MIND AND BODY PAIN CLINIC - PATIENT REGISTRATION FORM

Patient Information

First name: _____Last name: _____Middle Initial: _____

Address:_____City, State, Zip_____

Home phone :(___) ____-_____Work phone: (____) ____-_____Cell: (___) ____-_____

Birth Date: _____ Age: _____ Soc. Sec: _____ Sex: □ Male □ Female

Employment Status: □ Full Time □ Part Time □ Retired

Name of Employer:_____ Phone: _____

Address:_____ City, State, Zip: _____

Preferred Pharmacy:_____

Primary Physicians Name:_____Phone: (____) ____-_____

Address:_____City, State, Zip_____

Referred by: Doctor_____Attorney _____ Insurance Co._____ Worker's comp_____

Name of Referral; _____ Phone:(___) ____-_____

Address:_____City, State, Zip_____

EMERGENCY CONTACT _____ Phone:(___) ____-_____

Financial Responsibility (complete if other than patient)

First name: _____Last name: _____Middle Initial: _____

Address:_____

City, State, Zip: _____

Home phone :(___) ____-_____Work phone: (____) ____-_____Cell: (___) ____-_____

Birth Date:_____ Soc. Sec: _____

Insurance Information (please provide insurance card)

Name of Policy Holder:_____ Policy Holder Birth Date:_____

Relationship to patient: □ Self □ Spouse □ Child □ Other **Policy Hldr SSN/ID**:_____

Address (if different than patient's):_____

Name of Policy Holder's Employer:_____ City, State:_____

Name of Insurance Company:_____

Address:_____ City, State, Zip_____

Secondary Insurance Information (please provide insurance card)

Name of Policy Holder:_____ Policy Holder Birth Date:_____

Relationship to patient: □ Self □ Spouse □ Child □ Other **Policy Hldr SSN/ID**:_____

Address (if different than patient's):_____

Name of Policy Holder's Employer:_____ City, State:_____

Name of Insurance Company:_____

Address:_____ City, State, Zip_____

_____ _____ _____

Patient Signature Insured or Guardian Signature Date

Mind And Body Pain Clinic - Financial & Office Policies

Patient Name: _____ DOB: _____
Address: _____ Home Phone #: _____
_____ Work Phone #: _____
Emergency Contact Name: _____ Phone #:_____
Relationship to patient: _____

Payment Policy:

Payment is expected at time of service. Your co-pay, coinsurance, and/or deductible is due at time of visit. We accept ***cash only*** as a form of payment. You will be responsible for payment of any remaining balances from both entities after insurance is billed.

_____
(Initials)

Insurance Policy:

We will require a digital scan of your insurance card. We will bill your insurance company. Any deductible, coinsurance or non-covered services will be your responsibility.

For those plans that are non-contracted with our office, as a courtesy, we will submit claims to your carrier; any deductible, coinsurance or non-covered services will be your responsibility.

Monthly statements will be sent to collect those balances. Please inform our staff immediately of any insurance or address changes.

_____
(Initials)

Non-Covered Service Policy:

Certain services performed by our office are NOT COVERED by all insurance plans. We suggest you contact your insurance carrier to verify your benefits and understand any non-covered services will be your financial responsibility and payment will be required prior to your appointment. Medicare requires a signature on an Advanced Beneficiary Notice [ABN] for non-covered services. _____
(Initials)

Medical Records:

Should you request a copy of your medical records for a nominal fee. Please allow our office 7-10 business days for completion. _____
(Initials)

Delinquent Accounts Policy:

Delinquent accounts may be reported to our collection agency following normal collection procedures. If an account is reported to our collection agency a collection fee of 25% will be added to any outstanding balance. If a balance is over 61 days late, a 1.5% monthly interest fee will be added to the outstanding balance. The patient or guardian is responsible for payment of such collection fees and costs, including but not limited to reasonable attorney's fees, court costs, and service fees. Please inform our billing staff if you know your payment will be late in arriving or if payment arrangements are needed.

_____
(Initials)

Late Arrivals:

In order for our physicians to see their patients in a timely manner your help in arriving promptly for your appointment is required. If you are more than 10 minutes late, our office will reschedule your appointment to a new date and time. Tardiness affects your patient care as well as those patients that have a scheduled time after you.

We understand your time is valuable and will do our best to respect it and see you in a timely manner. Please be aware that sometimes certain situations and emergencies can occur and cause your provider to run late. Please be patient in these circumstances.

_____
(Initials)

Forms Policy:

Should you request our office to complete forms on your behalf for disability, work status, jury duty, FMLA, DMV, etc., there will be a charge of $20.00 per form. Payment of this charge is expected at time of completion.

_____
(Initials)

Appointment Cancellations/No Shows/Reschedules:

There is a **$50.00 charge per visit** for patients who cancel, reschedule or no show for an appointment without giving 24 hours notice. We understand unusual circumstances may arise. Please contact our office as soon as possible.

_____
(Initials)

Prescriptions:

Appointments are required for most medication refills. Please contact our office a minimum of 10 days prior to your scheduled refill date. Phone call refills are not allowed.

_____
(Initials)

Returned Checks:

Our office charges a $25.00 fee for all account closed, stop payment or non-sufficient funds returned checks.

_____
(Initials)

Referrals & Authorizations:

If a referral is required by your insurance carrier you will be asked to obtain the referral prior to your appointment. If no referral exists on file or your referral has not been received, your appointment may be cancelled. Our office will obtain authorization for your procedure prior to scheduling your appointment. We suggest you contact your insurance carrier to verify your coverage, benefits and preauthorization requirements prior to having any procedures performed. Claims are paid based on medical necessity. Please be aware authorizations and referrals are not a guarantee of payment.

_____
(Initials)

Workman's Compensation:

Our office will require you to inform us of any changes regarding your workers compensation claim. The following information is required: Adjustors Name, claim status, (litigation, supportive care, claim closed, new injury), DOI, carrier, claim number and claims address. Please have this information available prior to your appointment time.

_____
(Initials)

_____
(Patient/Guarantor **Printed Name**)

_____ Date_____
(Patient/Guarantor **Signature**)

Mind and Body Pain Clinic
2516 Samaritan Dr. Ste M
San Jose, CA - 95124

ASSIGNMENT OF BENEFITS and CONSENT TO TREAT

It is the policy of Mind and Body Pain Clinic (MBPC) that all patients are presented with an assignment of benefits statement to complete and sign when a patient checks in for appointments.

PAYMENTS

I hereby direct my health insurance plans/network/organization/plan, Medicare, or third party administrator of any such health care plan (hereinafter separately or collectively referred to as "Plans") to direct payments directly to MBPC on my behalf, whenever possible. If you receive payment from insurance for our services, we must be paid immediately. Failure to do so might result in immediate referral to a collection agency.

ASSIGNEMNT OF BENEFITS

In consideration of services provided, I hereby assign, MBPC, the benefits due me My Health Care costs and expenses otherwise payable to me, for the Plan(s), policy or policies that I have in effect for Plan(s) coverage, insurance coverage and policy(s) named, whichever applicable.

CONSENT TO TREAT

I hereby authorize Mind and Body Pain Clinic and all persons acting as agents thereof, as well as all medical personnel to whom I am referred, to furnish all forms of reasonable diagnostic, preventive, therapeutic and medical treatment to me.

Patient Name: _____

Patient/Legal Guardian Signature:_____ Dated: _____

CONSENT TO DISCUSS OR RELEASE MEDICAL INFORMATION

I, _____, give Dr. Singh and his office permission to discuss and/or disclose my medical history and information with the following people (e.g. family members):

1) _____

2) _____

3) _____

Please select all that apply. Where you list more than one communication option, please indicate which you prefer.

☐ **Phone ____** Preferred

I want you to contact me by telephone at _____

☐ Do ☐ Do not leave messages on my answering machine.
☐ Do ☐ Do not leave messages with any other person.

☐ **Mail ____** Preferred

Address: _____

_____

☐ **E-mail ____** Preferred

E-mail address: _____

☐ **Fax ____** Preferred

Fax number: _____

I understand that I may revoke this authorization at any time notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt.

I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.

I understand that I have the right to receive a copy of this authorization.

Signed: _____ Dated: _____

Print Name: _____

If not signed by the patient, please indicate relationship: _____