PCT
PAIN CONSULTANTS OF TEXAS
Phone: (956) 727-7246 PAIN
Fax: (956) 728-8827
Eliel Nataki M.D.
Pain Medicine Specialist

Patient Registration Form

Name:_____ Date of Birth:_____

Home Address:_____ City: _____ State:_____Zip Code:_____

Home Phone #:_____ Cell Phone #:_____

Social Security # :_____ Social Security # :_____

Employer Name:_____ Employer Number #:_____

Emergency Contact:

Name:_____ Phone #:_____ Relation:_____

Name:_____ Phone #:_____ Relation:_____

Insurance Policy Holder Information:

Name:_____ Insurance Name:_____

Date of Birth:_____ Relation:_____

Address:_____ City:_____ State:____ Zip Code:_____

ID #:_____ Group #:_____ Phone #:_____

I have read all the information and have truthfully completed the above information. I certify that this information is true and correct to the best of my knowledge. I will notify Pain Consultants of Texas of any changes to the above information. Pain Consultants of Texas will submit claims to my insurance on my behalf, however if any reason payment in not issued, I understand that I am fully liable for all remaining balances. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.

_____ _____

Signature. Date.

Phone: (956) 727-7246 PAIN

PCT
PAIN CONSULTANTS OF TEXAS

Fax: (956) 728-8827

Eliel Nataki M.D.
Pain Medicine Specialist

Medical Release Form

I, _____. (date of birth)_____, authorize and agree for _____ to release all of my medical information pertaining to my healthcare, advice and/or treatment to Pain Consultants of Texas.

Please include the following medical information if applicable:

- Physician's progress notes
- Lab reports
- Radiology reports (e.g. MRIs, CTs and X-Rays)

Please fax the records to (956) 728-8827 or mail them to:

Pain Consultants of Texas
6801 McPherson Rd Ste. #334
Laredo TX. 78041

For further information, please call (956) 727-7276

_____ _____

Patient's signature. Date.

Phone: (956) 727-7246 PAIN

PCT
PAIN CONSULTANTS OF TEXAS

Fax: (956) 728-8827

Eliel Nataki M.D.
Pain Medicine Specialist

CONSENT TO TREATMENT & FINANCIAL RESPONSABILITY.

1, _____. Consent to treatment at PAIN CONSULTANTS OF TEXAS, And I'm understand that I may discontinue treatment at any time.

I understand that in order to receive appropriate treatment, I will undergo a clinical evaluation consisting of, but not limited to, a medical history and evaluation, and may include an X-Ray, MRI, Physical Therapy evaluation, physical capacities evaluation, and psychological assessment. The purpose of the evaluation is top assist top identifying the cause of my problem and applying the most effective medical treatment possible.

I understand the facility fees of the center. services provided by physical therapist and psychologist, x-rays, interpretation of x-rays and laboratory investigations are separate from physician's fees.

1. I consent to being photographed for identification.
2. As part of the medical procedures or tests, I understand that I may be tested for H.I.V
3. Guarantee of payment: I agree to be responsible to the center of charges resulting from services and supplies rendered at its prevailing rates. unless I qualify for a discount. I agree all bills are due in full upon demand. Should I fail to honor this agreement , I agree to pay any collection cost or attorney fees resulting from the collection of my accounts. No granting of extension, indulgences or forbearances to the patient or any responsible party and no delays or lack of diligence on the part of the center in enforcing any rights than one person this obligation shall be joint and several.
4. Assignment of benefits other than (Medicare and Medicaid)
5. I hereby assign all right and privileges and authorize payment directly to the center for any claim files on my behalf or on the behalf of the person for whom I am duly authorized to sign for insurance benefits. I agree this assignment primary to any assignments given after this date including any cost relative top attorney fees. I also understand that I am financially responsible for the center for co-pays, deductibles, co-insurances, and charges no covered by this assignment or by my insurance plan or not paid on timely basis by the insurance company.
6. Assignment of benefits (Medicare and Medicaid): I request that payment of authorized Medicare and /or Medicaid benefits be made to the center or on my behalf for any services or supplies furnished by the center, including physician services. I authorize any holder of medical or other information about me to release it to the center for Medicare or Medicaid services and its agents, as appropriate, any information need it to determine those benefits for related services. I understand that I am responsible for any coinsurance, unmet deductibles, and services and items no covered, by Medicare and /or Medicaid.
7. The assignment of benefits is intended to grant the center all rights that I may have in connection with benefits or other rights, under ERIS, any play documents applicable to me, or applicable laws or regulations, including Medicare and Medicaid, associated with the services to the same extent, and to the fullest extent that I would be entitled or have the power to exercise such rights on my own behalf or on behalf of my covered dependents.
8. I give my consent for the phone numbers listed to be used to contact me. If direct contact is noted made with me, I consent for a message to be left with either an answering machine or whoever answers the phone.

Home: _____ Work:_____ Cell:_____

Phone: (956) 727-7246 PAIN

PCT
PAIN CONSULTANTS OF TEXAS

Fax: (956) 728-8827

Eliel Nataki M.D.
Pain Medicine Specialist

I herby authorize all professional staff to release any information acquired in the course of examination and treatment to: (1) referring physician, (2) insurance company, (3) workers compensation carrier , (4) the center's attorney's and consultants in accordance with applicable privacy laws.

I have read the foregoing and I understand it. Any question that have arised or occurred to me have been answered to my satisfactions.

Date:_____ Patient's Signature:_____

Whitness: _____ Insured Signature:_____