Maui Pain Clinic, LLC

Confidential Patient Information

PATIENT INFORMATION (please print):

Patient Name: _____

Address: _____

PO Box: _____ **City, State, Zip:** _____

Date of Birth: _____ **Social Security #:** _____

Male ☐ **Female** ☐ **Single** ☐ **Married** ☐ **Other** ☐ **Ethnicity:** _____

Phone #: _____ **Cell Phone #:** _____

Employer: _____ **Work Phone #:** _____

E-Mail Address: _____ **Referred By:** _____

INSURANCE INFORMATION (please print):

Insurance Company: _____ **Subscriber's Name:** _____

Subscriber's DOB: _____ **Policy #:** _____

Subscriber's Sex: **Male** ☐ **Female** ☐ **Relationship to patient:** _____

Insurance Company: _____ **Subscriber's Name:** _____

Subscriber's DOB: _____ **Policy #:** _____

Subscriber's Sex: **Male** ☐ **Female** ☐ **Relationship to patient:** _____

Worker's Comp Company: _____

Adjuster name & phone #: _____

Claim #: _____ **DOI:** _____ **Employer:** _____

RESPONSIBLE PARTY INFORMATION IF OTHER THAN PATIENT (please print):

Name: _____ **Phone #:** _____

Address: _____ **City, State, Zip:** _____

I hereby authorize my physician to furnish information to insurance carriers or government agencies concerning my illness and treatments and I hereby assign to them all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amounts not covered by insurance. There will be a $15.00 charge for all returned checks. A copy of this signature is as valid as the original.

If I am covered by Medicare, I authorize any holder of medical information about me to release to the Health Care Financing Administrator and its agents any information needed to determine these benefits payable for related services.

I have received and/or read the Notice of Privacy Practices in accordance with the Health Insurance Portability and Accountability ACT of 1996 (HIPPA)

Signature of patient/Legal guardian: _____ **Date:** _____

Patient's name: _____ Date: _____

Receipt of Notice – Privacy Policies

I, _____, have read and understand the privacy policies given. I have been given a copy of the privacy policies of the **MAUI PAIN CLINIC.**

Patient's signature: _____ Date: _____

Assignment of Insurance Benefits

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered, and/or for services to be rendered. This will be appropriate without obtaining my signature on each claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____, hereby authorize _____

Name of Insurance

to pay and hereby assign **MAUI PAIN CLINIC, LLC** all benefits, if any, otherwise payable to me for his/her service(s) as described on the attached forms. I understand I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to **MAUI PAIN CLINIC, LLC** will be credited to my account, in accordance with the above said agreement.

Patient's signature: _____ Date: _____

Financial Agreement

I understand that I am financially responsible for all charges incurred for services rendered at **MAUI PAIN CLINIC, LLC** whether it is paid by my insurance carrier or payor.

I understand that I am financially responsible, if I have not met my insurance deductible and/or if I have a co-payment associated with my treatment(s).

If I unable to make my scheduled appointment, I will contact **MAUI PAIN CLINIC** at least 24 hours prior to my appointment to cancel or re-schedule. If I do not contact, I am aware I could be charged a fee.

Patient's signature: _____ Date: _____

Opioid Risk Tool (ORT)

Name: _____ **Date:** _____

Are there any family members that have substance abuse in the following areas?

Alcohol abuse in *female* family member	Yes (1)	No (0)
Alcohol abuse in *male* family member	Yes (3)	No (0)
Illegal drug abuse in *female* family member	Yes (2)	No (0)
Illegal drug abuse in *male* family member	Yes (3)	No (0)
RX drug abuse in *female* family member	Yes (4)	No (0)

If you are a *FEMALE*, please complete the following:

I have a personal history of alcohol abuse	Yes (3)	No (0)
I have a personal history of illegal drug abuse	Yes (4)	No (0)
I have a personal history of RX drug abuse	Yes (5)	No (0)
I am in between the ages of 16 and 45	Yes (1)	No (0)
I have a personal history of preadolescent sexual abuse	Yes (3)	No (0)
I have/am ADD, OCD, Bipolar, Schizophrenic	Yes (2)	No (0)
I have or have had depression	Yes (1)	No (0)

If you are a *MALE*, please complete the following:

I have a personal history of alcohol abuse	Yes (3)	No (0)
I have a personal history of illegal drug abuse	Yes (4)	No (0)
I have a personal history of RX drug abuse	Yes (5)	No (0)
I am in between the ages of 16 and 45	Yes (1)	No (0)
I have a personal history of preadolescent sexual abuse	Yes (0)	No (0)
I have/am ADD, OCD, Bipolar, Schizophrenia	Yes (2)	No (0)
I have or have had depression	Yes (1)	No (0)