Murphy Pain Center Registration Form

Name: ____
Last name First name Middle name

Date: _________________________

Home Phone: __________________________ Cell Phone: ______________________

SSN: _______________________________ Email: _________________________

Address: _____________________________ City: ___________________________

State: ______________________________ Zip code: ________________________

Sex (circle one): M F Date of Birth: ______________ Age: ________

Marital Status: (circle one): Single Married Widowed Divorced Partnered

Ethnicity: (circle one): Non-Hispanic/Non-Latino Hispanic/Latino

Race: (circle one): African American Asian White Indigenous American Pacific Islander Decline

Primary Language: (circle one): English Spanish Other ____________________

Employer: ____

Or (circle one): Retired Unemployed Student Disabled

Employer Address: ____

City, State, Zip: ____

Occupation: ____

Business Phone: (____)____

IN CASE OF EMERGENCY NOTIFY ____

Phone: ______________________________ Relationship to patient: ___________________

INSURANCE INFORMATION

A. Primary Insurance Company: ____

ID #: ____ Group #:___________________________

Name of Policy holder:____________________________ Birthdate of Policy holder:___________________

Their relationship to you (circle one): Self Spouse Parent Other________________________

Does your PRIMARY Insurance Co require a REFERRAL # from your Primary Physician? YES NO

B. Secondary Insurance Company: ____

Name of Policy holder:____________________________ Birthdate of Policy holder:___________________

Their relationship to you (circle one): Self Spouse Parent Other__________________________

Does your Secondary Insurance Co require a REFERRAL # from your Primary Physician? YES NO

C. Do you have Medicaid or Medicaid managed care? (circle one) YES NO

D. MEDICARE Questionnaire: (If you do not have Medicare, please skip to Section **F**)

Do you have any group health plan coverage through **your** current employer? (circle one): YES NO

If YES to above, how many employees, including yourself, work for your employer? (All locations)

(circle one): 1-19 20-99 100 or more

Are you retired? (circle one): YES NO. Are you covered through COBRA? (circle one): YES NO

Do you have group health plan coverage through **your spouse's** employer? (circle one): YES NO

If YES to above, how many employees, including your spouse, work for their employer? (All locations)

(circle one): 1-19 20-99 100 or more

Is your spouse retired? YES NO Is your spouse covered through COBRA? YES NO

E. Are you receiving **Black Lung Benefits**? (circle one): YES NO

F. Are you seeking care related to an injury or illness which another party could be held responsible or could be covered under no-fault, automobile, worker's compensation, or liability insurance? (circle one): YES NO (If NO, then skip this section.)

Type of accident (circle one): Motor Vehicle Work Related (W/C) Other: ___________________

If Motor Vehicle (MVA), is your PIP exhausted? (circle one): YES NO

Date of accident or injury: _________________ Part(s) of body injured: ____________________________

Employer (if W/C):____

Name of Insurance Company:___________________________________ Claim #:___________________

Case Worker or Adjuster's Name:__________________________________ Phone #: __________________

Release of Records, Request for Treatment and Release of Information & Assignment of Benefits:

I authorize Murphy Pain Center to release the necessary information regarding services as rendered to me and allow a photocopy of my signature to be used in submitting and processing of health insurance claim forms.

I hereby request treatment from Murphy Pain Center, and I authorize Murphy Pain Center to obtain any and all medical records necessary for my care. I specifically release Murphy Pain Center from all liability in obtaining these records as outlined in the Privacy Act or other such legislation.

I authorize my health insurance carrier to issue payment of benefits directly to James Patrick Murphy, MD, PSC dba Murphy Pain Center for payment of services rendered.

Signature: ____ Date: ___________________

Non-Covered Services, Referrals, and Copayments:

I accept responsibility for any charges not covered by my insurance. I will be responsible for verifying the practitioners at Murphy Pain Center are participating providers with my insurance carrier(s). If a referral is needed, it is my responsibility to obtain this before my appointment. I understand co-payments and balances due are expected at the time of service.

I attest the information provided in this registration is accurate and complete. I agree to report any changes in my address, phone number or insurance status. I understand dishonest or misleading information may be cause for termination.

As a service to our patients, we may provide a courtesy appointment reminder call and possibly other important calls that may be placed using a prerecorded message. By providing your home/cell phone number, you consent to receiving such calls.

Signature: ____ Date:___________________

Office Use Only:

Review by:____ Date:_____________________

JPM 2/26/2021