# Dolora Pain Management Associates, P.C.

12434 E. 12 Mile Rd. Suite #203
WARREN, MI 48093

| PATIENT INFORMATION | | | |
|---|---|---|---|
| NAME (Last, First, Middle) | BIRTHDATE | SSN # | SEX |
| | | | |

| ADDRESS | | |
|---|---|---|
| | | |
| CITY, STATE, ZIP | HOME PHONE/CELL PHONE | ALTERNATE PHONE |
| | | |
| REFERRING or PRIMARY CARE PHYSICIAN NAME/PHONE NUMBER | EMAIL ADDRESS FOR PATIENT PORTAL ACCESS | |
| | | |

| EMERGENCY CONTACT or PERSONAL REPRESENTATIVE INFORMATION | |
|---|---|
| NAME (Last, First) | RELATIONSHIP |
| | |
| HOME PHONE | SPOUSE'S BIRTHDATE (IF APPLICABLE) |
| | |

**DOES THE PERSON LISTED ABOVE HAVE YOUR PERMISSION TO MAKE MEDICAL DECISIONS FOR YOU? YES ☐ NO ☐**

| Sign Below If You Want this Person to Make Medical Decisions for You: | **Date:** |
|---|---|
| | |

**HIPAA Acknowledgement: By signing below, I acknowledge that I have received the attached Notice of Privacy Practices.**

| **Signature of Patient or Personal Respresentative :** | **Date:** |
|---|---|
| | |

**By signing below, I give Dolora Pain Management Associates, P.C. permission to give information regarding my medical condition or treatment *only to the people listed below*:**

| Name | Relationship |
|---|---|
| Name | Relationship |

**Authorization for Assignment of Benefits/Information Release**

I, the undersigned, authorize payment of medical benefits to Dolora Pain Management Associates, P.C. for any services furnished me by Dolora Pain Management Associates, P.C. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company of their agent(s) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims or benefits.

| **Signature:** | **Date:** |
|---|---|
| | |

**Verification of Non-Injury**

I, the undersigned, agree that my illness or injury is ***NOT*** related to a Worker's Compensation, Automobile or other accident/injury claim in which a carrier other than my health insurance should be billed.

| **Signature:** | **Date:** |
|---|---|
| | |

***FOR MEDICARE PATIENTS ONLY***

**Medicare Signature on File**

I request that payment of authorized Medicare benefits be made on my behalf to Dolora Pain Management Associates, P.C. for any services furnished me by Dolora Pain Management Associates, P.C. I authorize any holder of medical information about me to release the information to the Centers for Medicare and Medicaid Services (CMS) and its agents in order to determine payable benefits for services rendered.

| **Signature:** | **Date:** |
|---|---|
| | |

**Medigap Signature on File (Medigap is any insurance that you may have that covers what Medicare *DOES NOT* cover)**

I request that payment of authorized Medigap benefits be made on my behalf to Dolora Pain Management Associates, P.C. I authorize any holder of medical information about me to release any information needed to determine these benefits or the benefits payable for related services to Centers for Medicare and Medicaid Services (CMS), its agents and my Medigap or other insurance policy.

| **Signature:** | **Date:** |
|---|---|
| | |

I consent to receive appointment reminders and health-related calls on the cell phone listed above. I also understand I may be charged for such calls by my wireless carrier.

| **Initial:** | Date: |
|---|---|
| | |

► **I acknowledge that the above information is true and accurate.**

| **SIGNATURE OF PATIENT/REPRESENTATIVE** | **DATE** |
|---|---|
| | |