CAPITAL CITY PAINCARE

SARAH BLAKE MD
3600 OLENTANGY RIVER ROAD • BUILDING 480 • COLUMBUS, OHIO 43214
PHONE 614 - 442 - 0700 • FAX 614 - 298 - 8199 • capitalcitypaincare.com

Dear Patient:

Thank you for choosing Capital City Pain Care as your pain care provider.

Please fill out the enclosed forms and questionnaire.

Please bring any radiology reports and radiology CDs.

Please bring your insurance cards, copay, and picture ID.

Regretfully, if you forget your insurance cards, copay, or drivers license, we will need to reschedule your appointment.

We do not bill commercial or government insurance for personal injury or motor vehicle accident claims. You need to make arrangements with your attorney.

Workman's compensation consults require C9 approval.

Your appointment is scheduled for:

_____

ON CALL PHYSICIAN
614 - 947 - 9173

OUTREACH CLINIC
408 GLESSNER AVENUE
MANSFIELD, OHIO 44903

Capital City Paincare
REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid		
Nickname:	Social Security no.:	Email address:	Birth date: / /	Age:	Sex: ❑ M	❑ F	
Street address:	P.O. Box:	Home phone no.: ( )					
City:	State:	ZIP Code:	Cell phone no: ( )				
Occupation:	Employer:	Employer phone no.: ( )					
Employer address:	Spouse's name:	Spouse's SSN:					
Whom may we thank for referring you?							

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )		
Is this person a patient here? ❑ Yes ❑ No					
Occupation:	Employer:	Employer address:	Employer phone no.: ( )		
Is this patient covered by insurance? ❑ Yes ❑ No					
Please indicate primary insurance	❑ Medicare	❑ Medical Mutual	❑ Aetna	❑ Cigna Healthcare	❑ United Health Care
❑ Blue Cross/Blue Shield	❑ Medicaid	❑ Self Pay	❑ Other		

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )	Cell phone no.: ( )

INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to **Dr. Blake** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature *Relationship* *Date*

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Dr. Blake** for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier aggress to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature *Date*

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Financial Policy

Our practice is committed to providing you the best healthcare possible as well as helping you receive the best reimbursement for those services. We are also committed to filing correct claims to all insurance carriers. The Capital City Pain Care staff is happy to assist you with any questions you may have about your account or balance with us.

Our Responsibilities

• We understand that health insurance can be confusing. Therefore, while it is ultimately your responsibility to know your insurance plan, we will make reasonable efforts to assist you by verifying that you have an active policy at your insurance company. This does not guarantee payment of service, it only verifies that you have actual coverage.
• As a courtesy to you, our office will send bills for our services to your insurance company on your behalf.
• We will bill your insurance company in a timely manner.
• We will keep your personal medical and account information confidential according to state and federal laws.

Patient Responsibilities

• Present a copy of your health insurance identification card, and pay your copay each visit.
• Pay your bill on time (within 30 days of receiving a statement)
• Your appointment time is set aside specifically for you. If you are unable to keep an appointment, you are required to provide us with a 24-hour notice. Failure to do so will result in a $50 no-show fee. This fee is not covered by your insurance. You are responsible for paying this fee before you are able to schedule another appointment.

Non-Covered Services are Your Responsibility

Insurance companies do not pay for all medical services, even those that might be helpful to the patient. When a service is not covered by your insurance policy, you are responsible for paying the bill.

Federal law addressing insurance claims require that we submit every claim to an insurance company accurately, reporting the exact services performed and the exact reason for performing them. We cannot change this information just so the claim can be paid by the insurance company.

Please remember that it is up to you to understand the requirements of your individual insurance plan and that if a visit is not approved, your insurance company may not cover the service and you will be responsible for the bill. If you're not sure if a service is covered by your plan, we will be glad to call your insurance company in advance to see if you are going to be responsible for the bill.

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