# 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 an advance directive? Yes______ No______

## 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