Dr. Miller • Dr. Patel • Dr. Bansal • Dr. Goodman • Dr. Chakravarthy

Coastal Pain & Spinal Diagnostics Medical Group, Inc.

6221 Metropolitan St., Suites 100/201 Carlsbad, CA 92009 • Phone (760) 753-7127 • Fax 760-334-0399 2020 Camino Del Rio N., Ste. 805, San Diego, CA 92108 • www.CoastalPainGroup.com

NEW Patient Registration and Lien

Patient Legal Name____ DOB _____________ Sex ___________

Address ____ City ________________ State _____ Zip _________

Primary Phone #: ______________________________ Email: ____

Attorney: _______________________________________ Attorney Phone # ____________________________

I authorize Coastal Pain & Spinal Diagnostics Medical Group, Inc. to perform or cause to have performed such examinations and/ or tests and to render such treatment and prescribe such medication. I understand that treatment rendered by Coastal Pain & Spinal Diagnostics Medical Group, Inc. is under the discretion of their providers and their professional skills to assist with recovery but such recovery cannot be guaranteed, and that such physician/ physician assistant cannot be responsible for the normal risk attending medical test or treatment.

I further authorize and direct my physician/ physician assistant to furnish my attorney with detailed medical reports concerning my injuries and an itemed statement of charges incurred as a result of my accident.

I further authorize and instruct my attorney to withhold my share of the proceeds of any settlement of recovery, to pay directly to my physician such sum as may be due and owing said doctor for all medical services rendered to me, either by reason of the above accident or otherwise. Said physician is granted a lien on my client, suit or recovery for said sum.

I understand that I remain directly responsible to said doctor for his fees for medical services rendered to me, and that my obligation to pay medical fees is not contingent upon receipt of any settlement or recovery from the parties responsible for the above accident.

I waive the Statue of Limitations regarding Coastal Pain & Spinal Diagnostics Medical Group, Inc. right to recover.

SIGN:____DATE:________________________

Please fill out both sides of this form →

AUTHORIZATION OF RELEASE OF HEALTH CARE INFORMATION

By signing below, I authorize release the following my medical records listed below to Coastal Pain & Spinal Diagnostics Medical Group, Inc. as part of my continuity of care. **Records:** I authorize the release of my medical records including but not limited to: Complete Medical Records, Imaging Reports, Laboratory Reports, Hospital Records, Prescription Data, Other Consultation Notes, Office/Progress Notes, Surgical Reports, Billing Records, Records related to treatment of mental illness, Records related to alcohol or substance abuse as well as those regarding infectious diseases. **Term**: This authorization will remain in effect for one (1) year from the date this authorization is signed. Refusal to sign/right to revoke: I understand that I may refuse to sign or may revoke (at any time) this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my healthcare provider. A photocopy, fax of electronic copy of this authorization shall be considered as effective and as valid as the original.
RECORD HOLDER INFO:

NAME:______________________________________DATE OF BIRTH:__________________________

SIGN:_______________________________________DATE:___________________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been given access to read the Notice of Privacy Practices of Coastal Pain & Spinal Diagnostics Medical Group, Inc. and all affiliate providers. I also have been made aware that I can receive a copy of the Notice of Privacy Practices upon my request. This notice describes how Coastal Pain & Spinal Diagnostics Medical Group, Inc. and all affiliate providers may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information. Our Notice of Privacy Practices is subject to change. If we change our Notice, you may obtain a copy of the revised notice by accessing our website, www.coastalpaingroup.com, or by contacting any staff person involved in your care.

SIGN:_______________________________________DATE:___________________________________

OPEN PAYMENT DATABASE

The Open Payments Search Tool is used to search payments made by drug and medical device companies to physicians, physician assistants, advanced practice nurses and teaching hospitals. By signing, I acknowledge and understand I may access this tool by visiting https://openpaymentsdata.cms.gov/

SIGN:_______________________________________DATE:___________________________________

Please fill out both sides of this form →