PATIENT INFORMATION

First Name: _____ Middle _____

Last Name: _____ Title _____

Address: _____

Zip Code: ☐☐☐☐☐ ☐☐☐☐ City: _____ State : _____

Home Phone: ☐☐☐ ☐☐☐ ☐☐☐☐ Cell Phone #: ☐☐☐ ☐☐☐ ☐☐☐☐

Office Phone: ☐☐☐ ☐☐☐ ☐☐☐☐ Contact #: ☐☐☐ ☐☐☐ ☐☐☐☐

SSN #: ☐☐☐ ☐☐ ☐☐☐☐ Date of Birth: Month ☐☐ Day ☐☐ Yr ☐☐☐☐

Marital Status ☐ Single ☐ Married ☐ Partner ☐ Significant Other ☐ Separated ☐ Divorced ☐ Widowed

Insurance: ☐ Commercial ☐ Medicare ☐ Medicaid ☐ Self Pay ☐ Worker's Comp ☐ MVA ☐ Personal Injury

Referred By: ☐ Physician _____ ☐ Self ☐ OR _____

Have you seen Dr. Kohrman before? ☐ Yes ☐ No ☐ When ? _____

Family Physician: _____ Where : _____

Employer: _____ Employed how long? _____

Address: _____

Zip Code: ☐☐☐☐☐ ☐☐☐☐ City: _____ State : _____

Primary Insurance: ☐ **Commercial** ☐ **Medicare** ☐ **Medicaid** ☐ **Self Pay** ☐ **Worker's Comp** ☐ **MVA**

Carrier Name: _____ Effective Date: ☐☐ Month ☐☐ Day ☐☐☐☐ Yr

Ins ID #: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Group #: ☐☐☐☐☐☐☐

Subscriber's Last Name: _____ First Name: _____ M.I.: _____

Relationship: ☐ Self ☐ Spouse Subscriber's Date of Birth ☐☐ Month ☐☐ Day ☐☐☐☐ Yr

Address: _____

Zip Code: ☐☐☐☐☐ ☐☐☐☐ City: _____ State : _____

Home Phone: ☐☐☐ ☐☐☐ ☐☐☐☐ Cell Phone #: ☐☐☐ ☐☐☐ ☐☐☐☐

Office Phone: ☐☐☐ ☐☐☐ ☐☐☐☐ Contact #: ☐☐☐ ☐☐☐ ☐☐☐☐

Subscriber's SSN #: ☐☐☐ ☐☐ ☐☐☐☐ Subscriber's Sex ☐ Male ☐ Female

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Secondary Insurance: ☐ **Commercial** ☐ **Medicare** ☐ **Medicaid** ☐ **Self Pay** ☐ **Worker's Comp** ☐ **MVA**

Carrier Name: _____ Effective Date: ☐☐ Month ☐☐ Day ☐☐☐☐ Yr

Ins ID #: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Group #: ☐☐☐☐☐☐☐

Subscriber's Last Name: _____ First Name: _____ M.I.: _____

Relationship: ☐ Self ☐ Spouse Subscriber's Date of Birth ☐☐ Month ☐☐ Day ☐☐☐☐ Yr

Address: _____

Zip Code: ☐☐☐☐☐ ☐☐☐☐ City: _____ State : _____

Home Phone: ☐☐☐ ☐☐☐ ☐☐☐☐ Cell Phone #: ☐☐☐ ☐☐☐ ☐☐☐☐

Office Phone: ☐☐☐ ☐☐☐ ☐☐☐☐ Contact #: ☐☐☐ ☐☐☐ ☐☐☐☐

Subscriber's SSN #: ☐☐☐ ☐☐ ☐☐☐☐ Subscriber's Sex ☐ Male ☐ Female

WHAT PHARMACY DO YOU GO TO?

Name: _____

Address: _____

Zip Code: ☐☐☐☐☐ ☐☐☐☐ City: _____ State : _____

Phone #: ☐☐☐ ☐☐☐ ☐☐☐☐ Fax #: ☐☐☐ ☐☐☐ ☐☐☐☐

WHAT MAIL-IN PHARMACY DO YOU GO USE? Do they have a 90 day supply? ☐ Yes ☐ No ☐ Maybe

Name: _____

Address: _____

Zip Code: ☐☐☐☐☐ ☐☐☐☐ City: _____ State : _____

Phone #: ☐☐☐ ☐☐☐ ☐☐☐☐ Fax #: ☐☐☐ ☐☐☐ ☐☐☐☐

AUTHORIZATION & ASSIGNMENT

Unless you have provided insurance information, you are responsible for payment of services when rendered.
Patients who carry Medical / Surgical Insurance should remember that Professional Services (Physician's Fees) are charges to You (or the patient) and not to the Insurance Company. Each Insurance Company has it's own policy or policies concerning payment of services. Some pay fixed allowances for certain procedures and others pay a percentage of the charge. There are no standard Usual Customary and Reasonable (UCR) charges that all of the Insurance Companies follow. It is your responsibility to know what your policy covers. *It is your responsibility to pay any deductible amount, co-pay amount, or any other balance not paid for by your Insurance Policy / Company.*

If this amount is assigned to a Collection Agency and / or it's Attorney for collection and / or suit, Southern Pain and Rehab, LLC / Dr. Kohrman shall be entitled to reasonable fees and the cost of collection.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment will be considered as valid as the original.

ALL PATIENTS (COMMERCIAL INSURANCE, MEDICAID, MEDIGAP, WORKER'S COMP, MVA)

I request that payment of authorized Insurance Benefits be made either to me or on by behalf to Southern Pain and Rehab, LLC /Dr. Kohrman for any services furnished to me by that physician.
I authorize release to my Insurance Company and it's agents any medical information about me needed to determine the payments for related services.

Signature: _____ **Date** ☐☐ Month ☐☐ Day ☐☐☐☐ Yr

First Name: _____ **Last Name:** _____

MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare Benefits be made either to me or on by behalf to Southern Pain and Rehab, LLC / Dr. Kohrman for any services furnished to me by that physician.
I authorize release to the Centers for Medicare and Medicaid Services and it's agents any medical information about me needed to determine the payments for related services.

Signature: _____ **Date** ☐☐ Month ☐☐ Day ☐☐☐☐ Yr

First Name: _____ **Last Name:** _____

AKNOWLEDGEMENT OF NOTICE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

Signature: _____ **Date** ☐☐ Month ☐☐ Day ☐☐☐☐ Yr

First Name: _____ **Last Name:** _____