Comprehensive Pain Centers

4825 West Tilghman Street, Allentown, PA 18104 610-366-9000 Fax: 610-366-9229

PATIENT DEMOGRAPHIC INFORMATION **TODAY'S DATE ______________________**

NAME ____
ADDRESS ____
____
SEX ____
HOME PHONE ( ) ______________________________
WORK PHONE ( ) ______________________________

SOC. SEC. # ____
OCCUPATION ____
DATE OF BIRTH ______________________________________
FULL TIME STUDENT? ☐ YES ☐ NO
ARE YOU DISABLED? ☐ YES ☐ NO

SPOUSE'S NAME ______________________________
SPOUSE'S EMPLOYER __________________________
____
ADDRESS ____
____

PERSON TO NOTIFY IN EMERGENCY:
NAME ____
ADDRESS ____
PHONE ( ) ______________________________________
RELATION ____

HOW DID YOU HEAR ABOUT US? – (Circle One)
ADVERTISEMENT? **TV** **Radio** **Direct Mail**
Word of Mouth **Newspaper Ad**
OTHER ____

REFERRING PHYSICIAN:
NAME ____
ADDRESS ____
____
PHONE ( ) ______________________________________

I AM HERE TODAY FOR TREATMENT RELATED TO:
( ) WORK INJURY – DATE ____________________
( ) AUTO ACCIDENT – DATE _________________
( ) OTHER ___________________________________
____

FAMILY PHYSICIAN:
NAME ____
ADDRESS ____
____
PHONE ( ) ______________________________________
____

COMMERCIAL

Name:____
I.D.# ____
GROUP # ______________________________________
SUBSCRIBER'S NAME ___________________________
RELATIONSHIP TO PATIENT ____________________
SUB. DATE OF BIRTH __________________________
SOC. SEC. # __________________________________

WORKER'S COMPENSATION/ AUTO
INS. CO. ______________________________________
ADDRESS ______________________________________
____
PHONE ( ) ____________________________________
CLAIM # ______________________________________
ADJUSTER ____________________________________
HAS INJURY BEEN REPORTED TO YOUR EMPLOYER? ☐ YES ☐ NO

MEDICARE

I.D. # ____
NAME OF INSURED ____________________________
DO YOU HAVE 65 SPECIAL? ☐YES ☐ NO
IF YES I.D. # __________________________________
GROUP # ______________________________________

OTHER/MEDICAL ASSISTANCE
COMPANY NAME _______________________________
ADDRESS ______________________________________
____
PHONE ( ) ____________________________________
NAME OF INSURED ____________________________
POLICY # ______________________________________
GROUP # ______________________________________
CONTACT ______________________________________

REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO COMPREHENSIVE PAIN CENTERS *(CPC)* FOR ANY SERVICES FURNISHED ME BY *CPC*. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO *CPC* FOR ANY AMOUNT NOT COVERED BY THIS AUTHORIZATION. I WILL BE NOTIFIED WHEN FINAL ACTION (REJECTION, ETC.) BY MY INSURANCE CARRIER HAS BEEN RECEIVED BY *CPC.* PAYMENT WILL BE EXPECTED WITHIN 10 DAYS OF THAT NOTICE. IN THE EVENT THAT THIS ACCOUNT IS PLACED WITH AN ATTORNEY OR COLLECTION AGENCY, THE UNDERSIGNED IS REPONSIBLE FOR COLLECTION FEES, REASONABLE ATTORNEY'S FEES AND COURT COSTS.

PATIENT'S SIGNATURE ____ **DATE** __________________________

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PATIENT NAME_________________________________DATE____________DATE OF BIRTH_____________________

CONSENT TO USE AND DISCLOSURE OF INFORMATION FOR TREATMENT PAYMENT OR OPERATIONS

- I hereby consent to the use and disclosure of information in my medical records for treatment, payment and health care operations purpose: I understand that this consent is voluntary. I understand that information in my medical records may be used and disclosed to persons other than Lehigh Valley Pain Management/Tilghman Medical Center to carry out their responsibilities in connection to my medical health care treatment, in payment for health care services rendered to me and in activities related to health care operations.

Initials: __________

- I understand that additional information on Lehigh Valley Pain Management/Tilghman Medical Center privacy practices related to my medical record is available from the Lehigh Valley Pain Management/Tilghman Medical Center's Notice of Privacy Practices, a copy of which has been-made available to me, and which I have read or do not wish to read, prior to signing this consent.

Initials: __________

- I understand that changes in Lehigh Valley Pain Management/Tilghman Medical Center privacy practices will result in modifications to the Notice of Privacy Practices and that up-to-date notices will be available at the reception desk of Lehigh Valley Pain Management /Tilghman Medical Center at 4825 Tilghman Street, Allentown PA 18104.

Initials: __________

- I understand that I may request Lehigh Valley Pain Management/Tilghman medical Center to restrict how or to whom my medical records are used or disclosed, but that Lehigh Valley Pain Management/Tilghman Medical Center may refuse the restrictions I request. However if Lehigh Valley Pain Management/Tilghman Medical Center agrees to the restrictions, it is bound to them when disclosing information in my medical records.

Initials: __________

- I understand that I can revoke this consent at any time, by notifying Lehigh Valley Pain Management/Tilghman Medical Center in writing, but if I do, it won't have any effect on actions Lehigh Valley Pain management/Tilghman Medical Center took before they received the notification.

Initials: __________

- I understand that this consent applies to the use and disclosure of information for treatment, payment or operations purposes only and that Lehigh Valley Pain Management/Tilghman Medical Center may decline to provide medical health care services to me if I do not sign it.

Initials: __________

- I understand and hereby agree to be financially liable for and to pay to Lehigh Valley Pain Management/Tilghman Medical Center the amount of certain health care services which may not be covered under my insurance plan because plan determined to be not medical necessary. If my insurance denies payment, I agree to be personally and fully responsible for payment.

Initials: __________

____ ______________________
Signature of Patient or Patient's Representative **Date**

Printed Name of Patient Representative____

Relationship to Patient____

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MEMBER FINANCIAL LIABILITY ACKNOWLEDGEMENT FORM

THE UNDERSIGNED MEMBER HEREBY AGREES TO BE FINANCIALLY LIABLE FOR ANY SERVICES THAT MAY NOT BE COVERED UNDER THEIR INSURANCE PLAN.
I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS

PRINT NAME OF PATIENT SIGNATURE OF PATIENT DATE

IN THE EVENT THE ABOVE METIONED PATIENT IS A MINOR, THE UNDERSIGNED PARENT /GAURDIAN OF THAT MINOR AGREES TO BE FINANCIALLY LIABLE FOR THE SERVICES DESCRIBED ABOVE.

PRINT NAME OF PARENT/GUARDIAN SIGNATURE OF PARENT/GUARDIAN DATE

UNDERSTANDING OUR BILLING POLICY

CO-PAYS ARE YOUR RESPONSIBILITY TO PAY AT THE TIME OF YOUR APPOINTMENT. WHEN YOU SIGN IN AT THE FRONT DESK YOU WILL BE ASKED TO PAY YOUR CO-PAY AND ANY BALANCETHAT IS DUE. WE WILL CHARGE A SURCHARGE OF $10.00 IF THE CO-PAY IS NOT PAID AT THE TIME OF APPOINTMENT. MOST SERVICES ARE BILLABLE TO YOUR INSURANCE. IF, HOWEVER YOU HAVE A MAJOR MEDICAL POLICY OR A PLAN THAT DOES NOT COVER OFFICE VISITS, WE DO ASK FOR PAYMENT AT THE TIME OF SERVICE. FOR ANY BALANCE OWED, PAYMENT ARRANGEMENTS CAN BE MADE BY CALLING **610-366-9242**. IF THE ACCOUNT IS NOT PAID AFTER THE FIRST STATEMENT IS SENT IT IS CONSIDERED **PAST DUE.** IT IS IMPORTANT THAT WE HEAR FROM YOU AT THIS POINT OF TIME. THIRTY DAYS FROM YOUR PAST DUE BILLING YOU WILL RECEIVE YOUR LAST STATEMENT WHICH IS CONSIDERED A **FINAL NOTICE**. IF PAYMENT IS NOT RECEIVED WITHIN 10 DAYS OF THIS STATEMENT AND WE HAVE NOT HAD ANY CONTACT\PAYMENT FROM YOU, WE WILL UTILIZE THE SERVICES OF OUR PROFESSIONAL COLLECTION AGENCY. IT IS IMPORTANT FOR YOU TO CONTACT US IMMEDIATELY WITH ANY INQUIRIES OR CONCERNS. WITHOUT CONTACT FROM YOU, THE ABOVE POLICY WILL BE FOLLOWED.

TELEPHONE CONSUMER PROTECTION ACT (TCPA):

YOU AGREE, IN ORDER FOR US TO SERVICE YOUR ACCOUNT OR OT COLLECT MONIES YOU MAY OWE, LEHIGH VALLEY PAIN/TILGHMAN MEDICAL CENTER, AND/OR OUR AGENTS MAY CONTACT YOU BY TELEPHONE NUMBER ASSOCIATED WITH YOUR ACCOUNT, INCLUDING WIRELESS TELEPHONE NUMBERS, WHICH COULD RESULT IN CHARGES TO YOU. WE MAY ALSO CONTACT YOU BY SENDING TEXT MESSAGES OR E-MAIL, USING ANY E-MAIL YOU PROVIDE TO USE. METHODS OF CONTACT MAY INCLUDE USING PRE-RECORDED/ARTIFICAL VOICE MESSAGES AND/OR USE OF AUTOMATIC DAILING DEVICE, AS APPLICABLE.

AGREEMENT TO PAY: I, THE UNDERSIGNED, ACCEPT THE FEE CHARGED AS LEGAL AND LAWFUL DEBT AND AGREE TO PAY SAID FEE, INCLUDING ANY/ ALL COLLECTION AGENCY FEES, (33.33%), ATTORNEY FEES AND /OR COURT COSTS, IF SUCH BE NECESSARY. I/WE HAVE READ THIS DISCLOSURE AND AGREE THAT THE LEHIGH VALLEY PAIN/TILGHMAN MEDICAL CENTER, ITS EMPLOYEES AND/ OR AGENTS MAY CONTACT ME/US AS DESCRIBED ABOVE.

RESPONSIBLE PARTY SIGNATURE DATE