Center for Pain Medicine
Clinic & Surgery Center

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 via TeleVox, an 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. Please be aware this also includes payments for Procedures. If you have a remaining deductible, Out of Pocket or copay, these will be collected before or at time of procedure. Check with your insurance for remaining deductibles, Out of Pocket balances and copays if unsure.

No Insurance: If you have no insurance, we collect $265 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 and same day cancellations: There will be a **$100** fee if you do not show for **ANY** visits or procedures you are scheduled for. 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. **Pump refill patients:** If you cancel or no show your appointment the day of your pump fill, whether you have commercial, or Government Insurance Programs, you will be responsible for the cost of the medication that Center for Pain Medicine has specifically ordered for you. Due to no show or cancellation this medication cannot be used for other patients and will need to be discarded. You are also responsible for the $100 no show fee.

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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.

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 Billing Department or 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.

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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

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PATIENT'S BILL OF RIGHTS

1. The patient has the right to receive treatment in a safe setting without regard to race, color, religion, sex, age, disability, genetic information, or national origin.

2. The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of his/her action.

3. The patient has a right to obtain from his/her physician complete, current information concerning their diagnosis, treatment, and prognosis.

4. The patient will be a participant in decisions regarding the intensity and scope of treatment.

5. The patient has the right to receive from his/her physician, information necessary to give informed consent prior to the start of any procedure and/or treatment.

6. The patient has the right to obtain his/her medical records.

7. The patient has the right to expect that all communications and records pertaining to his/her care should be treated as confidential, and to expect personal privacy.

8. The patient has the right to expect reasonable continuity of care.

9. The patients has the right to examine and receive an explanation of his/her bill regardless of the source of payment.

10. The patients has the right to know that the facilities personnel who care for the patient are qualified through education and experience to perform the services for which they are responsible.

11. The patient has the right to be informed that he/she may change primary or specialty physicians if other qualified providers are available.

12. The patient has the right to know that he/she is responsible for providing to his/her caregivers the most accurate and complete information.

13. The patient has the right to be advised if the Center proposes to engage in or perform human experimentation affecting his/her care or treatments (and) has the right to refuse participation.

14. The patient has a right to express grievances and suggestions to the organization, including about treatment or care that is (or fails to be) furnished.

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15. The patient has a right to have an Advance Directive, such as a living will or health care proxy.

16. The patient has the right to be fully informed before any transfer to another facility or organization.

17. The patient or the patient's designated representative has the right to participate in the consideration of ethical issues that arise in the care of the patient.

18. The patient has the right to know about the Center's rules and regulations that apply to his/her conduct as a patient.

19. The patient has the right to be free from all forms of abuse or harassment at the center, and know that this organization affirms that mistreatment, neglect, and physical, sexual and verbal/psychological abuse is prohibited.

20. The patient has the right to be informed if a health care provider does not have liability coverage.

21. The patient has the right to exercise these rights without being subject to discrimination or reprisal.

22. The patient has the right to submit a complaint to the Administrator, CPM Surgery Center 2401 41st St. S. Fargo, ND 58104. Phone: 701-551-6980, Facsimile: 701-551-6984, https://centerforpainfargo.com

23. The patient has the right to submit a complaint to the CEO, CPM Surgery Center 2401 41st St. S. Fargo, ND 58104. Phone: 701-551-6980, Facsimile: 701-551-6984, https://centerforpainfargo.com

24. The patient has the right to submit a complaint to The Division of Health Facilities, 600 East Blvd Ave, Dept. 301, Bismarck, ND 58505-0200, Phone: 701-328-2352, Facsimile: 701-328-1890, http://www.ndhealth.gov/HF/

25. The patient has the right to submit a complaint to The Joint Commission, One Renaissance Blvd. Oakbrook Terrace, IL 60151, Phone: 1-800-994-6610, www.jointcommission.org

26. The patient has the right to submit a complaint to Medicare Beneficiary Ombudsman (MBO) Phone: 1-800-MEDICARE and ask the Medicare representative to submit your complaint to the Ombudsman, https://www.cms.gov/center/special-topic/ombudsman/medicare-beneficiary-ombudsman-home

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Advance Directive Policy

The policy of the Center is that while under the care of the Center, all measures will be taken if an emergency arises to sustain life and to be transported in the case of an emergency to an acute care facility, even though the patient has advanced directive documents in place.

Financial Disclosure

CPM surgery center is a limited liability corporation (LLC). The center is owned by Majid Ghazi, MD.

HIPAA Privacy Notice

Please be advised there is a copy of the Privacy Notice available at the front desk for your review. You may also print a copy of the notice from our website at: www.centerforpainfargo.com

PATIENT ACKNOWLEDGMENT

We are delighted that you have chosen Center for Pain Medicine Surgery Center for your elective procedure.

Patient Name:_____ Date:_____

I certify that I have received written documentation of the following items:

1. Patient's Bill of Rights
2. Advanced Directives Policy
3. Financial Disclosure
4. Notice of Privacy Policies

I understand that this information is being provided for my benefit. Should I have any questions regarding its content, I should contact Center for Pain Medicine for Clarification.

_____ _____

Patient Signature Date

If patient is a minor or unable to sign, complete the following:

_____ _____ _____

Signature Relationship to patient Date

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HIPAA ACKNOWLEDGEMENT/CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (ie: my insurance company);
- Obtaining prior authorization from my insurance company;
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, prior authorization and healthcare operations, but that you are not required to agree to these restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name: _____

Signature: _____

Signature Date: _____

Relationship to Patient (if patient unable to sign): _____

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