



**ADVANCED
PAIN MANAGEMENT**

Welcome To Our Office

PATIENT INFORMATION

Patient Name	Social Security No.
Street	Date of Birth Gender M__F__
City & State Zip Code	Occupation
Telephone -Home	Full-time _____ Part-time_____ Retired_____
Telephone - Work	Unemployed_____ Student_____ (full or part time?)
Telephone - Other	Employer Name & Address
Marital Status: Single ___ Married ___ Significant Other ___ Widowed ___	Emergency Contact; (name)
	Relationship: Phone#
Primary Care Physician	Referred by?

FINANCIAL RESPONSIBILITY (please give insurance cards to front desk with this form)

Primary Insurance	Secondary Insurance
Primary Insurance Name	Secondary Insurance Name
Name of Insured	Name of Insured
Relationship to Insured:	Relationship to Insured:
Insured Social Security No	Insured Social Security No
Insured Date of Birth	Insured Date of Birth
Insurance Policy ID #	Insurance Policy ID #
Group #	Group #
Claims address:	Claims address:
Telephone:	Telephone:

- **All co-payments and/or deductible payments are due at the time of your visit today.**
- **If you do not have insurance, payment in full is expected at the time of your visit today.**

Payment for Professional Services Rendered

I understand that many procedures performed by Advanced Pain Management (APM) are highly specialized and demand extensive education and training. I also understand that the fees for services provided by APM may exceed the amount paid by my insurance company. I agree to pay APM the contractually agreed upon co-insurance, deductible, or eligible charge as determined by the contract APM currently has with my insurance carrier. In those situations wherein APM **is not a contracting provider** with my insurance company, I understand that I must pay that portion, if any, of my bill that is not covered by my health insurance. I understand that by signing this agreement as patient or as agent, I obligate myself to pay my account in full.

Patient Signature: _____ Date _____