Interventional Pain Physicians
Of South Florida

Nancy Erickson, D.O.

PATIENT INFORMATION

Today's Date: _____

Patient's Name: _____ D.O.B.:_____

Last First Middle

Street Address: _____ Apt. #: _____

City/State/Zip Code: _____

Home Phone #: _____ Work Phone #: _____

Please check if we may leave a message on your answering machine ☐ Yes ☒ No

Driver's License #: _____ State: _____

Sex: ☐ Female ☐ Male Marital Status: ☒ Single ☐ Married ☐ Divorced ☐ Widowed ☐ SO

Spouse's Name: _____ Spouse's Work #: _____

Your Employer: _____Employer's Address: _____

City/State/Zip Code: _____Employer's Phone #: _____ Position: _____

Next of Kin: _____ Relationship: _____Home Phone #: _____

Person to Notify in Emergency: _____ Relationship: _____Home Phone #: _____

Responsible Party's Name: _____Relationship to Patient: _____

Prescription Coverage: _____BIN #_____PCN:_____ Rx ID #_____ RxGR: _____

Referred By: _____ Phone #: _____

Primary Care Physician's Name:_____Phone #:_____Fax #_____

I, _____, authorize Interventional Rehabilitation of South Florida to release or discuss information related to my medical condition (including information related to my treatment plan, test results, medical information and billing information) to the following named persons*:

_____

ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I AUTHORIZE: The release of any medical information that is needed for submission to my insurance carrier in order to process a claim for utilization review or quality assurance activities.

I ASSIGN: All medical and/or surgical benefits including major medical benefits to which I am entitled to

A photocopy of this authorization shall be considered as effective and valid as the original.

I AGREE: To accept responsibility for any balance remaining after insurance pays or, if an HMO participant, any appropriate co-payment, deductible, or non-covered. If I do not have insurance coverage, I agree to adhere to payment arrangements made at the time of my appointment, and to be responsible for any legal fees, costs, and expenses incurred by

_____Dr. Nancy Erickson_____
Name of Physician or Group

In the pursuit of the collection of fees due to them for services provided. I understand that this form or a copy thereof is valid for twelve months.

_____ _____
Patient/Subscriber Signature Date