

Preferred Office
Trevose _____
Chalfont _____
Marlton NJ _____



DATE: _____ (PLEASE PRINT CLEARLY)

PATIENT NAME: _____

DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY #: _____

GENDER: MALE FEMALE OTHER **MARITAL STATUS:** SINGLE MARRIED WIDOW DIVORCED SEPARATED

EMAIL ADDRESS _____

PHONE #: _____ SECONDARY PHONE #: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

E-MAIL: _____ OCCUPATION: _____

EMPLOYER: _____ EMPLOYER PHONE: _____

EMERGENCY CONTACT: _____

EMERGENCY CONTACT NUMBER: _____ RELATIONSHIP: _____

REFERRING PHYSICIAN: _____ PHONE NUMBER: _____

PRIMARY CARE PHYSICIAN: _____ PHONE NUMBER: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PRIMARY INSURANCE COMPANY: _____

SUBSCRIBER ID: _____ GROUP: _____

IF OTHER THAN THE PATIENT, PLEASE TELL US ABOUT THE POLICY HOLDER

POLICY HOLDER'S NAME: _____ POLICY HOLDER'S DATE OF BIRTH: _____

POLICY HOLDER'S PHONE #: _____ RELATIONSHIP TO PATIENT: _____

POLICY HOLDER'S EMPLOYER: _____ EMPLOYER PHONE #: _____

STREET ADDRESS OF POLICY HOLDER: _____

CITY: _____ STATE: _____ ZIP CODE: _____

SECONDARY INSURANCE COMPANY: _____

SUBSCRIBER ID: _____ GROUP: _____

**IF YOU ARE RECEIVING WORKMANS' COMPENSATION BENEFITS OR AUTO BENEFITS, PLEASE COMPLETE BELOW
ALONG WITH YOUR PERSONAL INSURANCE ON PAGE 1**

WORKMAN'S COMPENSATION INFORMATION

NAME OF INSURANCE CO _____ PHONE # _____
ADDRESS _____ CITY _____ STATE _____
DATE OF INJURY _____ CLAIM NUMBER _____ ADJUSTER NAME AND # _____
NCP NUMBER _____ WCAIS DOCUMENT _____
CITY AND STATE WHERE INJURY OCCURED _____
EMPLOYER NAME AND ADDRESS _____
APPROVED INJURIES _____
YOU HAVE AN ATTORNEY YES _____ NO _____
PLEASE PROVIDE ATTORNEY INFORMATION _____ PHONE # _____

AUTO ACCIDENT INFORMATION

NAME OF INSURANCE CO _____ PHONE # _____
ADDRESS _____ CITY _____ STATE _____
DATE OF INJURY _____ CLAIM NUMBER _____
ADJUSTER NAME _____ PHONE # _____ FAX # _____
CITY AND STATE WHERE INJURY OCCURED _____
APPROVED INJURIES _____
ATTORNEY YES _____ NO _____ ATTORNEY NAME _____
ATTORNEY ADDRESS _____ PHONE # _____
INJURIES SUSTAINED AND APPROVED FOR REATMENT: _____

Signature Page for Financial Responsibility

I/WE UNDERSTAND THAT I/WE ARE FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I/WE AGREE TO ACCEPT TOTAL RESPONSIBILITY FOR ALL DAMAGES AND AGREE TO PAY AT THE TIME SERVICES ARE RENDERED, OR NOT LATER THAN 30 DAYS OF SUCH SERVICES. IN THE EVENT OF DEFAULT, I/WE AGREE TO PAY ALL COSTS OF THE COLLECTIONS, INCLUDING ATTORNEY FEES.

Date

* _____

Patient or Responsible Party Signature

PRACTICE POLICIES

DISCLOSURE NOTICE: Any legal claims or civil actions, including, but not limited to, a claim for medical malpractice in any way related to your office visit /procedure, and medical services provided Fox Chase Pain Management dba Delaware Valley Pain and Spine Institute and its employees, shall be brought solely in the Courts of Bucks County, in the Commonwealth of Pennsylvania.

AT DVPSI, OUR MISSION IS TO DELIVER HIGH-QUALITY MEDICAL CARE. TO HELP US ACHIEVE OUR GOAL AND SERVE YOU BETTER, WE REQUEST THAT ALL PATIENTS ADHERE TO THE FOLLOWING ADMINISTRATIVE POLICIES. YOUR COOPERATION IS GREATLY APPRECIATED AND HELPS ENSURE A SMOOTH EXPERIENCE FOR EVERYONE. PLEASE BE AWARE THAT NON-COMPLIANCE WITH THESE POLICIES MAY RESULT IN ADDITIONAL FEES AND DELAYS IN YOUR APPOINTMENT. THANK YOU FOR YOUR UNDERSTANDING AND COOPERATION.

HIPAA

THIS IS A MEDICAL CONSENT REQUIRED BY LAW TO ENSURE THAT YOU ARE AWARE OF THE WAYS IN WHICH DELAWARE VALLEY PAIN AND SPINE MAY USE YOUR HEALTH INFORMATION FOR TREATMENT.

YOUR MEDICAL HEALTH INFORMATION IS CONFIDENTIAL. ALL INFORMATION PERTAINING TO YOUR HEALTH AND THE CARE THAT YOU RECEIVE, OR PAYMENT FOR THAT CARE, IS CONSIDERED CONFIDENTIAL AND PROTECTED BY DELAWARE VALLEY PAIN AND SPINE INSTITUTE. THE USE AND DISCLOSURE OF MEDICAL INFORMATION IS DESCRIBED IN DETAIL IN OUR PRIVACY NOTICE. THIS IS POSTED FOR REVIEW IN OUR OFFICES.

USING AND DISCLOSING INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. DELAWARE VALLEY PAIN AND SPINE BY LAW IS AUTHORIZED TO USE AND DISCLOSE YOUR MEDICAL INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS. DELAWARE VALLEY PAIN AND SPINE IS A PARTICIPANT IN VARIOUS HEALTH INFORMATION EXCHANGES WHERE WE DISCLOSE YOUR HEALTH INFORMATION, AS PERMITTED BY LAW, TO OTHER HEALTHCARE PROVIDERS FOR YOUR TREATMENT, OR FOR PAYMENT OR OTHER HEALTHCARE OPERATIONS PURPOSES. FOR EXAMPLE, WE CAN SHARE THE NECESSARY INFORMATION IN ORDER TO BILL YOUR INSURER. PLEASE REFER TO THE PRIVACY NOTICE FOR ADDITIONAL INFORMATION.

RESTRICTIONS ON HOW DELAWARE VALLEY PAIN AND SPINE USES AND DISCLOSES YOUR PERSONAL HEALTH INFORMATION. YOU CAN ASK DELAWARE VALLEY PAIN AND SPINE TO RESTRICT THE MEDICAL INFORMATION USED OR SHARED ABOUT YOU FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS. WE MAY NOT BE ABLE TO AGREE WITH YOUR REQUEST, AND WILL TELL YOU SO. IF WE DO NOT AGREE WITH YOUR REQUEST, WE ARE BOUND TO FOLLOW IT.

YOUR RIGHT TO REVOKE YOUR CONSENT. YOU CAN REMOVE YOUR CONSENT AT ANYTIME, AS LONG AS YOU DO SO IN WRITING. YOUR REMOVAL OF THE CONSENT WILL NOT APPLY TO ANY USE OR DISCLOSE BY DELAWARE VALLEY PAIN AND SPINE PRIOR TO THE REQUEST TO REMOVE THE CONSENT. THIS WILL NOT APPLY TO THE ORIGINAL CONSENT DATE UPTO THE REQUESTED REMOVAL DATE.

I HEREBY AUTHORIZE RELEASE OF MEDICAL INFORMATION NECESSARY FOR THE PREPARATION OF INSURANCE CLAIMS ON MYSELF AND AUTHORIZE THE INSURANCE TO MAKE PAYMENT DIRECT TO THE PHYSICIAN ON ANY UNPAID CLAIM. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE CLAIMS, INCLUDING ELECTRONIC SUBMISSIONS.

Date

*_____
Patient Signature

Optional: RELEASE OF YOUR PERSONAL HEALTH INFORMATION. PLEASE INDICATE IF YOU ARE GIVING PERMISSION TO DISCUSS YOUR HEALTH INFORMATION WITH A MEMBERS OF YOUR FAMILY OR A FRIEND. Please print.

Name: _____ Relationship _____ Phone # _____

Name: _____ Relationship _____ Phone # _____

Date

Patient Signature

PRACTICE POLICIES

APPOINTMENT TIME

ALL NEW PATIENTS ARE REQUIRED TO ARRIVE 30 MINUTES PRIOR TO THEIR SCHEDULED APPOINTMENT TIME. RETURNING PATIENTS ARE REQUIRED TO ARRIVE 15 MINUTES PRIOR TO YOUR APPOINTMENT TIME.

FINANCIAL POLICY

- IT IS YOUR RESPONSIBILITY TO CANCEL OR RESCHEDULE YOUR OFFICE VISIT WITH A MINIMUM OF 24-HOURS ADVANCED NOTICE. FAILURE TO DO SO MAY RESULT IN A \$25 FEE FOR OFFICE VISITS AND \$50 FEE FOR PROCEDURES.
- IF YOU FAIL TO KEEP YOUR SCHEDULED APPOINTMENT, DVPSI RESERVES THE RIGHT TO CHARGE A \$25.00 FEE FOR OFFICE VISITS AND \$50 FEE FOR PROCEDURES.
- WE ACCEPT CASH, CREDIT CARD, DEBIT CARD, AND CHECKS. THERE IS A \$50.00 FEE FOR RETURNED CHECKS

MEDICATION REFILLS

- DVPSI REQUIRES ALL PATIENTS TO SIGN AN OPIOID AGREEMENT PRIOR TO RECEIVING PRESCRIPTIONS FOR CONTROLLED SUBSTANCES. MANDATORY URINE SCREENING AND COMPREHENSIVE URINE TESTING IS REQUIRED.
- ALL REFILLS FOR CONTROLLED SUBSTANCES SHOULD OCCUR AT THE TIME OF YOUR OFFICE VISIT.
- IT IS YOUR RESPONSIBILITY TO SCHEDULE A FOLLOW-UP APPOINTMENT PRIOR TO YOUR NEXT REFILL.
- PLEASE ALLOW 1 BUSINESS DAY TO PROCESS ALL REFILL REQUESTS MADE BY PHONE OR THROUGH THE PORTAL.
- PLEASE ALLOW ONE WEEK FOR YOUR INSURANCE TO AUTHORIZE YOUR MEDICATION. PLEASE CHECK WITH YOUR PHARMACY FOR UPDATES.
- MEDICATIONS PRESCRIBED DURING YOUR OFFICE VISIT WILL BE ELECTRONICALLY SENT TO YOUR PHARMACY BY THE END OF THE VISIT DAY.

INSURANCE REFERRALS

- IT IS YOUR RESPONSIBILITY TO OBTAIN REFERRALS, IF NECESSARY, FROM YOUR PRIMARY PHYSICIAN BEFORE YOUR OFFICE VISIT. FAILURE TO DO SO MAY REQUIRE YOU TO RESCHEDULE YOUR APPOINTMENT. WE REQUIRE REFERRALS 48 HOURS IN ADVANCE.
- WHILE DVPSI WILL OBTAIN ALL AUTHORIZATIONS REQUIRED BY YOUR INSURANCE COMPANY FOR PROCEDURES, IT IS YOUR RESPONSIBILITY TO OBTAIN THE APPROPRIATE REFERRAL, WHEN NECESSARY, FOR THE PROCEDURE. REFERRALS ARE REQUIRED FOR ALL HMO INSURANCES.

IMAGING AND TEST RESULTS

- IMAGING ORDERED BY THE PRACTICE THAT REQUIRE AUTHORIZATIONS ARE OBTAINED BY DVPSI AUTHORIZATION SPECIALISTS, IF YOUR INSURANCE REQUIRES AN AUTHORIZATION, YOU MUST PROVIDE THE FOLLOWING OR WE WILL BE UNABLE TO PROCESS AN AUTHORIZATION.
 - NAME AND ADDRESS OF FACILITY
 - NPI NUMBER OF FACILITY

- ALL TEST RESULTS WILL BE REVIEWED AT YOUR FOLLOW-UP VISIT. IT IS YOUR RESPONSIBILITY TO SCHEDULE A FOLLOW- UP VISIT IN ORDER TO REVIEW YOUR RESULTS.
- PLEASE BRING TO YOUR OFFICE VISIT ALL IMAGES AND REPORTS THAT APPLY TO YOUR COMPLAINT. THE DISCS ARE USUALLY PROVIDED BY THE IMAGING FACILITY, BUT IN CERTAIN CIRCUMSTANCES, YOU MAY NEED TO REQUEST A COPY YOURSELF.

PLEASE SIGN BELOW INDICATING YOU HAVE READ DELAWARE VALLEY PAIN AND SPINE INSTITUTE'S PRACTICE POLICIES IN FULL.

Date

* _____
Patient Signature

Date of Birth

Patient Name Printed

Revised March 2026