Peninsula Pain Clinic, PLLC
An Affiliate of
SOUNDPAIN ALLIANCE

New Patient Registration

Last Name:_____ First Name:_____ Middle Initial:_____

Date of Birth:_____/_____/_____ Gender:_____ Social Security #:_____

Marital Status (circle one): Divorced / Married / Separated / Single / Widowed

Home Phone: _____ Work: _____ Cell: _____

Address: _____ City: _____ State: ____ Zip: _____

E-mail: _____ Employer: _____

Work Status (circle one): Full-time/ Part-time/Not employed/Active military/Student/Retired /Self Emp

GUARANTOR'S INFORMATION SAME AS ABOVE [ ]

Last Name:_____ First Name:_____ Middle Initial:_____

Date of Birth:____/____/_____ Gender:_____ Relationship to patient:_____

Home Phone: _____ Work: _____ Cell: _____

Address: _____ City: _____ State: ____ Zip: _____

INSURANCE INFORMATION

Primary Insurance Co.:_____ Policy #:_____

Insurance Co. Phone:_____ Group #:_____

Subscriber's Name:_____ Date of Birth:__/__/___ Relationship to patient:_____

Secondary Insurance Co.:_____ Policy #:_____

Insurance Co. Phone:_____ Group #:_____

Subscriber's Name:_____ Date of Birth:__/__/___ Relationship to patient:_____

Work Related? Yes [ ] No [ ] Employer:_____ City:_____

Claim Manager Name:_____ Date of Injury:____/____/_____

Claim Manager Phone:_____ Extension:_____ ***Automobile Accident?*** Yes [ ] No [ ]

EMERGENCY CONTACT

Name:_____ Phone:_____ Relationship to Patient:_____

PHYSICIAN/ PHARMACY INFORMATION

Referring Physician:_____ Phone:_____

Primary Care Physician:_____ Phone:_____

Pharmacy:_____

All of the information I have provided is correct

PATIENT / GUARDIAN SIGNATURE:_____ DATE:_____

ETHNIC BACKGROUND

RACE: o *American Indian/Alaska Native* o *Asian* o *Black/African American*
o *White/Caucasian* o *Native Hawaiian or Other Pacific Island* o *Other Race* o *Decline*

ETHNIC GROUP: o *Hispanic/Latino* o *Latin American* o *Mexican* o*Mexican/American*
o *Mexican/American Indian* o *Not Hispanic/Latino* o *Decline*

PREFERRED LANGUAGE: o *English* o *Spanish* o *Other*_____

ASSIGNMENT OF MEDICAL BENEFITS

I, (Printed legal name of primary Insurance holder), _____assign all medical and/or surgical benefits to which I am entitled, including private insurance and any other health plan to: Sound Pain Alliance. 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 hereby authorize said assignee to release all information necessary to secure payment. This may include related drug and/or alcohol abuse treatment, AIDS/HIV, or psychiatric information; including records protected by federal regulations (42 CRF Part 2) as required to qualify for health benefit payment.

I understand that I am financially responsible for all charges incurred from medical treatment at this facility, whether they are paid by my insurance carrier or not, (public assistance recipients exempt). I also understand that all charges are due upon receipt of statement from this facility unless other arrangements are made with the bookkeeping department. If, for any reason, it becomes necessary for this office to engage an attorney or collection agency to secure payment from me, I agree to pay all reasonable interest charges, attorney fees and/or collection costs.

IF YOUR INSURANCE COMPANY SENDS PAYMENT TO YOU, AND YOU HAVE A BALANCE DUE AT THIS OFFICE, PLEASE ENDORSE THE CHECK AND FORWARD IT ALONG WITH THE EXPLANATION OF BENEFITS WHEN RECEIVED.

PATIENT / GUARDIAN SIGNATURE:_____ DATE:_____

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HIPAA Privacy Authorization

I hereby give authorization for release of my protected health information:

Last Name:_____ First Name:_____ Middle Initial:_____

Date of Birth:_____/_____/_____ Social Security #:_____

Home Phone: _____ Work: _____ Cell: _____

Address: _____ City: _____ State: ____ Zip: _____

I _____ give my permission to Peninsula Pain Clinic, PLLC and Sound Pain Alliance to release information in regards to appointment dates/times and my protected health information, including but not limited to, insurance, address, phone number(s), test results, health care information and treatment to the following parties:

Name of person: _____ Relationship to Patient: _____

Name of person: _____ Relationship to Patient: _____

I understand that:

- I may revoke this authorization at any time, in writing. My revocation will not apply to information already retained, used or disclosed in response to this authorization. Unless revoked, the automatic expiration date will be 12 months from the date of the signature (unless otherwise indicated.)
- Unless the purpose of this authorization is to determine payment of a claim or benefits, the provision of treatment or payment for my care may not be conditioned upon my signing of this authorization.
- The information authorized for release may include information which may indicate the presence of a communicable disease or a noncommunicable disease.
- The information authorized for verbal release also may include protected health information related to mental health (RCW 71.05.620)
- The information authorized for verbal release also may include drug/alcohol abuse treatment records (42 CFR Part 2). By signing below, I authorize any such records included in my health information to be release.

PATIENT / GUARDIAN SIGNATURE:_____ DATE:_____

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Patient Payment Policy

Thank you for choosing Peninsula Pain Clinic as your pain specialist. We are committed to providing you with the highest quality of health care and strive to keep healthcare affordable in our office. As such, we provide this document to ensure your understanding of the payment policies. Please read the following office payment policy carefully and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you upon request.

Payment Policy

- At the time of service, you are required to pay any applicable copay. A$ 10.00 fee will be assessed to your account for a copay not paid in full at time of service. This fee will be required to be paid prior to your next visit. After your insurance is billed, you are responsible for any remaining balance.
- Payment for service is due in full at the time of service provided you have no insurance.
- We accept cash, check, Visa, and MasterCard. Any returned check is subject to a $50.00 return check fee that will be required to be paid prior to your next visit.
- Unless canceled at least 24 hours in advance, your account will be charged $75.00 for a missed appointment. This fee will be required to be paid prior to your next visit.
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- Please note that your insurance company will not cover any of the additional fees listed above.
- Prior to procedures, you must pay a pre-procedure deposit, predetermined based on your insurance.
- If you are in need of a payment plan, you can discuss options with the billing staff.
- If your account is overdue for longer than 90 days, it may be referred to a collection agency. Payments over 30 days past due from the date of the invoice will include a IO% APR billing fee.

Insurance

As a courtesy, we file your insurance claims. It is your responsibility to notify us of any changes to your insurance coverage. It is your insurance policy. It is your responsibility to know your policy in regards to benefits, maximums, waiting periods, benefit year, and patient responsibility. We will provide information required by your insurance company regarding the treatment provided by us. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays.

_____	_____	_____
Patient Name	Date	Patient/Guarantor Signature