COASTAL VIRGINIA SPINE & PAIN CENTER

PATIENT REGISTRATION

PLEASE PRINT

LAST NAME: _____ **First:**_____ **MI:** ___

Date of Birth: _____ **Sex** ___ **M** ___ **F** **Social Security #:**_____

Address:_____ **City**_____ **State**_____ **Zip**_____

PHONE: HOME:_____ **CELL:**_____ **WORK:**_____ **E-MAIL:** _____

Referring Physician: _____**Patient PCP:** _____

Preferred Pharmacy: _____**Pharmacy Phone:**_____

EMERGENCY CONTACT: _____ **Relationship to Patient:** _____ **Phone:**_____

Employer: _____ **Phone:** _____

Marital Status: _____ **If married, Spouse's Full Name:**_____

INSURANCE INFORMATION

(if Worker's Comp, please write W/C under Primary Insurance)

PRIMARY INSURANCE PLAN: _____

ID#_____ GROUP #:_____

Policy Holder: ☐ **SELF** ☐ **OTHER**

If other: Last Name: _____ First Name_____ MI_____

Relationship to Patient: _____Policy Holder: Date of Birth:_____ Last 4 digits of SSN: _____

Address if different from patient: _____

SECONDARY INSURANCE PLAN: _____

ID#_____ GROUP #:_____

Policy Holder: ☐ **SELF** ☐ **OTHER**

If other: Last Name: _____ First Name_____ MI_____

Relationship to Patient: _____Policy Holder: Date of Birth:_____ Last 4 digits of SSN: _____

Address if different from patient: _____

The information below will be used to improve the quality of healthcare by granting us the ability to measure and minimize care dis-parities based on ethnicity, race and preferred language. It gives the practice an accurate estimate of our patient population, and accordingly assesses the need for different services such as interpreter services translated patient forms and cultural competency

RACE: (Please check one) ☐ **DECLINED** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Other Race ☐ White

ETHNICITY: (Please check one) ☐ **DECLINED** ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown

ASSIGNMENT and RELEASE

- I hereby assign my insurance benefits to be paid directly to the physician.
- I understand that I am financially responsible for all non-covered services
- I authorize the physician to release any information required to process this claim

SIGNED: _____ **DATE:**_____

GENERAL CONSENT/AGREEMENT
OUTPATIENT SERVICES

1. **CONSENT TO TREATMENT:** I hereby consent to treatment by Coastal Virginia Spine & Pain Center (COVA), their associates, and/or assistants, and accept responsibility for payment of fees for such medical services. I understand that treatment may include injections, manipulations, medication management, medical appliances, and/or other procedures as deemed necessary and appropriate. I understand that I could be tested for HIV, and have the right to opt out. I understand that my consent will be requested for HIV and other testing in case of an unintended exposure of a healthcare worker.

2. **PAYMENT FOR SERVICES**: I understand that COVA may bill my health plan for the care I receive. I agree that payments from my health plan may go directly to COVA. If I should receive the payments, I understand that I will be responsible for paying COVA. I understand that I must pay any co-payment or other part of the bill that my health plan says I must pay. I know that I may need to pay this before I am treated. I understand and agree that if my plan does not pay the physician or their associates/assistants, I will have to do so. I understand that COVA will hold me responsible in any one of the following situations:

   a. When I choose to have a service that my health plan covers, but I do not obtain the required referral or authorization from my health plan.
   b. When I choose not to use my health plan and agree to pay for services myself. *(Use Do Not Bill Insurance Form)*
   c. When my health plan does not participate with COVA for the services I want, or need, and I agree to pay for my care myself.
   d. When I receive services that are not covered under my health plan.

3. **ADVANCED DIRECTIVES**: COVA does not honor Advanced Directives. Unexpected complications due to procedures and/or treatment are not natural causes, and therefore will be treated. This means that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative, or other stabilizing measures, and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatment, or withdrawal of treatment measures already begun, will be ordered in accordance with your wishes, Advanced Directive, or Health Care Power of Attorney. The admitting facility is not affiliated, or in partnership with COVA.

4. **ELECTRONIC PRESCRIBING**: I authorize SureScripts, an electronic prescribing network, to release my medication refill history to COVA for the purpose of continued treatment.

5. **RELEASE OF INFORMATION**: I authorize COVA to release healthcare information for purposes of treatment, payment or healthcare operations. Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under Worker's Compensation.

   If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim, or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, laboratory reports, operative reports, physician progress notes, physical therapy notes and consultations.

   Federal and state laws may permit this medical practice to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include, but not limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access by information; aggregating and comparing my information for quality

improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to blood borne diseases, such as HIV and AIDS.

6. **DISCLOSURE TO FAMILY AND FRIENDS**: I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

NAME	RELATIONSHIP	CONTACT NUMBER

7. **COMMUNICATION CONSENT and TELEPHONE CONSUMER PROTECTION ACT**: I agree that when I provide my landline or cell phone number(s) below, I am giving express consent for COVA and its associates, assignees, successors, and agents, to contact me at these numbers, or at any number that is later acquired for me and to leave live or pre-recordered messages on voicemail or to text, regarding scheduling or scheduled appointments, my services, or my bill. For greater efficiency calls or texts may be delivered by an auto-dialer. I realize that as a consequence of providing this consent, I may receive future calls or text messages that deliver pre-recorded messages by or on behalf of COVA. Charges from your carrier may apply. Providing a telephone or cell number is not a condition of receiving services.

   You may be contacted via voicemail or text to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health information. I consent to receiving healthcare communications at the phone number provided. This request to receive text messages applies to future communications unless I request a change in writing.

   Home Phone: _____ Cell Phone: _____

   OR

   ____ (initials) _____ I decline to receive communications via text

8. **NOTICE OF PRIVACY PRACTICES**: I acknowledge that I have received/reviewed COVA's Notice of Privacy Practices. I understand that I may contact the Privacy Officer if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

9. **AUTHORIZATION FOR RELEASE OF PRESCRIPTIONS**: I hereby authorize COVA Spine and Pain Center to release my prescriptions to the following in the event that I am unable to pick up my prescriptions.

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

I agree to the items as outlined in the Agreement,

Name (Print): _____

Signature: _____ Date: _____

Relationship to Patient (Self/Parent/Personal Representative):_____