Phone: (956) 727-7246 PAIN

Fax: (956) 728-8827

Eliel Nataki M.D.

*Pain Medicine Specialist*

## Formulario de Registro del Paciente

Nombre: ______________________________________________

Fecha De Nacimento: ____________________ Seguro Social #:____________________

Direccion: ________________________________________ Codigo Postal:________________

Numero De Casa#: ________________________ Numero Celular#: ____________________

Numero de Trabajo#: ______________________ Numero De Licencia #____________________

Contacto de emergencia:

Nombre: ___________________________________ Telefono#: ________________

Relacion: ___________________________

### Titular de la Poliza Seguro

Nombre: ______________________________________________

Fecha De Nacimento: ________________________ Relacion: ________________________

Dirrecion: ______________________________________________

Numero De Telefono#: _____________________________________

He leido toda la informacion I se ha completado con sinceridad la informacion anterior. I Certifico que este informacion es verdadera I correcta a lo mejor de me conocimiento. I le notificare a Pain Consultants of Texas, de cualquier cambio de lo anterior. PCT presentara reclamaciones a mi seguro de mi parte, din embargo sip or cualquier razon el pago no es problema, yo entiendo que soy plenamente responsible de todos los saldos restantes. Yo entiendo y estoy de acuerod en que a pesar de mi estado de seguro, soy el/la responsible por el saldo de mi cuenta por los servicios profesionales prestados.

______________________________________ ______________________

Firma: Fecha:

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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

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## CONSENT TO TREATMENT & FINANCIAL RESPONSIBILITY

I, ________________________________. Consent to treatment at PAIN CONSULTANTS OF TEXAS,

And I 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 a psychological assessment. The purpose of the evaluation is to assist in identifying the cause of my problem and applying the most effective medical treatments possible.

I understand that facility fees of the center, services provided by physical therapists and psychologist, x-ray, 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 chargers 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 benefit other than( Medicare and Medicaid)
5. I hereby assign all rights 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 to attorney fees. I also understand that I am financially responsible for the center for co-pays, deductibles, co-insurances, and charges not covered by this assignment or by my insurance plan or not paid on a 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 and Medicaid services

and its agents, as appropriate, any information needed to determine these benefits or benefits for related services. I understand that I am responsible for any coinsurance, unmet deductibles, and services and items not 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 dependants.
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:

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 questions that have arisen or occurred to me have been answered to my satisfactions.

Date: ______________________________ Patient's Signature: ____________________________

Witness: ____________________________ Insured Signature: _____________________________