Delaware Back Pain
& Sports Rehabilitation Centers
Depend on us to get you better faster.

Date: ___-___-___
Patient ID #: _____
Name: _____
FK RH OM GW MT SM EH
FOR OFFICE USE ONLY

Patient Registration Information

DEMOGRAPHIC INFORMATION

LAST NAME: _____ FIRST NAME: _____ M.I. _____

D.O.B.: _____ M / F SSN: _____

Address: _____

City: _____ State: _____ ZIP: _____

Please complete all that apply neatly, check your preferred communication:
□ Home Phone: _____ □ Cell Phone: _____
□ Email Address: _____

Race: □ Asian □ African-American □ Pacific Islander/Hawaiian □ Caucasian □ Native American □ Other □ Decline
Ethnicity: □ Hispanic/Latino □ Non-Hispanic/Latino □ Decline Driver's License #: _____

Marital Status: _____ Spouse Name: _____ Spouse D.O.B.:_____

Spouse Phone Number: _____ Authorized to discuss care? Y/N

EMPLOYMENT

Employer: _____

Occupation: _____ Date of Hire: _____

Status: □ Full Time □ Part Time □ Contract □ Full Time Student □ Part Time Student □ Self Employed □ Retired
□ Active Military □ Temporarily Unemployed □ Unemployed □ Leave of Absence □ Other
Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

Additional Financially Responsible Party

Name: _____ Relationship: _____

Phone: _____ Employer: _____

EMERGENCY CONTACTS

LAST NAME: _____ FIRST NAME: _____ M.I. _____

Phone: _____ D. O.B. _____ Relationship: _____

Authorized to discuss care? Y/N Can we leave medical information on their voicemail? Y/N

LAST NAME: _____ FIRST NAME: _____ M.I. _____

Phone: _____ D. O.B. _____ Relationship: _____

Authorized to discuss care? Y/N Can we leave medical information on their voicemail? Y/N

PLEASE FILL OUT BOTH SIDES OF THIS FORM

FOR OFFICE USE ONLY

_____ _____
STAFF INITIALS DATE

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ADDITIONAL PERSONAL INFORMATION

By providing the information below you are acknowledging that we may call and leave medical information regarding your visit with the recipient.

LAST NAME: _____ FIRST NAME: _____ M.I. _____

Phone: _____ D. O.B. _____ Relationship: _____

LAST NAME: _____ FIRST NAME: _____ M.I. _____

Phone: _____ D. O.B. _____ Relationship: _____

MEDICAL INFORMATION

Primary Care Physician: _____ Referring Physician: _____

Preferred Pharmacy: _____ Pharmacy Phone: _____

Pharmacy Address: _____

_____

INSURANCE INFORMATION

PRIMARY Insurance Company Name: _____ Plan Name: _____

Plan Number #: _____ Group # _____

Effective Date: _____ Phone Number: _____

Policy Holder: _____ Relationship: _____ D. O.B.: _____

SECONDARY Insurance Company Name: _____ Plan Name: _____

Plan Number #: _____ Group # _____

Effective Date: _____ Phone Number: _____

Policy Holder: _____ Relationship: _____ D. O.B.: _____

Patient Signature: _____ Date: _____

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Insurance Disclosure- Workers' Compensation or Motor Vehicle Accident

When treating for injuries sustained at work, we will bill your workers' compensation insurance. When treating for motor vehicle injuries, we will bill your personal injury protection (auto insurance). Please be advised, if your workers' compensation claim or motor vehicle insurance payer denies payment for services provided by Delaware Back Pain, we may transfer your charges to your health insurance payer for reimbursement. In the case of a motor vehicle accident, it is your responsibility to complete the personal injury protection (PIP) application process with your auto insurance. Failure to do so within 2 weeks of your initial visit may lead to automatically billing your health insurance.

As you are aware, charges billed to your health insurance, may be subject to a copay, coinsurance and/or deductible expenses that are part of your patient responsibility. Once services are billed to your health insurance, you will be expected to pay your copay, coinsurance or deductible (whichever may apply) at the time of service.

Please sign and date below to confirm your understanding of this policy.
Thank you.

Patient Name: _____

Patient Signature: _____

Date: _____

FOR OFFICE USE ONLY

_____ _____
Staff Initials Date

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Patient ID #: _____

Name: _____

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Formulary Benefits Data Consent Form

Formulary Benefits data are maintained for health insurance providers by organizations known as pharmacy Benefits Managers (PBM). PBM's are third-party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan. We may need access to your data maintained by the PBM's to know which drugs are covered by your insurance plan.

This consent will enable Delaware Back Pain and Sports Rehabilitation Centers to:

- Determine the pharmacy benefits and drug copays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preferences rank (if available) within a drug class for non-formulary medications.
- Determine if a patient's health plan allows electronic prescribing to Mail order pharmacies, and if so, e-prescribe for a patient by any provider.

By signing this consent form, you are agreeing that Delaware Back Pain and Sports Rehabilitation Centers can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Printed Patient Name: _____ D.O.B.: _____

Signature of Patient (or representative): _____ Date _____

Relationship if other than patient: _____

Consent Denied: _____ Date _____

FOR OFFICE USE ONLY

_____ _____
STAFF INITIALS DATE

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Patient ID #: _____
Other ID #: _____
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NO SHOWS/LATE CANCELLATIONS POLICY

We have been facing an increasing problem with no shows and last minute cancellations. This is not fair to patients hoping to be seen for same-day appointments and to our staff who need to stay later to accommodate those visits when spots earlier in the day go unused. We understand that there are circumstances and/or changes in your schedule that may prevent you from keeping your appointment.

If this situation arises, we ask that you call us at least one business day in advance and we will gladly reschedule your appointment. Please be advised that late cancellation, not showing, or rescheduling the appointment in less than one business day from the time of the appointment will result in the following charges:

$ 25.00 FOR MISSED FOLLOW-UP VISIT

$50.00 FOR MISSED INITIAL CONSULTATION OR EMG VISIT

$100.00 FOR MISSED PROCEDURE SCHEDULED AT A SURGERY CENTER

The charge cannot be billed to an insurance carrier. Therefore, it is **YOUR** financial responsibility.

Appointments will not be rescheduled until the missed appointment charge is paid. Medical care will not be denied for emergency situations or at the treating physician's discretion.

Patient Signature: _____ Date: _____

FOR OFFICE USE ONLY

_____ _____
STAFF INITIALS DATE

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Patient ID #: _____

Name: _____

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Our Financial Policy

Dear Patient:

Thank you for choosing us as your healthcare provider. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatments needed to restore your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our office staff.

We ask that all patients read and sign Our Financial Policy, as well as complete our Patient Information Forms prior to seeing the doctor.

As a service to you, we will process your insurance claim for you. By signing this form, you are assigning your benefits from your carrier to Delaware Back Pain, so that the physician will be reimbursed directly for the services rendered to you. Your patient responsibility will be due at the time of service. As we do accept your assignment of benefits, you must understand that:

1. Your insurance policy is a contract between you, your employer, and/or the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company.
2. All changes are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We encourage you to review your policy guidelines to be sure of your coverage.
3. Fees for these services, along with unpaid deductibles and co-payments, will be billed directly to you once we have received payments and/or notice from your insurance carrier.
4. If the insurance company does not pay your balance within 30 days, we ask that you contact the carrier to help speed things up.
5. If the insurance company does not pay your balance due within 90 days, we may then require you to pay the balance due, and you may seek reimbursement from your insurance carrier.
6. If your treatment is related to a personal injury case (motor vehicle accident) or work related injury, we understand that legal action by your attorney can often extend for some time. In this instance, we will be willing to waive payment from you until settlement. Please be aware that it is your responsibility to provide our office with complete billing information, (i.e., insurance carrier's name, full address, claim number, and adjustor's name and phone number). We do not bill attorneys. We will be happy to forward copies of our billing for your attorney's records.

Please note that if you are unable to keep your appointment, contact our office as soon as possible so that we may offer another patient your appointment time. Please see our No Show/Late Cancellation Policy, as fees may apply.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Again, thank you for choosing us as your healthcare provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

Insurance Assignment: *I hereby assign to Rehabilitation Associates (T/A Delaware Back Pain & Sports Rehabilitation Centers) all payments for medical services rendered to myself or my dependent. I understand that I am responsible for any amount not covered by insurance.*

Signature: _____ Date: _____

Insurance Authorization: *I hereby authorize Rehabilitation Associates (T/A Delaware Back Pain & Sports Rehabilitation Centers) to furnish information to the insurance carrier(s) regarding my illness or injury.*

Signature: _____ Date: _____

HIPPA Policy

My signature below confirms that I have been made aware of the **Notice of Privacy Practices** and can be provided a copy upon request.

Signature: _____ Date: _____

FOR OFFICE USE ONLY

_____ _____
STAFF INITIALS DATE