Date: Apt Date: Apt Time:

Last Name:	First Name:
Address:	Apt. or P.O. Box:
City:	State:
Zip Code:	Date of Birth:
Phone Numbers	
Home Phone: ( )	Email:
Work Phone: ( )	
Cell Phone: ()	

Emergency Contact

Last Name:	First Name:
Phone: ( )	Relationship:

Problem/Condition

Description of Problem:	Referred by:
Date of Onset:	

Primary Insurance

Insurance:	ID Number:
Group Number:	Claim Number:
Deductible:	Max Annual Benefit:
Copay:	Coinsurance:
Subscriber Information	
Subscriber's Name:	Subscriber Relation to Patient: ☐Self ☐Spouse ☐Parent ☐Other
Subscriber's Date of Birth:	
Insurance:	ID Number:
Group Number:	Claim Number:
Deductible:	Max Annual Benefit:
Copay:	Coinsurance:

Secondary Insurance

Insurance:	ID Number:
Group Number:	Claim Number:
Deductible:	Max Annual Benefit:
Copay:	Coinsurance:
Subscriber Information	
Subscriber's Name:	
Subscriber's Date of Birth:	
Subscriber Relation to Patient: ☐Self ☐Spouse ☐Parent ☐Other	

HIPPA

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can be and will be used to:

- Conduct, plan and direct my treatment and follow up care among the multiple healthcare providers who may be involved in the treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

A complete disclosure of the Notice of Privacy Practices was offered to me

Please list the family members or other person, if any, whom we may inform about your general medical condition, diagnosis, appointments, test results, or other health care information (including treatment, payment and healthcare operations). You are not required to list anyone, but if you do you are authorizing that person to have complete access to your medical and/or payment information.

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Our office staff will NOT leave any confidential health information on voicemail. We will only leave a call back number for your prompt attention to reach us during business hours. If you have any special requests please inform our receptionist or your Health Care staff.

Please Print Name:_____ DOB:_____

Signature:_____ Date:_____

Patient or Guardian Agreement:

☐ I acknowledge that BATTLE BORN PAIN & SPINE may disclose protected health information for the purposes of payment, treatment and healthcare operations (please refer to COR SPINE AND PAIN CENTER's Notice of Privacy Practices for additional information). I acknowledge that I was offered or provided a copy of the Notice of Privacy Practices.

All Patients:

☐**CONSENT TO TREATMENT**: I consent to receive services and any ancillary services that are deemed medically necessary or appropriate by my treating physician.

I understand that: I was provided with an option to receive a copy of the Privacy Practices for COR SPINE AND PAIN CENTER and have waived that option. This is posted in the practice waiting area and is also located on the website.

Family & Friends Release of Information

List family and friends, *if any,* whom we may inform about your general medical condition and your diagnosis.

Name	Relationship	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____

For TriCare Patients – Social Security Number of Guarantor _____

This Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE

Battle Born Pain & Spine
Martin Jose Arraiz Professional Corporation
6255 Sharlands Avenue
Reno, NV 89523
Office: 775) 245-6117 Fax: (775) 245-6118

STATEMENT OF FINANCIAL POLICY AND FINANCIAL RESPONSIBILITY

1. **PAYMENTS AND FEES.** BATTLE BORN PAIN & SPINE (the Provider") accepts payment in the form of cash, and credit or debit cards, but no checks. Payment for copays, deductible amounts, or out-of-pocket payments are due at the time of service, and if the patient is a minor, the parent or legal guardian will be responsible for the payments. There will be no billing to other parents or outside individuals. The Provider will discuss fees prior to the start of the appointment. Patients without insurance will be responsible for payment of the full fee at the time of service.

2. **INSURANCE.** The Provider will bill patient's insurance for accepted and contracted insurance carriers. However, for out-of-network insurance carriers, the patient is responsible for submitting a superbill for reimbursement, if applicable, and will need to pay for the cost of the visit at the time of the appointment.

   The patient authorizes payment directly to the Provider for charges associated with the patient's office visit. It is the patient's responsibility to know his/her medical insurance coverage details, deductibles, and limits. If the insurance carrier payment is not received within sixty (60) calendar days from the date of service, the patient will be billed for the full visit fee and will be expected to pay within thirty (30) days or at the time of the next visit, whichever is sooner, or else the patient risks being sent to collections. At times, insurance companies are not clear about Provider reimbursement, and the Provider will not be held responsible for erroneous information provided by any insurance company. It is the patient's responsibility to inform the office of changes to his/her insurance policy(ies).

3. **IDENTIFICATION.** It is required that I bring my insurance card and/or a valid government issued photo ID to each visit (e.g., driver's license).

4. **FINANCIAL AGREEMENT.** I agree, whether signing as a patient, parent, guarantor, or agent of the patient, that in consideration of the services provided by the Provider to the patient, I will promptly pay all bills in accordance with the Provider's standard charges for such services, as well as in accordance with applicable federal and state laws and regulations. Should my account be referred to an attorney or collection agency for collection, I will pay actual attorney's fees and collection expenses. I understand that all delinquent accounts shall be charged interest at the legal rate.

Battle Born Pain & Spine
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6255 Sharlands Avenue
Reno, NV 89523
Office: 775) 245-6117 Fax: (775) 245-6118

I understand that I have a right to request an explanation of the Provider's billing process and a list of the provider's charges for any service(s) I might receive. If I am unable to make a payment or if I have questions regarding my bill, I will contact the Provider in a timely manner.

By signing this form, I understand that all references in this form to "I", "me", or "my" refer to the patient.

I have read and agree to the above terms of the Statement of Financial Policy and Financial Responsibility:

Name of Patient: (Please Print) _____

Signature of Patient: _____ Date: _____

Name of parent/legal guardian: (If applicable, Please Print) _____

Relationship of parent/legal guardian to patient: (If applicable, Please Print) _____

Signature of parent/legal guardian: (If applicable, Please Print) _____ Date: _____