, your insurance company may request additional information directly from you. It is your responsibility to provide your insurance with the requested information in a timely manner. Failure on your part to respond to an insurance request may result in you being held financially responsible for any and all charges not paid by your insurance.

Facility Charges: It is important for you to understand there is a difference between seeing our physicians for an office visit (professional) and receiving services from our physicians in one of our Ambulatory Surgery Centers (ASC) (facility). Any time you receive services in one of our ASCs, you will receive a separate bill for your financial responsibility for services provided in the ASC. When services are provided at one of our ASC's, you may have a facility and a professional cost share. Payments made towards office visits do not cover your financial responsibility for services provided in one of our ASC's.

Missed Appointments for Professional Charges: As a courtesy to our Physicians and other patients, we ask that you **cancel your appointment 24 hours prior to the scheduled time**. Missed appointments that are not canceled 24 hours prior will be **subject to a \$50.00 missed appointment fee**. This fee must be paid immediately and may cause an interruption in care should it not be paid.

Thank you for taking the time to review our Payment Policy. We appreciate your understanding of our policy and practices for our office. Please let us know if you have any questions or concerns.

I have read and understand the Payment Policy and agree to abide by its guidelines:

Name of Patient or Responsible Party

DOB

Signature of Patient or Responsible Party

Date