RICHMOND SPINE Interventions & Pain Center

Registration Form

IMPORTANT: Please complete all sections of this form. Do not leave any unanswered items. If the question does not apply, you may put "N/A".

Personal Information

_____

First Name Middle Name Last Name

_____

Street Address

_____

Street Address Line 2

_____

City State Zip Code

Date of Birth:

_____ / _____ / _____

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Separated

☐ Widow ☐ Other _____

Contact Preference: ☐ Home Phone ☐ Mobile ☐ Work

Home Number: (_____) _____ - _____

Mobile Number:(_____) _____ - _____

Work Number: (_____) _____ - _____

Can we send you a mobile text message? *(This is for appointment reminders or patient portal registration. We promise not to spam you!)* ☐ Yes ☐ No

E-mail _____@_____.com

(Providing your email address authorizes RSIP to send electronic correspondence to you. You may unsubscribe at any time.)

Would you like to register for the patient portal? ☐ Yes ☐ Not Today

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Race: ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian and Native ☐ Hawaiian or Other Pacific Islander Ethnicity _____ ☐ Not Hispanic or Latino

Language _____

Are you covered by an insurance company? ☐ Yes ☐ No

Primary Insurance Company: _____

Primary Subscriber Number: _____

Secondary Insurance Company: _____

Secondary Subscriber Number: _____

Emergency Contact Name: _____ Relationship to Patient: _____

Home Phone_____ Mobile Phone_____

Primary Care Physician Name: _____ Office Phone Number: _____

Referring Provider Name: _____ Office Phone Number: _____

Preferred Pharmacy Name: _____ Phone Number: _____

Pharmacy Address: _____

I AUTHORIZE THE REVIEW OF ANY REPORT GENERATED UNDER MY NAME IN THE VIRGINIA PRESCRIPTION MONITORING PROGRAM (PMP). ☐ Yes ☐ No

Signature: _____ Print Name: _____

Date Signed: _____ / _____ / _____

Cancellation / No-Show Policy

Our goal is to provide quality individualized medical care in a timely manner. No-shows, late shows, and cancellations inconvenience those individuals who need access to medical care. We would like to remind you of our policy regarding missed appointments.

If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will allow another patient access to timely medical care.

By making an initial appointment with one of our physicians, nurse practitioners, or physician assistants, you are agreeing to abide by the billing policies of our practice. There will be a fee, billed to you personally if you do not provide at least a 24-hour notice of cancellation or change to your appointment date/time.

How to Cancel Your Appointment: To cancel your appointment, please call **804-378-1800**. If you do not reach the call center, you may leave a detailed message on our voicemail. If you would like to reschedule your appointment, please leave your name and phone number. We will return your call promptly.

Late Cancellations: A cancellation is considered to be late when the appointment is canceled without 24-hour advance notice.

No-Show Policy: A “no-show” is a patient who misses an appointment without canceling it. A failure to be present at the time of a scheduled appointment will be recorded in the patient’s chart as a “no-show”. There are no health insurance policies that cover fees for missed appointments or “no-show”'. Our staff will be happy to answer any further questions regarding this policy.

By signing below I acknowledge that I have fully read and agree to the terms of Richmond Spine Interventions and Pain Center policy.

Signature: _____ Print Name: _____

Date Signed: _____ / _____ / _____

Authorization to Discuss or Release Confidential Patient Information

☐ I hereby authorize Richmond Spine Interventions and Pain Center to discuss my medical and/or financial information** with the following person(s):

Contact 1:

First Name: _____

Last Name: _____

Relationship to Patient: _____

Phone Number: _____

Contact 2:

First Name: _____

Last Name: _____

Relationship to Patient: _____

Phone Number: _____

☐ I do not permit anyone other than myself to receive my medical or financial information, this includes picking up prescriptions or other documents related to my care.

☐ I would like to discuss this with a provider

If Richmond Spine Interventions and Pain Center is unable to reach you in person for any reason (lab results, referrals, appointments, prescriptions, etc)

Do we have permission to leave a message on your voicemail? ☐ Yes ☐ No

Please Confirm Your Phone Number: _____

Signature: _____ Print Name: _____

Date Signed: _____ / _____ / _____

Release of Medical Information for Billing Purposes

I hereby authorize Richmond Spine Interventions and Pain Center to release medical information to Medicare, my employer's benefits department, or my other insurance company, for the sole purpose of obtaining payment for my medical care. Although medical information is confidential, many carriers require medical documentation before payment for services. I understand that only information about obtaining payment for my care will be released. I agree that a copy of this release may be used instead of the original.

I am aware that I may request that this Release of Medical Information may be revoked at any time by providing my physician's office with a dated and signed letter. I have read and agreed to these terms.

Do you acknowledge and agree to the terms of our Release of Medical Information for Billing Purposes Policy? ☐ Yes ☐ No

Payment for Medical Services

I hereby assume financial responsibility for all charges incurred for services rendered. I understand that I will be required to pay co-payments, amounts applied to deductibles, and the balance of bills not paid under the benefits of my current insurance policy. If I am unable to make payment in full for my medical treatments within 30 days, I agree to call the business office and make payment arrangements.
I hereby authorize payment for all medical insurance benefits which are payable under the terms of my insurance policy, to be paid directly to Richmond Spine Interventions and Pain Center or designees for services rendered.

I certify that the information I have reported regarding my insurance coverage is accurate and correct. I authorize the physician's office to verify insurance coverage and benefits allowed under the insurance company's policy.

I understand that it is my full responsibility that any third party which I direct Richmond Spine Interventions and Pain Center to bill, in the event of non-payment for whatever reason under the benefits of my current insurance policy, I will pay immediately. It is further agreed that in the event I fail to pay upon demand, should my account be referred to an outside collection agency or an attorney, I accept full responsibility to pay all collection costs not to exceed 30% and interest of 1.5% per month not to exceed 18% per annum and reasonable court costs.

Do you acknowledge and agree to the terms of our Payment for Medical Services Policy? ☐ Yes ☐ No

Signature: _____ Print Name: _____

Date Signed: _____ / _____ / _____