

Patient Registration Form

General Patient Information:

Name: _____ Date: ____/____/____

Address: _____ City: _____

State: _____ Zip Code: _____

Home Phone: (____) _____ Work Phone: (____) _____

Cell Phone: (____) _____

Date of Birth: ____/____/____ Age: _____ SSN: _____

Marital Status: ☐ single ☐ married ☐ partnered ☐ widowed ☐ divorced

Gender: ☐ M ☐ F

Occupation: _____ Employer: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Phone #: _____

Who may we thank for referring you? _____

Insurance Carrier:

Primary: _____ Secondary: _____

If you, the patient, are not the insured please provide the following:

Name: _____ DOB: _____ SSN: _____

I request that payment of authorized insurance benefits be made to the physician/supplier for any services furnished by that physician/supplier. I authorize any holder of medical information about me to release to the insurance carrier and/or its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payments be made and authorize release of medical information necessary to pay the claim. If at the time of service, I state I have valid insurance coverage, but later if it is determined, for whatever reason, I was not covered, I acknowledge and agree that I am responsible for the entire fee. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as co-insurance and the deductible is based upon the charge determination of the Medicare carrier. My signature authorizes release of the information to the insurer or agency shown. I understand that the responsibility of arranging care under a contracted provider or securing authorizations for referrals, tests, labs, etc. lies with the patient.

Signature of Patient or Guardian

Date

MEDICATION LIST

Patient Name _____

Date _____

Allergies: _____

Please fill in your **CURRENT MEDICATIONS ONLY**:
(ALL prescription and non-prescriptions medications, including vitamins and herbs.)

[illegible]

PARAGON PAINCARE

CONSENT FORM

(Consent for Purposes of Treatment, Payment and Healthcare Operations)

I consent to the use of disclosure of my protected health information by Paragon Paincare for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of Paragon Paincare. I understand that diagnosis or treatment of me by Paragon Paincare may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Paragon Paincare are not required to agree to the restrictions that I may request, however, if Paragon Paincare agree to a restriction that I request, the restriction is binding on Paragon Paincare.

I have the right to revoke this consent, in writing, at any time, except to the extent that Paragon Paincare has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Paragon Paincare Notice of Privacy Practices prior to signing this document. The Paragon Paincare Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Paragon Paincare. The Notice of Privacy Practices for Paragon Paincare 1016 Laurel Street, San Carlos, CA. 94070. This Notice of Privacy Practices also describes my rights and Paragon Paincare responsibilities with respect to my protected health information.

Paragon Paincare reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practice by calling the office and request a revised copy to be sent in the mail or obtain one at a the time of my next appointment.

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

DATE: _____

PARAGON PAINCARE

John Schoenberger , M.D, Medical Director

FINANCIAL POLICY

CASH PATIENTS

- Full payment is due at the time of your visit or service.
- We accept cash, check, Visa, and Mastercard.

PPO HEALTH PLANS

- Co-payments are due at the time of your visit or service.
- If your co-payment is not made at the time of your visit a \$15 processing fee will be added to your statement.
- You will be responsible for any coinsurance and deductible.

NON PARTICIPATING HEALTH PLANS

Payment is due at the time of your visit or service. The amount to be paid will be calculated upon completion of your visit or service. We will submit claims to your insurance company for you. Your insurance claim is filed as a courtesy to our patients. We will not become involved in disputes between you and your insurance carrier.

INSURED PATIENT RESPONSIBILITY

Your insurance policy is a contract between you and your insurance company. It is important that you understand your insurance and its provisions. If you are unsure, then the customer service department of your insurance company can help you.

By signing this document, you authorize the office of Paragon PAINCARE to release all information necessary to secure the payment of benefits from your insurance carrier.

We will do everything we can to obtain reimbursement from your insurance. However, you are responsible for payment for services rendered within a reasonable time-

REGARDLESS OF THE STATUS OF YOUR CLAIM. This applies to claims that have not been paid after **60 days** from their submission to your insurance.

MEDICARE

If you are covered by Medicare, we require that you have proof of such coverage for billing purposes.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

CANCELLATIONS AND NO- SHOWS

The office of Paragon Paincare requires ***24-hour notice*** if you are unable to keep your scheduled appointment. You will be charged a fee if you do not provide this required notice. This fee is your responsibility and will not be billed to your insurance carrier. Appointment reminder calls are a courtesy. It is your responsibility to be mindful of your appointment date and time.

I have read and understand the above statements.

Patient/ Responsible Party Signature

Dated

PARAGON PAINCARE SERVICES AND PATIENT POLICIES

1. Office hours are Monday, Tuesday, Thursday, and Friday 9:00a.m. to 5:00p.m. Our office is closed for lunch between 12:00p.m. to 1:00p.m. on these days. Our office is closed on Wednesdays.
2. Contacts with the office outside of regular hours of operation are strictly reserved for emergency or urgent matters. Please note this does not include rescheduling appointments, medication refills, medication adjustments, or conversations with Dr. Schoenberger that are meant to be discussed during visits.
3. You are required to have a primary care physician to address basic and ongoing medical needs. Dr. Schoenberger cannot serve you in this capacity. He is here solely to serve your pain management needs.
4. It is your responsibility to regulate your medications. Contacts with the office regarding prescription refills in between visits should be made limited. When refill requests are made they must be at least THREE BUSINESS DAYS in advance. Requests are to be faxed by your pharmacy or called in to the office. Refills of controlled medications will be handled in conjunction with a visit and, therefore, your attendance is necessary to continue this therapy. Same day refill requests will not be honored. Walk- in refill requests will not be honored. Early refill request will not be honored.
5. Should you be unable to attend your appointment for any reason, it is required that at least 24 hours notice be given or a charge for that visit can be expected. This charge is dependant on the length of your appointment and will be a minimum of \$50.00. Your insurance will not reimburse for this and can not be billed for this. This becomes your full responsibility. Late cancellations mean the denial of care to a fellow pain patient who may be in need of that appointment time. Our office has a continual list of patients waiting for cancellations.
6. Paragon PAINCARE is not an urgent care facility nor is it a walk-in clinic. We understand that the needs of pain patients are very specialized. We recognize that pain is unpredictable and can require urgent attention. Dr. Schoenberger extends every effort to assist in these instances, however due to advanced scheduling; you may likely be referred to an urgent care facility or the emergency room. It is your responsibility to schedule your appointments in advance.
7. Pain is a complex medical problem and requires adequate time to assess and treat. Every effort will be exerted to ensure that you are seen on time with minimal delays, however due to the unpredictable nature of individual patient needs, Dr. Schoenberger can run behind. Should this situation arise, we request your patience.
8. Should you request that disability paperwork or letters be written on your behalf, please note there will be a wait period and a charge of \$50.00.

I have read and I understand the above list of Paragon PAINCARE Services and Patient Policies. I further understand that failure to comply with these policies may result in discharge from care.

Signature of patient or personal representative

Date

PARAGON PAINCARE

CONSENT TO RELEASE PERSONAL INFORMATION

To
FAMILY MEMBER OR FRIEND

Date: _____ Patient's Name: _____

DUE TO OUR POLICY, AND HIPPA REGULATIONS, WE CANNOT DISCLOSE ANY MEDICAL INFORMATION TO FAMILY MEMBERS AND/OR FRIENDS. IF THE PATIENT CHOOSES TO DESIGNATE A FAMILY MEMBER AND/OR FRIEND TO OBTAIN PERSONAL INFORMATION WE REQUIRE A SIGNED CONSENT FORM FROM THE PATIENT. IN ADDITION TO THE AUTHORIZED PERSON'S NAME, RELATIONSHIP TO THE PATIENT, DATE OF BIRTH, ADDRESS AND PHONE NUMBER, THE PATIENT WILL NEED TO INDICATE EXACTLY WHAT TYPE OF INFORMATION THAT CAN BE PROVIDED. PLEASE ONLY DESIGNATE ONE INDIVIDUAL TO OBTAIN SUCH INFORMATION.

DESIGNATED RECIPIENT OF PERSONAL INFORMATION

Name: _____ D.O.B.: _____

Relationship to Patient: _____

Address: _____

Phone Number: (H): _____ (W): _____

INFORMATION APPROVED TO BE RELEASED TO THE ABOVE DESIGNATED PERSON

- ☐ NO INFORMATION IS TO BE RELEASED ☐ ALL MEDICAL/BILLING INFORMATION
☐ ONLY THE FOLLOWING INFORMATION MAY BE RELEASED:

Patient's Signature

Date

consent-familyfriendsfor.doc