Teddie Joe Snodgrass, Inc.
DBA: Snodgrass' Pain & Family Clinic

Patient Registration Form

Online Patient Portal Registration

Date: ________________________ Date of Birth: _________________________

Name: ____
Last First Middle

Address: ____

____
City State Zip Code

Social Security ________-______-__________ Sex: Male Female

Mobile: _____________________________ Home Phone: _________________________

Employer: ___________________________ Telephone # __________________________

Status: Married Single Divorced Separated Widowed

Spouse's Name: _________________________ Telephone # __________________________

Emergency Contact: ______________________ Telephone # __________________________

Primary Care Physician: __________________ Telephone # __________________________

Do you have any health insurance coverage? Yes No

If so, please give your insurance card to the receptionist, so we may obtain a copy for prior approvals and diagnostic studies performed outside of Snodgrass' Pain & Family Clinic.

How did you hear about us?

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Teddie Joe Snodgrass, Inc.
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Acknowledgment of Receipt of Privacy Notice
in Combination with Voluntary Consent Acknowledgment

As a patient of Snodgrass' Pain & Family Clinic, I have been provided with its Notice of Privacy Practices which describes how medical information about me may be used or disclosed and informs me of my individual privacy rights. I acknowledge that I have received the Notice of Privacy Practices and understand how medical information about me may be used, the duties of Snodgrass' Pain & Family Clinic, and my rights to privacy protection and access to my medical information.

Consent

I give consent for medical information about me to be used and disclosed for the purposes of treatment, legal, payment or health care operations. I understand that the privacy regulations allow Snodgrass' Pain & Family Clinic to use or disclose my medical information for these purposes and that my consent is not required. Snodgrass' Pain & Family Clinic is obtaining my consent to provide additional assurances regarding the privacy of my medical information. I understand that l have the right to make a request to revoke this consent and instead request a restriction on the use of my medical information at any time. I further understand that Snodgrass' Pain & Family Clinic may choose not to agree to the request for a restriction of the uses or disclosures of my medical information for purposes of treatment, legal, payment or health care operations.

____ ________________________

Signature of Patient or Representative Date

Consent for Care and Treatment

I, the undersigned, hereby agree and give my consent for Snodgrass' Pain & Family Clinic to furnish care and treatment considered necessary and proper in treating my condition. I understand that Snodgrass' Pain & Family Clinic may not be able to request prior authorizations for medications, referrals and diagnostic studies from some insurance carriers.

Authorization for Signature on File and Release of Information

I, the undersigned, hereby authorize the office of Snodgrass' Pain & Family Clinic to affix my name to any documents related to all health benefits due me. I authorize the release of any information relating to my health care claims. A photocopy of this authorization shall be valid as an original.

Financial Responsibilities

I certify that the information provided is correct. I understand that I am personally responsible to pay all charges for services rendered to me. I understand that Snodgrass' Pain & Family Clinic

does not accept or file any claims on my behalf for services rendered for pain management. Pain Management is payable in full at appointment with cash or credit card. I understand that I cannot file claims with Medicare and I may not be reimbursed by other commercial insurance carriers. I understand and agree that if it becomes necessary to commence legal action, I am responsible for all cost and money owed.

Cancellation Policy

I understand that New Patient Deposits are non-refundable. If I cannot keep my scheduled follow-up appointment, I will give Snodgrass' Pain & Family Clinic at least a 24-hour notice so I may reschedule my follow-up appointment and so that reserved time may be offered to another patient. There will be a charge of $50.00 for NO SHOW appointments, inability to pay at time of service or cancellations with less than 24-hour notification. I understand that I am responsible for any cancellation fee.

I have read and fully understand all the above information and hereby agree to comply as outlined above.

____ ______________________

Patient's Name (print) Date of Birth

____ ______________________

Signature of Patient or Representative Date

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Confidentiality Questionnaire

Please answer the following questions so that we may convey important information to you in the most efficient manner while still insuring confidentiality of any or all medical information.

Do you wish to allow certain family members (including your spouse and children) and or friends access to your medical information such as x-rays or lab reports, appointments, insurance matters, or your general medical condition? **YES** **NO**

If so, please list their names below. No information will be given to anyone whose name you have not listed below.

________________________________ _____________________
Name and Relationship Phone Number

________________________________ _____________________
Name and Relationship Phone Number

Do you have an answering machine/voicemail at home? **YES** **NO**

If so, may we leave confidential messages regarding things such as appointment changes and requests for you to call us back? **YES** **NO**

Do you have voicemail set up on your cell phone? **YES** **NO**

If not, we require that your voicemail box be setup so we will be able to leave confidential messages regarding things such as appointment changes and request for you to call us back.

________________________________ _____________________
Patient's Name (print) DOB

________________________________ _____________________
Patient's Signature Date

____
Witness

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SUMMARY OF NOTICE OF PRIVACY PRACTICES

The following information is a summary of the NOTICE OF PRIVACY PRACTICES, which is posted in the office in full text. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your medical information. We must provide you with a copy of this notice. We must follow the terms of this notice. If the notice is changed in any material way, a revised notice will be available upon request.

We will use your medical information for Treatment. For example, a therapist who is providing your care will report any changes in your condition to your doctor. We will use your medical information for Payment. For example, we may need to give your insurance plan information about your diagnosis, treatment and supplies used. We will use your medical information for Health Care Operation. For example, we may use your medical information to evaluate our services.

We may contact you at any phone number or address you have provided to remind you of an appointment or other health care matters or to obtain payment for our services. We may use and disclose your medical information to inform you of treatment alternatives or other health related benefits and services.

We may disclose your medical information to family members or others who are involved in your care or payment for that care.

We may use your medical information for any uses that are required or permitted by law.

Other uses and disclosures will be made only with your written authorization. You may cancel an authorization at any time by notifying us in writing.

You have the following rights: Right to privacy notice; Right to notice of nondiscrimination; Right to request restriction on uses and disclosures of your medical information; Right to receive confidential communications; Right to inspect and a copy of your medical information; Right to request an amendment to your medical information; Right to an interrupter; and Right to an accounting of disclosures of your medical information

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