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12499 University Ave Suite 280 Clive, Iowa 50325 P.515-245-6425 F.515-280-6954

**Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**First Middle Last**

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_**

**Sex: M / F Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: S M D W Social Security\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Phone( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Secondary( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I give permission to leave detailed messages on the following phone numbers regarding appointments and tests results. Primary Secondary Work**

**Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Declined**

**Ethnicity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Language\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Family Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance Information**

**Primary Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Subscriber Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Group\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Copay\_\_\_\_\_\_\_\_\_\_ Group \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOB\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Worker’s Comp Y/ N Date of Injury\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pending Litigation Y/N**

**Is today’s visit related to work comp or motor vehicle accident YES NO**

**HIPAA Communication**

**I give permission to the following person(s) to receive information from Medical Center Anesthesiologists, P.C, doing business as Pain Specialists of Iowa, P.C. and Mercy Medical Center regarding my medical care.**

**Name of friend or relative** **Relationship** **Phone Number**

1. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**This form of communication will be used as the standard until revoked in writing by the patient or his/her guardian.**

**Patient (guardian) Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# CANCELLATION POLICY/ “NO SHOW” POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment book.

**A $50 NO SHOW FEE WILL BE BILLED ON ALL FAILED APPOINTMENTS OR CANCELLATIONS WITHOUT 24HOUR NOTICE**

1. If an appointment is not cancelled at least 24hrs in advance you will be considered a “no-show”.
2. If two appointments are “no-showed” you will be given a reminder phone call.
3. If three appointments are “no-showed” in a three month time period no further appointments will be scheduled with any provider. Your referring physician will be notified as well.

# ACKNOWLEDGEMENT OF PRIVACY NOTICE

I acknowledge that I have received a copy of the Pain Specialists of Iowa Privacy Notice which summarizes some of the ways my protected health information may be used and disclosed

# PAYMENT AND BILLING POLICY

I acknowledge that I have reviewed a copy of the Pain Specialists of Iowa Payment and Billing Policy. I am aware that if I proceed with interventional treatment at Westlakes Surgery Center I will ***receive a statement from Medical Center Anesthesiologist and Pain Specialist of Iowa for physician services. I will also receive a statement from West Lakes Surgery Center, which will include charges for the use of the room, supplies or equipment during the visit***.

# MERCY ONE CENTER FOR PAIN MEDICINE AND MERCY NORTH ANKENY

# BILLING POLICY

Please be advised, there will be insurance payment differentials for all visit types between Pain Specialists of Iowa, Mercy One Center for Pain Medicine, and Mercy North Ankeny. Mercy One Pain and Mercy North are considered an OUTPATIENT HOSPITAL VISIT and not a standard office visit. This will result in a facility fee from the hospital that is not covered by commercial insurance plans. Any questions regarding your coverage will need to be directed to your insurance company regarding OUTPATIENT HOSPITAL VISITS vs OFFICE VISITS

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**(Signature of Patient)** **(Date Signed)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Personal representative of individual, If individual unable to sign) (Date Signed)**

All copies of office policies are available upon request