Patient Registration

PLEASE BRING YOUR INSURANCE CARDS AND PHOTO ID

PATIENT INFORMATION

Personal Information

Date: _____ Birthdate: _____ Soc. Sec. #_____ Sex: _____

Last Name: _____ First Name: _____ Middle Name_____

Address_____City/State/Zip_____

Occupation: _____ Referred by Doctor:_____

Contact Information (please include your email for access to your medical records online)

Home Phone: _____Cell: Phone_____ **Email**: _____

In the event of an emergency, who should we contact (please list phone number different from your own:

Name: _____ Relationship: _____ Contact Phone: _____

*Insurance Information (**skip this step if you have insurance cards**)*

Primary Insurance	**Secondary Insurance**
Insurance Company_____	Insurance Company_____
ID #_____	ID #_____
Name of Insured_____	Name of Insured_____
Relationship to Patient_____	Relationship to Patient_____
Insured's birthdate_____	Insured's birthdate_____
Soc. Sec #_____	Soc. Sec #_____

Financial Arrangements

For your convenience, we offer the following methods of payment.

Cash, Personal Check, Visa, Master Card and Discover

Payment in full, co-insurance or co-pay, if applicable, are due at check-in each appointment

Responsible Party

Who is responsible for the account (**if same as above please mark "Same as above"**)?

Name_____Relationship to patient_____

Birthdate_____ Driver's License #_____ Soc. Sec. #_____

Address_____City/State/Zip_____

Work Phone_____ Home Phone_____

Authorization and Release

I authorize Pain Treatment Centers of America, PLLC (PTCOA) & Interventional Surgery Institute (ISI) to treat me. I authorize payment directly to PTCOA for all medical or surgical benefits otherwise payable to me under the terms of my insurance.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my child/dependents.

I understand that this office, pursuant to HIPAA rules and regulations, may use and disclose my protected health information, with certain limits and protections, for treatment, payment, and health care operations activities. A photocopy of this authorization shall be considered as effective and valid as the original. I also attest I have been given a copy of HIPAA rules and regulations described above.

I authorize the release of any information including the diagnosis and the records of treatment or examination rendered to me or my child/dependent during the period of such care to third party payers and/or other health care practitioners involved in my healthcare.

Patient Signature_____Date_____

Parent/Guardian _____Date_____

If signed by legal representative, please provide representative documentation as required by state law, i.e. Power of Attorney, Health Care Surrogate, Living Will, or Guardianship Papers. Please keep in mind that Pain Treatment Centers of America, Interventional Surgery Institute and our staff will provide full resuscitative measures while in our facility.

Owners Meraj Siddiqui, MD & Ronald Tilley MD

Thank you for filling out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask-we are always happy to help.