New Patient Form – Pain Care Advisors, LLC

PATIENT INFORMATION:

Patient Name: Date of Birth:

Ethnicity: Race:

Address:

City: State: Zip Code:

Home Phone #: Cell Phone #: Work Phone #:

Email Address: Social Security #:

EMERGENCY CONTACT INFORMATION:

Emergency Contact: Contact Phone #:

PHARMACY INFORMATION:

Pharmacy Name:

Pharmacy Address:

REFERRALS / PHYSICIAN INFORMATION:

Referring Physician: Primary Care Physician:

HEALTH INSURANCE INFORMATION:

Primary Insurance*: Subscriber Name:

Secondary Insurance*: Subscriber Name:

IS THIS VISIT DUE TO AN INJURY? YES ☐ NO ☐ Due to: WORK COMP ☐ AUTO ☐ PERSONAL INJURY ☐

If yes, please provide the following:

Address:

Claim #:

Adjuster: Phone #:

PRIVACY AUTHORIZATION:

I authorize the following person(s) to inquire and discuss my medical or surgical care and treatment with the physician:

1. Phone #:

2. Phone #:

3. Phone #:

I authorize release of any medical information necessary to process any insurance claims and I authorize payment of medical benefits directly to the physician or supplier of services for myself or dependents. I understand I am responsible for any deductibles, co-insurance or amounts for services not covered by the insurance carrier. In signing this form, I am also authorizing the physician to examine and treat me and electronically download previous prescription information.

Signature: **Date:**

IF YOU HAVE A LIVING WILL OR POWER OF ATTORNEY, PLEASE CHECK THIS BOX ☐

Please provide your insurance card(s)

Universal Consent Form - Pain Care Advisors, LLC

Date ___ /___ /___

CONSENT FOR TREATMENT _____ I hereby consent to the administration and performance of anesthesia and treatments by Pain Care Advisors, LLC which, in the judgment of the physician, may be considered necessary or advisable for the diagnosis or treatment for the condition for which I am presenting myself. I understand that the practice of medicine and surgery is not an exact science and acknowledge that no guarantees have been made to me. I authorize Pain Care Advisors, LLC to request and receive information, including my medical records and previous prescription information from my treating physician(s) or agents.

PAYMENT AND ASSIGNMENT OF INSURANCE BENEFITS _____ I hereby assume full responsibility for and agree to pay all costs, charges and expenses incurred by me for the medical care provided to me either through my insurance coverage or directly. In consideration of those services, I hereby assign, transfer and convey to Pain Care Advisors, LLC all of my rights, title and interest in my medical insurance for medical expense reimbursement, including, but not limited to, adding dependent eligibility, and to have a policy continued or issued in accordance with the terms of benefits under any insurance policy continued or issued. If my medical insurance coverage is not sufficient to satisfy such cost, charges and expenses in full, or I do not follow guidelines of my insurer and the resulting balance is not covered by the Assignment of Insurance benefits, I will be fully responsible for payment of the balance. I understand it is my responsibility to understand my insurance coverage for my medical visit.

MISSED APPOINTMENTS _____ I understand that multiple or excessive missed appointments may result in a charge to my account or discharge from the practice. Unforeseen circumstances will be considered by the physician.

RECEIPT OF NOTICE OF PRIVACY PRACTICES _____ I acknowledge that I have received Pain Care Advisors, LLC Notice of Privacy Practices. I understand that the notice describes the uses and disclosures of my protected health information by Pain Care Advisors, LLC and informs me of my rights with respect to my protected health information.

DISCLOSURE STATEMENT _____ My physician may decide to call in consultants who also may not be employed by or agents of Pain Care Advisors, LLC and who practice in other specialties to provide care to me. I understand that Pain Care Advisors, LLC does not exercise any control or authority over any physicians' professional or allied health professionals' judgment, diagnosis or treatment decisions that are not employed by Pain Care Advisors, LLC.

AMERICANS WITH DISABILITIES _____ In compliance with the Americans with Disabilities Act, qualified interpreters and other auxiliary aids and services are available free of charge to people with disabilities.

By signing this consent form, I acknowledge that I have read and understand the aforementioned, and accept its terms.

Patient Name: _____ **Date of Birth** ___ /___ /___

Patient Signature: _____

Parent/Guardian/Legal Guardian Signature: _____

Relationship to Patient / Reason Patient is Unable to Sign: _____