*Vivek A. Manocha M.D.*
*Physiatrist and*
*Interventional Pain Specialist*
*578 North Main.*
*Springboro, OH. 45066*

## PATIENT INFORMATION

| | | | |
|---|---|---|---|
| FIRST NAME | MI | LAST NAME | GENDER |
| STREET ADDRESS | | | DATE OF BIRTH |
| CITY, STATE, & ZIP CODE | | | |
| HOME PHONE NUMBER | | CELL PHONE NUMBER | WORK PHONE NUMBER |
| SOCIAL SECURITY NUMBER<br>_____-_____-_____ | | MARITAL STATUS<br>____SINGLE ____MARRIED ____DIVORCED ____WIDOW(er) | |

## GUARANTOR ( If Different From Above)

| | | | | |
|---|---|---|---|---|
| FIRST NAME | MI | LAST NAME | | DATE OF BIRTH |
| STREET ADDRESS | CITY | STATE | ZIP | PHONE NUMBER(S) |
| SOCIAL SECURITY NUMBER<br>_____-_____-_____ | | EMPLOYER | | ADDRESS |

## EMPLOYMENT & INSURANCE INFORMATION

| | | |
|---|---|---|
| PRIMARY INSURANCE | POLICY HOLDER | POLICY HOLDER SS# |
| PRIMARY INS. HOLDERS NAME | DATE OF BIRTH | RELATIONSHIP TO PATIENT |
| SECONDARY INSURANCE | POLICY HOLDER | POLICY HOLDER SS# |
| SECONDARY INS. HOLDERS NAME | DATE OF BIRTH | RELATIONSHIP TO PATIENT |
| EMPLOYER | FULL TIME STUDENT<br>_____YES _____NO | PRIMARY CARE PHYSICIAN<br>NAME PHONE # |
| EMERGENCY CONTACT<br>NAME: | PHONE NUMBER(S): | |

DO YOU HAVE AN ADVANCE DIRECTIVE,(LIVING WILL) IF YES, AT WHICH HOSPITAL IS IT FILED?

HOW DID YOU HEAR ABOUT OUR OFFICE?

FRIEND/FAMILY_____ PHYSICIAN_____ ADVERTISEMENT_____

**INTERVENTIONAL SPINE & PAIN CENTER**
**POLICY, AUTHORIZATIONS, & FINANCIAL AGREEMENT**

APPOINTMENT POLICY:

At Interventional Spine & Pain Center we are concerned about your health care. We would like you to know by not keeping your scheduled appointments hinders our ability to provide you with quality care. Interventional Spine & Pain Center requires a 24 hour notice for all cancellations. This allows us to offer another patient that time spot and prevents a cancellation fee from being applied to your account. Our No Show fees are not payable by your insurance carrier and will be your responsibility. The No Show fees vary by appointment type. For an office visit the "no show" fee is $25.00 and the injection visit "no show" fee is $35.00. By failing to contact the office to cancel your appointment may result in the physician letting you go from his/her practice. Patients Initials _____ This is stating the patient has read the above.

AUTHORIZATIONS:

I authorize examination, diagnosis, and general treatment (including but not limited to, use of x-ray and other non-invasive procedures such as diagnostic test) to be performed by the physicians and staff of Interventional Spine & Pain Center. I realize that if a medical procedure is required, I will be given additional information.

I understand that as part of my healthcare, this practice originates and maintains health records and radiology films describing my health history, symptoms, examination and test results, diagnosis, treatment and plans for future care and treatment. The health records and radiology films will be retained by Interventional Spine & Pain Center even if my healthcare provider(s) leave the practice.

I authorize the release of any medical information necessary to process insurance claims and request payment of benefits either to myself or the party who accepts assignment/participates.

FINANCIAL AGREEMENT:

I understand the bill is my responsibility. I assign and authorize payments be made directly to Interventional Spine & Pain Center of all insurance benefits and agree to pay any balance due.

I understand that I will be responsible for any additional fees incurred from the following:
**Returned Checks**
**Missed Appointments**
**Non-payment of co-pays or deductibles at time of service**
**Copies of Medical Records**

PRESCRIPTION REFILL REQUESTS:

With any long-term drug, we require an office visit once a month, unless the physician deems otherwise. We request a 72 hour notice if you are requesting a refill to be called into your pharmacy.

By signing the line below you are stating that you have read and agree to all portions of this contract.

_____ _____
Signature of patient or patient's representative Date

_____ _____
Printed name of patient or patient's representative Representatives relationship to patient