21st CENTURY
Pain Management

PATIENT REGISTRATION FORM

PATIENT NAME: **DATE:**

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize direct payment of my insurance benefits to 21st century pain management or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that 21st century pain Mgmt. is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS: I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's medical records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to 21st century pain Mgmt. Group or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION: I certify that I have received and read a copy of the 21st century pain Mgmt. Patient Information Privacy Policy. I hereby authorize 21st century pain Mgmt. or the physician individually to release any of my or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

REVIEW OF RECORDS: I understand and authorize that 21st century pain Mgmt. or the physician will review my hospital records and or my pharmacy records.

LAB/X-RAY/DIAGNOSTIC SERVICES: I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT: I hereby consent to evaluation, testing, and treatment as directed by my 21st century pain Mgmt. physician or his or her designee.

PATIENT SIGNATURE: _____ **DATE:** _____

GUARANTOR SIGNATURE: _____ **DATE**:
_____ (If different from patient) GUARANTOR NAME (Please Print):
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