Dear Patient,

We are pleased to welcome you to Fox Chase Pain Management, a practice dedicated to relieving pain with minimally invasive procedures and device implants.

We ask that you please arrive 15 minutes prior to your appointment and bring the following documents:

* Driver’s License/ ID Card
* Insurance Card(s)
* Completed New Patient Paperwork

At your initial visit you will be examined by a physician, and a treatment plan will be developed and discussed with you. Please be advised that all treatment plans are subject to approval by your insurance company.

Due to medical standards and regulations, it is the office policy that prescriptions for opioid medications will not be provided at the initial visit. If another physician prescribes your pain medication, please expect to receive future prescriptions from them until a thorough evaluation can be completed by our providers. The decision for the physician to provide opioid medication in the future will be determined on a case by case basis.

Please feel free to call us at any of our locations if you have any questions.

We look forward to meeting you.

Sincerely,

**Fox Chase Pain Management Staff**

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| **PATIENT INFORMATION**  Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last First M. (preferred name)  Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth Date: \_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_  Gender: Male Female Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Race: White Black or African American American Indian or Alaskan Native Asian  Native Hawaiian or other Pacific Islander Hispanic Decline to provide this info  Ethnicity: Hispanic or Latino Not Hispanic or Latino Decline to provide this info  Driver’s License # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone (Home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Work): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Cell): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  In case of emergency contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How did you hear about our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Primary Insurance**  Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insurance Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insurance Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insured’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_  Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insured’s Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Secondary Insurance (if applicable)**  Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insurance Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insurance Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insured’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_  Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insured’s Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Workers’ Compensation, Auto Billing Information**  Insurance Carrier Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claim # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Accident/ Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_ City and State of Injury:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Adjuster:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Nurse Case Mgr: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Attorney: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| I certify that the information I have reported is correct.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Patient Signature Date |

**FINANCIAL POLICY**

We are dedicated to you, and our goal is to provide exceptional medical care. We realize that the financial aspect of medicine is overwhelming, and we are committed to work with you and your insurance company to make the process as easy as possible. We are providing you with the following information to clarify your financial responsibility.

1. **INSURANCE.** We participate in most insurance plans. If we do not participate with your insurer, payment in full is expected at each visit. It is your responsibility to provide your most up-to-date insurance information at the time of your visit. Unpaid balances due to errors or omissions in the information you provide may result in leaving you responsible for payment of the bill.
2. **COPAYS AND DEDUCTIBLES.** We are contractually obligated by your insurance carrier to collect your co-payment at the time of service. Failure on our part to collect co-payments can be considered fraud. If you are unable to pay for your services or co-pay at the time of service, you will not be seen, and your appointment will be rescheduled.
3. **NON-COVERED SERVICES**. Please be aware that some-if perhaps not all- of the services you receive may be non-covered or not considered reasonable or necessary by Medicare and other insurers. You must pay for these services at the time of the visit. Please sign the Advanced Beneficiary Notice for coverage of these services.
4. **CLAIMS SUBMISSION**. As a courtesy to you, we will file your primary and secondary insurance claim at no cost to you. However, we will not wait more than 45 days for the insurance to pay. After 45 days it is your responsibility to contact your insurance company and follow up on why your claim has not been paid. You must take the necessary action required to get your claim paid and communicate your actions to our office. Failure to assist our office in obtaining payment of your insurance claim will result in the total charges being transferred to the patient.
5. **NONPAYMENT**. If your account is over 60 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if the balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. In the event your account must be turned over for outside collections, you will be billed and are responsible for all fees involved in the collection process. Returned checks are subject to a handling fee of $25.00.
6. **MISSED APPOINTMENTS**. We impose a $30.00 no-show/ late cancellation fee. Please realize that no-shows and late-cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No-shows and cancellations delay the delivery of health care to other patients, most of who are in severe pain. A “late cancellation” is cancelling an appointment without calling us to cancel 24 hours in advance of an appointment. A “no show” is missing a scheduled appointment. We understand that emergencies occasionally arise when an appointment cannon be kept, and these situations will be considered on a case-by-case basis.
7. **QUESTIONS.** If you have questions about your bill or if you cannot pay the balance in full within 14 days, please contact our Patient Accounts Specialist to see if you qualify for special payment options. All questions relating to your bill should be addressed to the Accounts Specialists and not the medical staff. The Accounts Specialist can be reached at 215-613-4121.

**I HAVE READ AND AGREE WITH THE TERMS OUTLINED ABOVE**

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Signature of Patient o Legal Representative Date

If signed by legal representative, relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT FOR TREATMENT**

I give permission to the physicians and staff of Fox Chase Pain Management (“the practice”) to administer or perform medical treatment. I acknowledge that risks, if any, will be explained to me as well as any other medical options. I understand that no guarantee can be made as to the efficacy or outcome of treatment. The practice may also use my Protected Health Information (PHI) to treat me or to disclose to other healthcare providers, such as my referring physician or primary care physician, for purposes related to my treatment.

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Signature of Patient o Legal Representative Date

If signed by legal representative, relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT TO RELEASE INFORMATION**

I consent that the practice may release any medical information that has been obtained during my course of treatment to any lab, hospital, physician or insurance company to answer any inquiries per federal and state regulations. The practice may use or disclose my PHI internally or disclose my PHI to healthcare providers and entities as necessary to operate their business. The practice may use and disclose my PHI to contact me for appointment reminders and to inform me of potential treatment option or alternatives. The practice may use and disclose my PHI to advise a friend or family member that is involved in my care or assists in taking care of me. My PHI may also be used and disclosed when federal, state or local law requires. The practice may share my PHI with third party “Business Associates” that perform activities on their behalf such as billing software maintenance.

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Signature of Patient or Legal Representative Date

**FINANCIAL CONSENT**

I hereby authorize direct remittance of payment of insurance benefits to the practice for all covered medical services rendered. I understand and agree this Assignment of Benefits will have continuing effect for as long as I am being treated by the practice and will constitute a continuing authorization, maintained on file with the practice for subsequent and continuing treatment, services, and/or supplies provided to me by the practice. The practice my use and disclose my PHI in order to directly bill and collect payment for services and items I receive, to obtain payment from me or from third parties that may be responsible for such costs, or to assist other health care providers in their billing and collections I accept legal responsibility for charges that my insurance company does not cover and will pay for them at the time of my visit unless prior arrangements have been made. I am also responsible for all legal fees, collection fees, and interest incurred in the event my account becomes delinquent. I understand that the practice may not be a participating provider with my insurance company. Should I receive payment directly from the insurance company, I agree to forward the check and “Explanation of Benefits” to the practice within 10 days of receipt. If I fail to provide this information, I understand that I will be held legally responsible for payment in full for all services or equipment that has been provided.

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Signature of Patient or Legal Representative Date

**WRITTEN ACKNOWLEGMENT OF NOTICE OF PRIVACY PRACTICES**

I have received a copy of Fox Chase Pain Management’s Notice of Privacy Practices that describes how my health information is used and shared. I understand that the practice has the right to change this notice at any time. I may obtain a current copy by contacting the Privacy Officer at the physician’s office.

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Signature of Patient or Legal Representatvie Date