Acct # _____

Resp Party # _____

Pain Treatment Center

Innovative, personalized solutions for effective pain relief

F/C _____

DR _____ LOC _____

PATIENT INFORMATION

Patient: _____ Title: Mr./Mrs./Other: _____ Suffix: Jr/Sr/Other: _____
Last First Middle

Mailing Address: _____ _____ _____ _____
City State Zip

Home Ph.: _____ Work Ph.: _____

Date of Birth: _____ Sex: M or F

Social Security # _____

Marital Status: Married Single Widowed Divorced (circle one)

Employment Status: Fulltime Self Employed Parttime
(circle one) Not employed Unknown Retired Military Active

Employer: _____

Student Full or Part time (circle one)

Is Injury Work Related: _____

Date of Injury (if applicable): _____

REFERRAL INFORMATION

Referred By: _____ Clinic Name _____

Address: _____ _____ _____ _____
City State Zip

What doctor are you seeing today? _____

Have you visited the practice previously _____ Yes _____ No

How did you first hear about our medical practice?

_____ Yellow pages _____ Doctor Referral

_____ Friend/Relative _____ Newspaper

_____ Television _____ Radio

_____ Billboard _____ Other

RESPONSIBLE PARTY INFORMATION

IF OTHER THAN PATIENT, SEND STATEMENT / BILL TO:

Responsible Party: _____ Title: Mr./Mrs./Other: _____ Suffix: Jr/Sr/Other: _____
Last First Middle

Mailing Address: _____ _____ _____ _____
City State Zip

Home Ph.: _____ Work Ph.: _____

Date of Birth: _____ Sex: M or F

Social Security # _____

Marital Status: Married Single Widowed Divorced (circle one)

Employment Status: Fulltime Self Employed Parttime
(circle one) Not employed Unknown Retired Military Active

Employer: _____

Employer Address: _____ Business Phone: _____

PERSON TO CONTACT FOR EMERGENCY

Name: _____ Relationship to Patient _____

Phone No. _____

INSURANCE INFORMATION

PRIMARY INSURANCE:

Ins Company: _____

Address: _____

City/State: _____ Zip _____

Patient's Relationship to Insured: Self Child Mate Other

Group #: _____ Policy #: _____

CoPay: Primary Care: _____ Specialist:_____

Insured's Name: _____

SECONDARY / SUPPLEMENTAL:

Ins Company: _____

Address: _____

City/State: _____ Zip _____

Patient's Relationship to Insured: Self Child Mate Other

Group #: _____ Policy #: _____

CoPay: Primary Care: _____ Specialist:_____

Insured's Name: _____

INSURED INFORMATION

Address: _____

City/State: _____ Zip _____

Home Ph.: _____ Work Ph.: _____

Date of Birth _____ Sex: M or F

Employer: _____ Status: _____

Address: _____

City/State: _____ Zip _____

Home Ph.: _____ Work Ph.: _____

Date of Birth _____ Sex: M or F

Employer: _____ Status: _____

BY signing this, I hereby consent to treatment by any physician (and whomever they may designate as their assistant) of Pain Consultants of South MS, PA to perform treatment to me.

By signing this, I hereby acknowledge PAIN CONSULTANTS OF SOUTH MS AND PAIN TREATMENT CENTER, LLC has the right to the use and disclosure of protected health information for treatment, payment and health care operations, and that I have reviewed the Notice of Privacy Practices for Protected Health Information. I understand I have the right to restrict how protected health information is used or disclosed, and that PAIN CONSULTANTS OF SOUTH MS AND PAIN TREATMENT CENTER, LLC is not required to agree to any restriction, but if agreement is reached, PAIN CONSULTANTS OF SOUTH MS AND PAIN TREATMENT CENTER, LLC is bound by the agreement.

_____ _____

Signature Date

Charges not covered by Medicare or Managed Care will be the patient's responsibility, please ask if you have any questions. I verify this information is true and accurate as of the below indicated date. I recognize that current, valid insurance information is necessary for reimbursement.

_____ _____

Signature Date

HIPPA REGULATIONS

Due to HIPPA policies and procedures, please list who we have the authority to speak with in regards to your financial account and medical records other than yourself.

Name _____ Relationship _____

Name _____ Relationship _____

By signing this, I hereby acknowledge the Pain Consultants of South MS and Pain Treatment Center, LLC has the right to speak with the above names regarding your account status of your care.

_____ _____

Signature Date