PAIN CARE CONSULTANTS PC – THOMAS W HANLON MD

PATIENT INFORMATON

Patient Name: _____ Date: _____

DOB: _____ Height: _____ Weight: _____

SSN: _____ Smoking: _____ Preferred Language: _____

Address: _____ City, State, Zip: _____

Preferred Phone #: _____ Email Address: _____

Emergency Contact: _____ Phone Number: _____

Pharmacy _____ Phone Number: _____

MEDICAL HISTORY

Please list any Surgeries:

_____
_____
_____
_____

Medication Allergies:

_____
_____

Current Medication:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

PAIN CARE CONSULTANTS PC – DR THOMAS HANLON
PATIENT MEDICAL HISTORY

Which of the following conditions are you currently being treated or have been treated for in the past (please check and specify condition)

Heart Disease: _____

Diabetes: _____

High or Low Cholesterol: _____

High or Low Blood Pressure: _____

Headaches or Migraines: _____

Lung or breathing problems:_____

Kidney, Bladder or Prostate Problems: _____

Ulcer or colitis or other stomach issues: _____

Anemia or Other Blood Conditions: _____

Depression or Anxiety or psychiatric Care: _____

Thyroid issues: _____

Cancer: _____

Seizures or any other neurological conditions: _____

Liver issues:_____

Please list any other medical conditions not listed above:

_____
_____
_____
_____
_____
_____

Pain Care Consultants PC
Thomas W Hanlon MD

Patient Financial Obligation Agreement

Payment at Time of Service:

1. We accept cash, checks, debit and credit cards. A $30.00 fee will be charged for all checks which are returned for insufficient funds.
2. Insurance required co-payments are due at time of service.
3. All outstanding patient balances are due at time of service or you may be asked to reschedule your appointment.
4. Your co-pay amount is subject to change depending on your insurance plan and/or any procedures that may be provided during your visit.
5. All outstanding balances must be paid prior to your next visit or you may not be scheduled until payment is made.
6. **Overdue accounts that are sent to collections must be paid in full before any appointment are made for you.**

Billing Process:

1. We will bill your insurance first. It is your responsibility to inform the office if treatment is covered by a third party – Auto insurance, Workers Compensation, or Liability Insurance Company rather than your health insurance. You are required to provide all necessary information to the office regarding your insurance.
2. You are required to provide personal health insurance information as of back up insurance to any third party carrier. If we are not provided with the information and we get a denial from your third party carrier you will be billed and responsible for the bill.
3. If you receive payment directly from your insurance carrier we expect to receive payment in full from you within 10 days of the receipt of payment. You will be held responsible for payment for any charges incurred.
4. It is your responsibility to notice Pain Care Consultation – Dr Thomas Hanlon of any changes in your health insurance
5. If your health insurance requires a referral you are responsible to have your primary care physician send a referral to our office prior to your appointment. If you do not have a referral and one is required you will be responsible to pay for the visit. If you have questions regarding your eligibility or coverage you should call the number on the back of your insurance card.

It is your responsibility to notify this office of any change in address, phone, or insurance coverage. We reserve the right to report delinquent accounts to credit bureaus, assess a collection fee, take other collection action, or terminate you as a patient from out practice.

You may contact our office Monday thru Friday 9:00 am to 4:00 pm at (570)861-8200 to discuss payment options. We may require all co-pays be paid before payment arrangements will be made on other outstanding balances.

If you are unable to keep and appointment we ask that you call and cancel with our office. All patients that are a no-show for their appointments will be assessed a $25.00 no show fee which must be paid before any further visits are scheduled.

Please sign below stating that you have received this statement are aware of your financial obligations with our office.

Print Patient Name: _____

Patient Signature: _____Date: _____

PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:

EFFECTIVE APRIL 14TH 2003 THE FEDERAL HIPPA PRIVACY RULE REQUIRES OUR PRACTICE TO COMPLY WITH CERTAIN LEGAL REQUIREMENTS DESIGNED TO PROTECT YOUR PERSONAL HEALTH INFORMATION. HIPAA GIVE INDIVIDUALS THE RIGHT TO REQUEST RESTRICTIONS ON USES AND DISCLOUSURES OR PROTOECTED HEALTH INFORMATION (PHI). THE INDIVUDUAL IS ALSO PROVIDED THE RIGHT TO REQUEST CONFIDIENTIAL COMMUNITCATIONS OF PHI BE MADE BY ALTERANTIVE MEANS, SUCH AS SENDING CORRESPONDENCE TO INDIVIDUAL'S OFFICE INSTEAD OF HOME. WE MAY NEED YOUR WRITTEN AUTHROZATION TO RELEASE PHI IF YOU ARE THE ONE REQUESTING THE RELEASE.

I wish to be contacted in the following manner:

Check all that apply

Home Telephone: _____

1. Ok to leave detailed message on home answering machine_____
2. Leave message with call-back number only_____

Work Telephone: _____

1. Ok to leave detailed information _____
2. Leave message with call back number only_____

Written Communications:

1. Ok to mail to home address_____
2. Ok to mail to work/office_____

Ok to fax detailed information to this number: _____

You can communicate information about to:
Check all that apply

1. My spouse: _____
2. Family Members:_____
3. Caregivers:_____
4. Other:_____

Print Patient Name:_____

Signature and Date:_____