SunCoast Pain Management

PATIENT INFORMATION SHEET

Name: _____
Last First Middle

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Social Security Number: _____ Date of Birth: _____

Age: _____ Sex M F

Employer: _____ Phone: _____

Position: _____ Department: _____

Spouse's Name: _____ Phone: _____

Social Security Number: _____

Employer: _____ Phone: _____

Is this from a Car Accident? Yes or No **Is this from a Worker's Comp Injury? Yes Or NO**

****

If patient is a minor:

Responsible Party: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Social Security Number: _____

Date of Birth: _____ Age _____ Sex M F

****

Emergency Contact:

Name: _____ Phone: _____

_____ Relative _____ Friend _____ Neighbor

Primary Insurance Company: _____

Policy Number: _____ Group Number: _____

Address on back of card: _____

Phone number on back of card: _____

Policy Holder: _____ Relation: _____

Policy Holder's

Date of Birth: _____

Social Security Number: _____

Secondary Insurance Company: _____

Policy Number: _____ Group Number: _____

Address on back of card: _____

Phone number on back of card: _____

Policy Holder: _____ Relation: _____

Policy Holder's

Date of Birth: _____

Social Security Number: _____

Workman's Compensation Company: _____

Employer: _____ Date of Injury: _____

Adjuster: _____ Case Manager: _____

The undersigned hereby authorizes treatment and the release of information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for bendfits for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned has personally signed the particular claim.

Signature: _____ Date: _____

Print Name: _____ Witness: _____

SunCoast Pain Management, P.A.

Acknowledgement of Receipt: Notice of Privacy Practice

I, _____ hereby acknowledge that I have received a
(print name)
copy of the "Notice of Privacy Practice" from the staff of SunCoast Pain Management, P.A. A list of potential disclosures, my rights as a patient, and a complaint process is included. I understand that any questions that I may have can be answered by the center's Privacy Officer or acting Office Manager.

Signed: _____

Date: _____

Witness: _____

For Office Use Only!

I have made a good faith effort to obtain a written acknowledgement of receipt of the Sun Coast Pain Management Notice of Privacy Practices from the above named patient, but was unable to for the following reason:

____ Language Barrier

____ Patient Cannot Read

____ Patient Objects

____ Read Later and Return

____ Unable to Sign

____ Other: _____

_____ _____

Employee Name Date

SunCoast Pain Management, P.A.

I, _____, hereby authorize the physicians and staff of SunCoast Pain Management, P.A., to give the following people information concerning my health and well being.

_____ Spouse Name: _____

_____ Significant Other Name: _____

_____ Other Person Name: _____

Name: _____

Name: _____

The following information may be given to the above individuals:

_____ Appointment Time _____ Procedures

_____ Test/Lab Results _____ Billing/Financial Information

_____ Medications _____ Any other information regarding my health

I also authorize SunCoast Pain Management, P.A. to leave a message on my answering machine or with someone at my residence regarding upcoming appointments.

_____ Yes

_____ No

I understand I may revoke this consent at any time by giving written notice to SunCoast Pain Management, P.A. making this disclosure.

Signed: _____ Date: _____
(Patient/Parent/Legal Guardian)

Witness: _____ Date: _____

SUNCOAST PAIN MANAGEMENT, P.A.

#4 Doctor's Drive, Suite C
Ocean Springs, MS 39564

1720 A Medical Park Drive
Suite 310
Biloxi, MS 39532

PATIENT'S NAME: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Authorization is hereby granted to release information to:

_____
NAME OF INSURANCE COMPANY

ASSIGMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to SunCoast Pain Management, P.A. of the expense benefits otherwise payable to me but not to exceed SunCoast Pain Management's regular charges for this period of care. I understand that I am financially responsible to SunCoast Pain Management, P.A. for charges not covered by my insurance plan.

Date: _____ Signed: _____

SunCoast Pain Management, P.A.
FINANCIAL POLICY

Patient's Name: _____ Date of Birth: _____/_____/_____

Thank you for entrusting us with your medical needs. Our goal is to provide you with the quality care in a friendly comfortable atmosphere and in the timeliest manner possible. We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship.

GENERAL OFFICE RULES We believe your time is as valuable as ours. We do not overbook patients except in cases of emergency and we do our best to stay on schedule to avoid any delays to you. Please assist us in our efforts to stay on schedule by arriving on time for your scheduled appointment. If you arrive more than 15 minutes late it may be necessary to reschedule your appointment for a later time.

Our receptionists are required to keep patient demographic information as up to date as possible. They will be required to get a copy of your insurance card and driver's license. Please understand that we may ask you if any changes have occurred with your insurance, address or phone number on subsequent visits. This information helps us to better serve you.

Please realize that it is each individual's responsibility to keep track of appointments made. If you need to cancel an appointment, 24 hours notice is required so that we may schedule another patient in the time slot reserved for you. On occasion you may not receive a courtesy reminder call, however, please realize it is each individual's responsibility to keep track of appointments made. When calling in to cancel your appointment please make sure to document the name of the person you spoke with and the time and date that you made the call.

_____ Initial **If you do not cancel your appointment 24 hours in advance, a $35.00 fee will be charged to your account and is payable prior to future visits.**

_____ Initial **Any returned checks are subject to a $30.00 service fee.** Any returned check must be resolved before any future appointments will be arranged.

_____ Initial **Payment for Co-Pays, Deductibles or any procedure not covered by insurance will be collected before you are seen for your appointment.** The parents (or guardian) accompanying a minor will be responsible for payment.

INSURANCE As a courtesy to you, we will bill your insurance company and assist you in receiving maximum benefits. Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We WILL NOT become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, pre-existing conditions, etc. If your insurance company mails you a check, please contact us as this check may be fore services rendered. If your insurance company has not paid the FULL BALANCE within 60 days you are responsible for payment of the balance of the account. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise it is recommended that you contact our billing department so that a payment plan can be initiated, so that your account will not be turned over to collections. If your account does become delinquent and sent to collections the collection service cost will also be your responsibility. **It is the ultimate responsibility of the patient to understand his/her insurance coverage. Insurance policies may change and/or insurance company representatives may not always give us correct or consistent information. In the event of denials, errors, or non-covered services, the patient is responsible for all services rendered. If you have an outstanding balance with Sun Coast Pain Management you will be required to make monthly payments on this balance. Our Billing Department will be glad to assist you in these matters. _____**

Initial

MEDICARE/MEDICAID The federal government requires that all Medicare/Medicaid claims be filed by the facility. Therefore, you must show your insurance card on EACH visit to our office. We regret the inconvenience, but in order for you to receive benefits, the federal government requires that all the rules be followed to their specifications.

We thank you for understanding our financial policies. This has become necessary in order to continue to accept insurance plans without having patients pay the balance up front and then wait themselves for reimbursement from their insurance company. Our goal is to make your visit with us pleasant and professional. If you have any questions please feel free to ask our staff for assistance. Thank you again for choosing us for your care.

Provider and patient agree that this Financial Policy is necessary for us to continue to provide your medical services. Failure of the patient to abide by the terms of this financial Policy may result in termination of your care by the Provider(s) at Sun Coast Pain Management.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____ _____/_____/_____ _____

Patient (or Responsible Party) **Date** **Witness**

I acknowledge receipt of a copy of the Agreement on the date stated above _____

Initial