Clearwater Pain Management Associates

430 Morton Plant Street, Ste. 210
Clearwater, Fl 33756
Ph:(727)-446-4506-- F:(727)- 446-4695

7800 66 Street North, Ste.202
Pinellas Park, Fl 33781
P:(727)-431-7737 -- F:(727)-431-3718

- **Dr. Chen**
- **Dr. Kaiafas**
- **Dr. Ladhani**

Please complete the following information and sign and date.

Date: _____ Patient Name: _____
Patient DOB: _____ Patient SSN: _____Gender: M / F Marital Status: _____
Patient Home Phone Number: _____E-Mail_____
Patient Primary Address:_____
_____
Race: (White / Black / Asian / American Indian / Pacific Islander / Other)
Ethnicity: Hispanic / Non-Hispanic Language: _____
Pharmacy and Address: _____
Allergies: _____
Emergency Contact: _____ Relationship: _____

- Allowed to make medical decisions

Insurance Information:

Primary Insurance Subscriber Name: _____
Primary Insurance Subscriber Relationship: _____
Primary Insurance: _____
Ins. Address: _____
ID#_____ Group#_____ Phone#_____
Secondary Insurance: _____
Ins. Address: _____
ID#_____ Group#_____ Phone#_____
AUTO_____ D.O.A.:_____ Adjuster: _____ Phone#_____
W/C _____ D.O.I.: _____ Employer: _____
Claim#_____
Was this an on the job injury? Y / N

Responsible Party:

Name: _____ Relationship to patient: _____
Address: _____ Phone Number: _____
SS#_____ DOB: _____ Employed By: _____

PLEASE PROVIDE YOUR INSURANCE CARD AND DRIVERS LICENSE SO WE CAN MAKE A COPY FOR YOUR FILE.

AUTHORIZATION TO RELEASE INFORMATION FOR INSURANCE PURPOSES:I hereby authorize Clearwater Pain Management Associates to release any information in the course of my examination and treatment for insurance purposes, including, but not limited to, Medicare, Medicaid, and private insurance carriers.

AUTHORIZATION TO PAY BENEFITS: I hereby authorize payment directly to Clearwater Pain Management Associates of all appropriate payments. This authorization includes, but is not limited to Medicare (HCFA 1500, Blocks 12 and/or 13), Medicaid, and other governmental and private insurance coverage.

AUTHORIZATION OF PAYMNT TO CLEARWATER PAIN MANAGEMENT ASSOCIATES. I hereby agree to be fully responsible for any amounts remaining unpaid 60 days after the date of the service.

ACCEPTANCE OF PERSONAL RESPONSIBILITY. I fully understand, and agree, that if the service(s) provided to me by Clearwater Pain Management are not covered by my insurance company (including but not limited to Medicare, Medicaid, and other insurance), that I will be personally responsible for the payment of all charges. Although Clearwater Pain Management will attempt to ascertain whether the services are covered, Clearwater Pain Management Pain Management cannot be responsible for final determination of coverage- this is between me and the insurance company.

AS A COURTESY TO OUR PATIENTS. Clearwater Pain Management Associates will contact the insurance for which we cannot be responsible for lapses in coverage, incorrect information we receive from you or your physician, or failure of the insurance company to provide authorization. You will ultimately be responsible for payment of your bill if your insurance company refuses to pay or pays incorrectly.

AUTHORIZATION TO DONWLOAD MEDICATION HISTORY. I authorize Clearwater Pain Management Associates to download my medication history and Rx benefits into my account from an Rx clearinghouse.

Signed: _____ Date: _____

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