RichmondSpine
INTERVENTIONS & PAIN CENTER

Patient Demographic Form

Please consider registering for our **Patient Portal!** Once you have registered, you will be able update your demographic information, view your medical records online, send secure messages to our staff, request appointments and much more. All you need to provide is an email address and you can sign up at the time of your appointment. Please ask one of our staff members if you would like to register and we will be happy to set you up!

Name: ____ DOB: ______/_______/________

Home Phone: (   )______________ Mobile: (   )_________________ Work: (   )_______________

Address: ____

City: ____ State: ________________ Zip: _________________

Email: ____@_____________________ . ____________

Race: ____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Contact preference: ☐ Home ☐ Mobile ☐ Work Martial Status: __________________________

Emergency Contact: ______________________________________ Relationship: ___________________

Home: _____________________________________ Mobile: _____________________________________

Would you like to register for the patient portal today? ☐ yes ☐ no

Can we send you a mobile text message? ☐ yes ☐ no

Primary Care Physician: ____ Phone: ________________

Referring Physician: ____ Phone: ________________

Pharmacy: ____ Phone: ________________

Primary Insurance Company: ____

Secondary Insurance Company:____

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No Show/Cancellation Policy

Dear Patient,

Please be aware that by making an initial appointment with our physician, nurse practitioner or physicians assistant, you are agreeing to abide by the billing policies of our practice. There will be a fee, billed to you personally, if you do not provide at least a 24 hour notice of cancellation or change your appointment date/time. This policy will be enforced for both new patients as well as established patients. In addition is also a fee that will be billed to you personally if you do not come in or "no show" for your appointment.

There are no health insurance policies that cover fees for missed appointments or "no show" appointments.

Our staff will be happy to answer any further questions regarding this policy.

______________________________________ ________________
Acknowledgement of Receipt Date

____
Relationship to Patient (if someone other than patient)

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Authorization to Discuss & Release Confidential Patient Information

I, ____,
hereby authorize Richmond Spine Interventions and Pain Center to discuss my medical and/or financial information ** with the following person(s):
**This includes, but is not limited to, picking up prescriptions, samples, excuses, or other documents left for pickup if the patient (named above) is unable to do so.

Name	Relationship	DOB
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

This consent is valid until such time as I provide Richmond Spine Interventions and Pain Center written revocation of this document.

If Richmond Spine Interventions and Pain Center is unable to reach you in person for any reason (lab results, referrals, appointments, prescriptions, etc.): Do we have permission to leave a message on your voice recorder and/or voicemail? □ yes □ no
Phone number: (   ) ___________ - ____________________

______________________________ ______________________________
Patient/Gaurdian Date

______________________________ ______________________________
Witness (STAFF Only) Date

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Release of Medical Information for Billing Purposes

I hereby authorize Richmond Spine Interventions and Pain Center to release medical information to Medicare, my employer's benefits department, or my other insurance company, for the sole purpose of obtaining payment for my medical care. Although medical information is confidential, many carriers require medical documentation prior to payment for services. I understand that only information pertaining to obtaining payment for my care will be released. I agree that copy of this release maybe used in place of the original.

I am aware that I may request that this Release of Medical Information may be revoked at any time by providing the physician's office with a dated and signed letter. I have read and agree with these terms.

Payment For Medical Services

I hereby assume financial responsibility for all charges incurred for services rendered. I understand that I will be required to pay co-payments, amounts applied to deductibles, and the balance of bills not paid in accordance with the benefits of my current insurance policy. If I am unable to make a payment in full for my medical treatment within 30 days, I agree to call the business office and make payment arrangements.

I hereby authorize payment for all medical insurance benefits which are payable under the terms of my insurance policy, to be paid directly to Richmond Spine Interventions and Pain Center or designates for services rendered.

I certify that the information I have reported regarding my insurance coverage is correct. I authorize the physician's office to verify insurance coverage and benefits allowed in accordance with the insurance company's policy.

I understand that it is my full responsibility that any third party which I direct Richmond Spine Interventions and Pain Center to bill, in the event of non-payment for whatever reason in accordance with the benefits of my current insurance policy, I will pay immediately. It is further agreed that in the event I fail to pay upon demand, should my account be referred to an outside collection agency an or an attorney, I accept full responsibility to pay all collection cost not to exceed 30% and interest of 1.5% per month not to exceed 18% per annum and reasonable court costs.

______________________________ ____________________

Patient or Responsible Party's Signature Date