PainCare
manage pain • improve life

Patient Registration and Consent for Treatment

Name (First, MI, Last):_____ **Gender**: ☐ Male ☐ Female

Date of Birth: _____/_____ /_____ **Marital Status:** ☐ Single ☐ Married **Social Security #**: **XXX - XX -** _____

Address:_____

City, State: _____ **Zip Code**: _____

Phone (Home):_____ **Phone** (Cell):_____ **Phone** (Work):_____

Email: _____ **Primary Care Provider:**_____ **Referring Provider:**_____

*We may wish to communicate upcoming appointment information, test results and/or other information regarding your medical care. What is the best phone number for contact where we may also leave messages? ☐ Home ☐ Cell ☐ Work

Emergency Contact: _____

Relationship: _____ Phone:_____

- The above listed contact (with photo identification) can pick up prescriptions if you are unavailable? ☐ Yes ☐ No
- *(Optional)* If you would like to give us permission to discuss personal information in your medical record with someone other than yourself, please name them specifically below:

_____

Race ☐ White ☐ Black or African American ☐ Asian ☐ Other
☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

Preferred Language ☐ English ☐ Other (specify):_____

Ethnicity ☐ Non-Hispanic or Latino ☐ Hispanic or Latino ☐ Other

*Insurance Information** *(please present card for copying)*

Primary Insurance: _____ Subscriber: _____

Insurer ID#:_____ Subscriber's Date of Birth:_____

Group #:_____ Relationship to patient:

Claims Address: _____ ☐ Self ☐ Spouse ☐ Other

Secondary Insurance: _____ Subscriber: _____

Insurer ID#:_____ Subscriber's Date of Birth:_____

Group #:_____ Relationship to patient:

Claims Address:_____ ☐ Self ☐ Spouse ☐ Other

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_____

- **The above information is thorough and accurate to the best of my knowledge. Any changes to the above information will be communicated with the office.**
- **I consent to evaluation and treatment by any provider at PainCare Centers. I hereby authorize release of medical information that is necessary for my further treatment.**

_____ _____

Patient Signature (or Guardian) Date

Financial Policy and Consent for Billing

Payment Policy:

We ask that you read through the financial policy and sign the bottom prior to treatment. Co-pays are due at the time of service, or full payment is due for self-pay patients unless prior arrangements have been made with our billing department. We accept cash or credit cards (Visa, MasterCard and Discover). On a limited basis checks may be accepted and there is a service charge on any returned check; payment in full will be required within 10 days of notice.

Insurance:

Our office will kindly bill your insurance company. We participate with a number of medical insurance plans that we will contact to verify eligibility and benefits. Please realize that you have the **ultimate responsibility of verifying the coverage with your insurance.** You acknowledge that we may be an out of network provider with your insurance. You are also aware that in some circumstances your insurer will send payment directly to you. You agree to endorse the insurance check and forward funds to the appropriate entity above within 30 days of receipt. You will be responsible for any balance not paid or denied by your insurance carrier. Patients who do not supply accurate insurance information will be considered self-pay. You must inform our office of any changes in your insurance, as you are the policyholder and it is your responsibility.

Insurance Referrals:

If your plan requires a referral from your Primary Care provider, it is your responsibility to obtain it before seeking treatment from us. If a claim is denied due to a lack of referral you will be responsible for charges. You understand that you are financially responsible for claims denied or not covered by your insurance carrier for failure to obtain a referral.

Missed Appointments:

If you are unable to keep your appointment you must notify the office at least 24 hours prior to your scheduled appointment as courtesy to the doctors, staff and other patients. If you cancel or "no-show" without sufficient notice, you may be subject to a fee, payable by you, not your insurance company.

Please let us know if you have any questions regarding our Financial Policy.

I, the undersigned, hereby authorize and direct my insurance carrier to pay benefits for services rendered, directly to **Pinewood Professionals, LLC** or any of its affiliates including but not limited to: **Dr. O'Connell's PainCare Centers** and **John Kane, CRNA**.

I have read and agree to the terms of the above information. I understand payment is expected at the time services are rendered and that I am responsible for any balance.

Patient Name (Please print):_____

Signature of Patient or Legal Representative:_____ **Date:**_____