

ADMISSION DATA

Date: M / F **Last Name:** _____ **First Name:** _____ **MI:** _____
DOB: _____ **Home Phone:** _____ **Cell Phone:** _____

Address: _____ Street _____ City _____ State _____ Zip _____

SSN: _____ **Employer:** _____ **Work Phone:** _____

Race: (African American) (American Indian/Alaska Native) (Asian) (Caucasian)
Ethnicity: (Hispanic) (Non-Hispanic)
(please check one)

Responsible Party Name and Address if Different from Above:

Relation to Responsible Party: _____ **Rspnsble Party DOB:** _____ **Rspnsble Party SSN:** _____

Responsible Party Employer: _____ **Employer Phone:** _____

Emergency Contact Name/Relationship: _____ **Phone:** _____

Referring Physician: _____
Primary Care Physician: _____

Surgeon: _____

Primary Insurance Co: _____ **Secondary Insurance Co:** _____

Policy Number: _____ **Policy Number:** _____

Group Number: _____ **Group Number:** _____

I, the above policy holder, with the aforementioned Insurance Company, herby authorize any benefits due me under this policy to be paid in accordance with this assignment. In consideration of surgical, medical and/or anesthesia services rendered), _____ on _____, I hereby assign and transfer any benefits due me under (Patient name) (date) the above described contract as follows insofar, as they are necessary to cover the expenses.

A photo copy of this assignment shall be considered effective and valid as the original

FINANCIAL AGREEMENT

I hereby authorize direct payment to Midwest Pain Center of any insurance benefits otherwise payable to me for this admission at a rate not to exceed the regular charges. It is agreed that payment to Midwest Pain Center, pursuant to this authorization by an insurance company, shall discharge said insurance company of any and all obligations under a policy to the extent of such payment, I understand that I am financially responsible for charges not covered by this assignment. I understand that as a courtesy, Midwest Pain Center will file my primary insurance.

In consideration of the services to be rendered to me, I HEREBY INDIVIDUALLY OBLIGATE MYSELF TO PAY THE ACCOUNT OF MIDWEST PAIN CENTER IN ACCORDANCE WITH THE REGULAR RATE. Should the account be referred to an attorney or licensed collection agency for collection, I shall pay reasonable attorney's fees and collection expenses. All delinquent accounts (those not paid within sixty (60) days from date of services) shall bear interest at the legal rate.

I understand that Midwest Pain Center shall have the right at any time to refuse medical care or treatment for me.

I certify that I am the patient, or am duly authorized by the patient as patient's general agent, to execute this document and accept its terms.

HIPAA AND PATIENT BILL OF RIGHTS GIVEN

Signed: _____ Dated: _____ Witness: _____