Name: _____ Social Security #: _____

Date of Birth: ____/____/_____ Sex ( ) Female ( ) Male

Address: _____
Street City State Zip

County: _____

Home Phone: _____ Alternate Phone: _____

Employer: _____
Name Address

EMAIL address: _____

Marital Status: ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed

Race: ( ) White ( ) African American ( ) Hispanic ( ) Asian ( ) Other not listed _____

Insurance Information

Please complete entire section

Health Insurance #1 _____ Policy # _____ Group # _____

Name of Insured: _____ Social Security # _____
Date of birth: __/____/_____

Health Insurance #2 _____ Policy# _____ Group # _____

Name of Insured: _____ Insured's date of birth ____/___/_____

****Is the visit due to a work related injury? ( ) Yes ( ) No**
****Is the visit due to an auto related accident? ( ) Yes ( ) No**
****Have you ever been seen in another pain clinic? ( ) Yes ( ) No**

Whom may we contact in the case of an emergency?

Name _____ Phone: _____ Relationship:_____

Physician Information

Family Physician _____
Name Address

Phone #: _____

Referring Physician _____
Name Address

Phone #: _____

Pharmacy: _____ Phone #: _____

Date:

Lifetime Authorization

I. **TREATMENT AUTHORIZATION** – I the below named patient, hereby give Pain Medicine Associates, Physicians, and staff consent for medical treatment.

II. **RELEASE OF INFORMATION** – I, the below named patient, hereby authorize any physician/staff of Pain Medicine Associates, examining and /or treating me to release to any third party payor (such as an insurance company or governmental agency) any medical condition or records concerning diagnosis and treatment as necessary to determine the benefits payable.

I the below named patient, hereby authorize the release of any medical information to my referring physician as well as my family physician, (if they are not the same).

III. **PHYSICIAN INSURANCE ASSIGNMENT** – I, the below named subscriber, hereby authorize payment directly to any physician of Pain Medicine Associates.

IV. **MEDICARE/MEDICAID** – Patient's certification authorization release information and payment request. I authorize any holder of medical or other information about to release to Social Security Administration any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance payments pertaining to treatment shall be assigned to Pain Medicine Associates, physicians.

V. **I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE.** This assignment will remain in effect until revoked by me in writing.

I understand it's my responsibility to pay any deductible amount, co-insurance or any other balance not paid by my insurance or third party within a reasonable period of time not to exceed sixty (60) days.

I understand that I will be charged a $25.00 no show fee if I do not cancel scheduled appointment 24 hours in advance.

_____ _____

Patient Signature Date

MEDIGAP (SECONDARY INSURANCE) SIGNATURE

Medicare Patient's with a secondary insurance

I request that payment of authorized MEDIGAP benefits be made on my behalf to Pain Medicine Associates, P.C. for any services rendered to me. I authorize Pain Medicine Associates, P.C. physicians/staff to release any medical information necessary to determine benefits payable.

_____ _____

Patient's Name Date

PAIN MEDICINE ASSOCIATES, PC

HIPAA

ACKNOWLEDGEMENT

I, _____, acknowledge that I have received a copy of PAIN MEDICINE ASSOCIATES, PC Notice regarding *Privacy of Health Information* and *Patient Rights and Responsibilities* and have been advised that a copy is available upon request.

_____ _____
Please Print Name of Patient Date of Birth

_____ _____
Signature Date

_____ _____
Witness Relationship to Patient

CONTACT INFORMATION

I, _____, give my permission for PAIN MEDICINES ASSOCIATES, PC to contact me at the following (please initial and fill in the numbers accordingly including area code).

INITIALS

_____ **Home phone#** _____

_____ **Work#** _____

_____ **Family Member's #** _____

_____ **Pharmacy Name** _____

_____ **Pharmacy #** _____

_____ **Cell#** _____

Do we have permission to leave a message or discuss your condition with anyone other than you?
_____ yes no _____ Name and Relationship: _____

May we leave a message on your answering machine?

_____ yes no _____

I understand that in order for Pain Medicine Associates to provide quality care, I give permission to Pain Medicine Associates physicians and employees to contact my primary care physician, referring physician, physical therapist, psychologist, pharmacists and other practitioners. I understand that Pain Medicine Associates' release to contact others involved in my care is a part of good medical practice.

_____ _____
Date Signature