Arkansas Spine and Pain
CENTER OF EXCELLENCE

5700 West Markham Street
Little Rock, Arkansas 72205

Phone 501.227.0184
Fax 501.227.0187

Is the problem for which you are being seen the result of:
Work related injury? _____ Auto accident? _____ Other accident? _____
Give the date and brief description please _____

Patient's Name _____

Mailing Address _____ City _____ St _____ Zip _____

Telephone: Home (____) _____ Work (____) _____ Cell (____) _____

What number may we leave a message on? Home ( ) Work ( ) Cell ( ) Do not leave a message ( )

Age _____ Birthdate ____/____/____ SS# _____ Sex: Male ( ) Female ( )

Single ( ) Married ( ) Widowed ( ) Divorced ( )

Email Address _____

Patient's Employer _____ Address _____

Spouse's Name _____ SS# _____ Cell # _____

Additional Contact Person _____ Relationship _____

Telephone: Home (____) _____ Work (____) _____ Cell (____) _____

Family Physician _____ Address _____

Referring Physician _____ Address _____

How did you hear about our practice? _____

Have you ever seen any doctor in this group? _____ When? _____

If Minor, Parents or Guardians Name: _____ Relationship: _____

Telephone: Home (____) _____ Work (____) _____ Cell (____) _____

DOB _____/_____/_____ SS# _____ Employer _____

I hereby authorize Arkansas Spine and Pain to release any information acquired in the course of my examination or treatment to my primary and/or referring physicians and my listed insurance companies. Additional parties will be supplied reports if requested below.

Patient or Guardian's Signature _____ Date _____

Name of additional requested parties (attorney, employer, etc) _____

_____

Please list all applicable insurance coverage. Failure to provide all coverage could result in reduction of benefits.

Commercial Insurance

Patient's Name_____ DOB _____

1st Insurance Co. _____ Policy # _____ Group# _____

Address _____ City _____ St _____ Zip _____

Subscriber's Name _____ SSN _____ DOB _____

Subscriber's Employer _____

2nd Insurance Co. _____ Policy # _____ Group# _____

Address _____ City _____ St _____ Zip _____

Subscriber's Name _____ SSN _____ DOB _____

Subscriber's Employer _____

Financial Agreement

I herby request and authorize my insurance company and/or companies to pay directly to Arkansas Spine and Pain, 5700 West Markham Street, Little Rock, AR 72205, any proceeds payable under the terms of my policy and/or policies. I understand that any unpaid balance not covered by my policies is my obligation and will be paid by me. I hereby authorize release of information to my insurance company as requested in my course of treatment. Promise to Pay for services provided to the above mentioned names patient. I agree to pay said doctor, its agents and assign all money which shall become due. The doctor will bill all insurance companies to no charge providing we have an insurance assignment and authorization when required.

I hereby assign payment of medical benefits to Arkansas Spine and Pain for services rendered. I understand that I am financially responsible for all charges whether or not they are paid by said insurance. I also understand that as long as I have provided a copy of my insurance card that includes a claims filing address my insurance will be filed as a courtesy to me and that it does not relieve me of my responsibility to my account.

Signature _____ Date _____

Release of Medical Information

I consent to the release of any medical information necessary to process insurance claims for services rendered.

Signature_____ Date _____

Would you like to give permission for us to speak to anyone other than your physician(s)?

If so please list their names and relationship below. Please PRINT to avoid errors.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Co-payments, Co-Insurance and Deductibles

Please be prepared to pay any applicable co-payments each time services are rendered. Co-payments depend on your coverage. Co-insurance (your share) and deductibles (yearly payments made by you) are determined after your insurance carrier processes your claim(s). We ask that the balance be paid within 30 days of receiving your first statement. Failure to pay any amounts due, including past due balances, will result in your appointment being rescheduled unless prior arrangements have been made with our billing office. For your convenience we accept cash, checks, MasterCard, Visa, American Express and Discover. We do charge $35.00 for all return checks.

Non-Payment

If your account is over 90 days past due, your account will be referred to our outside collection agency. If your account is over 120 days past due, your account will be reviewed for possible discharge from care.

I have read and understand the above payment policy.

Signature_____ Date _____