

DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY CARE PHYSCIAN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REFERRING PHYSICIAN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHARMACY (NAME AND NUMER):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHARMACY (ADDRESS):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT AND RELATIONSHIP (NAME):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT (NUMBER):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**PATIENT CONSENT FOR TREATMENT**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the patient and/or legal guardian of said patient do hereby give my consent for medical treatment and examination under the care of the practice and deemed necessary. As with any procedure, there are certain inherit risks to include, but not limited to: worsening of pain, no pain relief, toxic drug reaction, bruising, bleeding, swelling at the injection site and infection.

The patient or legal representative of the patient must acknowledge this documentation by signing below as indicated. This consent will serve as identification documentation for the duration of the treatment for the particular condition or injury.

**PATIENT CONSENT TO PHOTOGRAPH**

*It is the policy of this facility to take the photograph
of each patient for proper identification.*

The patient or legal representative of the patient must acknowledge this documentation by signing below as indicated. This consent will serve as identification documentation for the duration of the treatment for the particular condition or injury.

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Today's Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness to Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



**Authorization for Claims Payment and Reviews**

1. **\_\_\_\_\_\_Assignment and Coordination of Insurance Benefits** - I agree to provide information regarding all group hospitalization, health maintenance organization, Workers' Compensation, automobile, and other health care benefits (“Insurance Plan(s)”) to which I may be entitled. I hereby assign payment(s), if any, from my Insurance Plan(s) to Center for Pain Management (or its affiliate) and each of the independent contractor physicians and/or

professional corporations for services rendered to me. The direct payment hereby assigned and authorized

includes any Insurance Plan(s) benefits to which I am otherwise entitled, including any major medical benefits

otherwise payable to me under the terms of my policy, but is not to exceed the balance due to the Center for Pain

Management (or its affiliate), the independent contractor physicians and/or professional corporations for services

rendered to me during the applicable periods of medical care.

2. **\_\_\_\_\_\_Unauthorized, Non-Covered, or Out of Plan Services** - I understand if my Insurance Plan(s) does not

consider this or any service rendered a covered service or has not authorized this service, they will not pay for this

service during this clinic or outpatient visit. I agree to be fully responsible for payment to Center for Pain

Management for this service if determined by my Insurance Plan(s) to be a non-covered service. I also understand

and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be

required to pay a larger co-payment, co-insurance or other charge In the event my Insurance Plan(s) does not

reimburse these services provided to me, I acknowledge I will be responsible for any remaining balance.

3. **\_\_\_\_\_\_For Medicare Recipients Only** - I certify the information given by me in applying for payment under

Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on

my behalf to the Center for Pain Management and/or independent contractors for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related services. In the case of Medicare Part B benefits, I request payment either to myself or to the party who accepts assignment.

4. **\_\_\_\_\_\_No-Show Appointments** - I understand that I will be charged a $50 no show fee for appointments for

which I do not cancel by 2 pm the day before. I also understand that I will be charged a $150 fee if I do not cancel by 2 pm the day before for all scheduled procedures.

By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and

have them answered and accept the above conditions and terms and I agree to pay all charges for which I may be

legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered. I also

agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay

the reasonable attorneys' fees and other collection costs incurred by Center for Pain Management .

*I understand and agree this document will remain in effect for all future outpatient or physician office visits to Center for Pain Management, unless specifically rescinded in writing by me.*

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:

Relationship to Patient:



**PATIENT NAME: DOB:**

**CONSENT TO DISCLOSE MEDICAL INFORMATION**

**What type of message can we leave for you???**

In an effort to better serve you, Center for Pain Management needs to know what type of messages we can leave on your message machines/voicemail and whether or not we may contact you via email or text messaging. Please indicate your preference for contacting you by phone.

**Center for Pain Management may leave a detailed message on my answering machine/voicemail:**

**YES NO Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If no, we will leave enough information for you to call us back.**

**Center for Pain Management will always leave detailed information when confirming your appointments, unless otherwise indicated by you, the patient.**

|  |  |  |
| --- | --- | --- |
| **AGREE** |  | **DISAGREE if you disagree, a message to call us back will be left on your answering machine/voicemail****.** |
|  |  |
|  |  |  |

**Center for Pain Management may send email containing personal health and appt information to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_: I realize it will be sent as encrypted email unless I specifically request it to be sent without encryption.**

**YES NO Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Center for Pain Management may leave a detailed message by texting to the following number (I realize this is not a secure manner in which to transmit personal information) n:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**YES NO Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



**Who may we speak to concerning your Protected Health Information???**Please tell us to whom we may disclose or discuss your Protected Health Information. Please check the types of information that you authorize Center for Pain Management to disclose/discuss with indicated family/friends:

 **Relationship**

 **Relationship**

**My Entire File or specifically: (circle choices)**

Diagnosis Progress to Date Dates of Treatment

Prognosis Billing Information Treatment Plan Symptoms

Test Results Modalities & Frequencies of Treatment Furnished Other

I understand that I may revoke or change this authorization at any time by completing another. Consent to Disclose Medical Information form. I understand that I will not be denied or refused treatment if I refuse to sign this authorization. I understand that I have the right to receive a copy of this authorization, if requested. I understand that this authorization will not expire.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**CANCELLATION/MISSED VISIT POLICY**

Our goal is to provide quality individualized medical care in a timely manner. No-shows, late shows and cancellations inconvenience those individuals who need access to medical care. We would like to remind you of our policy regarding missed appointments.

**Cancellation of an Appointment**: In order to be respectful of the medical needs of other patients, please be courteous and call our office promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call before 2 pm the business day prior. Appointments are in high demand, and your early cancellation will allow another patient access to timely medical care.

**How** **to Cancel your Appointment**: To cancel your appointment, please call 407-478-0007. If you do not reach the receptionist, you may leave a detailed message on our voice mail. If you would like to reschedule your appointment, please leave your name and phone number. We will return your call promptly.

**Late Cancellations:**A cancellation is considered to be late when the appointment is cancelled after 2 pm the business day prior.

**No Show Policy:**A “no-show”, is a patient who misses an appointment without cancelling it. A failure to be present at the time of a scheduled appointment will be recorded in the patient’s chart as a “no-show”. This includes arriving 15 minutes after your scheduled appointment.

All no-show appointments have a penalty assigned that must be paid prior to being seen for the next appt. These penalties are not billable to, nor reimbursable by insurance companies and are the financial obligation of the patient/responsible party. The fee for a missed visit appointment is $50 and for a scheduled procedure appointment, $150.

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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