PATIENT INFORMATION & RESPONSIBILITY FORM

PERSONAL INFORMATION: **TODAY'S DATE: _____/_____/_____**

Patient Name: First: ______________________________Middle: ___________________ Last: __________________________________

Social Security Number: __________________________ Email Address: ____

Home Address: _______________________________________ City: ______________________ State: _________ Zip:___________

Mailing Address if different: ________________________________ City: ___________________ State: _________ Zip:__________

Marital Status: M / D / W / S DOB: ______/_____/______ Sex: M / F Preferred Language: ________________________

Race:____ Ethnicity: ____

Home Phone: _______________________ Work Phone: _________________________ Cell Phone: _________________________

Emergency Contact Name: ____________________________ Relationship: ______________________ Phone #: __________________

Employer Name: _______________________________________ Position: _____________________ Phone #: __________________

Referring Physician: ____ Phone #: _____________________________

Primary Care Physician: ____ Phone #: _____________________________

How did you hear about us: ____

INSURANCE INFORMATION: ***You will be asked for a copy of your insurance card(s) at each visit.***

Is the Insurance in your name: Y / N If no, who carries this insurance: ___________________________ DOB: ____/_____/____

Primary Ins: ____ ID #: ___________________________ Group #: __________________

Ins Phone #: _________________________ Address: ____________________________________ Effective Date: ________________

Secondary Ins: ____________________________________ ID #: ___________________________ Group #: _______________________

Subscriber's Name: ____ DOB: ____/_____/_____

Ins Phone #: _________________________ Address: ____________________________________ Effective Date: ________________

RESPONSIBLE PARTY (IF OTHER THAN SELF, OR IF PATIENT IS A MINOR):

Name: ______________________________________ DOB: ______/______/______ Social Security Number: ___________________

Relationship: ________________________________ Email Address: ____

Home Address: ________________________________ City: ______________________ State: ____________ Zip: _______________

Mailing Address: ______________________________ City: ______________________ State: ____________ Zip:_______________

FOR WORKERS' COMPENSATION OR AUTO INJURIES ONLY: ***Please provide us a copy of your claim acceptance or denial letter.***

Workers' Comp: _______ MVA: _______ Insurance/Carrier: ______________________________ Claim #: ______________________

DOI: ____/_____/_____ Claims Representative: ___________________________________ Phone #: ___________________________

Accepted Condition(s) for this Injury: ____

Authorization Required? Y / N Authorization #: ____

ASSIGNMENT OF BENEFITS:

By signing this form, I authorize Oregon Interventional Pain Consultants, on behalf of my provider, to bill my insurance and release any information necessary to secure payment of benefits. I acknowledge that I am financially responsible for all the charges whether or not paid by the insurance. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, I the undersigned, agree to pay for all the costs and expenses, including reasonable attorney fees.

I hereby authorize assignment and payment of major medical benefits due to me to the Oregon Interventional Pain Consultants. A photocopy of this assignment is to be considered as valid as an original.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I had the opportunity to review and read a copy of the Oregon Interventional Pain Consultants' Privacy Policy. I hereby authorize Oregon Interventional Pain Consultants or the provider individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO CALL, MAIL, OR E-MAIL:

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize Oregon Interventional Pain Consultants representatives or my provider to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Oregon Interventional Pain Consultants to that effect in writing.

LAB/RADIOLOGY/DIAGNOSTIC SERVICES &/OR MEDICATIONS:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, other diagnostic services or medications. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment as directed by my Oregon Interventional Pain Consultants physician or his/her designee.

Patient Signature or Guarantor	Date
Description of Guarantor's Authority, if required:	

Revised 08/30/16