Pacific Spine & Pain Center

INNOVATIVE SOLUTIONS FOR PAIN™

A Division of Bay Area Surgical Specialists

PATIENT INFORMATION

Patient First Name	Middle Name	Last Name	Age	Birth Date

Mailing Address	City	State	Zip

Street Address	City	State	Zip

Home Phone	Cell Phone	Employer Name (for work comp only)	Employer Phone	Position

Marital Status (Circle One) M S W D P	Social Security #	Doctor to Be Seen	Primary Doctor	Referring Doctor

May we leave medical info on voicemail? Home Cell Both

May we contact you at work? Yes No

Best number for reminder message? Home Cell

Email Address:

Race (Optional) Check One:

American Indian or Alaska Native □ Asian □ White □ Hispanic □ Native Hawaiian or Other Pacific Islander □

Black or African American □ Other □ Prefer Not To Answer □

Ethnicity

Hispanic or Latin □ Not Hispanic or Latin □ Prefer Not To Answer □

Preferred Language

EMERGENCY CONTACTS

Emergency Contact Name #1 (Spouse if married)	Relationship:	Personal Number:	Work Number:

PHARMACY INFORMATION

Name of Pharmacy:	Address:	Phone Number:

PRIMARY INSURANCE INFORMATION

Name of Primary Insurance Company	Name of Subscriber	Relationship to Patient

Subscribers Birth Date	Subscribers Social Sec. #	Subscriber/Member/Claim #	Group #

Subscribers mailing address if different than yours:

Adjuster Name:	Adjuster Phone:	Adjuster Fax:	Date of Injury:

SECONDARY INSURANCE INFORMATION

Name of Secondary Insurance Company	Name of Subscriber	Relationship to Patient

Subscribers Birth Date	Subscribers Social Sec. #	Subscriber/Member/Client ID #	Group #

Subscribers mailing address if different than yours

IF PATIENT IS UNDER 18 YEARS OLD PLEASE COMPLETE THIS SECTION

Legal Guardian's Full Name	Relation to Patient	Birth Date

Guardian's Social Security #	Guardian's Phone #

Mailing Address If Different Than Above	City State	Zip

Guardian's Employer Name	Position/Title	Employer Phone #

Acknowledgement

I acknowledge that I have received the Notice of Privacy Practices from Pacific Spine and Pain Center.

X _____ Date _____

Pacific Spine & Pain Center
INNOVATIVE SOLUTIONS FOR PAIN™
A Division of Bay Area Surgical Specialists

Name: _____ Date of Birth _____

Reason for pain management: _____

Medications	Strength	Frequency

Please write additional medications on back of page

Medical history (other health problems): _____

_____

_____

_____

Allergies (please list ALL): _____ No known drug allergies (fill in bubble) ◯

_____

_____

_____

Surgeries: _____

_____

_____

_____

Hospitalizations: _____

_____

_____

_____

Family history:

- Alcohol abuse (if yes, who?) _____
- Addictions problems (if yes, who?) _____
- Any pertinent health problems (if yes, who?) _____

  _____

Social history:

- Tobacco: ◯ Never ◯ Former – Date Stopped: _____ ◯ Current – Date Started: _____

  If current: ◯ Some days ◯ Everyday Quantity/Frequency: _____
- Alcohol: ◯ Never ◯ Former – Date Stopped: _____ ◯ Current – Date Started: _____

  If current: ◯ Some days ◯ Everyday Quantity/Frequency: _____
- Drug use: _____

Previous treatments for condition (injections, surgery, physical therapy, previous medications, etc. and dates):

_____

_____

_____

_____

_____

_____

Please sign and date to verify all of the above information is correct and true

X _____ Date: _____

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to Brandon Sorensen, M.D. as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits. In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of Employee Retirement Income Security Act of 1974 ("ERISA") breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Printed Name _____

Signature: _____ Date: _____

FINANCIAL RESPONSIBILITY POLICIES

Pacific Spine and Pain Center participates in most insurance plans, including Medicare. Pacific Spine and Pain Center does not participate in Medicaid. I understand this office will make every effort to obtain payment from the insurance carrier, Medicare, and/or other third party payor. I acknowledge and understand services may be denied for any and all reasons, including, but not limited to pre-existing conditions, routine, experimental, not reasonable or necessary, trauma, injury or work related, etc.

I acknowledge I am financially responsible for all fees incurred for services rendered regardless of insurance. Furthermore, in the event I do not have insurance, I understand that payment in full is expected at each visit. I acknowledge that failure to comply with the financial policies of this practice will place my status at this practice in jeopardy.

All co-payment and deductibles must be paid at the time of service. I understand that this arrangement is part of the contract between Pacific Spine and Pain Center and my insurance company. I understand that failure Pacific Spine and Pain Center to collect co-payments and deductibles from me may be considered fraud.

Any unpaid balance owed on my account may be assessed at the rate of 1.5 % per month (18% per year). If bills remain unpaid for more than sixty (60) days this practice will proceed with legal action to collect the account. I understand I will be responsible to pay for any fees incurred for the collection of my bill. This includes, but is not limited to outside collection agency fees, interest charges, attorney fees, and court costs

If my insurance pays me directly, I agree to forward the payment to this office within 10 days of my receipt of payment. I further understand that failure to comply with this policy will place my status at this practice in jeopardy, as well as proceeding with legal action to collect the account. In addition to the balance due, any collection agency fees and/or attorney fees will be assessed to the account.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Printed Name _____

Signature: _____ Date: _____