# IFPain Associates

Isaiah Florence, MD

Date:_______________

**Patient Information**

Last Name:________________________First Name:__________________________M:__________________

Sex: Male / Female Date of Birth:________________Social Security:_____________________

Marital Status: Single / Married / Divorced/ Widowed E-Mail Address:___________________________

Address:___________________________________Town:____________________State/Zip:______________

Primary Telephone Contact #_____________________Cell Telephone Contact #_____________________

Next of Kin:______________________________________ Relationship:______________________________

Address:_____________________________________________________Phone:_________________________

**Referring Doctor:______________________________Primary Care Doctor:_______________________**

Employer/School:__________________________________Occupation:_______________________________

**Pharmacy Name, Address, Phone:____________________________________________________________**

**Primary Insurance Information**

Type: Health Insurance Workers Comp Auto/PIP Accident Non/Self-Pay

**Subscriber's Name:_______________________________________ Date of Birth:_______________**
Address:__________________________________________________ SS#________________________
**Insurance Company:_______________________________________ Date of Accident:____________**
Address:__________________________________________________ Phone#_____________________
Group/Claim #_____________________________________________ Policy/ID#__________________
Case Manager:_____________________________________________ Phone #____________________

**Secondary Insurance Information**

Type: Health Insurance Workers Comp Auto/PIP Accident Non/Self-Pay

**Subscriber's Name:_______________________________________ Date of Birth:_______________**
Address:__________________________________________________ SS#________________________
**Insurance Company:_______________________________________ Date of Accident:____________**
Address:__________________________________________________ Phone#_____________________
Group/Claim #_____________________________________________ Policy/ID#__________________
Case Manager:_____________________________________________ Phone #____________________

**PLEASE BRING TO YOUR SCHEDULED APPOINTMENT:**

- **INSURANCE ID CARD** AND REFERRAL IF NECESSARY
- **WORKER'S COMP OR AUTO-PIP CLAIM INFORMATION** IF APPLICABLE, INCLUDING INSURANCE COMPANY ADDRESS, CLAIM NUMBER AND DATE OF ACCIDENT, ADJUSTER/CASE MANAGER'S NAME AND PHONE NUMBER, AND YOUR ATTORNEY'S NAME, ADDRESS AND PHONE NUMBER
- **MRI, CT SCAN** OR X-RAY FILMS AND REPORTS (EVEN IF FILMS ARE 2-3 YEARS OLD)
- A **LIST OF ALL MEDICATION** THAT YOU ARE CURRENTLY TAKING
- **COMPLETED PATIENT FORMS** (attached)
- NAME AND ADDRSES OF YOUR **REFERRING AND PRIMARY DOCTOR**

**IF YOU HAVE ANY QUESTIONS REGARDING YOUR APPOINTMENT, PLEASE CALL 201-287-1100**

# IFPain Associates

**Patient Name:______________________________ DOB____/_____/_____**

## PAYMENT AUTHORIZATION FORM

For and in consideration of services rendered, I agree to make payment to IFPain Associates when billed for any and all charges not covered by valid insurance benefits. I authorize payment directly to IFPain Associates for health insurance benefits payable to me under terms of my policy but not to exceed the balance due for services performed during this period of treatment. IFPain Associates may seek, release and verify all or part of my medical and/or financial records to any person, corporation or government agency which is or may be liable under a statute, regulation or contract to IFPain Associates, myself, a family member or my employer for all or part of the IFPain Associates charge.

If any of the following changes: patient's address, patient's phone number, patient's insurance information or any other information necessary for IFPain Associates process my medical bill, the patient must inform IFPain Associates promptly.

In the event the provider's charges are outstanding, I hereby authorize the provider to file such claim and/or action on my behalf so that the provider may receive payment of their charges. I understand that if the provider does not receive payment from the insurer, I remain personally responsible for payment of the provider's charges.

Medicare – Authorization to release information and payment request:
I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to this or a related Medicare claim. I request that direct payment of authorized benefits be made on my behalf. I assign benefits payable for physician's services to the physician or organization furnishing the services or authorize such payment or organization to submit a claim to Medicare for payment.

Please check the appropriate box: (MEDICARE CERTIFICATION)

I am entitled to benefits under Medicare Hospital Insurance, Part A.

YES_______ NO_______

I am entitled to benefits under Medicare Hospital Insurance, Part B.

YES_______ NO_______

________________ ______________________________________________

Date Signature

# IFPain Associates

**Patient Name:______________________________** **DOB____/_____/_____**

Please initial where applicable and sign at the bottom that you understand your responsibilities:

It is your responsibility to make sure that your accident insurance company has authorized your office visit. If your insurance company does not pay for the visit, you will be held accountable for the entire charge.

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It is **your responsibility** to adhere to all of the regulations and requirements of **your health plan**, in or out of network. If your health plan requires you to obtain a written referral and/or authorization number from your Primary Care Doctor for your office visit, **you must supply us with the referral/auth number.** If you do not, **you will be responsible for the entire charge of the office visit.** This is a rule of the Health Plan that you selected. We will help you when able but ultimately **this is your responsibility.**

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Patient's Signature___________________________________

Date______________________

# IFPain Associates

## PATIENT DISCLOSURE OF HEALTH CARE INFORMATION

**In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. The individual is also provided the right to request confidential communications or**

**It is our policy to contact the patient using their Primary Telephone Contact Number (as listed on their Patient Information Sheet) and if necessary then using the Secondary Telephone Contact Number. It is also our policy to leave a detailed message if necessary. Please note below if you want any exceptions to our policy.**

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of IFPain Associates "Notice of Privacy Practices."

As required by the Privacy Regulations, a staff member from IFPain Associates has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware that IFPain Associates has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

***As in our "Notice of Privacy Practices," we may disclose your healthcare information to other healthcare professionals for continuity of care, immediate family members to include spouse, parents, adult and children guardians. We may also need to disclose it to billing staff, legal counsel and insurance companies for the purpose of treatment, payment or healthcare operations. If you wish to file a "Request for restriction," please check and sign below.***

☐ I wish to restrict my Private Healthcare information: I have filed a Request of Restriction Form

____________________________ __________________

Patient Signature Date

____________________________ __________________

Print Name Birth Date