ARKANSAS PAIN CARE CLINICS
PHYSICAL THERAPY AND REHAB

PATIENT INFORMATION

Patient's Last Name First Middle	O Mr. O Mrs.	O Miss O Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? O Yes O No	If not, what is your legal name?	(Former Name):	Birth Date: / /	Age:	Sex: O M O F

Street Address:	Home Phone No: ( ) Cell Phone No: ( )	Social Security No: Drivers License No:

P.O. Box:	City:	State:	Zip Code:

Occupation:	Employer:	Work Phone No: ( )

INSURANCE INFORMATION

(Please give your insurance card(s) to the receptionist)

Referring Physician:	Phone No: ( )	Fax: ( )
Primary Care Physician:	Phone No: ( )	Fax: ( )

Person Responsible for Bill:	Birth Date: / /	Address: (If Different)	Home Phone No: ( )

Occupation:	Employer:	Employer Address:	Drivers License No:

Is this patient covered by insurance? O Yes O No

Primary Insurance: Address:

Subscriber's Name:	Subscriber's SS No:	Birth Date: / /	Group No:	Policy No:	Co-Payment: $

Patient's Relationship to Subscriber:	O Self	O Spouse	O Child	O Other	Subscriber's Employer:

Secondary Insurance: Address:

Subscriber's Name:	Subscriber's SS No:	Birth Date: / /	Group No:	Policy No:	Co-Payment: $

Patient's Relationship to Subscriber:	O Self	O Spouse	O Child	O Other	Subscriber's Employer:

EMERGENCY INFORMATION

Emergency Contact:	Relationship to Patient:	Home Phone No: ( )	Alt Phone No: ( )

HIPAA CONSENT

1) I understand and have access to the *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:
   a) The right to review the notice prior to signing the consent
   b) The right to object to the use of my health information for directory purposes, and
   c) The right to request restrictions on the use or disclosure of my health information for treatment, payment, or health care operations
2) I understand that as part of my health care, Arkansas Pain Care Clinics originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and plans for treatment. I understand that this information serves as:
   a) A basis for planning my care and treatment
   b) A means of communication among the many health professionals who contribute to my care
   c) A source of information for applying my diagnosis and surgical information to my bill
   d) A means by which a third-party payer can verify that services billed were actually provided, and
   e) A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.
3) I understand that Arkansas Pain Care Clinics is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.
4) I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax, email or electronic transmission over internet based secure servers.

I accept and understand the terms of this consent with restrictions (if any) to the use or disclosure of my health information as noted below.

FINANCIAL CONSENT

5) I understand and agree that I am financially responsible for payment of all charges incurred in connection with my diagnosis and/or treatment at Arkansas Pain Care Clinics. Whether or not my insurance company, or any third party,

SEE REVERSE

pays any part of my charges, and whether or not I engage in any legal action to attempt collection from a third party, I am responsible for timely payment of all charges when due.

6) I hereby assign to Arkansas Pain Care Clinics, it's affiliated practices and physicians, to the extent necessary to satisfy my outstanding indebtedness, all sums payable to me pursuant to any health benefit plan, or policy of insurance, settlement, or judgment.
7) I agree that if the treating physician(s), their designees, agents, assigns and employees, is/are required to appear or testify, provide depositions, perform research, or engage in any other activity in connection with any legal or court proceeding in connection with my diagnosis and/or treatment, that Arkansas Pain Care Clinics shall receive full payment of the estimated cost of such services, in advance. Such services will be payable at a rate not less that Five Hundred ($500) Dollars per hour, portal to portal. Payment shall not be delayed by, nor predicted upon, the outcome of such legal or court proceeding.
8) I understand that all records created in connection with my medical care are the property of Arkansas Pain Care Clinics. If I require copies of such records, I agree to pay search and copying fees, in accordance with the fee schedule of Arkansas Pain Care Clinics.
9) I agree that all charges are due and payable upon the completion of service, and that any finance charges on the unpaid amount(s) shall commence on the date of such service. I agree to pay a re-billing charge of Five (5%) Percent of the unpaid balance, or Five ($5) Dollars, whichever is greater, for any payment past due more than Thirty (30) days.
10) I agree to pay the sum of Thirty ($30) Dollars for handling any check I issue to Arkansas Pain Care Clinics, its affiliated practices and physicians that is dishonored by my bank.
11) I agree to pay the full amount of all collection costs, including re-billing charges, certified or registered mail costs, collection agency fees, and/or attorney's fees, necessary to collect any unpaid balance.
12) I agree that my treatment at Arkansas Pain Care Clinics may discontinue until my account is settled in full or on mutually arranged plans.
13) The above billing and financial information is true to the best of my knowledge. I am fully responsible for providing the correct insurance and contact information. I am responsible to also check with my insurance if a prior authorization for a procedure or office visit is required.
14) I understand that Arkansas Pain Care Clinics and its affiliated practice entities and physicians offer a fifty (50) percent discount on the scheduled fee for their services if payment is made at the time service is rendered.
15) I also authorize Arkansas Pain Care Clinics, its affiliated practice entities and physicians or insurance company to release any information necessary to process my claims.

TREATMENT CONSENT

In consideration for medical services rendered or to be rendered to me at my request, I hereby agree to the following:

16) I voluntarily present myself for diagnosis and treatment. I consent to the rendering of whatever medical care may be necessary and/or appropriate in connection with my condition. I authorize Arkansas Pain Care Clinics treating physician(s), their designees, agents, assigns, and employees:
    a) to perform radiological studies (commonly known as X-rays); diagnostic studies; laboratory procedures; blood tests; and any and all other diagnostic procedures and medical treatment that the treating physician(s) or physician assistant(s) may deem necessary; and
    b) to perform such medical, surgical, and other procedures the treating physician(s) or physician assistant(s) may deem necessary.
17) If any person employed by Arkansas Pain Care Clinics is directly exposed to my blood or bodily fluids in a manner which may transmit Human Immunodeficiency Virus (HIV) – the virus that causes Acquired Immunodeficiency Syndrome (AIDS) – I acknowledge that either:
    a) I may consent to testing for HIV and to the release of my test results to the person who is exposed; or
    b) Arkansas Pain Care Clinics will inform the County Health Director of such incident, who may require HIV / AIDS testing.
18) I acknowledge that no guaranties, warranties, or representations have been made to me regarding the results of the diagnosis or treatment to be rendered.
19) I authorize Arkansas Pain Care Clinics, the treating physician(s), physician assistant(s), their designees, agents, assigns and employees:
    a) to release to any insurance company, review organization, health care service plan, worker's compensation insurer, or any other party directly or indirectly responsible for payment of any portion of the incurred charges, or to any health care facility or agency, or to any collection agency, such information as may be necessary to secure payment of incurred charges to Arkansas Pain Care Clinics; and
    b) to release to the court, in case of legal action by or against Arkansas Pain Care Clinics, the treating physician(s), and/or their designees, agents, assigns and employees, such information as may be necessary for the prosecution or defense of such legal action
    c) to discuss any aspects of my medical care with any medical provider to whom or by whom my case may be referred.
20) I release Arkansas Pain Care Clinics, the treating physician(s), their designees, agents, assigns, and employees, from any and all liability which may arise from the release of such information as described in paragraphs 19a, 19b, and 19c above.
21) It is expressly understood that, as used in this document, the terms "I", "me", or "my" shall, where appropriate, refer to the patient and to all legal representative of the patient and guarantors executing this agreement. If the patient is under eighteen (18) years of age or incapacitated, the undersigned warrants that he or she has authority to sign this document on behalf of the patient.
22) This Agreement shall be governed by and construed in accordance with the laws of the State of Arkansas and available on the website.

HIPAA Restrictions:	Witness:
Patient/ Representative Signature	Date: