Nathan Miller, MD | Yogesh Patel, MD | Ankush Bansal, MD | Evan Goodman, MD

Coastal Pain & Spinal Diagnostics

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

Appointment Date: _____

Check-in time: _____

Physician: _____

Dear Sir or Madam,

Welcome to Coastal Pain & Spinal Diagnostics Medical Group. We thank you for choosing us to assist with your pain management.

Enclosed you will find several forms which we require you to complete prior to your first appointment. If any part of the form(s) is unclear or is not applicable to you, please leave it blank and be sure to ask us about it upon check in. Your physician will use your initial questionnaire as a guide at your first visit to direct your future care.

To maintain a high quality of care, clear communication between you and your physician is required. The enclosed forms are an important part of our communication therefore we do request that each form be completed prior to your initial appointment. Please be aware that incomplete forms could result in the delay of your appointment or possibly cause your appointment to be rescheduled. If you should have any questions, please contact our New Patient Coordinator (760-753-7127 ext. 1306).

We request that you bring the bottles of **ALL** your current medications to your appointment. The enclosed medication list will also need to be completed by you, listing your current medication(s) and medications that you have taken in the last 6 months.

Please make sure you bring all pertinent MRI's, CT's, X-rays and other radiology films to your first visit. You can obtain these films at the facility where the test was performed. We will send the films back with you after the visit. If you are having any trouble securing your films, please check with our office staff for assistance.

Lastly, your physician may utilize his physician assistant to assist him with your care and treatment here at Coastal Pain & Spinal Diagnostics. Please be assured that your physician and the physician assistants work closely together to assure excellent pain management care.

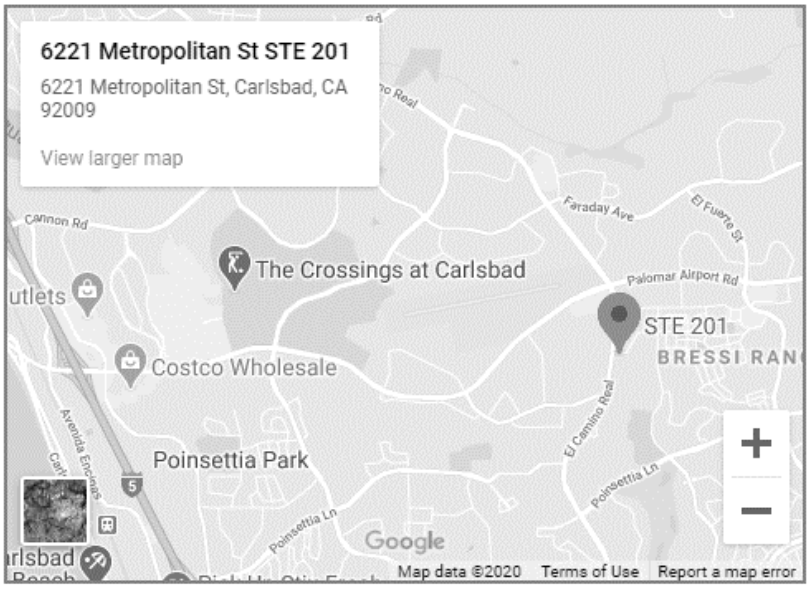
We look forward to meeting with you, and thank you again for choosing Coastal Pain.

Coastal Pain &
Spinal Diagnostics

DIRECTIONS TO CARLSBAD LOCATION

- **From Interstate 5**
- Exit Palomar Airport Road, head East (Inland)
- Right (South) onto El Camino Real
- Left at Town Garden Road (2nd light)
- Take the first right onto Metropolitan Street
- Enter into the Bressi Ranch Medical Plaza on your right

- **From San Marcos**
- San Marcos Blvd turns into Palomar Airport Road, continue West on Palomar Airport Road
- Turn Left (South) on to El Camino Real
- Left at Town Garden Road (2nd light once on El Camino Real)
- Take the first Right onto Metropolitan Street
- Enter into the Bressi Ranch Medical Plaza on your right



Mission Valley Location

DIRECTIONS TO MISSION VALLEY LOCATION

- From I-8 East towards El Centro keep right- take auto Circle Ramp towards Mission Center Road/Art Institute
- Turn Left onto Auto Circle
- Stay Straight on Mission Center Road
- Turn Right onto Camino De La Reina
- Turn Right into Plaza 2020
- Office on 8th floor inside building

Coastal Pain &
Spinal Diagnostics

Registration

Patient Legal Name_____D.O. B _____ Sex_____

Email _____ ☐ Yes, I would like to access to the online patient portal

SS#_____Marital Status_____Phone _____ Cell _____

Emergency Contact_____Phone _____Relationship _____

Current Employer_____Occupation_____

Spouse Name_____Spouse Employer_____

Referring Physician_____Phone #_____

Primary Care Physician_____Phone #_____

Primary Insurance_____Phone # _____ID#_____

Subscriber Name_____Subscriber SS#_____Subscriber DOB _____Group # _____

Secondary Insurance_____Phone # _____ID#_____

Subscriber Name_____Subscriber SS#_____Subscriber DOB _____Group # _____

Work Comp Carrier Name_____Phone # _____
Claims Address_____City_____State_____Zip_____
Claim # _____DOI _____Primary Treating Physician _____

Type of Injury _____Adjuster _____Phone # _____

Employer at time of injury _____Phone #_____ Attorney Phone #_____

I understand that patients with medical insurance professional services are rendered and charged to the patient, not the insurance company. In the event insurance payments are received directly by me for services rendered that have not been paid for, I commit to immediately sign over and forward those payments to the doctor. I accept financial responsibility for all charges incurred. If my account is referred for outside collection, I may be charged a service charge. If a legal settlement occurs on my behalf (i.e. PI Claim) for services rendered by Coastal Pain & Spinal Diagnostics Medical Group, Inc. and a refund is requested by my private insurance carriers(s), I acknowledge and understand that I hold full financial responsibility for all billed charges during the affected service date(s).

AUTHORIZATION: I hereby authorize payment directly to Coastal Pain & Spinal Diagnostics Medical Group, Inc for medical services rendered and to release any information acquired during my examination or treatment to my insurance company and/or referring entity. I also acknowledge and understand that I am solely responsible for keeping my account current and accurate at all times with Coastal Pain & Spinal Diagnostics Medical Group, Inc which includes demographics, insurance information and balances due. Failure to notify Coastal Pain & Spinal Diagnostics Medical Group of updates to account may result in being financially responsible for all services rendered.

Patient's / Guardian's Signature_____Date _____

Witness if signed by someone other than patient _____

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Authorization for Release/Request of Health Information

Patient Name: _____ Date of Birth: ____/_____/_____

Authorization for use of Health information *(Select one of the following)*

☐ I authorize the record holder named below to release my health records to **Coastal Pain & Spinal Diagnostics Medical Group, Inc.** during the term of this authorization.
Mail to: 6221 Metropolitan Street, Suite 201, Carlsbad, CA 92208 or Fax to: (760) 334-0399

☐ I authorize Coastal Pain & Spinal Diagnostics Medical Group, Inc. to release my records to the provider/group/person (circle one) listed below during the tern of this authorization

Current Records Holder or Requestor of Records:

Name: _____ Tel. (____) _____ Fax (____) _____

Address: _____ State _____ Zip Code _____

This authorization permits the above-named healthcare provider to disclose/request the following medical records:

☐ All of my information that the provider has in his/her possession, including information relating to any and all medical history, mental or physical condition and any treatment received by me, including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes and other mental health information, drug, alcohol or other controlled substance information, billing information, correspondence, and records from my other healthcare providers that the above named healthcare providers may hold.

☐ All my health information described above except the following _____
_____

☐ Only the following records or types of health information (insert dates of treatment, types of treatment or other designation):
_____

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.
Revocation: I understand that the authorization will remain in effect until the term of this authorization expires or I provide a written notice of revocation to my healthcare provider at my healthcare provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my healthcare provider in reliance on this authorization before it received my written notice of revocation.
Questions: I may contact my provider's office for answers to my questions about the privacy of my health information. I understand that I have the right to receive a copy of this authorization from my healthcare provider.
Photocopy: A photocopy, fax of electronic copy of this authorization shall be considered as effective and as valid as the original.

Print Name: _____ Sign _____ Date: _____

Witness Name: _____ Sign _____ Date: _____

If individual is unable to sign this authorization please complete the following

Signature of personal representative _____Relationship: _____Date: _____

Witness Name: _____ Sign _____ Date: _____

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Designation of Personal Representative

I _____ give my full permission to Coastal Pain & Spinal Diagnostics Medical Group, Inc. to disclose details of my billing records, medical records and to discuss my treatment/care either verbally or in written form with the designated person listed below

I authorize _____

Relationship to patient: _____ Tel: _____

I understand that I can revoke this authorization at any given point by contacting **Coastal Pain & Spinal Diagnostics Medical Group, Inc.**

Patient Signature: _____ Date: _____

☐ **Check this box only if you DECLINE authorizing an individual.** Your billing records, medical records, and medical treatment/care will only be released to you.

Internal Use Only

Patient has elected to revoke this authorization as of _____
Date

Patient spoke with _____

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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.

_____ _____
Signature of Patient or Responsible Party Date

_____
Printed Name

Coastal Pain & Spinal Diagnostics

Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to delivering outstanding healthcare. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment of services is a part of that relationship. The following is a summary of our payment policy, which we require you to read and sign prior to any treatment.

We accept **Debit, Cash and Checks**

INSURANCE CLAIMS

We will bill all medical insurance companies as a courtesy to you at no additional charge. We do collect any deductible, copayments or past due balances prior to treatment. **You are responsible for knowing your insurance benefits, deductibles and exclusion(s) of your policy.**

Failure to provide our office with accurate and complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination for your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of our usual and customary charges not covered by insurance.

SELF-PAY ACCOUNTS

If you do not have medical insurance, payment for all professional services is expected at the time of your visit. If you pay the charges in full on the day of the service, you will be eligible for our timely payment discount rate. Partial payments or payments made after the date of service will be subject to our full usual and customary rates. All quoted fees may be subject to change after 30 days. **The flat rate only covers standard office visits, injections, procedures or labs will be charged extra.**

MISSED APPOINTMENTS

Failure to cancel a scheduled appointment 24 hours in advance and not showing up for a scheduled appointment will result in a $50 **NO SHOW** fee. Arriving over 10 minutes late to a visit may result in rescheduling your visit and will also result in a $50 No Show Fee. Please help us serve you better by keeping scheduled appointments.

PAST DUE ACCOUNTS

All patient-responsible balances that remain delinquent after 120 days, with no response from our requests for payment, may be referred to a collection agency. Once an account is turned over to the collection agency, the patient or responsible party will need to settle the debt with the agency prior to scheduling any further treatment.

I understand that I am financially responsible for all charges whether paid by insurance or not. Payment is due and payable at the time services are rendered unless prior arrangements have been made with a billing coordinator. All returned checks are subject to a $25 return check fee. Check writing privileges will be revoked and all future payments will be accepted as cash, credit card or money order.

I authorize and request my insurance company to pay all claims directly to Coastal Pain & Spinal Diagnostics and will relinquish any payments assigned to me to Coastal Pain. I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I have read and understand this Financial Policy and by signing below, agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____ _____

Signature of Patient or Responsible Party Date

_____

Printed Name