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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 ☐

GRANITE STATE PAIN ASSOCIATES

GRANITE STATE SURGICENTER

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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:

☐ 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_____

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: _____