Tennessee Physical Medicine and Pain Management

PATIENT REGISTRATION FORM

Referring Physician :_____

Patient Name:_____**SS#**_____

Home Phone:( )_____**Cell Phone:**( )_____**Other Phone:**( )_____

Address:_____ _____

City, State, Zip _____ **Date of Birth** _____Sex: M ☐ F ☐

E-mail_____**Primary Language:**_____ _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Nat Hawaiian/Pacific Islander ☐ Other ☐ Race Unknown ☐ White ☐ Decline to Answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Decline to Answer

_____

Pharmacy Name_____ Pharmacy Phone#_____

_____

Primary Insurance:_____ (circle one) Self / Spouse / Parent

Secondary Insurance:_____ (circle one) Self / Spouse/ Parent

<u>Primary or Secondary Insured Information (if different from patient)- THIS MUST BE COMPLETED</u>

Name: _____ **Date of Birth:** _____**SS#**_____

Spouse/Insured Employer:_____**Phone #:** _____

Financially Responsible Party: _____
Last Name First Name Middle Initial

Emergency Contact_____ _____ _____
Full Name work/cell # home #

_____

Is this an approved work related injury? Yes ☐ No ☐ Employer _____
Is this related to a recent accident? Yes ☐ No ☐ Type of accident? _____Date:_____

If you answered not to both of the above and you are not being treated under a Worker's Compensation plan, skip this section.

Insurance and Appointment Agreement: ALL appointments must have authorization from your Adjuster, Employer and / or your Nurse Case Manager prior to any treatment. If authorization is not obtained, you may be responsible for payment of ALL charges incurred. Completion of ALL forms is necessary to process your claim properly. If you are unable to keep a scheduled appointment it must be cancelled 24 hours in advance by your Adjuster, Employer and / or Nurse Case Manager. Failure to cancel with a 24 hour notice could result in a charge to your Workers Compensation insurance.

Date:_____Signature:_____

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If you would like to indicate a relative or friend who can have access to your medical records, receive medical information, receive test results, or communication with our office about your health, please list below.

_____ _____

Date Last Name First Name Middle Initial

Advance Beneficiary Notice / Agreement: Your insurance carrier may not cover properly filed charges for certain tests, visits or procedures if it deems them "not-covered". Your signature indicates that you agree to be financially responsible for these types of services when they are provided.

Date:_____ Signature: _____

Insurance and Collection Agreement: I hereby authorize Tennessee Physical Medicine and Pain Management (TPMPM) to furnish diagnosis codes and medical records to my insurance carrier concerning my illness, medical conditions and treatment for billing purposes. I hereby assign to Tennessee Physical Medicine & Pain Management all insurance payments for medical services provided to me and/ or my dependents. I agree that I am financially responsible for my bill regardless of insurance coverage**. I agree to pay all co-payments at time of service.** In the event that Tennessee Physical Medicine & Pain Management deems it necessary to pursue collection of mine and/or my dependents account through a collection agency, I agree to pay all costs of collection, including reasonable court costs.

Date:_____Signature:_____

I have received a copy of the Notice of Privacy Practice for Tennessee Physical Medicine & Pain Management. The practice reserves the right to modify the Privacy Practice as outlined by HIPAA regulations.

Date:_____Signature:_____

_____ I hereby agree to allow TPMPM to leave messages on my answering machine, including medical information.

_____ I do not agree to allow TPMPM to leave messages on my answering machine, including medical information.