
Date of Visit: _____/_____/_____

## PATIENT REGISTRATION FORM

Patient Name: _____ Date of Birth: _____/_____/_____
(Last Name, First Name, Middle Initial)

Social Security: _____-_____-_____ Gender: Male _____ Female _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Marital Status: Single_____ Married _____ Divorced _____ Widowed _____ Other _____

Email Address: _____

Employer Name & Address: _____

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## EMERGENCY CONTACT

Name: _____ Relation to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Phone: _____

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## PHYSICIAN & PHARMACY INFORMATION

Primary Care Physician & Phone: _____

Referring Physician & Phone: _____

Pharmacy Name, Location & Phone: _____

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**As required by the Patient Protection & Affordable Care Act, please provide the following:**

Race:

_____ American Indian or Alaska Native

_____ Asian

_____ Black or African American

_____ Native Hawaiian or other Pacific Islander

_____ Caucasian

_____ Other

_____ I prefer not to answer

Ethnicity:

_____ Hispanic or Latino

_____ Not Hispanic or Latino

_____ I prefer not to answer

Preferred Spoken Language:

_____ English _____ Spanish

_____ Other_____


## INSURANCE INFORMATION

**Primary** Insurance: _____

Claim Mailing Address: _____

ID#: _____ Group #: _____

Insured Name (if different from the patient):_____

Date of Birth: _____/_____/_____ Social Security: _____-_____-_____

**Secondary** Insurance: _____

Claim Mailing Address: _____

ID#: _____ Group #: _____

Insured Name (if different from the patient):_____

Date of Birth: _____/_____/_____ Social Security: _____-_____-_____

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## GUARANTOR INFORMATION
**(Individual responsible for payment, if different from the patient)**

Name: _____

Patient Relationship to Guarantor: Self _____ Spouse _____ Child _____ Other _____

Date of Birth: _____/_____/_____ Social Security: _____-_____-_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Guarantor's Employer: _____

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## NOTICE OF PRIVACY PRACTICE

You may share health information about the patient's condition with:

_____

(List the names of individuals to whom you wish to grant authorization to share medical information.)

Summit Pain Alliance

## WORKER'S COMPENSATION OR AUTO ACCIDENT

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### ATTORNEY INFORMATION

Attorney Name: _____ Phone: _____

Firm Name: _____

Address: _____

City: _____ State: _____ Zip: _____

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### WORKER'S COMPENSATION

Accepted Body Part: _____ Date of Injury: _____

Adjuster Name: _____ Phone: _____

Insurance Name: _____ Claim #: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Employer Name: _____

Employer Address: _____

**********

### AUTO ACCIDENT

Date of Injury: _____ Passenger _____ or Driver _____

**Patient's** Auto Insurance: _____ Claim #: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Adjuster Name: _____ Phone: _____

Policyholder Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Name of **Liable Party** (At Fault Driver): _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

**Liable Party's** Auto Insurance: _____ Claim #: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Adjuster Name: _____ Phone: _____

Policyholder Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____


## RELEASE OF INFORMATION & FINANCIAL POLICY

Thank you for choosing Summit Pain Alliance as your health care provider. The following is a statement of our Release of Information/Financial Policy which we require you read and sign prior to any treatment.

**RELEASE OF INFORMATION/MEDICAL RECORDS**
By signing this form, you authorize Summit Pain Alliance or his/her designee(s) to release and disclose such medical records, information and documentation as may be necessary or appropriate in order to process insurance claims and to obtain payment on your behalf. You also authorize the release of information acquired in the course of your examination or treatment and all information pertaining to your history and progress in your case. This includes any alcohol or drug abuse data that may be protected by Federal Regulations - 42CFR Part 2. You agree that a photocopy your original authorization shall be considered equally authentic.

**REGARDING INSURANCE**
We cannot bill your insurance company unless you provide us with your insurance information and any special claim forms required by your insurance company. We accept assignment of insurance benefits. That means your insurance will pay us directly the amount due based upon your benefit coverage. By signing this form, you authorize assignment of your benefits to Summit Pain Alliance for treatment and related services. However, we do require, as your insurance benefits require, payment of co-pays, co-insurance and deductibles at the time of service. Your insurance policy is a contract between you and your insurance company.
*Please know your benefits. Please be aware that only your insurance company can tell you if the services provided are covered under your benefit plan.*

While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. In the event that your account is turned over to an outside collection agency, you will be responsible for an additional 30% of the balance owed and/or all the attorney fees and costs incurred to collect the unpaid debt.
*Those Insurance Plans in which we are a Participating Provider*.

All co-pays and deductibles are due at the time of treatment. Prior to seeking payment from you, we will work with these plans to obtain payment. In the event that your insurance coverage changes to a plan in which we are not a participating provider, refer to the paragraph below.
*Those Insurance Plans in which we are NOT a Participating Provider*.

If your insurance company has not paid your account in full within 45 days of the billed date, the balance is your responsibility. Your assistance in collection from your insurance company may be required.

**WE ACCEPT PAYMENT IN THE FORM OF CASH, CHECK, VISA OR MASTERCARD**
**(THERE WILL BE A $25.00 FEE FOR RETURNED CHECKS)**

**(CONTINUED ON NEXT PAGE)**


**USUAL AND CUSTOMARY RATES**
Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. The federal government agency that administers the Medicare and Medicaid programs, has determined that except for certain circumstances, the discounting or waiving of a patient's co-pay or deductible is unlawful. Additionally, under the new HIPAA regulations, we are now not allowed to discount or waive patient's co-pays or deductibles as outlined by benefit plans offered by other third party payers. You are responsible for payment unless we are a participating provider for your insurance company.

**PATIENT BALANCES**
Patients are responsible for full payment at the time of service if not covered by some other third party such as Medicare, Medicaid or private insurance.

**CASES INVOLVING AN ATTORNEY**
If you are receiving services for an auto accident, worker's compensation case or personal injury and you are working with an attorney, we will also require information relating to your group health coverage. Both your group health and the appropriate auto carrier will be billed at the same time. This procedure is necessary in order to have a claim on file with the group health in case the auto carrier does not pay or is exhausted at some point during your treatment. This procedure not only protects Summit Pain Alliance, but you as the patient.

**MISSED APPOINTMENTS**
Please help us serve you better by keeping scheduled appointments. We recognize there are times when it is not possible to keep appointments. If you are not able to keep an appointment, please call our office at least 24 hours prior to the appointment time. If you consistently miss scheduled appointments, our policy is to charge **$50.00 for missed appointments** and you will be held responsible for payment.

**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)**
HIPAA is a protective measure safeguarding patient privacy and confidentiality. By signing this agreement I acknowledge that I have received information pertaining to my rights as covered under the Health Insurance and Portability and Accountability Act of 1996.

I have read and understand the above statements in the Release of Information/Financial Policy concerning my payment responsibility.

| _____ | _____ | _____ |
|---|---|---|
| Signature of Patient or Responsible Party | Print Name | Date |
| _____ | _____ | _____ |
| Signature of Co-Responsible Party | Print Name | Date |