PAINRELIEF
OF DAYTON

Interventional Pain Medicine
for Spine & Chronic Pain Care
Board Certified • Fellowship Trained

www.painreliefofdayton.com

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PATIENT INFORMATION

Last Name _____ First _____ MI _____
Address _____ City _____ ST _____ Zip _____
Phone #'s (home) _____ (cell) _____ (work) _____
DOB _____ SSN_____ Sex M/F Marital Status _____
Family Physician _____ Employer _____

Is your visit due to a Work Related Injury or Automobile Accident Y/N

INITIAL CONSENT FOR TREATMENT

I desire to be treated at Pain Relief of Dayton by Dr. Ricardo Buenaventura. I understand that I may discontinue treatment at any time. I authorize for the examination, diagnosis, and general treatment which may include but not limited to a clinical evaluation, medical history, physical examination, psychological examination. The purpose of such evaluations is to assist in identifying the cause of my problem and applying the most appropriate medical treatments possible. I understand and consent to the administration of an evaluation. After my evaluation, my doctor may offer treatment options which may include but not limited to non-narcotic medications, physical therapy, injection therapy, chiropractic treatments, diagnostic imaging, or psychological therapy as considered necessary and advised by my physician.

I understand that treatments provided by Pain Relief of Dayton are voluntary, and in no way guaranteed to relieve my pain fully or completely.

POLICIES AND ADDITIONAL OFFICE PROCEDURES

Missed Appointment Policy
Not keeping scheduled appts hinders our ability to provide quality care. We require a 24 hour notice for all cancellations. This allows us to offer your time slot to another patient. A failure to provide cancellation notice will result in a $25.00 fee to your account. This is not payable by your insurance and will be your responsibility.

Co-Payments and Deductibles
All copayments and unmet deductible amounts will be due at the time of service. Our office will make every effort to notify you of deductible amounts but ultimately you are responsible for knowing this information.

Financial Agreement
I understand that the bill is my responsibility. I assign and authorize payments be made directly to Pain Relief of Dayton of all insurance benefits and agree to pay any balance due. I understand that I will be responsible for additional fees incurred from the following: Returned Checks, Missed Appts, and Non-Payment of co-pays, deductibles or co-insurance and Copies of Medical Records.

Signature of Patient or Patient's Representative: _____
Printed Name of Patient or Patient's Representative: _____
Today's Date: _____