

AIPM – Demographic / Insurance / Release Form

Physician: Dr. DOSS / Dr. KANG / Dr. KIZINA

Date: ____/____/____

Patient Information:

Name: _____
Last Name First Name Middle

Social Security #: _____ - _____ - _____ DOB: ____/____/____ Age: _____

Sex: M / F Marital Status: Single / M / Sep / Div / Wid

Home Address: _____
Street Apt#

City/State/Zip: _____

Home Phone: (_____) _____ - _____ Cell: (_____) _____ - _____

Employer: _____ Phone: (_____) _____ - _____

Address: _____

Emergency Contact: _____ Phone: (_____) _____ - _____

Insurance Information:

Primary Insurance: _____ Phone: (_____) _____ - _____

Policy #: _____ Group: _____

Secondary Insurance: _____ Phone: (_____) _____ - _____

Policy #: _____ Group: _____

Provider Information:

Whom may we thank for your referral to our office? _____

Referring Physician's address: _____

Phone: (_____) _____ - _____

Primary Care Physician: _____

Phone: (_____) _____ - _____

Advanced Interventional Pain Management, LLC

Insurance companies have several types of plans with varying patient responsibilities. It is important for you to advise us of any changes in your healthcare coverage. This ensures that your medical services will be covered.

If you are covered by a managed care program, you will be responsible for your co-pay. If your plan requires referrals, you are responsible for obtaining them and bringing them at the time of your visit. You are also responsible for any deductibles and/or co-insurance as per your contract with your insurance company.

Please understand that as the patient, you are ultimately responsible to know your coverage/requirements and are accountable for all payments of medical bills.

X _____
INITIALS

Notice of Privacy Practices

By signing below, I am aware that all medical matters handled in/at Advanced Interventional Pain Management, LLC are kept privately and will not be disclosed to any other source without my knowledge or consent.

X _____
PATIENT'S SIGNATURE

Consent to Release Information

By signing this form, I hereby authorize AIPM, LLC to release any medical information to the physicians involved in my care or to authorized parties: (i.e. ins. comp, lawyer's offices, etc.). I consent that the practice may call my house or other designated locations and leave a message on voicemail or in person in reference to appointment reminders and insurance matters, and in addition, the practice may mail to my home any correspondence related to this office.

I designate the following representative(s) whom the provider/office staff may communicate with on my behalf. If you do not designate anyone, our office will be unable to speak or release any medical information to anyone in your family or friends regarding your medical condition.

Authorized Representative's Full Name

Relationship to patient

Consent to Obtain Information

I hereby authorize AIPM, LLC to obtain any/all medical records from other offices and facilities (i.e. doctor's office, radiology facilities, laboratories, etc.)

X _____
PATIENT'S SIGNATURE

I acknowledge I have read and signed all of the above and understand I am solely accountable for all the matters listed above.

Date

Patient's Name (PRINT)

X _____
PATIENT'S SIGNATURE

Assignment of Benefits

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Advanced Interventional Pain Management, LLC medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Advanced Interventional Pain Management, LLC to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Advanced Interventional Pain Management, LLC on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred on the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

X _____
Patient / Responsible Party Signature

Date

Witness

Date

SURGERY CENTER OWNERSHIP DISCLOSURE FORM

This is to inform you that Dr. _____ has a financial interest in Wayne Surgical Center, LLC, a surgery center at which he performs surgery on his patients.

If you require surgery, Dr. _____ may perform the surgery at Wayne Surgery Center, LLC. You may, of course, seek treatment at another facility of your own choice.

Please acknowledge receipt of this disclosure by signing and dating this form.

X _____
PATIENT'S SIGNATURE

Date