VALLEY PAIN CENTERS

CONFIDENTIAL PATIENT INFORMATION – PLEASE PRINT LEGIBLY

Referring Physician _____ **Today's Date** _____

First Name _____ **MI** ____ **Last Name** _____

Address _____ **Home Phone** (_____)_____

City _____ **State** ____ **Zip** _____ **Cell Phone** (_____)_____

Social Security Number _____ **Date of Birth** ____/____/_____ **Age** _____ **Sex:** ☐ **F** ☐ **M**

Marital Status: (Circle One) ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Single** ☐ **Separated**

Email:_____

Occupation _____**Employer** _____

Office Address _____ **Work Phone** (_____)_____

Emergency contact person name:_____ Phone (_____)_____

Do you have/need an advance directive?Yes☐ No☐ Valley Pain Centers does not recognize Advanced Directives

CONFIDENTIAL INSURANCE INFORMATION – PLEASE PRINT LEGIBLY

Insured First Name _____ **MI** ___ **Last** _____

Relation to Patient _____ **Birthdate** _____/_____/_____ **Soc Sec#** _____/_____/_____

Address if different than patient: _____

Employer _____ Occupation _____

ASSIGNMENT, RELEASE AND INFORMED CONSENT

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Valley Pain Centers and/or Southwest Pain Specialists all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance company. In the event the payment is not made and this account is referred for collection, I will pay the cost of collection. If suit or action by an attorney is instituted, I will pay reasonable attorney fees in said suit or action. Invoice payments will be due upon receipt and are considered past due thirty (30) days from date of invoice, including acceptable lien cases. Interest at the rate of 1.5% monthly will apply to past due amounts. Additionally, I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions and acknowledge receipt of Privacy Notice given to me **(Federal HIPPA Privacy Practices).**

X _____ **Date**: _____

Patient / Responsible Party Signature