PATIENT REGISTRATION & INTAKE FORM

LAST Name _____ **FIRST** Name _____M.I.___
Address _____City_____
State ____ Zip _____ Home Phone ( ) _____
Work Phone ( ) _____ Cell Phone ( )_____
Birth Date ____/____/____ Age _____ SEX ____ Work Status: F/T P/T Student
SSN: _____/____/_____ Marital Status: (S M W D) Guarantor: _____
Who may we thank for referring you? _____
Driver' License. No. _____ State ____
Email _____ (*Your e-mail will NOT be sold or traded!)*
Primary Care Physician: _____ Telephone:_____
Address: _____
May we share this information with your Primary Care Physician? (Y N)
Employer Name:_____ Employer Phone: _____
Employer Address: _____
Primary Insurance Co. Name: _____
Primary Insurance Co. Address:_____
Policy # _____ Group #:_____
Secondary/ Other Insurance Co. Information if Applicable:_____
_____
_____

Patient Declaration of Understanding and Agreement

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that all monies be credited to my account upon receipt. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, all fees for professional services rendered me will be immediately due and payable. In the event of my default, I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection. I also authorize the release of any medical or other information necessary to process this claim.

Notice of Privacy Practices (HIPPA Acknowledgement and Consent)

I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for NOVA Headache & Chronic Pain Center. I hereby consent to the use and disclosure of my personal health information for the purposes of examination, diagnosis, treatment, payment and health care operations.

Patient Signature_____ Date ____

Guardian Signature if Minor Patient: _____ Date ____

Informed Consent & Patient Authorization and Assignment

(Instructions: Please initial each segment as you read them and sign and date the bottom of this form)

Patient name: Date of Birth:

Release of Information and Consent to Treatment

All information contained herein is true and correct.

I have been informed of my diagnosis and wish to receive treatment at NOVA Headache & Chronic Pain Center. I permit its employees to treat me in ways they judge are beneficial to me. I understand that this care may include an examination, consultation, and treatment. No guarantees have been made, expressed or implied as to the outcome of this care.

I give permission to NOVA Headache & Chronic Pain Center to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment and/or payment for services provided.

I authorize NOVA Headache & Chronic Pain Center and/or its subsidiaries and affiliates to obtain medical records and/or professional information from my physician or other medical professional on my behalf as it relates to my treatment.

The signature below certifies that I have read and understand the above information.

Initial: _____

Authorization and Assignment of Insurance Benefits

NOVA Headache & Chronic Pain Center, as a courtesy to you, will verify your coverage and bill your insurance company directly. However, your insurance policy represents a contractual relationship between you and your insurance carrier. Their first responsibility is to their policyholder and not to NOVA Headache. Because of this, you are ultimately responsible for the payment of your bill. You are responsible for payment of any deductible and co-payments as defined by your contract. We expect these payments at the time of service. You are responsible for any amounts ***not*** covered by your insurer. If your insurance carrier denies any part of your claim, or if you elect to continue therapy past their arbitrarily determined "approved" period, you will be responsible for the additional fees for services. Many insurance companies have additional stipulations that may affect your coverage.

I understand these policies and agree to pay NOVA Headache & Chronic Pain Center, its agents or assigns, for the services provided to me or the party named above. If any law, such as workers' compensation, or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

For the treatment provided to me, I hereby authorize the obligated insurance carrier to pay by check, made out and mailed to: **NOVA Headache & Chronic Pain Center, 8993-A Cotswold Drive, Burke, VA 22015, Tax ID #:26-3261197**, any benefits allowed or otherwise payable to me under the stipulations of my policy. (If my policy prohibits direct payment to the doctor, I hereby authorize you to make the check payable to me and it shall be mailed to NOVA Headache & Chronic Pain Center as above)

This is a direct assignment of my rights and benefits under this policy and includes all rights to collect payment directly from my insurance company. A photocopy of this document shall be considered as effective and valid as the original.

Initial _____

Patient/Guardian Signature_____Date_____