Pain Specialists of Orange County

(949) 297-3838

Patient Registration

Choose Office Location: Mission Viejo Laguna Hills Irvine San Clemente Fountain Valley

Last Name _____ First Name_____ Middle _____

Street Address _____ Apt _____

City _____ State _____ Zip _____Home Phone ( ) _____

Social Security # _____Date of Birth _____Age _____ Marital Status _____

Driver License # _____ Employer _____ Phone ( ) _____

Employer's Address_____ City _____State _____Zip_____

Email _____ May we contact you via email for appointment reminders and other communications? Y N

Spouse Name _____Social Security #_____ Phone ( ) _____

Emergency Contact _____ Relationship _____ Phone ( ) _____

INSURANCE INFORMATION

Primary Insurance _____ Policy Holder's Name _____

Address _____ City _____State _____ Zip_____

Insured ID# _____Group # _____ Phone ( ) _____

Work Comp Insurance _____Adjuster's Name _____

Address _____ City _____ State_____ Zip_____

Claim # _____ DOI _____ Phone ( ) _____

Release of Information: I authorize the release of my medical records to any insurance company, adjuster, examiner or attorney requesting information regarding my treatments. A photocopy of this release shall be considered effective and as valid as the original.

Signature of Patient/ Guarantor/ Guardian _____Date_____

Assignment of Benefits: I authorize payment of medical benefits directly to **Pain Specialists of Orange County** and/or its affiliate facilities **Spinal*CARE* Surgicenter** and **Mission Hills Surgicenter** for services rendered.

Signature of Patient/Guarantor/Guardian_____Date_____

Responsible Party's Name _____ Relationship to patient_____

Street Address _____ Apt _____ Phone ( ) _____

City_____State _____ Zip _____

Payment in full maybe required at the time of service. For your convenience, we accept personal checks, visa/master charge, and cash. Any Medical Insurance, which you may have, is intended to protect you against financial loss and payment in full for your care is your responsibility regardless of insurance coverage.

Treatment Authorization: I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient, authorized to furnish the information requested. I have read the above paragraph regarding payment of fees, and I understand that I am solely responsible for all charges incurred, regardless of insurance coverage or the liability of another party. I will make sure that my claims are paid promptly.

Signature Patient/Guarantor/Guardian_____Date_____

PAIN SPECIALISTS OF ORANGE COUNTY
NOTICE OF PRIVACY PRACTICES

TO OUR PATIENTS:

The privacy of your health information is very important to us. We want you to understand how we use and disclose your information and your rights to this information. We ask you to review our Notice of Privacy Practice that describes the legal duties with respect to your healthcare information.

HOW WE USE HEALTHCARE INFORMATION:

We use information regarding you to provide treatment, insure appropriate payment for the treatment(s) we provide, and monitor the quality of our operation.

WHEN WE MAY DISCLOSE INFORMATION:

In certain limited cases, we are permitted to disclose healthcare information. Example, when there is a serious threat to your health and or safety, for Workers' Compensation, to reduce public health risks, or when concerned with law enforcement. In addition, we may disclose information to tell you about related services and alternate treatment and to discuss health related research with your permission.

INFORMATION RIGHTS:

- You will have the right to know how we use your healthcare information, who we can give it to and your rights to this information.
- You have the right to ask us to restrict our uses and disclosures where we believe such restrictions will not harm you and where it is possible for us to do so.
- You have the right for a confidential communication of your healthcare information. For example, you can ask for a conversation to be held in private or for your billing to go to another address.
- You have the right to look or copy information in your chart, unless the doctor feels this would be harmful to you or someone else.
- You have the right to request that we amend your records, if we agree it is inaccurate or incomplete.
- You have the right to ask us for information regarding who we have disclosed your healthcare information to, someone other than those treating you, handling your bills, for our internal operation, or when you have authorized release of information.

Please sign below that you have reviewed our Notice of Privacy Practices. If you have any questions, please feel free to speak to your Physician or our Office Manager.

Printed Name: _____ Signature: _____