Patient Registration

Today's Date:		Email:		
Patient's Last Name: First: Middle:		☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital Status: ☐ Sin ☐ Mar ☐ Div ☐ Sep ☐ Wid	
Language: ☐ English ☐ Spanish ☐ Chinese ☐ Russian ☐ Other: _____		Race: ☐ America Indian ☐ Black ☐ Asian ☐ Native Hawaiian ☐ White ☐ Other _____	Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown	
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Date of Birth:	Age:	Sex:
Street Address:		Social Security #:	Home Phone #:	
City:	State:	Zip Code:	Cell Phone #:	
Occupation:	Employer:		Employer Phone #:	
Referred to office by (please check one box): ☐ Dr. _____		☐ Family ☐ Friend	☐ Insurance Plan ☐ Internet ☐ Other:	
Other family members seen here: Name:	Relationship:			
Pharmacy Name:	Cross Streets:		Ph #:	
Referring Doctor Name: Address: Phone #:				
Primary Care Doctor Name: Address: Phone #:				

Is this being billed under Worker's Compensation? ☐ Yes ☐ No		Is this being billed under a Lien w/ an atty? ☐ Yes ☐ No			
Name and address of Primary Insurance:					
Subscriber's Name:	Subscriber's SS #	Birth Date:	Policy / Member ID #:	Group #:	Co-Pay:
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:					
Name and address of Primary Insurance:					
Subscriber's Name:	Subscriber's SS #	Birth Date:	Policy / Member ID #:	Group #:	Co-Pay:
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:					

Emergency Contact Person:	Relationship:	Phone #:
Pharmacy:	Cross Streets:	Phone #:

AUTHORIZATION & ASSIGNMENTOF BENEFITS: The above information is true to the best of my knowledge; I authorize my insurance benefits to be paid directly to EVPC. I understand that I am financially responsible for any co-payments, deductibles or uncovered amounts. I also authorize EVPC or insurance company to release any information required to process my claims. I consent to the performance of examinations and diagnostic procedures my physician considers to be medically necessary. I authorize EVPC to disclose health information necessary to process claims related to my care and to other health care providers for continuing care and treatment. I have received a Notice of Privacy Practices and have been provided an opportunity to request restrictions to the use and disclosure of my health information.

Patient / Guardian Signature	Date

AUTHORIZATION / REALEASE of MEDICAL INFORMATION

I authorize the release of any information including diagnosis and the records of any treatment rendered to me during the period of such care to the third party payers. I authorize and request my insurance company to pay directly to East Valley Pain Center, P.C. any insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services rendered. I agree to be responsible for payment of all balances on services rendered to me or my dependents.

Patient Signature	Date	Front Office Initial
_____	_____	_____

CONSENT TO RELEASE INFORMATION TO FAMILY MEMBERS

I hereby give my consent to release information from my medical and / or financial records from East Valley Pain Center, P.C., to only the person(s) listed below:

1.	2.	3.

☐ **I DENY ALL access of information to any of my family members.**

Patient Signature	Date	Front Office Initial
_____	_____	_____

CONSENT TO RELEASE INFORMATION TO PHYSICIANS

I hereby give my consent to release information regarding my treatment and / or copies of my medical record to any referring physician and / or my primary care physician.

Patient Signature	Date	Front Office Initial
_____	_____	_____

CONSENT TO REQUEST INFORMATION

I hereby give my consent to for East Valley Pain Center, P.C., to request medical information and/or copies of my medical record regarding my treatment from my referring physician and/or primary care physician of record. I hereby give my consent for East Valley Pain Center, P.C. to request medical information and reports from hospitals, other doctor's offices, laboratories and radiology facilities pertaining to my medical care.

Patient Signature	Date	Front Office Initial
_____	_____	_____

PAYMENT AND CONSENT FORM

Insurance: If I have an insurance with which the Practice participates, a claim for reimbursement for services rendered will be submitted based on the information I provide to EVPC. If due to incomplete or incorrect information, payment has not been received by the practice within 45 days from the date of services; all charges become my responsibility and are immediately payable by me.

Referrals / Authorizations: I understand that without a referral / authorization from my insurance carrier, I am financially responsible for all charges I incur. (Applies if this is a requirement by your insurance plan).

Patient responsibility for Non-Contracted Insurance Plans: My signature below acknowledges that the office of East Valley Pain Center, P.C., has informed me that they are not contracted with my insurance plan. As a courtesy, they will provide me with a listing of the services (procedures) and the reasons for the services (diagnoses) for me to submit to my insurance company for possible reimbursement.

Self-Pay: On the day services are rendered and I do not have health insurance or do not want my insurance to be billed, I agree to be financially responsible for all charges incurred. I will pay in full for services rendered at the time of the visit and will pursue reimbursement from third parties (if it pertains) myself.

Missed Appointments: We reserve the right to charge a fee of $25.00 if you fail to provide at least 24 hours' notice to cancel or fail to show up for an appointment. Procedures scheduled must be cancelled within a 48 hours' notice or a fee of $45.00 or $90.00 will be charged (determined by the type of procedure). East Valley Pain Center, P.C., reserves the right to discharge a patient in the event of 3 no-shows or late cancellations. All missed appointment fees must be paid in full before future care is rendered.

Returned Checks: There will be a returned check fee of $35.00 assessed for any check returned for insufficient funds.

This agreement is valid for all episodes of care rendered by Nand K. Bhardwaja, M.D. / East Valley Pain Center, P.C. I permit a copy of this authorization and agreement to be used. By signing below, the patient, legal guardian, or responsible party agrees to make all required payments as provided above.

Signature: Date:

Printed Name:

HIPAA Privacy Notice

THIS JOINT NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. You have the following rights with respect to your medical records/ health information:
    a) You have the right to inspect and copy your medical records. (Provider is entitled to charge you a reasonable fee related to the cost of copying your records).
    b) You have the right to seek or amend your medical records, and if Provider does not agree with your request, to note your objection in the medical record.
    c) You have the right to receive confidential communications of your health information and to direct the place and manner of communication.
    d) You have the right to request restrictions on the use and disclosure of your protected health information; however Provider is not required to agree to restrictions not guaranteed by law. You will be informed if Provider does not agree to a requested restriction.
    e) You have the right to request an accounting list of disclosures of your protected health information made by Provider. (Except for disclosures for treatment, payment, or health care operations; to you; incident to a use or disclosure set forth in this joint notice; to persons involved in your care; for notification purposes; for national security or intelligence purposes; to law enforcement officials; as part of a limited data set.
    f) You have the right to receive a paper copy of this notice.
2. Provider may use and disclose your protected health information to contact you as a reminder about scheduled appointments or treatment, or to tell you about or to recommend possible alternative treatment or other health related benefits or service that may be of interest to you.
3. The general Authorization and Release of Medical Records that you sign authorizes your medical care provider, EVPC, to disclose the information in your medical records to the extent needed for the following purposes:
    a) For the purpose of providing treatment to you. This would include, for example, sharing information with employees and contractors of Provider, or with other health care providers who are treating you or consulting in your care.
    b) For the purpose of arranging payment for your care. This would include, for example, your insurer, or other third-party who is responsible for paying all or part of the cost of your care.
    c) For the purpose of Provider's "health care operations." This would include such things as internal quality assessment activities, business planning and management, to evaluate our treatment and services or to evaluate our staff's performance while caring for you, resolutions of internal grievances and the provision of legal and auditing services.
    d) For the purpose of other health care providers who may be treating you or involved in your health care.
4. A specific authorization for release of medical records that you may sign authorizes Provider to make a specific disclosure that is not covered under section 3. A specific authorization will name the party to whom you are authorizing discourse, and will contain any limitations on the authority to disclose your records.
5. Patient may revoke an authorization by giving Provider a written notice of revocation.
6. Provider is required by law to maintain the privacy of protected health information, and to provide patients with this notice of its duties and practices, as well as changes to those practices. Patients will be provided with revised notices, as appropriate.
7. If a patient believes that his or her privacy rights have been violated, than patient may complain to Provider, or with the Secretary of the U.S. Department of Health and Human Services. Complaints to our Provider must be in writing. Provider will not retaliate in any way against a patient for filing a complaint.
    a) If you (patient) or guardian believe that your privacy rights have been violated, and wish to notify our practice, please call our office and ask to speak with our Privacy Officer: Practice Administrator.

If you have questions or would like additional information, please call the Practice Administrator at 480-632-0057.

Please acknowledge receipt of this notice.

_____ _____

Please PRINT – Last Name, First Date

_____

Signature