Advanced Pain Treatment Center
INNOVATIVE HELP FOR MANAGING YOUR PAIN

Pragya B. Gupta, M.D. F.R.C.S. (Edin), D.A.B.P.M.
Michael Danko, M.D.
Christopher M. Middendorf, D.O.

www.aptcmd.com

Patient Registration

Referring Dr.:_____ Referring Dr. Phone:_____

Referring Dr. Address: _____ City/State: _____ Zip: _____

Primary Care Dr (if different than above):_____

Patient Information

Name: _____ Date of Birth: _____ Age: _____
LAST FIRST MI
Social Security No.: _____ Sex: (Circle One) F M Marital Status: (Circle One) S M D W

Address: _____ City/State: _____ Zip: _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Employer/School: _____ Occupation: _____

Emergency Contact: _____ Relation: _____ Phone:(_____) _____-_____

Injury Information

Is your injury due to: (Circle One) Work Related Auto Accident Other Accident Gradual Sports Chronic

Date of Onset: _____ How did injury occur? _____

Area to be treated: _____

Are you off work due to injury? (Circle One) Yes No If YES, first date missed: _____

Insurance Information

Primary Insurance

Insurance Name: _____

Address: _____

City/State: _____ Zip: _____

Phone: (_____)_____-_____

Policy No: _____ Group No.: _____

Subscriber Name: _____

Subscriber Social Sec No: _____

Date of Birth: _____ Employer:_____

Insurance Deductible: _____

Secondary Insurance

Insurance Name: _____

Address: _____

City/State: _____ Zip: _____

Phone: (_____)_____-_____

Policy No: _____ Group No.: _____

Subscriber Name: _____

Subscriber Social Sec No: _____

Date of Birth: _____Employer:_____

Insurance Deductible: _____

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Workers Comp/Automobile Insurance

Claim No.:_____ Insurance Carrier: _____

Address: _____ City/State: _____ Zip: _____

Phone: (_____) _____-_____ Fax: (_____) _____-_____ Contact Person: _____

Injury Occurred In: (Circle One) Kentucky Ohio Indiana Other

Release of information and Financial Responsibilities:

All personal and medical information given by the patient to the clinic will be strictly considered confidential. However, the undersigned authorizes the clinic to release information to the insurance providers, third party payers, clinic personnel, physicians, or any medical staff for continuation or further treatment of the patient. The authorization includes the release of all relevant information, including but not limited to, medical documents, reports, psychological profile, etc. By signing this document, the patient confirms their understanding of the above-mentioned statement and is in agreement with it.

I understand that insurance is a method of reimbursing the patient of the fees paid to the doctors and is not a substitute for payment. It is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance. If this account is assigned to a collection agency or attorney for suit, the practice shall be entitled to reasonable attorney's fees and collection costs. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request the payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled, including Medicare, private insurance, and other health plans to the treatment center. This assignment will be in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not they are paid by my insurance.

Cancellation/No Show Policy

I understand that Advanced Pain Treatment Center has a Cancellation/No Show policy. I must give 24 hours notice before canceling a new patient or follow up appointment and 48 hours notice before canceling a procedure appointment. I understand that if I do not give proper notice of cancellation I will be subject to a fee of $50 for a new patient or follow up appointment and $200 for a procedure appointment. This fee covers administrative and operational costs. Any exceptions to this policy will be at the discretion of the administration. I understand this fee is not reimbursed by insurance and is solely the responsibility of the patient.

_____ _____

Signature of Patient/Guardian Date

IN ORDER TO CONTROL YOUR COST OF BILLING WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE TIME OF SERVICE. THANK YOU FOR YOUR COOPERATION.

EDGEWOOD OFFICE: 162 Barnwood Drive, Edgewood, KY 41017
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Email: info@aptcmd.com

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Phone: 513.492.9317 • Fax: 513.492.9325
Email: info@aptcmd.com