PAIN CONSULTANTS of ARIZONA

New Patient Information Record

All Information Must be Completed BEFORE the Doctor Will See You

Last Name _____ First _____ MI _____

Social Security #_____ Date of Birth _____ Gender: ☐ Male ☐ Female

Main Telephone ( ) _____ Other Phone ( ) _____

Address _____City _____State _____ Zip _____

Marital Status _____ Email Address: _____

Please check all that apply: ☐ Insurance ☐ Worker's Compensation ☐ Auto Accident ☐ Attorney

Employer _____ ☐ Retired ☐ Disabled ☐ Student ☐ N/A

Referring Physician_____ Telephone ( ) _____

Primary Care Physician _____ Telephone ( ) _____

Race ☐ African American ☐ American Indian or Alaska Native ☐ White ☐ Asian
☐ Native Hawaiian or Other Pacific Islander

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino Preferred Language_____

EMERGENCY CONTACT

Name _____ Relationship _____ Telephone ( ) _____

Acknowledgement of Policies and Privacy Practices

COMMUNICATION AUTHORIZATION

I hereby authorize Pain Consultants of Arizona (formerly Arizona Center for Pain Relief) to communicate with _____ regarding all aspects of my medical care and financial obligations. (Please write First and Last name of any individual that you want us to be able to discuss your care, cancel/reschedule appointments, and discuss financial obligations.)

TREATMENT AUTHORIZATION

I hereby authorize Pain Consultants of Arizona (formerly Arizona Center for Pain Relief) to render health care to me during my visit.

PRIVACY NOTICE

I have been given the option to review Pain Consultants of Arizona (formerly Arizona Center for Pain Relief)'s "Notice of Privacy Practices" that explains how my personal health information will be used. I am also aware that I may request a copy of the "Notice of Privacy Practices" at any time.

MEDICAL RECORDS

I am aware that I may request a copy of my medical records at any time. In addition, I understand that there may be a fee associated with my request and that without a release on file stating otherwise, my records can only be picked up by me or mailed to the address on file. Please note third party requests are also the patient's financial responsibility after 60 days of non-payment.

_____ _____ _____ _____

Signature Date Witness

PAIN CONSULTANTS of ARIZONA

Financial Policy & Waiver

Insurance Co-Payments/Deductible/Co-Insurance

In accordance with my insurance contract, I understand that **co-payments, deductibles, and co-insurance are due at time of service.** This contractual obligation requires that payments be made at time of service, so it may be necessary to reschedule my appointment if my co-payment, co-insurance, and/or deductible cannot be satisfied. **All outstanding patient balances over 30 days old will be subject to a 10% per annum interest rate.**

Verification of Benefits and Non-Covered Services

Insurance policies may differ per patient plan. Pain Consultants of Arizona (formerly Arizona Center for Pain Relief) may provide services that my insurance plan excludes. Although Pain Consultants of Arizona makes every attempt to notify me of my benefits, it is ultimately **my responsibility to verify and understand my coverage, benefits and exclusions**. **All non-covered services are my responsibility and may be due at time of service.**

Change of Insurance

I must notify Pain Consultants of Arizona within 30 days of new insurance so that all claims can be re-filed as appropriate. In the event that my insurance changes and **I fail to notify the office within 30 days, there will be a $75 administration fee** assessed upon the re-working of my account. The above fee **must be paid in full** at the time of notification or all outstanding balances will become my responsibility.

Private Pay

If I have no insurance coverage, or insurance with which Pain Consultants of Arizona does not participate, full payment is expected at time of service.

Collections

I understand that once an account is placed in a collection status, all future services must be paid in full at time of service. If my account is place into collections, I will be responsible for all collection costs equal to 50% of my outstanding balance, but no less than $25.

No Show/Late Cancellations

Office Visit cancellations made less **than 24 hours** in advance or if I "No Show" will be subject to a **$30.00** fee. **Procedure/EMG cancellations** made **less than 48 hours** in advance or if I "No Show" will be subject to a **$150.00** fee. These charges are my responsibility, will not be billed to my insurance carrier, and will be due at my next appointment.

Checks

Due to large quantities of returned checks, Pain Consultants of Arizona **does NOT accept checks for payment at time of service**. However, I can still submit payment by check for any statements received via mail. Returned checks will be subject to a **$50.00** returned check fee.

I have read and agree to abide by this financial policy and waiver

Signature	Date	Print Name

☐ Not Applicable

PAIN CONSULTANTS of ARIZONA

Insurance Information

Patient Name: _____ DOB: _____

PRIMARY INSURANCE

Insurance Company _____Benefits Number ( ) _____

Member # _____ Group # _____

Cardholder's Name _____DOB _____

Relationship to Patient_____Cardholder's Employer _____

SECONDARY INSURANCE (We ONLY bill secondary if Primary or Secondary is **Medicare**)

Insurance Company _____Benefits Number ( ) _____

Member # _____ Group # _____

Cardholder's Name _____DOB _____

Relationship to Patient_____Cardholder's Employer _____

Insurance Benefits

Arizona State Law requires that medical claims be paid by my insurance carrier within 30 days. As a courtesy, Pain Consultants of Arizona (formerly Arizona Center for Pain Relief) will bill my insurance for all covered services. If my insurance carrier has not appropriately paid the submitted claim within 30 days, all outstanding balances will become my responsibility.

Insurance Co-Payments/Deductible/Co-Insurance

In accordance with my insurance contract, I understand that **co-payments, deductibles, and co-insurance are due at time of service.** This contractual obligation requires that payments be made at time of service, so it may be necessary to reschedule my appointment if my co-payment, co-insurance, and/or deductible cannot be satisfied. **All outstanding patient balances over 30 days old will be subject to a 10% per annum interest rate.**

Secondary Insurance

I understand that Pain Consultants of Arizona **does not file claims with secondary insurance** carriers, **unless** I have **Medicare**, and I am fully responsible for secondary insurance amounts.

Insurance Authorization

I hereby authorize Pain Consultants of Arizona (formerly Arizona Center for Pain Relief) to furnish information to my insurance carriers, worker's compensation company and/or attorney concerning my illness and treatment.

Assignment of Benefits

I hereby assign to Pain Consultants of Arizona (formerly Arizona Center for Pain Relief) all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance.

_____ _____ _____

Signature Date Witness

PAIN CONSULTANTS of ARIZONA

Urine Drug Screening Program

This notice is presented to explain the policy of Pain Consultants of Arizona regarding Narcotic Prescriptions and our Urine Drug Screening (UDS) program.

The possible treatments available for pain include various modalities, one of which is the use of narcotic and/or non-narcotic prescription medications. While these medications may be extremely beneficial, as with any other treatment, there are certain risks associated with their use. Unfortunately, these risks include diversion, or obtaining prescriptions for recreational use or in order to illegally sell medication to others.

This is a major concern to us, as physicians. Additionally, this unsafe and concerning practice has reached national prominence, earning the attention of multiple government and law enforcement agencies, including the United States Drug Enforcement Agency. At Pain Consultants of Arizona, we take this matter very seriously.

As part of our desire to ensure proper medication utilization, we employ a urine drug screening program. This program allows us to confirm that medications are being taken as prescribed. It also allows us to ensure the absence of other harmful agents, including recreational or street drugs.

Please understand that a request to submit a sample is not an accusation. The vast majority of tests performed confirm proper medication usage. Additionally, we randomly test patients once per quarter, thus eliminating any bias we, as providers, may have. We appreciate your understanding and cooperation, and, of course, we remain available to discuss any questions, concerns, or comments you may have

Patient's Financial Responsibility

Regretfully, this may or may not be covered by your insurance. While a majority of insurance companies do, in fact, pay for this service some do not. For this reason, we have an advanced beneficiary notice that you will need to sign if you are screened at our facility. This notice simply states that you understand this screen may not be covered by your insurance, and in the event that it is not, you will be financially responsible for the fees incurred. We will do our best to work with you if your insurance does not pay for this service, but please remember it is ultimately up to you to be aware of your benefits.

Additionally, please be aware that we may use a third party lab for final confirmation of the screen. This means that you may receive an EOB (Explanation of Benefits) from your insurance regarding our initial screen and another one from the third party that confirms our results. If you have any questions regarding the billing from the third party lab, please contact them directly.

Please remember that you may or may not receive medications from our facility and thus may or may not be tested. This notification is given to prevent any confusion or misunderstanding in the future, and to ensure that all patients understand our commitment to providing the best care and service.