Center for Pain Medicine
Clinic & Surgery Center

Welcome to the Center for Pain Medicine

At Center for Pain Medicine, we hope you'll find that we view your health differently than you've ever experienced before. Here, the center of care is truly you.

Partnership; on your first visit we will explore your medical history and review your previous treatment. Getting to know you and learning your goals in relationship to health and pain management is critical to our success. We hope you'll find that as we work together, not only your pain improves but that your quality of life is markedly enhanced.

Commitment; we'd like to completely relieve your pain with one visit. However, we realize that for many this is not possible. While our goal is to aggressively treat your pain and control it quickly, some people suffer from conditions which are very difficult to treat. We are committed to working with you and finding the unique plan that works best for you.

Comprehensive Care; we will likely refer you to one or more of our trusted partners such as physical therapy or occupational therapy. Our goal is to provide you with a level of care that results in pain reduction, enhanced physical independence and improved quality of life.

Your first visit; please take your photo ID, insurance card, and current medication list to your first appointment. Insurance copays and deductibles are due at the time of service. Our insurance specialist will work with you if you need to set up a payment plan.

If you need to reschedule your appointment, please let us know 48 hours in advance. **A no show appointment for new patient evaluation, follow-up visit, or procedure and same day cancellation are assessed a $100 fee, due prior to rescheduling appointment.**

If you have any questions, please do not hesitate to contact our office. We look forward to your journey to better health!

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REGISTRATION FORM

ID: _____

PATIENT INFORMATION

Name: _____
First Full Middle Name Last

Mailing Address: _____

City: _____ State: _____ Zip:_____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Email Address: _____

Birthdate: _____/ _____ /_____ Sex: ____ M _____ F SSN: _____-_____-_____

Marital Status: ____ S ____ M ____ W ____ D ____ Other Spouse Name: _____

Employer: _____

Work Phone: (____) _____ May we contact you at work: _____ Y _____ N

Who referred you to us? ___ Self ___ Referring physician's name: _____

Primary care physician: _____

How did you hear about us? (Check the best answer)

____ Referred by another Physician

____ Staff ____ Sign ____ Billboard ____ Internet ____ Radio ____ Phone Book

____ Postcard ____ TV ____ Newspaper ____ Newsletter ____ Magazine ____ Event

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Work Phone: (_____) _____ Other: (_____) _____

HIPAA PASSWORD: _____

PREFERRED CONTACT

Our office will confirm your appointment 1 or 2 days prior to your appointment through our automated system.

I prefer to be contacted via:

_____ Home Phone _____ Cell Phone (call) _____ Cell phone (text) _____ Work Phone

Do we have permission to leave messages with a family member: _____ Yes _____ No

Do we have permission to leave a message on your answering machine: _____ Yes _____ No

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Person Responsible for Bill: (If other than patient & after insurance)

Responsible Party: _____

Relationship to Patient: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ SSN: _____-_____-_____

Birthdate: _____/ _____/ _____ Phone: (____) _____

Employer: _____

Work Phone: (_____) _____

Spouse or other parent (if patient is a minor): _____

Home: (_____) _____ Work: (_____) _____ Cell: (_____) _____

** If patient is 18 or over and making someone other than themselves the responsible party, they are authorizing Center for Pain Medicine to share financial information with the listed responsible party.

Insurance Information

Center for Pain Medicine policy is to have a copy of your current insurance card on file. In the event you do not have your card with you, your account will remain in self pay status until a copy of your current insurance is received.

If you have had a work related injury or a no-fault accident, it is your responsibility to notify Center for Pain Medicine of such a claim. If your medical insurance denies due to a work related injury, or a no-fault accident, your account will be your responsibility.

Is your treatment with Center for Pain Medicine due to a work-related injury? ____ Yes _____ No

Is your treatment with Center for Pain Medicine due to a no-fault injury? _____ Yes ____ No

Insurance No. 1

Name of Insurance Company: _____

Policy Holder's name: _____

Policyholder's Birthdate: _____

Policyholder's Address: _____ City: _____ State: _____ Zip: _____

Policyholder's ID: _____

Policyholder's Employer: _____

Relationship to Insured: _____

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Insurance Information Continued

Insurance No. 2

Name of Insurance Company: _____

Policy Holder's name: _____

Policyholder's Birthdate: _____

Policyholder's Address: _____ City: _____ State: _____ Zip: _____

Policyholder's ID: _____

Policyholder's Employer: _____

Relationship to Insured: _____

Insurance No. 3

Name of Insurance Company: _____

Policy Holder's name: _____

Policyholder's Birthdate: _____

Policyholder's Address: _____ City: _____ State: _____ Zip: _____

Policyholder's ID: _____

Policyholder's Employer: _____

Relationship to Insured: _____

YOUR SIGNATURE VERIFIES THAT THE INFORMATION PROVIDED IS ACCURATE.

_____ _____

Patient Signature/Legal Guardian **Date**

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PATIENT PAYMENT POLICY

Center for Pain Medicine strives to ensure a clear and understanding of your financial responsibility with respect to the medical services we provide. These policies apply to all procedures and departments.

Co-pays and Deductibles: We require payment of co-pays and deductibles at the time of service, and reserve the right to refuse treatment if not made.

No Insurance: If you have no insurance, we collect $250 for your initial office visit and $150 for your follow-up visit. (Note: there may be additional charges based on the level of care received and if scopes or procedures are required.) We collect partial payment on elective procedures at the time of service. A representative will contact you to arrange payment.

Payments: We accept cash, Visa, MasterCard, Discover, American Express and Care Credit. We also accept payment by check and debit cards. We may hold a credit card number on file to reserve an appointment. Center for Pain Medicine will send patients accounts to collections for balances not paid after receipt of two statements unless you make payment arrangements with our billing office. We reserve the right to require payment for services to be made at or before the time of service.

Outstanding Balances: We may refuse to see patients with balances over $250, and who are not making regular payments on the balance. If you have an unpaid balance at the end of a billing cycle, we apply a 2.5% of your balance late payment fee to your account. If you make a payment and it is insufficient to pay both the late payment charge and the principle amount due, we apply your payment to the late payment fee due and then we apply the remaining amount to the principal. In the event that your account is placed in collection, a collection fee of $25 will be added to your account, along with any attorney fees and/or court costs that may be necessary for recovery of the outstanding balance. In the event of an NSF check, there will be a **$30 NSF** charge added to the balance due.

No Show: There will be a **$100** fee if you do not show for your **ANY** visits or procedures. We require a 48 hour notice of cancellation. The fee will be collected before making another appointment. Notification allows the doctor to see another patient who needs to be cared for that day.

Claim Filing: We happily file your claim with your insurance company **AS A COURTESY. Please keep in mind that payment remains your responsibility. We do not enter disputes over insurance benefits.** We bill insurance in accordance with all federal, state and other contractual requirements in cases where we have an agreement or we are a participating provider. We expect payment in full from you if your insurance company delays processing of your claim for over 60 days. You agree to pay any portion of the charges not covered by insurance. If your insurance company sends payments directly to you, send or drop-off the payment to Center for Pain Medicine and we will apply it to your account. Failure to notify us of any work-related or no-fault injury may result in a claim denial with your medical insurance. If your medical insurance denies for this reason, your account will be your responsibility.

Medicaid: We file Medicaid patient's claims for the states of North Dakota and Minnesota. If you have assistance from another state, you will be responsible for payment of the services you receive and the filing of your own claims. **It is the Medicaid patient's responsibility to receive a referral if required.**

Pre-authorization: Most insurance companies require prior authorization before you have a procedure. It is ultimately your responsibility to obtain prior authorization. However CPM may provide this information on your behalf if requested to do so. Failure to obtain pre-authorization may result in your insurance company refusing to pay your claim. Any refusal of payment by insurance for this reason is your responsibility.

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Referrals: If you see a doctor that is out of network or if you use an insurance company that requires a referral, you are responsible for obtaining it from your primary care physician or the referring provider. Failure to obtain it may result in a lower payment or no payment from the insurance company or no benefits from your insurance company and you will be responsible for payment.

Surgery: Upon request, the Office Manager will explain a cost estimate, which shows your financial responsibility, based on the benefit levels and coverage of your insurance plan. The amount of which depends on your coverage and deductible amount.

Dependents: You are responsible for payment of services rendered to your dependents on your account. In cases where a written court order allows payment for medical costs associated with a dependent, it is your responsibility to obtain reimbursement from the other party involved.

Medical Records: For Medical records less than 10 pages there is no charge. Anything over 10 pages but less than 20 pages, we charge $5 and anything above 20 pages but less than 30, we will charge $10 for personal use.

I authorize Center for Pain Medicine to charge my credit card on file (stored in a secure system) for any Payment Plan Agreement I have with CPM.

Attestation Statement:
I have read, understood, and agree to the above Center for Pain Medicine Payment Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility. I authorize my insurance benefits to be paid directly to Center for Pain Medicine.

I authorize Center for Pain Medicine to release pertinent medical information to my insurance company when requested, in order to facilitate payment of a claim.

_____
Print Name of Patient

_____ _____
Signature of Patient (or responsible party if minor) Date