



Vivek A. Manocha M.D.
 Physiatrist and Interventional
 Pain Specialist
 578 N Main St.
 Springboro, OH. 45066

PATIENT INFORMATION

FIRST NAME	MI	LAST NAME	GENDER
STREET ADDRESS		DATE OF BIRTH	
CITY, STATE, & ZIP CODE			
HOME PHONE NUMBER	CELL PHONE NUMBER		WORK PHONE NUMBER
SOCIAL SECURITY NUMBER	MARITAL STATUS		
_____ - _____ - _____	___SINGLE___MARRIED___DIVORCED___WIDOW(er)		

GUARANTOR (If Different From Above)

FIRST NAME	MI	LAST NAME	DATE OF BIRTH
STREET ADDRESS	CITY	STATE	ZIP
PHONE NUMBER(S)	EMPLOYER		ADDRESS
_____ - _____ - _____			

EMPLOYMENT & INSURANCE INFORMATION

PRIMARY INSURANCE	POLICY HOLDER	POLICY HOLDER SS#
PRIMARY INSURANCE HOLDERS DATE OF BIRTH	RELATIONSHIP TO PATIENT	
SECONDARY INSURANCE	POLICY HOLDER	POLICY HOLDER SS#
SECONDARY INSURANCE HOLDERS DATE OF BIRTH	RELATIONSHIP TO PATIENT	
EMPLOYER	FULL TIME STUDENT	PRIMARY CARE PHYSICIAN
	___YES___ ___NO___	NAME PHONE #
EMERGENCY CONTACT		
NAME:	PHONE NUMBER(S):	

DO YOU HAVE AN ADVANCE DIRECTIVE,(LIVING WILL)	IF YES, AT WHICH HOSPITAL IS IT FILED?
HOW DID YOU HEAR ABOUT OUR OFFICE?	
FRIEND/FAMILY _____	PHYSICIAN _____
ADVERTISEMENT _____	



POLICY, AUTHORIZATIONS, & FINANCIAL AGREEMENT

APPOINTMENT POLICY:

At Interventional Spine & Pain Center we are concerned about your health care. We would like you to know by not keeping your scheduled appointments hinders our ability to provide you with quality care. Interventional Spine & Pain Center requires a 24 hour notice for all cancellations. This allows us to offer another patient that time spot and prevents a cancellation fee from being applied to your account. Our No Show fees are not payable by your insurance carrier and will be your responsibility. The No Show fees vary by appointment type. For an office visit the "no show" fee is \$35.00 and the injection visit "no show" fee is \$50.00. By failing to contact the office to cancel your appointment may result in the physician letting you go from his/her practice. Patients Initials_____ This is stating the patient has read the above.

AUTHORIZATIONS:

I authorize examination, diagnosis, and general treatment (including but not limited to, use of x-ray and other non-invasive procedures such as diagnostic test) to be performed by the physicians and staff of Interventional Spine & Pain Center. I realize that if a medical procedure is required, I will be given additional information.

I understand that as part of my healthcare, this practice originates and maintains health records and radiology films describing my health history, symptoms, examination and test results, diagnosis, treatment and plans for future care and treatment. The health records and radiology films will be retained by Interventional Spine & Pain Center even if my healthcare provider(s) leave the practice.

I authorize the release of any medical information necessary to process insurance claims and request payment of benefits either to myself or the party who accepts assignment/participates.

FINANCIAL AGREEMENT:

I understand the bill is my responsibility. I assign and authorize payments be made directly to Interventional Spine & Pain Center of all insurance benefits and agree to pay any balance due.

I understand that I will be responsible for any additional fees incurred from the following:

Returned Checks

Missed

Appointments

Non-payment of co-pays or deductibles at time of service
Copies of Medical Records

PRESCRIPTION REFILL REQUESTS:

With any long-term drug, we require an office visit once a month, unless the physician deems otherwise. We request a 72 hour notice if you are requesting a refill to be called into your pharmacy.

By signing the line below you are stating that you have read and agree to all portions of this contract.

Signature of patient or patient's representative

Date

Printed name of patient or patient's representative

Representatives relationship to patient