8279 Fredericksburg Road
San Antonio, Texas 78229
Phone: (888) 398-0252
Fax: (888) 398-0272

Registration Forms

PATIENT INFORMATION

Patient Name Last:	First:	Middle Name:	
Street Address:	City:	State:	ZIP Code:
Home phone:	Work phone:	Mobile phone:	
Social Security:	Birth Date:	Age:	
Sex: ❑ M ❑ F	Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black ❑ Caucasian ❑ Pacific Islander ❑ Declined ❑ Other *(Please check one)*		
Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Declined *(Please check one)*	Language:		
Marital status: ❑ Divorced ❑ Married ❑ Separated ❑ Single ❑ Widowed	Home Email:		
Employer Name:	Occupation:		
Employer Address:	City:	State:	ZIP Code:
Emergency Contact Name:	Emergency Contact Number:		

INSURANCE INFORMATION

Is this patient covered by insurance? ❑ Yes ❑ No **(Please give your insurance card to the receptionist)**

Health Insurance Carrier

Primary Insurance Name:	
Insurance ID:	Group#:
Group Name:	
Insured Name:	
Insured SSN:	Insured DOB:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I hereby authorize National Interventional Pain Associates of America PLLC. Doctors and staffs to examine me and make such tests and perform such procedures as are reasonable and necessary for diagnosis of my condition and also consent to required treatment. Release of any medical information is necessary in the course of my examination or treatment and for the process of this claim.

ASSIGNMENT OF BENEFITS: I hereby authorize payment from any insurance company or governmental agency directly to National Interventional Pain Associates of America PLLC. for any benefits. I also authorize National Interventional Pain Associates of America PLLC. to release any medical information necessary to expedite such insurance claims. I hereby agree to pay co-payments, co-insurances, or deductibles that apply to my insurance plans. Also, I hereby agree to pay the entire or remaining amount of my fees if such fees are not covered or paid by my insurance benefits within 90 days of billing. I permit a copy of above to be used in place of original, which has been filed in the office of National Interventional Pain Associates of America PLLC. I also understand that National Interventional Pain Associates of America PLLC. is required by applicable federal and state law to maintain the privacy of my "Protected Health Information" (PHI). A notice about their privacy practices, legal duties and my rights concerning my "PHI" is on display and offered to me at the front office.

Patient/Guardian signature	*Print Name*	*Date*