



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 # _____