www.PainMD.com

Patient Registration and Consent for Treatment
Financial Policy, Consent for Billing & Receipt of Documents

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

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

Mailing Address:_____ **City/State:** _____**Zip Code:** _____

Street 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:_____

- Can the above listed contact (with photo identification) pick up prescriptions if you are unavailable? ☐ Yes ☐ No
- If you would like to give us permission to discuss personal information in your medical record with someone other than yourself, please fill out the **Permission to Discuss Form**.

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

Preferred Language
- ☐ English
- ☐ Other:_____

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

Insurance Information* *(fill out completely)*

Primary Insurance: _____

Insurer ID#:_____

Group #:_____

Claims Address: _____

Subscriber: _____

Subscriber's Date of Birth:_____

Relationship to patient:

☐ Self ☐ Spouse ☐ Other

Secondary Insurance: _____

Insurer ID#:_____

Group #:_____

Claims Address: _____

Subscriber: _____

Subscriber's Date of Birth:_____

Relationship to patient:

☐ 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_____

PATIENT: Please initial this page ☐ **and continue to Page 2 for signature** CPS Update/Staff Initial ☐

GRANITE STATE PAIN ASSOCIATES

GRANITE STATE SURGICENTER

Patient Registration and Consent for Treatment

Financial Policy, Consent for Billing & Receipt of Documents

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.

The above information on all pages of this document is thorough and accurate to the best of my knowledge. For any changes to the above information, I will notify the office.
I consent to evaluation and treatment by any provider at Granite State Pain Associates / Granite State SurgiCenters. I hereby authorize release of medical information that is necessary for my further treatment.
I authorize release of information, including treatment and protected health information to my insurance company that is needed to process payment for services. I authorize my insurance carrier to pay benefits for services rendered, directly to PMC Medical Group, LLC or any of its affiliates.
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):_____ DOB _____

PATIENT/Authorized Person SIGNATURE: _____ Date: _____

Authorized Person NAME (print): _____ Relationship: _____

**** Receipt of Documents ***Patient: Complete below at the Office ******

I have received and understand the information contained in the following documents:

1. Notice of Privacy Policies
2. Patient Bill of Rights
3. Patient Responsibilities
4. Patient Complaint Procedure
5. Advance Directives Information
6. ASC Evacuation Plan

PATIENT/Authorized Person SIGNATURE: _____ Date: _____