MD PAIN

Patient Registration

Please review the following information and make sure it is correct to your knowledge. If information needs to be updated please update and let us know. Please sign at the bottom consenting the information listed is correct:

PATIENT INFORMATION

Patient Name:		**Maiden Name:**	
Current Address/PO Box:			
City:	**State:**	**Zip:**	
Primary Phone:	**Cell Phone:**	**Work Phone:**	
Email Address:			
Birth Date:	**Age:**	**Sex:**	**SS#:**
Emergency Contact:	**Relationship to Emergency Contact:**	**Phone:**	

Race/Ethnicity: [ ]Asian [ ]Black/African American [ ]Hispanic/Latino [ ]White [ ] Other:_____

How would you like to be reminded of appointments (PLEASE CHOOSE 1 OPTION and specify number):
[ ] Phone (_ _ _ - _ _ _ - _ _ _ _) [ ] Text (_ _ _ - _ _ _ - _ _ _ _)

Marital Status: [ ]Married [ ]Single [ ]Divorced [ ]Widowed

Family Doctor: Phone:	**Referring Doctor:** Phone:

RESPONSIBLE PARTY INFORMATION

Please complete if patient is under age 19

Responsible Party:		**Relationship to patient:**
Address/PO Box:		
Home Phone:	**Cell Phone:**	**Work Phone:**
Employer:		**Employer Address:**
If Minor, Other Parent's Name:		

PRIMARY HEALTH INSURANCE

Name of Insurance Company:	**Policy Number:**
Policy Holder's Name:	**Date of Birth:**
Relationship to Patient:	**Policy Holder SS#:**

SECONDARY HEALTH INSURANCE

Name of Insurance Company:	**Policy Number:**
Policy Holder's Name:	**Date of Birth:**
Relationship to Patient:	**Policy Holder SS#:**

Release of Information

I hereby authorize MD Pain LLC and its staff to release to the above company (ies) or its representatives, to myself, to my primary care or referring physician(s), and to consulting physicians any information used for treatment or payment.

Assignment of Benefits

Authorization: I authorize payment of benefits directly to MD Pain LLC, I understand that I am financially responsible for all charges not covered by my authorization.

HIPPA Privacy Notice

The signature below acknowledges that MD Pain has provided access to our Notice of Privacy Practices.

Consent to Medical Treatment

I knowing that I have (or had) a condition requiring diagnosis and medical treatment, do hereby voluntarily consent to such diagnostic examination procedures and x-rays and to such medical treatment by DR MASSEY/DR DONOVAN, his/her assistants, or his/her designees as necessary in his/her judgment.

PHI RELEASE

This authorizes MD Pain LLC to disclose your medical information to family members or friends designated by you, the patient. Please note this form does not alter our ability to communicate with family members involved in your care that are not designated below in the event of an emergency or other circumstance where you are unavailable and, in our professional judgment, we believe it is in your best interest to do so.

I am permitting the following person(s) access to protected health information (PHI) from MD Pain LLC:

Name: _____ **Relationship**: _____

Name: _____ **Relationship**: _____

_____ _____/_____/_____

Patient/Guardian Signature Date

MD PAIN LLC
FINANCIAL POLICY

At MD Pain LLC we are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Our fees for services are based on the level of professional skill required; the severity and complexity of the injury or illness, as well as the time spent treating you. The **patient or responsible party** is responsible for seeing that the entire bill is paid in full. Your clear understanding of our Financial Policy is important to our professional relationship.

Self-Pay Patients: Payment in full is required for all self-pay/uninsured patients. If you do not have insurance, you will be asked to pay for services at the time of your visit. For many services, you will receive a 20% discount for payment in full on the day of your visit.

Insurance: Billing of insurance is a courtesy we provide our patients and is not required by law. Our professional services are rendered to a person, not an insurance company. The insurance company is responsible to the patient and the patient is responsible to us. Therefore, if your insurance does not respond within 30 days the bill will become your responsibility. Please notify us if your insurance carrier or policy has changed.

Co-Payments: Your insurance contract REQUIRES that we collect your designated co-pay at the time of service. Please be prepared to pay your co-pay prior to each visit.

Deductibles: We will verify your insurance benefits and, at the time of your appointment, you will be expected to pay a deposit towards an estimated amount owed. Patients with high unmet deductible plans will be asked to remit a **minimum** deposit of $150 at the time of your visit. (We will collect your credit card information when you check in.) Following your appointment, as a courtesy we will bill your insurance company, and any patient responsibility portions are to be paid upon first receipt of your patient statement. If you have questions regarding any amount due after insurance has processed your claim please contact them directly.

Referrals: If your insurance plan requires a referral from your primary care physician, it is YOUR responsibility to obtain the referral prior to your appointment and have it with you at the time of the appointment. If you choose to seek the services of MD Pain LLC without the referral, YOU will be responsible for the payment of the charges,

Medicare: MD Pain LLC accepts Medicare assignment. By accepting assignment, we agree to accept Medicare's approved amount as payment for covered services. You, the patient, are responsible for any remaining balances. We will file a claim with your secondary insurance plan for you.

Medicare ABN Form: If you receive a service that may not be considered medically necessary by Medicare, you will be advised by the clinic staff and asked to sign an Advanced Beneficiary Notice (ABN). Medicare's determination that a service is not medically necessary does not mean that the service should not be provided to you. The Providers will recommend services based on your current health condition and their expert medical opinion. The ABN Form is your advance notification that the service(s) may not be covered, and you may be financially responsible. Testing or treatment will not proceed without your informed consent.

Medicaid: Clinic staff will verify Medicaid eligibility **at each visit**. Please have your current Medicaid card available. If a co-pay is required, your co-pay is due at the time of service.

Workers Compensation/Accident Cases: In order for us to file a claim with your work comp or other liability carrier you must provide complete billing information. Without this information we are unable to bill your insurance carrier and we will ask for payment in full at the time of service. Patients shall be financially responsible for medical services related to work comp/accident if insurance fails to pay in full. We do not bill attorneys for medical services.

Patient Statements: You will be mailed your patient statement if a balance is due on your account. Payment is due upon receipt of your statement. Please contact our Billing Department for questions or concerns regarding your statement.

Payment Arrangements: If you are unable to pay for your patient statement balance in full, contact our Billing Department to discuss payment options. Payment plans may be available to payoff balances within 90 days.

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Outstanding Balances: If you have any outstanding self-pay or insurance designated outstanding balances for co-pays, deductibles and other unpaid out-of-pocket expenses, you will be asked to remit payment at your next visit or you may be required to reschedule your appointment. Chronic non-payment of bills can constitute separation from the practice.

Collections: Unpaid balances will be forwarded to our collection agency. Once an account has been referred to a collection agency, you must work directly with them to satisfy your debt. If you return to our office for services, you will be required to pay in full **prior** to receiving any future services.

Payment Methods: We accept cash, checks and most major credit cards.

Responsible parties will be responsible for any expenses incurred in collecting the amounts owed, including attorney's fees, court costs and/or the collection agency fee. Any returned check from the bank for non-payment (insufficient funds) shall result in the patient's account being assessed a $25 fee per check returned.

I have read the Financial Policies of MD PAIN LLC and agree to comply with the Financial Policies. In addition, MD Pain LLC has my permission to provide medical documentation in order to obtain reimbursement.

Printed Patient Name: _____

Patient Signature: _____ Date: _____
(Patient or Parent of Minor)