PainMD.com

Patient Registration and Consent for Billing

Name (First, MI, Last)____

Mailing Address____Town/City/Zip____

Phone Number (H)____________________________ (C)____________________________ (W)____________________________

Email ____

DOB ______ - ______ - ______ **SSN** ______ - ______ - ______ **Sex** M / F **Marital Status** S / M

Race (Please circle – you may choose more than one): Hispanic | Asian | Caucasian | Black or African American | American Indian | Chinese | Filipino | Japanese | Native Hawaiian | Pacific Islander | Other | Decline to answer

Preferred language (Please circle): English / Other (specify) ____

Contact In Case of Emergency ____

Relationship ____________________________ Daytime Phone____________________________

We may discuss your care with ____________________________ Relationship ____________________________

Primary Care Provider____________________________ **Referring Provider**____________________________

INSURANCE INFORMATION - Please complete fully. If Workers Comp, see below.

Primary Insurance ____________________________ID# ____________________________Group# ____________________________

Subscriber (Person Responsible for Insurance Card)____

** DOB: _____-_____-______ ** SSN:______-____-______ ** Employer____

Referral needed for insurance? Yes / No Benefits Phone # (On back of Card) ____________________________

Secondary Insurance ____ ID# ____________________________

Tertiary Insurance ____ ID# ____________________________

Workers Compensation

Company ____ Address ____

Claim # ____________________________ Date of Injury ____________________ Body Part Covered ____________________

Case Manager ____________________________ Phone Number ____________________ Ext____________________

Employer at time of injury____ Contact Name/Phone____________________

Attorney Name____ Phone____________________________

I, the undersigned, hereby authorize and direct my insurance carrier to pay benefits for services rendered, directly to **Michael J. O'Connell, MD** or any of its affiliates including but not limited to:

Dr. O'Connell's Paincare Centers **John Kane, CRNA** **Pinewood Medical Laboratory**

and all laboratories performing tests on behalf of Pinewood Medical Laboratory including but not limited to:

UMASS Memorial Laboratory

I further understand I am financially responsible for claims denied or not covered by my insurance carrier for failure to obtain a referral or for any other coverage issues. I acknowledge that Paincare Centers or any of its affiliates including those listed above may be an out of network provider with my insurer. I am also aware that in some circumstances my insurer will send the payment directly to me. I agree to endorse the insurance check and forward it to the appropriate entity above within 30 days of receipt. I further authorize the use of my laboratory results (de-identified pursuant to law) obtained during the course of my treatment to be used for research, development and potential publication purposes by Paincare Centers or any of its affiliates including those listed above.

X____ **Date**____________________________

Signature of Patient or Dependent

For office use: PainCare Provider ________________________________Date seen______________ Patient #______________

Revised 11/22/2011