NP UP RT BIF RAF

Office Use_______

INJURY SPECIALISTS REGISTRATION FORM

(PLEASE PRINT)

Today's Date:__________ SS#: _____-_____-_______

Patients Name:_____________________________________ Birthdate: ___/___/______ Age: _____ Sex: M F

Street Address: ____________________________________ City: ____________________ State:_____ Zip:_________

Home Phone: (____) ____-______ Cell Phone: (____) ____-______ Email Address: ________________________________

Employer: _________________________________ Occupation: ________________________ Work Phone: (____) ____-_____

Employer Address: _________________________________ City: ________________________ State: _______ Zip: __________

Marital Status: Single Married Widowed Separated Divorced Emergency Contact Name: ______________________________

Relationship: ________________ Phone: (____) _____-_________ How did you hear about us? _______________________

Are you here for injuries sustained in a motor vehicle accident? NO YES

Date of accident: ____/____/_______ State: _______

♦ It is our policy to bill your health insurance for charges relating to all motor vehicle accidents ♦

Are you here for injuries sustained in a work-related accident? NO YES

Date of accident:____/____/______ Have you filed a work comp claim? NO YES-Claim Number:________________________

Contact Person/Employer: _______________________________ Phone: (____) ____-______

Are you being represented by an attorney? NO YES - Name: ____

Phone: (____) ____-_______ Address: ____

♦ HEALTH INSURANCE INFORMATION MUST BE COMPLETED ♦

PRIMARY INSURANCE INFORMATION

Name of Insurance Company: ____

ID: ____________________________________ Group: _____________________________ Copay: ___________

Subscriber's Name: __________________________________ SS# _____-____-______ Date of Birth: ____/____/_______

Relation to patient: _________________ Employer: _______________________________ Work Phone: __________________

SECONDARY INSURANCE INFORMATION

Name of Insurance Company: ____

ID: ____________________________________ Group: _____________________________ Copay: ___________

Subscriber's Name: __________________________________ SS# ____-___-_______ Date of Brith: ____/____/_______

Relation to patient: _________________ Employer: _______________________________ Work Phone: __________________

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance benefits and assign directly to **Gateway Pain Center, DBA Injury Specialists** 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 **Gateway Pain Center, DBA Injury Specialists** to release all information necessary to secure the payment of benefits. I authorize the use of my signature for all my insurance submissions. *I authorize **Gateway Pain Center, DBA Injury Specialists** to release a copy of this form to **Frontenac Surgery & Spine Care Center**, and **Rehab Dynamics** for insurance verification purposes in the event that I am referred to their facility for treatment. I also understand That if treated at **Frontenac Surgery & Spine Care Center**, I will receive a separate bill for the facility, or if treated by **Rehab Dynamics**, I will receive a separate bill for therapy services.*

Signature of Insured/Guardian: ____ Date: ____/____/_______

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Gateway Pain Center, DBA Injury Specialists** for any services furnished me by **Gateway Pain Center, DBA Injury Specialists**. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these 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 CMS-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of information to the insurer or agency shown. In Medicare assigned cases, the physicians 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, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare Carrier.

Beneficiary Signature: ____ Date: ____/____/________