The Pain Medication and Rehabilitation Center

Serving our patients, protecting our community

This information is required on your initial visit and will be requested annually. If any of the information below changes in the upcoming year, please advise the receptionist of those requests.

Patient Information:

Last Name: First Name: Middle:

Date of Birth: Gender: SS#

Home:

Address: City: State: Zip:

Home Phone:

Cell Phone: Email:

Employer: Work Phone:

Current Occupation:

Former Occupation:

Marital Status:

Spouse Information:

Spouse's Name: Date of Birth: SS#

Cell Phone:

Employer: Work Phone:

Insurance Information - Please present your INSURANCE cards and a photo ID

Do you have health care insurance?

Insurance Policy Holder: Self Spouse Other:

Primary Policy Holders Name:

Policy Holder's Employer & Phone:

Primary Insurance Carrier:

Group Number: Effective Date:

Do you have secondary insurance Name of carrier:

In case of Emergency - List a friend or relative not living at same address

Name: Relationship:

Cell Number: Home/Work Number:

Consent for Payment

I consent to treatment necessary for the care of the above-named patient. I authorize the release of all the medical records for the referring and/or family physicians to my insurance company via US mail or fax. I understand that payment for services due at each visit. All insurance will be filed as a courtesy. However, I understand that I am fully responsible for any charges that are incurred and if my insurance company should deny payment for any services rendered, I am fully responsible for payment. I agree to pay all reasonable attorney fees and collections cost in the event of default of payment of my charges

My signature below indicates that I have read, understand, and agree to the above terms and that I consent for treatment, release of medical information, insurance authorization and financial responsibility.

Name:

Signature: _____ Date:

For Medicare Patients only

I request that payment of authorized Medicare benefits be made either to me or on my behalf to PAIN MEDICINE AND REHABILITATION CENTER, to any services furnished to me by the physician/supplier. I authorize any holder of medical information about me be released to the Health Care Financing Administrator and its agents any information needed to determine these benefits payable to related services. I understand my signature indicates that payment is indicated Item 9 of HCFA-1500 form or elsewhere on other claim forms, or electronically submitted claims, my signature authorizes release of information to the insurer of the agency shown. In Medicare assigned cases, the physician/supplier agrees to accept the charge determination of the Medicare carrier as the full charge and I am responsible only for the deductible, coinsurance, and any non-covered services. Coinsurance and the deductible are based upon the charges determined by the Medicare carrier.

Name:

Signature: _____ Date: