**Patient Registration Agreement**

**Personal Information (*Please Print*):**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State/Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D/L # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State/Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender □ M □ F Age\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □Single □ Married □ Divorced □ Widowed

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone # Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Work

**Primary Insurance**

Insurance Company Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State/Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Subscriber (*if other than Patient*) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscribers Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\*\*\* PLEASE SUBMIT YOUR INSURANCE CARD AND PICTURE ID WITH THIS FORM, SO WE MAY MAKE A COPY.\*\*\****

**Secondary Insurance**

Insurance Company Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State/Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ASSIGNMENT OF INSURANCE BENEFITS**

I CERTIFY THAT I HAVE INSURANCE COVERAGE WITH THE ABOVE INSURANCE CARRIER(S) AND HEREBY AUTHORIZE PAIN MANAGEMENT INJURY RELIEF MEDICAL CENTER TO RE-LEASE TO THE CARRIER(S) ANY INFORMATION THAT IS NECESSARY TO OBTAIN INSURANCE BENEFITS. I ASSIGN TO PAIN MANAGEMENT INJURY RELIEF MEDICAL CENTER, ALL MY RIGHT, TITLE, AND INTEREST IN AND TO ANY AND ALL HEALTHCARE BENEFITS OTHERWISE PAYABLE TO ME FOR ANY MEDICAL TREATMENT, RENDERED BY PAIN MANAGEMENT INJURY RELIEF MEDICAL CENTER AS DESCRIBED IN THE ATTACHED MEDICAL CLAIM FORM. I UNDERSTAND THAT **I AM FINANCIALLY RESPONSIBLE** FOR ALL CHARGES INCURRED, WHETHER OR NOT PAID BY INSURANCE AND AGREE TO PAY ANY APPLICABLE DEDUCTIBLE AND CO-PAYMENT AMOUNT NOT COVERED BY MY INSURER, PLAN OR PAYER.

I UNDERSTAND THAT MY INSURANCE COMPANY MAY ISSUE A CHECK FOR SERVICES PROVIDED BY PAIN MANAGEMENT INJURY RELIEF MEDICAL CENTER, TO MY SELF OR POLICY HOLDER, (*AS THEY ARE AN OUT OF NETWORK PROVIDER*). AS PART OF THIS ASSIGNMENT I AUTHORIZE THE PROVIDER TO ENDORSE ANY CHECK MADE PAYABLE TO THE PROVIDER AND TO MYSELF FOR SERVICES RENDERED. IN ADDITION, I AGREE TO ENDORSE ANY INSURANCE CHECK SENT TO ME BY MY INSURANCE CARRIER FOR SERVICES RECEIVED AND FORWARD TO PAIN MANAGEMENT INJURY RELIEF MEDICAL CENTER (*WITHIN 10DAYS UPON RECEIPT OF SUCH CHECK)*.

IF I DEPOSIT SUCH A CHECK INTO MY PERSONAL ACCOUNT, I AGREE TO SEND PAIN MANAGEMENT INJURY RELIEF MEDICAL CENTER A PERSONAL CHECK FOR THE EQUIVALENT AMOUNT. FAILURE TO REMIT PAYMENT WITHIN THE GIVEN TIME FRAME CAN RESULT IN COLLECTIONS EFFORTS BY THE PROVIDER, OUTSIDE COLLECTIONAGENCY, AND/OR LEGAL ACTION.

Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If not signed by Patient (√)**: □ Parent (for a minor) □Guardian Minor/Other □ Spouse □ Beneficiary/ Representative

I agree to be treated by the staff at Pain Management and Injury Relief Medical Center. I may be contacted at any of the addresses and phone numbers given. I understand the reasons for contact are for appointment reminders, test results, and other matters related to my health. I have not included any phone numbers or addresses that I would not want my health professional to reference or use. I have read and Understand that Pain Management and Injury Relief is *OUT OF NETWORK* with my Insurance Company (except Medicare and some HMO’s) and that I may receive payment from my Insurance Company, and that I am fully responsible for forwarding that payment to “Pain Management Injury Relief Medical Center” with in 10days of receipt of said payment and copy of attached EOB (Explanation of Benefits). I understand that I am fully responsible for my deductibles and co-pay as outlined in my Insurance policy and any NON-COVERED Services (Not medically necessary, denied etc).

**INITIAL**\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CANCELLATION POLICY:**

There is a $50 **Late Cancellation Fee** (if you do not cancel 24 Hours before of your scheduled appointment).

There is a $50 **NO SHOW Fee** (if you fail to arrive for your scheduled appointment).

All Appointments are confirmed prior to appointment date. **INITIAL**\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COPIES of RECORDS**:

I Understand there is a $25 charge for copies of my medical records, extra copies of medical billing, beyond what has already been submitted to my Insurance Company. **INITIAL** \_\_\_\_\_\_\_\_\_\_\_\_

**Notices Of Privacy Practices:**

The Notice of Privacy Practices describes how Pain Management & Injury Relief Medical Center will use and disclose your Protected Health Information to provide treatment, to obtain payment, or for other purposes necessary to operate this medical practice.

Your Protected Health Information includes reason(s) for your admission, type of care and treatment you may receive, other information, including demographic information (e.g. your home address, age, gender, and so forth) that maybe necessary or helpful to identify you, or to assist your Physician and others to provide necessary medical care.

A Copy of our Notice of Privacy Practices is given to you upon admission or 1st day of service, whichever is earlier.

(Please see attached) **INITIAL** \_\_\_\_\_\_\_\_\_\_\_\_

**ARBITRATION:**

Attached you will find our Physician –Patient Arbitration agreement. By signing this agreement, you are agreeing that any dispute arising out of medical services you receive is to be resolved by binding arbitration rather than litigation.

Lawsuits are something that no one anticipates and hope to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians.

Arbitration agreements between healthcare providers and their patients have long been recognized and approved by the California Courts.

By signing the attached agreement, you are changing the process by which your claim will be resolved (this does not take away your rights). You may still call witnesses and present evidence. Each party selects an arbitrator (called Party arbitrators), who then select a third, neutral arbitrator. These three arbitrators then hear your case.

This agreement generally helps to limit the legal costs for both patients and physicians. This also can spare some of the rigors of trial and the publicity that may accompany judicial proceedings.

***Our Goal*** is to Provide medical care in such a way as to avoid any such dispute. We know that most problems begin with communication. If you have any questions about your care…***PLEASE ASK***. **INITIAL** \_\_\_\_\_\_\_\_\_\_\_\_

Please print and sign below for acknowledgment of Pain Management and Injury Relief’s patient registration agreement.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Self □ Parent □ Representative/Guardian

PRINT: Patient/Representative Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature