REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Legal Name: (Last, First, Middle)	Social Security no:	Birth date:	
	Primary Care Provider:	Referring Provider:	Age:	Smoker: ❑ Y ❑ N ❑ Former
Street address:	P.O. Box:	Phone no: Home / Cell	
Email:	City:	State:	ZIP Code:
Occupation:	Employer:	Employer phone no.:	

Preferred Language: ❑ English ❑ Spanish ❑ Other (Please Specify)

Race: ❑ Asian ❑ Black or African American ❑ Other Race ❑ White/Caucasian ❑ Declined to Specify

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Declined to Specify

Gender Identity: ❑ Male ❑ Female ❑ Transgender ❑ Other ❑ Declined to Specify

RESPONISBLE PARTY INFORMATION (IF DIFFERENT FROM ABOVE)

Name: (Last, First, Middle)	Birth date:	
Street address:	Phone no: Home / Cell	
P.O. box:	City:	State:	ZIP Code:
Relationship to Patient:	Employer:	Employer phone no.:

PRIMARY INSURANCE

Name of Insurance Company:	Policy#:	Group#:
Address of Insurance Company:	City:	State:	ZIP Code:
Name of Policy Holder:	Date of Birth:	Relationship:	Phone no:

SECONDARY INSURANCE

Name of Insurance Company:	Policy#:	Group#:
Address of Insurance Company:	City:	State:	ZIP Code:
Name of Policy Holder:	Date of Birth:	Relationship:	Phone no:

SIGNATURE OF PATIENT: _____ DATE: _____

PATIENT AUTHORIZATION

PLEASE HAVE YOUR INSURANCE CARDS AND PHOTO ID AVAILABLE FOR EACH VISIT. ALL COPAYS, AND BALANCES ARE DUE AT TIME OF SERVICE, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE AND DOCUMENTED.

I, _____, acknowledge that I am personally responsible for payment of any and all charges in correlation with my treatment whether or not payment may also be made in part by my insurance, Medicare, or any other health care service plan, financial assistance fund or welfare fund. By signing below, I assign any and all insurance benefits due and payable for the treatment provided.
All copays, coinsurance and deductibles are due and payable at the time of service. Maryland Pain and Spine Center LLC accepts; cash, check, debit cards, Discover, Master Cards and Visa. **All returned checks are will receive a $50 NSF fee.**

I also understand and agree that any balances due and not paid in full within 60 days of receipt shall be considered past due and my outstanding balance could be sent to a collections agency and I will be required to pay the entire amount plus any collection agency fees before being scheduled for future appointments.
A **$50** fee will be assessed for patients that do not provide 24-hour notice to cancel or reschedule an appointment. **$150** fee will be assessed for patients that "no-show" for procedures.

If you are chronically late for an appointment that requires a prescription a **$50** fee will be collected. Your appointment will be rescheduled, the refill of your prescription(s) will be at the discretion of Maryland Pain and Spine Center LLC providers. This fee is in addition to any copays, deductibles, coinsurances, or account balances.

Department of Motor Vehicle / Temporary Handicap Tag Application fee: **$20.00**

Overpayments will be refunded after all charges have been processed and paid by your insurance company. A refund check will be written and mailed within 30 days of your written refund request.
I understand and acknowledge the above fees. I understand these fees may change as needed without my prior notification.

Signature: _____(seal) Date: _____

PLEASE TURN OVER AND COMPLETE PAGE 2

PLEASE SELECT YES OR NO TO THE FOLLOWING QUESTIONS:

Maryland Pain and Spine Center LLC providers and staff may leave a detailed message on your answering machine **OR** voicemail regarding your personal health information, verifying appointments or to change appointments? **YES** **NO**

Maryland Pain and Spine Center LLC providers and staff may leave a detailed message with another family member regarding your personal health information, verifying appointments or to change appointments?
YES **NO**

If yes, please list who we can speak with:
_____

Maryland Pain and Spine Center LLC providers and staff may send information regarding your personal health information, verifying appointments or to change appointments by email?
YES **NO**

I authorize the release of medical information necessary in the coordination of my medical treatment/care.

Signature: _____(seal) Date: _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) ACKNOWLEDGEMENT

I have received a copy of the Maryland Pain and Spine Center LLC HIPAA **Notice of Privacy Practices**

Signature: _____(seal) Date: _____

NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting the office.
You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, and healthcare operations. We are not required to agree to this restriction, but if you do, we shall honor agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
The patient understands that:

1. Protected health operations may be disclosed or used for treatment, payment, or health care operations.
2. The patient may forbid disclosure of information about a test or treatment for which the patient has paid out-of-pocket.
3. The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this Notice.
4. The practice reserves the right to change the Notice of Privacy Practices.
5. The patient has the right to restrict uses of their information but the practice does not have to agree to these restrictions.
6. The patient may revoke the Consent in writing at anytime and all future disclosures will then cease.
7. The Practice may condition receipt of treatment upon execution of this consent.

Patient Name or Representative: _____

Signature: _____ DOB: _____

Witness: _____ Date: _____