



Patient Registration

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: _____

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 release/discuss personal information in your medical record with someone other than yourself, please fill out the **Authorization Form: PHI Release Authorization**.

We may need 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

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

The above information is thorough and accurate to the best of my knowledge. For any changes to the above information, I will notify the office.

PATIENT/Authorized Person SIGNATURE: _____ Date: _____

Authorized Person NAME (print): _____ Relationship: _____

CPS Update/Staff Initial



Consents and Terms

Name (First, MI, Last): _____ Date of Birth: ____/____/____

Insurance Information* (fill out completely)	
Primary Insurance: _____ Insurer ID#: _____ Group #: _____ Claims Address: _____ Subscriber: _____ Subscriber's Date of Birth: _____ Relationship to patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other	Secondary Insurance: _____ Insurer ID#: _____ Group #: _____ Claims Address: _____ Subscriber: _____ Subscriber's Date of Birth: _____ Relationship to patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> 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 _____

Please let us know if you have any questions.

Payment Policy: Payment is due at time of service: Co-pays are due; Full payment is due for self-pay patients. Cash or credit cards (Visa, MasterCard and Discover) are accepted. On a limited basis checks may be accepted. There is a service charge on any returned check; full payment required within 10 days of notice).

Insurance: The 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. 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. If your insurer sends payment directly to you, you agree to endorse the insurance check and forward funds to the appropriate entity above within 30 days of receipt. Patients who do not supply accurate and/or updated insurance information are Self-Pay.

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 are responsible for charges.

Missed Appointments: If you are unable to keep an appointment you must notify the office at least 24 hours prior to your scheduled appointment. If you "no-show" or cancel without sufficient notice, you may be subject to a 'no show' cash fee, payable by you, not your insurance company.

The above information is thorough and accurate to the best of my knowledge. I will notify the office of any changes within 30 days. If I do not notify the office of insurance changes, I am fully financially responsible.

I understand that rude or disrespectful treatment of staff is not tolerated and may result in my discharge. (e.g. using profanity, raising my voice, making vulgar or inappropriate comments).

I understand that my pain is my own pain, not my families' or spouse's. Therefore, I need to be the person to communicate with the Pain Management provider and his/her staff if at all possible

I consent to evaluation and treatment by any Provider at Granite State Pain Associates / Granite State SurgiCenters. I authorize my Provider to communicate with other providers regarding my treatment and care.

I acknowledge that I have a copy and/or access to the Notice of Privacy Practices.

I authorize release of records and information for treatment, payment and healthcare operations.

I authorize my insurance carrier to pay benefits for services rendered, directly to PMC Medical Group, LLC or any of its affiliates. I am financially responsible for claims denied or not covered by my insurance carrier.

I have read and agree to the terms of the above information.

CPS Update/Staff Initial

PATIENT/Authorized Person SIGNATURE: _____ **Date:** _____

Authorized Person NAME (print): _____ **Relationship:** _____