

REGISTRATION FORM



Today's Date: ____/____/____ (please print)

First Name: _____ Middle: _____

Last Name: _____

DOB: ____/____/____ Sex: M F Social Security: _____ - _____ - _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Please list two confidential numbers we can leave message with and contact you by:

Cell Phone No: (_____) _____ Other Phone No: (_____) _____

E- Mail: _____

Referring Physician: _____ Phone #: (_____) _____

Primary Care Physician: _____ Phone #: (_____) _____

Cardiologist: _____ Phone #: (_____) _____

Pharmacy: _____ Phone #: (_____) _____

Work Status: Retired Unemployed Student Full Time Part Time

Patient Occupation: _____

Patient Employer: _____ Employer Phone No. (_____) _____

Name of Primary Insurance: _____

Patient's Relationship to Subscriber: Self Spouse Child Other _____

Policy #: _____ Group #: _____

Subscriber's Name: _____

Subscriber's S.S. # _____ DOB: ____/____/____

Name of Secondary Insurance (if applicable): _____

Patient's Relationship to Subscriber: Self Spouse Child Other _____

Policy #: _____ Group #: _____

Subscriber's Name: _____

Subscriber's S.S. # _____ DOB: ____/____/____

Is this a Workers' Compensation Injury? Yes No If Yes – Please see the front desk

Name of Emergency Contact: : _____

Relationship to Patient: _____ Contact Phone No.:(_____) _____

Dallas Pain Consultants provides the opportunity for patients to communicate by email. By providing an electronic mail address to Dallas Pain Consultants, the patient acknowledges that medical information may be contained in these communications. Email should never be used for emergency problems. Dallas Pain Consultants cannot guarantee the security and confidentiality of e-mail communication and will not be liable for improper disclosure of confidential information that is not caused by Dallas Pain Consultants intentional misconduct. Initial _____

By signing below, you confirm that the information you have provided is correct and true to the best of your knowledge. It is your responsibility to inform Dallas Pain Consultants of any changes to any information above.

Patient's or Authorized Representatives Signature

Today's Date

Name: _____ DOB: _____



Financial Policy & Assignment of Benefits

Our financial policy outlines our practice guidelines which should allow you to receive all the benefits offered to you by your health plan. We ask that you read the following carefully and agree to our terms and conditions to which are necessary to facilitate your care.

- Insurance cards should be available upon request at all visits.
- We file claims as a courtesy to our patients and are only responsible for filing claims to contracted insurance companies and the member.
- Any dispute for unpaid charges from the insurance company will be billed to you the patient.
- **All copays, coinsurance & deductibles must be paid at the time of service, this is an insurance requirement and part of your contract with the insurance company.**
- **Contract** – Your insurance policy is a contract between you, your employer (if applicable) and the insurance company. We are not a party to that contract. It is important that you understand the provisions of your policy, as we cannot guarantee payment of claims. In the instance your insurance company denies payment for services provided you are responsible for payment of treatment
- **Procedures & Injections Costs** – In all cases we collect an **estimate** of your financial responsibility amount at the time of service. Procedures & injections may be rescheduled if the estimated amount is not paid on or prior to the time of service. This will be an estimate ONLY and may be subject to change depending on the services provided. We will either bill you for the remaining balance or credit any overpayment in a timely manner. Payment plans are available upon request, please contact us PRIOR to your appointment. Unless you make prior arrangements, our financial policy will stand.

Charges and Fees

- **Charges for Forms** - Our charge for completing FMLA, Disability or Life Insurance paperwork is \$35.00 per form and is due in full before the paperwork can be picked up, faxed or mailed. Allow 7-10 days processing.
- **No Show Fees** - We require 24-hour notice for appointment cancellations. In the event you do not give the required notification a no-show fee will be assessed. Office visits will incur a \$25.00 fee and procedures/injections will incur a \$100.00 fee. Patients who habitually fail to keep appointments may be discharged from our clinic.
- **Returned Checks** - A \$25.00 fee will be charged for any returned checks and we will no longer accept your checks.
- **Payment Methods** – We accept cash, checks (Under \$100), money orders and all major credit cards (VISA, Mastercard, Discover & American Express)
- **Account Billing Questions & Refunds** – Questions or concerns regarding your account or insurance claim can be directed to our billing department (214) 948-7700 Ext 201. If your account has a credit balance, we will issue a refund once all outstanding claims on your account have processed.

Assignment of Benefits:

Insurance is considered a method of reimbursing you the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage for the charge. It is your responsibility to pay any deductible amount, coinsurance, or any other balance not paid for by your insurance at the time of service.

I understand that I am responsible for providing **Dallas Pain Consultants** all insurance information at the time of registration to allow for verification of benefits, and that regardless of my assigned insurance benefits, I am responsible for the total charges for services rendered.

Initial_____

I hereby assign all medical and /or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and other health plans to **Dallas Pain Consultants**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether paid by said insurance. I hereby authorized said assignees to release all information necessary to secure payment

Initial_____

By signing below, you agree to all terms and conditions stated above, you fully understand DPC financial policy and as the patient you are ultimately responsible for all liable amounts.

X _____
Patient's or Authorized Representative's Signature Todays Date

Name: _____ DOB: _____



Nurse Practitioner & Physician Assistant Consent

Here at, Dallas Pain Consultants, we strive to offer you high quality medical care and give strong consideration to your wait time. We employ Advanced Practice Registered Nurses, also known as Nurse Practitioners and/or Physician Assistants to assist us in carrying out your plan of care. Nurse Practitioners and Physician Assistants have received advanced education and training in the provision of health care. They are graduates of a certified training program and licensed by the Texas State Medical Board. They can diagnose, treat and monitor routine and complex pain disorders as well as provide health maintenance care. If you are seen by one of these providers, your doctor will review your care with them as part of your treatment plan. "Supervision" does not require the constant physical presence of the supervising physician, but rather, observing the activities of accepting responsibility for the medical services provided.

I have read the above and understand that in this practice a team approach is used with my unique needs presented and reviewed by one or more physicians in the development of my plan of care. I also understand that from time to time I may be seen by any or all of the providers in this practice, including the physicians, Nurse Practitioners and Physician Assistant.

I hereby consent to the services of a Nurse Practitioner or Physician Assistant for my healthcare needs. I understand that I can refuse to see the Nurse Practitioner or Physician Assistant and request to see a physician. I understand that this may require my appointment to be rescheduled.

X _____
Patient's or Authorized Representative's Signature Today's Date

Disclosure of Physician Interest & Ownership

To better serve you, our physicians, have ownership or financial interests in various other health care providers and/or facilities. Today's medical business climate is very complicated, and physicians have little negotiation power with insurance companies. Our physicians are committed to providing high quality health care services to our patients and may refer you to one of these providers and/or facilities to receive health care items or services that he has determined you need. Their ownership interest in these often provides them a voice in administrative, clinical and operational policies. This involvement helps ensure the highest level of patient care and customer service. During a physician/patient relationship you may be referred to a provider/facility or service. I am providing this information to help you make an informed decision about your health care. However you have the right to choose your health care provider and you have the option to use a health care provider/facility/service other than the provider/facility/service to which you might be referred you. You will not be treated any differently if you choose to obtain health care from a provider/facility/service other than the provider/facility/service in which DPC Providers have an ownership or financial interest. If you require assistance we will be happy to provide information about alternative providers/facilities/services. A list of these facilities/providers is available upon request.

If you have questions, please do not hesitate to ask. We welcome you as a patient & we value our relationship with you. By signing below you acknowledge that you have read and understood this Disclosure, and that you are aware of the Physician ownership or financial interest.

X _____
Patient's or Authorized Representative's Signature Today's Date

Name: _____ DOB: _____



General Patient Consent for Care Form

I, the undersigned, hereby consent to medical care and treatment, as ordered by a provider, while such medical care and treatment is provided through Dallas Pain Consultants on an outpatient / office visit basis. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider, including treatment by a mid-level provider (Nurse Practitioner or Physician Assistant), and other health care providers or the designees under the direction of a physician, as deemed reasonable and necessary.

I agree and acknowledge that Dallas Pain Consultants is not liable for the actions or omissions of, or the instructions given by the physician/providers who treat me while I am a patient. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examinations at Dallas Pain Consultants facilities.

Telemedicine

I understand that telemedicine (defined as the use of medical information exchanged from one site to another via electronic communications for the health of the patient, including consultative, diagnostic, and treatment service(s)) may be employed to facilitate my medical care. All electronic transmission of data will be restricted to authorized recipients in compliance with Federal Health Insurance Portability and Accountability Act (HIPAA) and applicable state privacy laws.

To the Patient:

You have the right to discuss the treatment plan with your physician/provider about the purpose, potential risks and benefits of any tests/procedures ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

Signed Consent

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

X _____
Patient's or Authorized Representative's Signature Today's Date

