

PAIN AND SPINE CONSULTANTS, PA dba SPINE & PAIN CARE (SPC)

PATIENT INFORMATION				PRIMARY POLICYHOLDER'S INFORMATION			
NAME				NAME			
SS# / /		EMAIL		DATE OF BIRTH			
STREET ADDRESS				SS#			
MAILING ADDRESS			COUNTY	PHONE #			
PATIENT'S EMPLOYER INFORMATION				POLICYHOLDER'S EMPLOYER INFORMATION			
CITY & STATE		AGE	ZIP	EMPLOYER			
PHONE ()		CELL PHONE ()		STREET ADDRESS			
DATE OF BIRTH / /		SEX: M / F	MARITAL STATUS: S M W D	MAILING ADDRESS			
EMPLOYER				CITY & STATE		ZIP	
STREET ADDRESS				FULL TIME []		PART TIME []	
MAILING ADDRESS				POLICYHOLDER'S MAILING ADDRESS (IF DIFFERENT)			
CITY & STATE		ZIP		ADDRESS			
WORK PHONE #				CITY & STATE			
FULL TIME []		PART TIME []		ZIP			
PERSON RESPONSIBLE FOR BILL/GUARANTOR				PHONE #			
NAME				SECONDARY POLICYHOLDER INSURANCE			
SS#				PATIENTS RELATIONSHIP TO POLICYHOLDER			
STREET ADDRESS				NAME			
CITY & STATE		ZIP		DATE OF BIRTH			
DATE OF BIRTH / /				SS#			
PHONE #				PHONE #			
How did you hear us ? Doctor <input type="checkbox"/> Direct Mail <input type="checkbox"/> Bill-board <input type="checkbox"/> Radio <input type="checkbox"/> Friend or patient <input type="checkbox"/> TV <input type="checkbox"/> Our website <input type="checkbox"/> Internet <input type="checkbox"/> Newspaper <input type="checkbox"/>							
EMERGENCY CONTACT							
NAME		RELATIONSHIP		HOME PHONE #:		OTHER PHONE#	
YOUR DOCTORS							
Referring Doctor:		Family Doctor:		Psychiatrist:		Rheumatologist:	
How would you like to be contacted regarding appointments, treatment and/or other pertinent matters such as payment ?							
ANY METHOD:		HOME PHONE		Email:		CELL PHONE:	
Okay to leave message on answering machines ___ YES ___ NO (PLEASE CHECK ONE)							
HIPAA PRIVACY RELEASE							
NAME/RELATIONSHIP		PHONE:		NAME/RELATIONSHIP		PHONE	
NAME/RELATIONSHIP		PHONE:		NAME/RELATIONSHIP		PHONE:	
I authorize the person(s) listed above to receive all health information about appointments, treatment &/or other information pertinent to my healthcare &/or payment for my healthcare provided at any SPC location. I acknowledge receipt of the SPC Financial Policy; I am responsible for payment if the insurer denies my benefits as per SPC contract with my insurer. Scanned document is as good as original.							
I do not authorize any information to be disclosed to any other parties except to me as the patient. I am responsible for payment if the insurer denies my benefits as per SPC contract. _____ (YOUR INITIALS HERE) Scanned document is as good as original.							
PATIENT SIGNATURE				DATE			

Pain and Spine Consultants, PA dba Spine & Pain Care (SPC) GENERAL CONSENT TO TREAT, PATIENT AUTHORIZATION AND ACKNOWLEDGEMENT OF BENEFITS RELEASE

The following are the conditions for services provided by SPC for the patient whose name appears at the bottom of this page.

CONSENT FOR MEDICAL TREATMENT

I/we voluntarily consent to medical treatment and diagnostic procedures provided by SPC its associated physicians, clinicians and other personnel. I/we consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by my physician. I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

AUTHORIZATION FOR RELEASE OF INFORMATION

The practice and physicians are authorized to release any medical information required in the processing of applications or submission of information for financial coverage, discharge planning and further medical treatment. To include information referring to psychiatric care, sexual assault or tests for infectious diseases including AIDS/HIV for services provided during this visit. I/we also agree to the release of medical or other information about me to government federal or state regulatory agencies as required by law.

ASSIGNMENT OF INSURANCE BENEFITS

I/we guarantee payment of all charges made for or on account of the patient and I/we assign our rights in any insurance benefits or other funding to the physician at SPC. I/we understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits. I/we understand the SPC can obtain my/our credit report for review in collection of this debt. In the event that this account is placed with a collection agency or attorney for collection or collected following the SC Setoff Debt Collection Act, I/we shall pay all collections fees and costs, including reasonable attorney's fees. For Medicare beneficiaries: I/we have provided all necessary information for proper assignment of Medicare benefits.

WORKER'S COMPENSATION PATIENT RECORDS RELEASE AND AUTHORIZATION FORM

I understand that South Carolina and North Carolina

Worker's Compensation law provides that written information which pertains directly to a workers' compensation claim must be provided by a healthcare facility/physician to the insurance carrier, the employer, the employee, their attorneys, or the applicable State Workers' Compensation Commission pursuant to the SC Code Ann § 42-15-95 and NC ST § 97-27. I authorize SPC to provide copies of my medical records or to speak to duly authorized representatives of any of the above regarding my medical records, medical treatment, or condition.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I/we have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. *This document and Notice of Privacy may be accessed at www. GreenvillePain.com*

PAYMENT AND SERVICE FEES:

We collect co-pay and deductibles at the time of service, at registration. Cash Pay / Self pay patients: we collect full fee at the time of service, at registration.

We provide services not covered by your insurer, following are the most common, additional information available from SPC administrator. We need 7 days to complete your request. All fees are pre-paid and non-refundable. (These services may be free of charge at your PCP's office; we encourage you to use their free service)

- Writing a letter: \$15 per page
- Filling out forms: \$ 25 per page
- Check Returned: \$50
- Prescription without doctor visit: \$15

Please cancel or postpone your appointments if you are unable to keep them by giving us 24 hour notice during working days. Call 373 PAIN or email for quick confirmation *frontdesk@thiyaga.com*. We will be glad to offer your cancelled slot to a patient on waiting list.

- Cancelled appointment without 24 hour notice, during working days: \$ 50 (for follow up / med pick up) \$100 (for procedures)
- Missed appointment: \$100
- Above payment is collected before re-schedule.

Scanned or Faxed copy of this document is as good as original. I understand and accept terms and conditions mentioned above.

Patient Sign:.....

Patient Name:.....

Authorized SPC Staff:..... **Date:**.....