Bend Spine and Pain Specialists

Patient Information

Patient Name (last, MI, first)_____

Date of birth _____ Social Security # _____Sex _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____

Street Address (if different than mailing)_____

City _____ State _____ Zip _____

Primacy Health Care Provider _____ Phone _____

Referring Provider _____ Phone _____

My Pharmacy is _____

Employer Name _____ Phone _____

Emergency Contact _____ Phone _____

Relationship to patient _____

Primary Insurance _____ Subscriber Name _____

ID # _____ Group # _____

Secondary Insurance _____ Subscriber Name _____

ID # _____ Group # _____

Responsible Party _____

Bend Spine and Pain Specialists

Patient Releases & Consents

Release of Information: I give permission for Bend Spine & Pain Specialists to leave voice messages regarding my appointments at my home or cell numbers. I give permission for Bend Spine & Pain Specialists to leave message regarding treatment, billing and/or appointment information with _____.

Signed _____ Date _____

Rx History Consent: At any time I give permission to Bend Spine & Pain Specialists to inquire about my prescription history with any pharmacy if my doctor feels it is necessary.

Signed _____ Date _____

Assignment and Release: I, the undersigned, have insurance coverage with _____ and assign directly to Bend Spine and Pain Specialists, for all medical 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 insurance. 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 my insurance submissions.

Signed _____ Date _____

Medicare Authorization: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Theodore R. Ford for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits of the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurnace and the deductible are based upon the charge determination of the Medicare carrier.

Signed _____ Date _____

Notice of Privacy Practices: My health information may be created or received by Bend Spine and Pain Specialists and may be written or electronic records or spoken words. My health record may include information of my health history, health status, test results, diagnoses, treatments, procedures, prescriptions and similar types of health related information. I understand that I have the right to receive and review a written description of how Bend Spine will handle my health information. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by employees, staff and other office perwsonnel of Bend Spine and Pain Specialists and my rights regarding my health information. I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy of summary of the most current version of Bend Spine and Pain Specialists' Notice of Privacy Practices in effect will be posted in the waiting/reception area.

Signed _____ Date _____

Printed Name _____