PATIENT REGISTRATION

COMPREHENSIVE PAIN
MANAGEMENT SPECIALISTS

Note: This form may be completed manually or on your computer. To complete this form on your computer: *1. Type your answer in each field. 2. Save your work often on your computer or device. 3. Print the completed form and bring it with you to your first appointment.*

How did you hear about us?
- ☐ Newspaper
- ☐ Social media/Web search
- ☐ Insurance referral
- ☐ Family/Friend

PATIENT INFORMATION

NAME (Last, First, M.I.)	SSN	BIRTHDATE	LANGUAGE	PRIMARY CARE PROVIDER	SEX ○ M ○ F

BILLING ADDRESS	APT #	CITY	STATE	ZIP

PHYSICAL ADDRESS (If different from billing address)	APT #	CITY	STATE	ZIP

CELL PHONE XXX-XXX-XXXX	HOME PHONE XXX-XXX-XXXX	DAY PHONE XXX-XXX-XXXX	EMAIL ADDRESS (EXAMPLE@TEST.COM)

PREFERRED CONTACT METHOD (REQUIRED) ○ CELL ○ HOME ○ DAY ○ EMAIL	MARITAL STATUS	MOTHER'S MAIDEN NAME	RACE	ETHNICITY

EMERGENCY CONTACT NAME	PHONE NUMBER XXX-XXX-XXXX

PRIMARY EMPLOYER	SECONDARY EMPLOYER (If applicable)

ADDRESS	SUITE #	ADDRESS	SUITE #

CITY, STATE, ZIP	CITY, STATE, ZIP

WORK PHONE XXX-XXX-XXXX	OCCUPATION	WORK PHONE XXX-XXX-XXXX	OCCUPATION

POLICYHOLDER/GUARANTOR (If different than patient)

NAME (Last, First, M.I.)	SSN	BIRTHDATE	LANGUAGE	PRIMARY CARE PROVIDER	SEX ○ M ○ F

BILLING ADDRESS	APT#	CITY	STATE	ZIP

PHYSICAL ADDRESS (If different from billing address)	APT#	CITY	STATE	ZIP

CELL PHONE XXX-XXX-XXXX	HOME PHONE XXX-XXX-XXXX	DAY PHONE XXX-XXX-XXXX	EMAIL ADDRESS (EXAMPLE@TEST.COM)

PREFERRED CONTACT METHOD (REQUIRED) ○ CELL ○ HOME ○ DAY ○ EMAIL	MARITAL STATUS	MOTHER'S MAIDEN NAME	RACE	ETHNICITY

RELATIONSHIP TO PATIENT

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY #

NAME OF POLICY HOLDER	DOB	GROUP #

RELATIONSHIP TO PATIENT	COPAY AMT $

ADDRESS OF INSURANCE COMPANY	SUITE #	DEDUCTIBLE AMT $

CITY, STATE, ZIP	PHONE XXX-XXX-XXXX	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY #

NAME OF POLICY HOLDER	DOB	GROUP #

RELATIONSHIP TO PATIENT	COPAY AMT $

ADDRESS OF INSURANCE COMPANY	SUITE #	DEDUCTIBLE AMT $

CITY, STATE, ZIP	PHONE XXX-XXX-XXXX	EFFECTIVE DATE	EXPIRATION DATE

FINANCIAL POLICY: Payment in full or co-payment is expected at the time of service. Services provided that are not a covered benefit of your health plan will be your responsibility.

CONSENT TO TREATMENT/RELEASE OF INFORMATION: I grant Comprehensive Pain Management Specialists to administer medical treatment and perform medical procedures as deemed necessary. I authorize the release of medical information to my insurer, or the insurer's agents to process my payments for service. To the best of my knowledge, all of the information above is true and correct. **ASSIGNMENT OF BENEFITS:** I thereby assign all benefits payable by my insurance company to Comprehensive Pain Management Specialists.

PATIENT/GUARDIAN SIGNATURE _____ _____ _____

DATE RELATIONSHIP TO PATIENT

COMPREHENSIVE PAIN
MANAGEMENT SPECIALISTS

PATIENT FINANCIAL AGREEMENT

- **Co-Payments:** Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. Please help us in upholding the law by paying your co-payment at each visit.
- **Deductible Payments:** If your insurance requires you to meet a deductible before services are covered, payment must be made at the time of service. A $100.00 payment will be due at the time of service. Please note the $100.00 payment does not constitute payment in full and any additional balance must be paid upon receiving notification from our practice.
- **Claims Submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Payment from your insurance company is expected within 45 days. After 45 days, we will look to you for payment in full. You will be responsible for all non-covered services according to Medicare guidelines. We must have a copy of your most recent cards and any secondary insurance or supplement you may have. Accounts that are 90 days past due are subject to being sent to a collection agency or small claims court for the unpaid bills. If we receive notification that you are not eligible for coverage or we are not contracted with your insurance, you will be responsible for all charges incurred. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.
- **Preventive Care Services:** Routine exams are not always covered by your insurance. Please be aware that if an additional problem is addressed at the time of your visit, a co-pay, deductible or office visit fee may be charged. If services are denied for payment by your insurance or you have failed to provide us with your correct insurance information, you will be responsible to pay for these services.
- **Cash Pay Patients:** The amount you pay for today's scheduled office visit may not be your final payment. Other costs that may be accrued for today's appointment are including, but not limited to, laboratory tests, x-ray tests, any injections, special procedures or additional office visit charges.
- **Laboratory Bills:** Any laboratory procedures that are ordered during today's visit will be billed to you directly by the laboratory. Please contact your laboratory directly for any questions regarding your lab bill.
- **Missed Appointments:** Please note a $25.00 cancellation fee will apply for missed appointments or failure to cancel within 24 hours prior to your scheduled appointment time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.
- If at any time you should experience financial hardship and need to make special payment plan arrangements, please contact our billing office.

Assignment of Benefits: Authorization is hereby granted to release information as may be necessary to process and complete my insurance claim, and payment of medical benefit is to be paid directly to Comprehensive Pain Management Specialists for all services rendered. *Initials:* _____

I have read and understand the above statements. I agree to comply with the financial policies of the office and I am financially responsible for my account.

Patient or Guardian Signature: _____ *Date:* _____

Patient Name (please print) _____ *Date of Birth:* _____

COMPREHENSIVE PAIN
MANAGEMENT SPECIALISTS

PERMISSION TO DISCUSS PROTECTED HEALTH INFORMATION WITH OTHERS

I hereby grant permission to Comprehensive Pain Management Specialists to speak to the following individuals about my health and disclose my health information including billing and insurance. I understand this authorization does not include information regarding HIV, psychiatric, drug and/or alcohol records, which must be authorized on a separate release.

	NAME	DOB
Spouse		
Children		
Guardian		
Caregiver		
Sister		
Brother		
Friend		
Emergency Contact		
Other		

You may discuss my (please check all that apply)

☐ Visit Notes ☐ Laboratory Results ☐ X-rays ☐ Reports ☐ All Services and Treatment Rendered

I understand that I may revoke this authorization at any time in writing.

Patient Name (please print)_____ Patient Date of Birth_____

Patient/Guardian Signature_____ Date_____

COMPREHENSIVE PAIN
MANAGEMENT SPECIALISTS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

COMPREHENSIVE PAIN MANAGEMENT SPECIALISTS

I hereby acknowledge that I have been offered a copy of Comprehensive Pain Management's Notice of Privacy Practices. I have been advised that a copy of the current notice will be posted in the reception area, and that any amended Notice of Privacy Practices will be available at each appointment.

PATIENT NAME (please print) _____ PATIENT DATE OF BIRTH _____

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

___-___-_____ PATIENT PHONE XXX-XXX-XXXX

_____ NAME OF PHYSICIAN

If not signed by the patient, please indicate relationship:

- O Parent or guardian of minor patient
- O Guardian or conservator of an incompetent patient
- O Beneficiary or personal representative of deceased patient

☐ I would like to receive a copy of any amended Notice of Privacy Practices via e-mail.

My email address is: _____

LATEX ALLERGY QUESTIONNAIRE

COMPREHENSIVE PAIN
MANAGEMENT SPECIALISTS

Patient Name _____ Date of Birth _____

(5)... 1. Have you ever had an anaphylactic reaction to latex devises or products? ..... ○ Yes ○ No

(1)... 2. Do you have spina bifida, myeloma, or myelodysplasia? ..... ○ Yes ○ No

(*)... 3. Have you had a reaction to the following common sources of latex? ..... ○ Yes ○ No

Check all that apply:

- ☐ Balloons
- ☐ Latex birth control devices
- ☐ Erasers
- ☐ Hot water bottles
- ☐ Foam pillows
- ☐ Pacifiers, teething rings
- ☐ Rubber gloves
- ☐ Dental cofferdams
- ☐ Face masks
- ☐ Rubber bands, balls
- ☐ Baby bottles, nipples
- ☐ Elastic bandages
- ☐ Belts, bras, suspenders
- ☐ Cuffs, elastic waistbands
- ☐ Rubber grips
- ☐ Ostomy bags
- ☐ Footwear

(4)... If you have checked any of the above in #3, have you experienced any of the following reactions? ..... ○ Yes ○ No

- ☐ Wheezing/shortness of breath
- ☐ Immediately on contact to the food (Urticaria, Hives)
- ☐ Chest tightness

(*)... "YES" answers to the following indicate potential for latex sensitivity:

- ☐ Runny nose / congestion
- ☐ Itching (e.g., hands, eyes)
- ☐ Swelling
- ☐ Chapping or "cracking" of the hands

(*)... 4. Do you have any allergies/sensitivities to the following foods? ..... ○ Yes ○ No

Check all that apply:

- ☐ Avocados
- ☐ Bananas
- ☐ Potatoes
- ☐ Chestnuts
- ☐ Kiwis
- ☐ Peaches
- ☐ Papaya
- ☐ Tomatoes

(3)... If you have checked any of the above in #4, have you experienced any of the following reactions? ○ Yes ○ No

- ☐ Wheezing /shortness of breath
- ☐ Immediately on contact to the food (Urticaria, Hives)
- ☐ Chest tightness

(*)... "YES" answers to the following indicates potential for latex sensitivity:

- ☐ Runny nose / congestion
- ☐ Itching (e.g. hands, eyes)
- ☐ Swelling
- ☐ Chapping or "cracking" of the hands

(1)... 5. As an infant / child did you have multiple surgeries? ..... ○ Yes ○ No

(1)... 6a. Are you a health care worker and have repeated exposure to products containing LATEX? ..... ○ Yes ○ No

If yes, to which products do you have repeated exposure? _____

(1)... 6b. Does your job involve working in a factory where rubber or latex products are manufactured? ○ Yes ○ No

If yes, what products do you manufacture? _____

OFFICE USE ONLY

MAXIMUM SCORE POSSIBLE: 16-4 or below complete #1A & 1B

1. TOTAL SCORE _____
   If 5 or ABOVE, complete # 2&3 and INITIATE LATEX PRECAUTIONS
   If 4 or BELOW and "YES" ANSWERS are marked for SENSITIVITY - questions 3&4

1a. PHYSICIAN(S) NOTIFIED Yes (Name of MD / Time) _____ ☐ No

1b. Does Physician want to initiate LATEX PRECAUTIONS? ☐ Yes ☐ No

If 5 or above continue the following questions

2. Identification of the patient and room _____
   LATEX added to allergy computer screen? ☐ Yes - patient banded with "LATEX PRECAUTIONS" armband ☐ No
   LATEX PRECAUTIONS sticker ☐ Yes - on door ☐ Yes - on bed ☐ Yes - on wall ☐ Yes - on chart
   KARDEX marked with "LATEX PRECAUTIONS" ☐ Yes

3. Physician(s) Notified: Patient placed on "LATEX PRECAUTIONS" (Name of MD / Time) _____

_____ _____

RN/ LVN/ RT/ OT/ MA Date