NEW PATIENT INFORMATION

Pain Specialty Consultants, P.A. 1200 Brooklyn Ave #140
San Antonio, Texas 78212
Phone (210) 527 1166 ● Fax (210) 527 1163
www.paindoctorsa.com

Patient's Name_____ Today's Date_____

Date of Birth_____SSN:_____Email:_____

Driver's License #:_____Male ( ) Female ( )

Main Phone #:_____Cell phone#_____Work phone:_____

Full Mailing Address:_____

Primary Insured's Name_____Primary Insured's Date of birth_____

Primary Insured's Social Sec #_____Primary Insured's Employer_____

Primary Insured's Employer's Address_____
Emergency Contact Name: _____ Relationship**:_____**
Emergency Contact Address**:_____**
Emergency contact Phone: (bus.) _____ (cell) _____

Treating Physician (Primary Care)_____Phone #_____

Referring Physician_____Phone#_____UPIN_____

Lawsuit Pending ( ) yes ( ) no Attorney's Name _____Phone_____

Insurance Information:
Private( ) PPO( ) HMO( ) Medicare A ( ) B ( ) Medicaid ( )

Carrier 1:_____

Carrier2:_____

The undersigned hereby authorizes the release of any information relating to all claims for the benefits submitted on behalf of myself and /or dependants. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for service to be rendered without obtaining my signature on each and every claim to be submitted for myself and /or dependants and that I will be bound by this signature as though the undersigned had personally signed the particular claim and understand that I am financially responsible for all charges incurred. As a courtesy my insurance will be billed but any charge not paid by my insurance on each visit will be my responsibility. I understand that unpaid charges may be sent to a collection agency. I have also reviewed the Notice of Privacy Practices of Pain Specialty Consultants dated effective 4-14-03, which explains how my health information will be used and disclosed. I authorize that my records may be released to my treating physician, referring physician or physicians or entities involved in my care. I understand that I am entitled to receive a copy of the Notice of Privacy Practices. I also hereby consent to the use and disclosure of my health information for purposes of treatment, payment and other health care operations as set forth in the Notice of Privacy Practices. I will make the office aware of any insurance change prior to each visit or else be responsible for all the charges.

Signature:_____ Date:_____

Pain Specialty Consultants, P.A.

1200 Brooklyn Ave, Suite 140
San Antonio, TX 78212

Acknowledgement of Review of
Notice of Privacy Practices

I have reviewed the Notice of Privacy Practices of Pain Specialty Consultants, P.A. ("Pain Specialty Consultants") dated effective April 14, 2003, which explains how my health information will be used and disclosed. I understand that I am entitled to receive a copy of the Notice of Privacy Practices. I also hereby consent to the use and disclosure of my health information by Pain Specialty Consultants for purposes of treatment, payment and health care operations as set forth in the Notice of Privacy Practices.

_____

Signature of Patient or Personal Representative Date_____

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

Acknowledgement of Financial Policy

The undersigned hereby authorizes the release of any information relating to all claims for the benefits submitted on behalf of myself and / or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for service to be rendered without obtaining my signature on each and every claim to be submitted for myself and / or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim and understand that I am financially responsible for all charges incurred. As a courtesy my insurance will be billed but any charge not paid by my insurance will be my responsibility. If these charges are not paid within 30 days, then this may be sent to a outside collection agency which can impair my credit rating. I will make the office aware of any change in insurance, phone number and address prior to each visit or else be responsible for the charges.

Please call us during normal business hours and give us at least 24 hours to reschedule or cancel an appointment.

Payment of fees, co-pays and deductibles are due at the time of service and cannot be waived. Returned checks will accrue $30.00 returned check fee and any other bank fees payable only in cash.

I have read and understand the financial policy of the practice and agree to be bound by its terms. I also understand and agree that the practice may alter the terms at its discretion.

Signature of patient: _____
DOB:_____

Name of Patient (printed):_____
Date:_____

Pain Specialty Consultants, P.A.

Prafulla C. Singh, M.D.

•Diplomate American Board of Pain Medicine • Fellowship in Pain Management •Diplomate American Board of Anesthesiology

•Subspecialty Certification in Pain Management by American Board of Anesthesiology

1200 Brooklyn Ste 140, San Antonio, TX 78212

Phone: (210) 527 1166 Fax: (210) 527 1163

PHYSICIAN DISCLOSURE

As required by Section 102 .006 of the Texas Occupations Code

Texas law requires a physician to disclose to a patient those arrangements permitted under applicable Texas law whereby such physicians accept remuneration to secure or solicit a patient or patronage for a person licensed, certified or registered by a Texas health care regulatory agency. The purpose of this Disclosure is to notify you, the patient, that your attending physician(s) may receive remuneration for referring you to certain diagnostic testing laboratories, pharmacies, hospitals and/or other ancillary healthcare providers, for certain toxicology and pharmacogenomic testing services compounding pharmacy products diagnostic imaging services and other ancillary healthcare services.

Accordingly, I hereby acknowledge that my attending physician(s) have disclosed to me, at the time of initial contact and at the time of referral his or her affiliation, if any, with the diagnostic testing laboratory, pharmacy, or other ancillary healthcare provider for whom, I, the patient am being referred and (ii) that he/she will receive, directly or indirectly, remuneration for the referral to such diagnostic testing laboratory, pharmacy or other ancillary healthcare provider. I understand that I, the patient has the right to choose the providers of my health care services and/or products and, as such, I have the option of receiving ancillary healthcare services from any ancillary healthcare provider and/or facility that I choose.

Patient Name: _____

Patient Signature:_____ Date:_____