



PATIENT REGISTRATION

Today's Date: _____ Account #: _____
Name: _____ D.O.B. _____ Age: _____
S.S.#: _____ Sex: M F Marital Status: S M W D
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____
Occupation: _____ Employer: _____ Driver's License #: _____
Who referred you to our office: _____ Phone: (____) _____
Primary Care Physician: _____ Phone: (____) _____
Address: _____ City: _____ State: _____ Zip: _____
Reason for your visit: Auto Accident Workers' Comp Other: _____
Where would you like us to call you to remind you of your appointments and/other reason? _____

INSURANCE INFORMATION

PRIMARY INSURANCE:

Name of Insured: _____ D.O.B.: _____ S.S.#: _____
Insurance Company: _____ Phone: (____) _____
I.D. #: _____ Group Name #: _____
Address: _____

SECONDARY INSURANCE:

Name of Insured: _____ D.O.B.: _____ S.S.#: _____
Insurance Company: _____ Phone: (____) _____
I.D. #: _____ Group Name #: _____
Address: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: (____) _____ Cell #: _____

HIPAA PRIVACY ACT

We wish to inform you that your health information will be used for the following purposes: your treatment, healthcare coordination and payment for services rendered.

Health information includes: name, age, sex, social security, diagnosis among other. The information will only be used for the purposes previously outlined. You may restrict or amend your information, but we are legally not obliged to agree to your petition, in addition amendments are not restrictive.

Patient Signature (or legal guardian): _____ Date: _____

RELEASE OF INFORMATION

I hereby authorize the release of any information, including diagnosis and records/x-rays of any treatment, test or examinations rendered to patient during the period of such care to third party payers and/or other health practitioners, to Carlos J. Placer, M.D., for the purpose of evaluation and treatment.

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written authorization unless otherwise stated in the regulations. Therefore, I request that none of my records pertaining to the following be disclosed (choose all that apply):

Medical Psychiatric HIV Status Drug/Alcohol Abuse ARC/AIDS

Patient Signature (or legal guardian): _____ Date: _____

FINANCIAL POLICY

We will file your insurance claims for you on Medicare, Medicaid, Workers' Comp, Auto Insurance, and any other commercial insurance plan with which we participate. You will be responsible for payment of deductibles and/other co-payments at the time of service. Your insurance company has 45 days to make a payment. If payment is not received within that period and follow up reveals no error in billing, you will then be responsible for payment. Unless prior arrangements have been made, all overdue accounts are automatically sent to collections after ninety (90) days. A fee of \$25.00 will be added to your account for any NSF check written to Carlos J. Placer, MD., or Florida Spine, Sports & Rehabilitation, Inc.

I understand I am financially responsible for any non-covered insurance services. I have read and understand the above financial policy.

Patient Signature (or legal guardian): _____ Date: _____

OFFICE POLICIES

You are responsible for your appointment time(s). However, we may call to remind you of your appointment. Any missed appointments/no-shows, if not cancelled within 24 hours prior to the appointment time, will result in the following charge to the patient: \$25.00 for an office visit, \$50.00 for an EMG and \$100.00 for an Injection Block visit. You must call to reschedule and you will be given the next available appointment. Patients are required to provide a picture I.D. and fill out necessary forms, as requested by our office personnel and/or physician.

MEDICAL RECORDS

There may be a charge for the copies, postage and office services upon request of medical records. Medical records will be released upon receipt of payment as applicable.

☛ How would you like us to handle the release of your medical records: fax mail pickup (choose all that apply)

DISABILITY FORMS

There may be a charge of \$25.00 for any forms that the physician or staff is required to fill out and/or sign. For a disability parking permit, there will be a \$50.00 charge.

★ We need at least 72 hours to process any forms or medical records release.

OTHER COSTS

Prolotherapy has a cost of _____ per area, which is not covered by your insurance and is payable at the time of service.

APPOINTMENT TIME

We ask all patients to come at least 15 minutes prior to your appointment time.

EMERGENCY APPOINTMENTS

We will try to accommodate all emergencies within a timely manner and with appropriate action.

I understand and acknowledge that I have filled out this form to the best of my knowledge.

Patient Signature (or legal guardian): _____ Date: _____

Relationship to patient: _____ Date: _____