INTERVENTIONAL **PAIN** MANAGEMENT
www.NovaPainCenter.com
admin@NovaPainCenter.com

Faisal Sayeed, MD
ABA Board Certified

EDGEWOOD CENTER:
1952 Pulaski Hwy, Edgewood, MD 21040
P: 410-676-1463 | **F:** 410-676-0864

BEL AIR CENTER:
1 Barrington Pl, #103, Bel Air, MD 21015
P: 410-420-0210 | **F:**410-420-0212

AUTHORIZATION FOR RELEASE OF PHARMACY PROFILE

I_____, hereby voluntarily authorize the disclosure of
(Please Print)

information from my pharmacy health record.

PATIENT INFORMATION (Please print):

ADDRESS:_____

_____

DATE OF BIRTH:_____

PHARMACY NAME:_____

PHARMACY ADDRESS:_____

_____

PHARMACY PHONE AND FAX:_____

The information is to be provided to Dr. Faisal Sayeed of Nova Interventional Pain Management at the address(es) listed above for the purpose of pain management.

PLEASE FAX INFORMATION STARTING _____ TO THE PRESENT.

PLEASE FAX INFORMATION TO: (410)676-0864 (Edgewood Office)

(410)420-0212 (Bel Air Office)

_____

(PATIENT SIGNATURE AND DATE)

INTERVENTIONAL **PAIN** MANAGEMENT
www.NovaPainCenter.com
admin@NovaPainCenter.com

Faisal Sayeed, MD
ABA Board Certified

EDGEWOOD CENTER:
1952 Pulaski Hwy, Edgewood, MD 21040
P: 410-676-1463 | **F:** 410-676-0864

BEL AIR CENTER:
1 Barrington Pl, #103, Bel Air, MD 21015
P: 410-420-0210 | **F:**410-420-0212

Medication Alert

This is notification that if you are being prescribed any of the following medications including, Narcotic based medication, Muscle Relaxants, Sleeping pills, and anti-depressants may cause excessive drowsiness, fatigue with impaired ability to concentrate and to operate hazardous machinery or driving. It is highly recommended that you do not involve yourself in these activities on these medications.

Initial_____

NO SHOW & Cancellation Policy

Please keep in mind that we have an extensive amount of patients who are waiting to have procedures. We do require at least 48 hours notice for the cancellation of a procedure. If you fail to show or do not give at least 48 hours cancellation notice:

1. Any patients who are NO SHOW for procedure will be charged a no show fee of $50 and will be discharged from the practice.
2. Office visits and further treatment will be cancelled until the patient complies with prescribed treatment and/or the patient will be discharged.
3. There will be a No Show Fee and Cancellation Fee (with notification of less than 48 hours notice) of $50.00.

Initial_____

Patient Signature:_____ Date:_____

Physician Signature:_____ Date:_____

nova INTERVENTIONAL **PAIN** MANAGEMENT

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

Date: _____

Patient Name _____ Birthdate _____ Patient # _____

Chief Complaint: _____

History of present illness:

Location: _____
(Where is the pain/problem?)

Quality _____
(Example: normal versus abnormal color, activity, etc.)

Severity _____
(How severe is the pain/problem on a scale of 1-5 with 5 being the most severe?)

Duration _____
(How long have you had this pain/problem?, or, When did it start?)

Timing _____
(Does the pain/problem occur at a specific time?)

Context _____
(Where were you at the onset of this pain/problem?)

Associated signs/symptoms _____
(What other associated problems have you been having?

Modifying factors _____
(What makes the pain/problem worse or better?, or, Have you had previous episodes?)

Past Medical History

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles	no	yes	Anemia	no	yes	Back trouble	no	yes	Hepatitis	no	yes
Mumps	no	yes	Bladder Infections	no	yes	High Blood Pressure	no	yes	Ulcer	no	yes
Chickenpox	no	yes	Epilepsy	no	yes	Low Blood Pressure	no	yes	Kidney Disease	no	yes
Whooping Cough	no	yes	Migraine Headaches	no	yes	Hemorrhoids	no	yes	Thyroid Disease	no	yes
Scarlet Fever	no	yes	Tuberculosis	no	yes	Date of last chest x-ray _____			Bleeding Tendency	no	yes
Diphtheria	no	yes	Diabetes	no	yes	Asthma	no	yes	Any other disease (please list):	no	yes
Smallpox	no	yes	Cancer	no	yes	Hives or Eczema	no	yes			
Pneumonia	no	yes	Polio	no	yes	AIDS or HIV+	no	yes			
Rheumatic Fever	no	yes	Glaucoma	no	yes	Infectious Mono	no	yes			
Heart Disease	no	yes	Hernia	no	yes	Bronchitis	no	yes			
Arthritis	no	yes	Blood or Plasma Transfusions	no	yes	Mitral Valve Prolapse	no	yes			
Venereal Disease	no	yes				Stroke	no	yes			

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

_____ _____ _____
_____ _____ _____
_____ _____ _____

Medications: (Include nonprescription) _____
_____
_____

Have you ever taken Phen-Fen/Redux? ..... no yes

Patient social history:

Marital status	Single:_____	Married: _____	Separated: _____	Divorced:_____	Widowed:_____
Use of alcohol:	Never:_____	Rarely:_____	Moderate:_____	Daily:_____	
Use of tobacco:	Never:_____	Previously, but quit:_____		Current packs / day: _____	
Use of drugs:	Never:_____	Type/Frequency: _____			
Excessive exposure at home or work to:	Fumes:_____	Dust:_____	Solvents:_____	Air-borne Particles:_____	Noise:_____

Family medical history:

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Review of Systems: Please indicate any personal history below:

☐ **Constitutional Symptoms**
- Good general health lately . . . . No Yes
- Recent weight change . . . . . No Yes
- Fever . . . . . No Yes
- Fatigue . . . . . No Yes
- Headaches . . . . . No Yes

☐ **Eyes**
- Eye disease or injury . . . . . No Yes
- Wear glasses/contact lenses . . . . No Yes
- Blurred or double vision . . . . . No Yes

☐ **Ears/Nose/Mouth/Throat**
- Hearing loss or ringing . . . . . No Yes
- Earaches or drainage . . . . . No Yes
- Chronic sinus problem or rhinitis . No Yes
- Nose bleeds . . . . . No Yes
- Mouth sores . . . . . No Yes
- Bleeding gums . . . . . No Yes
- Bad breath or bad taste . . . . . No Yes
- Sore throat or voice change . . . . No Yes
- Swollen glands in neck . . . . . No Yes

☐ **Cardiovascular**
- Heart trouble . . . . . No Yes
- Chest pain or angina pectoris . . . No Yes
- Palpitation . . . . . No Yes
- Shortness of breath w/walking or lying flat . . . . . No Yes
- Swelling of feet, ankles or hands No Yes

☐ **Respiratory**
- Persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? . . . No Yes
- Spitting up blood . . . . . No Yes
- Shortness of breath . . . . . No Yes
- Wheezing . . . . . No Yes

☐ **Gastrointestinal**
- Loss of appetite . . . . . No Yes
- Change in bowel movements . . . No Yes
- Nausea or vomiting . . . . . No Yes
- Frequent diarrhea . . . . . No Yes
- Painful bowel movements or constipation . . . . . No Yes
- Rectal bleeding or blood in stool No Yes
- Abdominal pain . . . . . No Yes

☐ **Genitourinary**
- Frequent urination . . . . . No Yes
- Burning or painful urination . . . No Yes
- Blood in urine . . . . . No Yes
- Change in force of strain when urinating . . . . . No Yes
- Incontinence or dribbling . . . . . No Yes
- Kidney stones . . . . . No Yes
- Sexual difficulty . . . . . No Yes
- Male - testicle pain . . . . . No Yes
- Female - pain with periods . . . . No Yes
- Female - irregular periods . . . . . No Yes
- Female - vaginal discharge . . . . No Yes
- Female - # of pregnancies . . . . _____
- Female - # of miscarriages . . . . _____
- Female - date of last pap smear. _____

☐ **Musculoskeletal**
- Joint pain . . . . . No Yes
- Joint stiffness or swelling . . . . . No Yes
- Weakness of muscles or joints . . No Yes
- Muscle pain or cramps . . . . . No Yes
- Back pain . . . . . No Yes
- Cold extremities . . . . . No Yes
- Difficulty in walking . . . . . No Yes

☐ **Integumentary (skin, breast)**
- Rash or itching . . . . . No Yes
- Change in skin color . . . . . No Yes
- Change in hair or nails . . . . . No Yes
- Varicose veins . . . . . No Yes
- Breast pain . . . . . No Yes
- Breast lump . . . . . No Yes
- Breast discharge . . . . . No Yes

☐ **Neurological**
- Frequent or recurring headaches No Yes
- Light headed or dizzy . . . . . No Yes
- Convulsions or seizures . . . . . No Yes
- Numbness or tingling sensations No Yes
- Tremors . . . . . No Yes
- Paralysis . . . . . No Yes
- Head injury . . . . . No Yes

☐ **Psychiatric**
- Memory loss or confusion . . . . . No Yes
- Nervousness . . . . . No Yes
- Depression . . . . . No Yes
- Insomnia . . . . . No Yes
- Suicidal Thoughts . . . . . No Yes
- Violent or Unusual Thoughts . . . No Yes

☐ **Endocrine**
- Glandular or hormone problem . No Yes
- Excessive thirst or urination . . . . No Yes
- Heat or cold intolerance . . . . . No Yes
- Skin becoming drier . . . . . No Yes
- Change in hat or glove size . . . . No Yes

☐ **Hematologic/Lymphatic**
- Slow to heal after cuts . . . . . No Yes
- Bleeding or bruising tendency . . No Yes
- Anemia . . . . . No Yes
- Phlebitis . . . . . No Yes
- Past transfusion . . . . . No Yes
- Enlarged glands . . . . . No Yes

☐ **Allergic/Immunologic**

History of skin reaction or other adverse reaction to:
- Penicillin or other antibiotics . . No Yes
- Morphine, Demerol, or other narcotics . . . . . No Yes
- Novocain or other anesthetics . No Yes
- Aspirin or other pain remedies No Yes
- Tetanus antitoxin or other serums . . . . . No Yes
- Iodine, Merthiolate or other antiseptic . . . . . No Yes
- Other drugs/medications: _____

_____

Known food allergies: _____

_____

Environmental allergies: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of Parent or Guardian Date

Doctor's Review

_____ _____

Signature of Doctor Date

HEALTH HISTORY

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW FAISAL SAYEED, M.D. MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Faisal Sayeed, M.D. is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, either created by Faisal Sayeed, M.D. or received by Faisal Sayeed, M.D. from other healthcare providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this Notice. Faisal Sayeed, M.D. will abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of your protected health information.[1]

Faisal Sayeed, M.D. reserves the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current Notice from our office at any time.

Uses and Disclosures of Your Protected Health Information not Requiring Your Consent

Faisal Sayeed, M.D. may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and healthcare operations. There are certain restrictions on uses and disclosures of treatment records, which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results.

Treatment may include:
- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers;
- Consultations between healthcare providers concerning a patient;
- Referrals to other providers for treatment;
- Referrals to nursing homes, foster care homes, or home health agencies.

For example, Faisal Sayeed, M.D. may determine that you require the services of a specialist. In referring you to another doctor, Faisal Sayeed, M.D. may share or transfer your healthcare information to that doctor.

Payment activities may include:
- Activities undertaken by Faisal Sayeed, M.D. to obtain reimbursement for services provided to you;
- Determining your eligibility for benefits or health insurance coverage;
- Managing claims and contacting your insurance company regarding payment;
- Collection activities to obtain payment for services provided to you;
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges;
- Obtaining pre-certification and pre-authorization of services to be provided to you.

For example, Faisal Sayeed, M.D. will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis, and the services provided to you.

Healthcare operations may include
- Contacting healthcare providers and patients with information about treatment alternatives;
- Conducting quality assessment and improvement activities;
- Conducting outcomes evaluation and development of clinical guidelines;
- Protocol development, case management, or care coordination;
- Conducting or arranging for medical review, legal services, and auditing functions.

For example, Faisal Sayeed, M.D. may use your diagnosis, treatment, and outcome information to measure the quality of the services that we provide, or assess the effectiveness of your treatment when compared to patients in similar situations.

Sayeed, M.D. may contact you, by telephone or mail, to provide appointment reminders. You must notify us if you do not wish ive appointment reminders.

y not disclose your protected health information to family members or friends who may be involved with your treatment or care t your written permission. Health information may be released without written permission to a parent, guardian, or legal an of a child; the guardian of an incompetent adult; the healthcare agent designated in an incapacitated patient's healthcare of attorney; or the personal representative or spouse of a deceased patient.

re additional situations when Faisal Sayeed, M.D. is permitted or required to use or disclose your protected health information your consent or authorization. Examples include the following:

As permitted or required by law.
In certain circumstances we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of a crime [redacted]
Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on our premises.

For public health activities.
We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon receipt of written request from that agency. We are required to report positive HIV test esults to the state epidemiologist. We may also disclose HIV test results to other providers or persons when there has been r will be risk of exposure.

[1] s Notice is prepared in accordance with the Health [illegible]

child, but cannot disclose HIV test results in connection with the reporting or prosecution of alleged abuse or neglect. We may release healthcare records, including treatment records and HIV test results, to the Food and Drug Administration when required by federal law. We may disclose healthcare records, except for HIV test results, for the purpose of reporting elder abuse or neglect, provided the subject of the abuse or neglect agrees, or if necessary to prevent serious harm. Records may be released for the reporting of domestic violence if necessary to protect the patient or community from imminent and substantial danger.

- For health oversight activities.
  We may disclose healthcare records, including treatment records, in response to a written request by any federal or state governmental agency to perform legally authorized functions, such as management audits, financial audits, program monitoring and evaluation, and facility or individual licensure or certification. HIV test results may not be released to federal or state governmental agencies, without written permission, except to the state epidemiologist for surveillance, investigation, or to control communicable diseases.

- Judicial and Administrative Proceedings.
  Patient healthcare records, including treatment records and HIV test results, may be disclosed pursuant to a lawful court order. A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records except for HIV test results.

- For activities related to death.
  We may disclose patient healthcare records, except for treatment records, to a coroner or medical examiner for the purpose of completing a medical certificate or investigating a death. HIV test results may be disclosed under certain circumstances.

- For research.
  Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.

- To avoid a serious threat to health or safety.
  We may report a patient's name and other relevant data to the Department of Transportation if it is believed the patient's vision or physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information, including treatment records and HIV test results, may be disclosed where disclosure is necessary to protect the patient or community from imminent and substantial danger.

- For workers' compensation.
  We may disclose your health information to the extent such records are reasonably related to any injury for which workers compensation is claimed.

Faisal Sayeed, M.D. will not make any other use or disclosure of your protected health information without your written authorization. You may revoke such authorization at any time, except to the extent that Faisal Sayeed, M.D. has taken action in reliance thereon. Any revocation must be in writing.

Your Rights Regarding Your Protected Health Information

You are permitted to request that restrictions be placed on certain uses or disclosures of your protected health information by Faisal Sayeed, M.D. to carry out treatment, payment, or healthcare operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restriction, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would not apply when we are required by law to disclose certain healthcare information.

You have the right to review and/or obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. Faisal Sayeed, M.D. may deny an access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You may request that Faisal Sayeed, M.D. send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that Faisal Sayeed, M.D. not send information to a particular address or location or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing. We will accommodate reasonable requests by you.

You have the right to request that Faisal Sayeed, M.D. amend portions of your healthcare records, as long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied.

You may request to receive an accounting of the disclosures of your protected health information made by Faisal Sayeed, M.D. for the six years prior to the date of the request, beginning with disclosures made after April 14, 2003. We are not required, however, to record disclosures we make pursuant to a signed consent or authorization.

You may request and receive a paper copy of this Notice, if you had previously received or agreed to receive the Notice electronically.

Any person or patient may file a complaint with Faisal Sayeed, M.D. and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with Faisal Sayeed, M.D., please contact the Privacy Officer at the following:

[redacted]
Faisal Sayeed, M.D.
1952 Pulaski Highway
Edgewood, MD 21040
(410) 676-1463

It is the policy of Faisal Sayeed, M.D. that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

This Notice of Privacy Practices is effective April 14, 2003.

INTERVENTIONAL **PAIN** MANAGEMENT
www.NovaPainCenter.com
admin@NovaPainCenter.com

Faisal Sayeed, MD
ABA Board Certified

EDGEWOOD CENTER:
1952 Pulaski Hwy, Edgewood, MD 21040
P: 410-676-1463 | **F:** 410-676-0864

BEL AIR CENTER:
1 Barrington Pl, #103, Bel Air, MD 21015
P: 410-420-0210 | **F:**410-420-0212

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND RELEASE

I_____, acknowledge that I have received a copy of Nova Interventional Pain Management's Notice of Privacy Practices. This Notice describes how Nova Interventional Pain Management may use and disclose my protected heath information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

In addition, I give permission for the following individual(s) to have access to my medical record.

_____

_____

I hereby voluntarily authorize the release of my medical records to Nova Interventional Pain Management for the purpose of my medical care.

_____

Signature of Patient Date

INTERVENTIONAL **PAIN** MANAGEMENT

www.NovaPainCenter.com
admin@NovaPainCenter.com

Faisal Sayeed, MD
ABA Board Certified

EDGEWOOD CENTER:
1952 Pulaski Hwy, Edgewood, MD 21040
P: 410-676-1463 | **F:** 410-676-0864

BEL AIR CENTER:
1 Barrington Pl, #103, Bel Air, MD 21015
P: 410-420-0210 | **F:**410-420-0212

MEDICATION LIST

PATIENT NAME_____ DOB_____

HOME#_____ CELL#_____

PHARMACY_____ PHONE#_____

ALLERGIES – DRUG REACTIONS

PROBLEM (S)	MEDICATION/STRENGTH	DIRECTIONS	NUMBER REFILLS	START DATE

INTERVENTIONAL **PAIN** MANAGEMENT
www.NovaPainCenter.com
admin@NovaPainCenter.com

Faisal Sayeed, MD
ABA Board Certified

EDGEWOOD CENTER:
1952 Pulaski Hwy, Edgewood, MD 21040
P: 410-676-1463 | **F:** 410-676-0864

BEL AIR CENTER:
1 Barrington Pl, #103, Bel Air, MD 21015
P: 410-420-0210 | **F:**410-420-0212

MEDICATION CONTRACT

I, _____, have agreed to use the following medications as part of my treatment for chronic pain. I understand that these medications may not eliminate my pain but may reduce it and improve what I am able to do each day.

MEDICATION	DOSE	DIRECTIONS	QNTY PER MONTH

I understand the following guidelines for continuing pain treatment under the care of NOVA Interventional Pain Management.

1. I understand that I have the following responsibilities:
   - I will take medications at the dose and frequency prescribed.
   - I will not increase or change how I take my medications without the approval of this health care provider.
   - I will arrange for refills at the prescribed interval ONLY during regular office hours. I will not ask for refills earlier than agreed, after-hours, on holidays or on weekends.
   - I will obtain all refills for these medications only at _____ pharmacy (phone number:_____), with full consent for my provider and pharmacist to exchange information in writing or verbally.
   - I will not request any pain medications or controlled substances from other providers and will inform this provider of all other medication I am taking.
   - I will inform my other health care providers that I am taking these pain medications and of the existence of this contract. In the event of an emergency, I will provide this same information to emergency department providers.
   - I will protect my prescriptions and medications. I understand that lost or misplaced prescriptions will not be replaced.
   - I will keep medications only for my own use and will not share them with others. I will keep all medications away from children.
   - I agree to participate in any medical, psychological or psychiatric assessments recommended by my provider.
   - I will actively participate in any program designed to improve function, including social, physical, psychological and daily or work activities.

2. I will not use illegal or street drugs or another person's prescription. If I have an addiction problem with drugs or alcohol and my provider asks me to enter a program to address this issue, I agree to follow through. Such programs may include:

- 12-step program and securing a sponsor
- Individual counseling
- Inpatient or outpatient treatment
- Other:_____

If in treatment, I will request that a copy of the programs initial evaluation and treatment recommendations be sent to this provider and will not expect refills until that is received. I will also request written monthly updates be sent to verify my continuing treatment.

3. I will consent to random drug screening to assure I am only taking prescribed drugs. I understand that a drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking.

4. I will keep all my scheduled appointments. If I need to cancel my appointment, I will do so a minimum of 24 hours before it is scheduled.

5. I understand that this provider may stop prescribing the medications listed if:

- I do not show any improvement in pain or my activity has not improved.
- I develop rapid tolerance or loss of improvement from the treatment.
- I develop significant side effects from the medication.
- My behavior is inconsistent with the responsibilities outlined above, which may also result in being prevented from receiving further care from this clinic.

Signed:_____ Date:_____

Provider:_____ Date:_____

Personal Information

Todays Date_____

Name_____ Nickname_____

Birthdate_____ SSN_____

☐Male ☐Female ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Race_____ Ethnicity_____

Address_____

City_____ State_____ Zip_____

Employer_____ Occupation_____

Primary Care Physician_____

Referring Physician_____

Contact Information

Home Phone_____ Work Phone_____

Cell Phone_____ Email_____

Pharmacy & Location_____

Pharmacy Phone_____

Where do you prefer to receive calls? ☐Home ☐Work ☐Cell

When is the best time to reach you?_____

In the event of an emergency, who should we contact?

Name_____ Relationship_____ Phone_____

Insurance Information

Primary Insurance	Additional Insurance
Name of Insured_____	Name of Insured_____
Relationship to patient_____	Relationship to patient_____
Insured's birthdate_____	Insured's birthdate_____
SSN_____	SSN_____
Employer_____	Employer_____
Occupation_____	Occupation_____
Insurance Co_____	Insurance Co_____
Group#_____	Group#_____

Responsible Party

Who is responsible for the account?

Name_____

Relationship to patient_____ SSN_____

Address_____

City_____ State_____ Zip_____

Employer_____

Occupation_____

Work Phone_____ Home Phone_____

Cell Phone_____ Email_____

Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits other payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Any outstanding balance may be charged to my credit card

☐ Visa ☐Mastercard ☐American Express

Card Number_____ Expiration Date_____

X_____

Signature of patient or parent/guardian if minor

Financial Arrangements

For your convenience, we offer the following methods of payments.
Please check the option which you prefer.
Payment in full at each appointment.

_____ Cash

_____ Credit Card ____Visa ____MC ____AE

_____ I wish to discuss the offices' payment policy.

Thank you for filling out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask- we are always happy to help.