



REGISTRATION FORM

(Please Print)

Today's Date ____/____/____

PCP _____

PATIENT INFORMATION

Patient's Last Name	First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid
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Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
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Street Address	City	State	ZIP Code	Social Security	Home Phone No. ()
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Email Address:	State	ZIP Code
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P.O. Box	City	State	ZIP Code
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Occupation	Employer	Employer Phone No. ()
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Choose Clinic Because/Referred to Clinic by (Please check one box) Dr. _____ Insurance Plan Hospital

Family Friend Close to Home/Work Yellow Pages Other _____

Other Family Members Seen Here _____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ()
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Occupation	Employer	Employer Address	Employer Phone No. ()
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Is this patient covered by insurance? Yes No

Please indicate your insurance name:

Please indicate your insurance phone#

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment \$
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Patient's Relationship to Subscriber Self Spouse Child Other _____

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #
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Patient's Relationship to Subscriber Self Spouse Child Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ()	Work Phone No. ()
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Texas Pain Institute, insurance company or providers to release or obtain any information required to process my claims, render medical care to me or participate in my care.

X _____
PATIENT/GUARDIAN SIGNATURE DATE



Financial Policy

We, at the Texas Pain Institute are committed to provide you with the best possible medical care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility. Our Financial Policy is as follows:

Insurance Information:

Our clinic accepts insurance from most major insurance companies. As a courtesy, we will file your claim to the respective insurance company as a courtesy to you. However this does not diminish your responsibility for payment in full.

To avoid any, misunderstanding regarding payment for professional services, Texas Pain Institute request that you authorize all insurance company payments directly to our clinic. If you choose not to do so, all charges will be due and payable by you at the time of service. Upon receipt of payment, we will gladly provide you with the insurance form to file with your insurance company

On occasion your insurance may determine the care you have received is NOT a covered benefit. Please read your insurance handbook and be aware of what your insurance offers for benefits. When in doubt contact your insurance company directly for clarification. You will be responsible for care not covered by your insurance plan.

You will be responsible for any portion of your bill which is denied, applied to deductible, considered a co-payment or co-insurance portion or is considered non-covered by your insurance plan. Working together we can solve most insurance issues in a mutually acceptable manner.

Please read and initial below.

_____ **LIFETIME MEDICARE B SIGNATURE AUTHORIZATION:** I authorize Texas Pain Institute to release my information needed for this or other Medicare claims to the Social Security Administration and Health Care Financing Administration on my behalf. I request all benefits be assigned to Texas Pain Institute, and I understand that I am responsible for my health deductible and co-insurance

_____ **LIFETIME INSURANCE WAIVER:** I hereby state that I wish for Texas Pain Institute to submit my claim for medical services to _____ insurance company for services rendered for the accident date _____. I am not filing this claim with any other liability insurance company. You are responsible for your bill entirely. I authorize to release my medical records to my attorney: _____ address: _____ Phone: _____

_____ **WORKER'S COMPENSATION:** This authorizes my physician to furnish written reports and communicate orally with any representative, attorney for, or investigate from and Worker's Comp Carrier regarding my examination, diagnosis, treatment and prognosis concerning injuries sustained as a result of an accident occurring on: _____.

_____ **IF PATIENT IS UNDER 18:** I hereby give my permission for _____ to be treated by Texas Pain Institute. THIS MUST BE SIGNED IN ORDER TO FILE YOUR INSURANCE LIABILITY CLAIM.

Payment Policy

1. If you do not have insurance coverage FULL PAYMENT is expected at the time of service is rendered.
2. Co-payments or co-insurance must be paid at time of service is rendered. These payments are a required part of your contract with your insurance carrier and increase the cost of billing unnecessarily if not paid at the time of service.
3. We accept Cash, Credit Cards **VISA, MASTERCARD, AMERICAN EXPRESS AND DISCOVER** (Only in Person). We also accept Money Orders or Traveler's Checks

4. We do not accept company or personal checks

I have read and understand the Financial Policy of Texas Pain Institute.

Signature of Patient or Legal Guardian	Relationship to Patient	Date