MARYLAND PAIN AND SPINE CENTER, LLC

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Social Security no:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Email Address	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Ethnicity: Check one

❑ Hispanic/Latino ❑ Not Hispanic/Latino ❑ Refused to Report ❑ Undefined

Race: Check one

❑ Asian ❑ Black or African American ❑ Other Race ❑ White

FINANCIAL AUTHORIZATION AND RELEASE

I am ultimately responsible for payment of all charges for service rendered by Maryland Pain and Spine Center, LLC. For all contracted insurance carriers, I understand that I will be responsible for any **co-payments, deductibles, co-insurance** or any **services that are not considered medically necessary** by my insurance company and will be collected at the time of service.

I hereby authorize the release of pertinent medical information including the diagnosis and records of any treatment or examination rendered to me or my child, to my insurance carriers for the purpose of processing the claim.

I understand that this Authorization shall apply to all services provided to me, my dependents, or any other person for which I have assumed responsibility by signing below, from this date forward until it has been revoked in writing.

Signature of patient or parent if a minor (seal) Date

HIPAA AUTHORIZATION

I acknowledge that I have been explained and/or reviewed this office's notice of Privacy Practices in accordance with HIPAA regulations:

Signature of patient or parent if a minor Date

I authorize Maryland Pain and Spine Center, LLC to use and disclose my health information to provide treatment or services to coordinate or manage my health care or for medical consultations or referrals.

Signature of patient or parent if a minor Date

********I hereby decline to authorize any release of my information to anyone other than my insurance:

Patient's signature: _____ Date

I hereby authorize this office to release my information to the following person(s):

_____ _____ _____

Name. Phone Number Relationship

_____ _____ _____

Name Phone Number Relationship