Coastal Pain and Spine Center

PATIENT INFORMATION

Last Name:________________________ First Name:_________________________ MI:_______

Street Address (No PO Box):____

City: _________________________ State: __________________ Zip Code: _______________

Mailing Address (if different than above): ____

E-Mail Address: ____

Telephone: (Home) _________________________ (Mobile) ______________________________

Social Security Number (necessary for insurance filing): _________________________________

Date of Birth: ____________________ Sex: Male Female Martial Status: S M W D

Employment Status (circle one): Full Time Part Time Retired Not Employed Disabled

Spouse Name: ________________________________ Spouse Date of Birth: _______________

Spouse Social Security Number:____________________ Spouse Employer:________________

Referring Doctor: ______________________________ Phone: ___________________________

Referring Doctor Address: ____

Reason For Visit: ____

Was this a work injury? Yes No Was this a result of an auto accident? Yes No

Employer Information

Employer: ____

Employer Address: ______________________________ Phone: __________________________

Emergency Notification

Name: _________________________ Phone: ___________________ Relationship: ___________

Name: _________________________ Phone: ___________________ Relationship: ___________

POLICY HOLDER INFORMATION

Name: _____________________________________ Relationship: ________________________

Social Security Number (needed for filing claims): __________- __________-__________

Date of Birth: __________/__________/__________

PLEASE BRING YOUR INSURANCE CARDS TO THE APPOINTMENT

Medical Release Authorization and Insurance Agreement

I hereby authorize this office to apply for benefits on my behalf for covered services rendered. I request payment from my insurance to be made to Coastal Pain and Spine Center. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account.

I request that payment for authorized Medicare benefits be made either to me on my behalf or on my behalf to Coastal Pain and Spine Center. I authorize the holder of medical information about me to release the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I certify that the information I have reported to my insurance coverage is correct and further authorize the release of any necessary information, including medical information to my insurance company in order to determine insurance benefits to which I may be entitled. I may revoke this authorization at any time in writing.

I authorize Coastal Pain and Spine Center to release and/or send medical information regarding my case to other consulting and/or referring physicians.

Print Name: ____

Signature (required): __________________________________ Date: ____________________

Financial Responsibility Agreement

As a courtesy to you, our office will file a claim to your insurance carrier for your medical chargers. You will be responsible for any balance remaining after your insurance carrier paid. Insurance companies do not always pay what you expect them to pay. If there is a question or problem with the amount paid, this should be discussed with your insurance carrier.

We will not bill you for your medical charges that are not eligible for insurance payment until 60 days after the claim has been filed. If no payment has been made at that time, we ask that you notify your carrier that your claim has not been paid and that your doctor has requested payment from you.

Our office will be happy to assist you as best as we can. The bill, however, is your responsibility. If you have questions or problems, we will try to help. You may call our billing department to answer questions or arrange a payment schedule for large balances. Should timely payments of this account not be made, Coastal Pain and Spine Center may retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance. Any expense incurred by such action shall become an additional liability for you may be responsible.

I HAVE READ YOUR POLICY, UNDERSTAND AND IT, AND WILL COMPLY WITH ITS PROVISIONS.

Print Name: ____

Signature (required): ________________________________ Date: ______________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain right to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that directly and indirectly.
Conduct normal healthcare operations such quality assessments and physician certifications.

I am aware that your Notice of Privacy Practices containing a more description of the uses and disclosures of my health information is available in the reception area. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to address the above to obtain a current copy of its Notice of Privacy Practice.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restriction, but if you do not agree then you are bound to abide by such restrictions.

I have received a copy of the Notice of Privacy Practices for Coastal Pain and Spine Center, Inc.

_________________________________ _________________________

Name of Patient Date of Birth

_________________________________ _________________________

Signature Date

____

Signature of Patient Representative (Required if the patient is a minor)

OFFICE USE ONLY

I attempted to obtained the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: **Initials:** **Reason:**

Medical Release Form

SIGN ALL THAT APPLY

1. AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Coastal Pain and Spine Center to release any information required in the course of my examination or treatment, to my insurance company.

Signature of patient:____

2. AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Coastal Pain and Spine Center to release any information in the course of my examination or treatment, to the referring physician.

Signature of patient:____

3. AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the designated physician/hospital ________________________________
to release the requested medical records to Coastal Pain and Spine Center.
Fax: 843-757-6743 E-mail: coastalpainspine@yahoo.com

____ Progress Notes
____ Radiology Reports (CT Scan, DEXA Scan, X-Rays)
____ MRI Report
____ Lab Results
____ Operative Reports
____ Other ____

4. I hereby give my permission for the staff of Coastal Pain and Spine Center to leave messages regarding my treatment on my voicemail.

Print Name_______________________________ **Patient Date of Birth:**______________________

Signature of patient: ____