The entire staff at Atlantic Pain Management Specialists is committed to providing you excellent health care. Therefore, it is necessary that you read, complete and sign off on the following information. PLEASE PRINT CLEARLY

Last Name:_____ First Name: _____Initial: _____

DOB (MM/DD/YY): _____SSN: _____

Who Referred you to us ? _____ Phone #: _____

Reason for today's visit: _____

Is this due to an injury ? (circle) YES No Area of injury: _____

If YES, what was the date and place of injury? _____

Was this a motor vehicle accident? (circle) YES NO Was this a work related injury? (circle) YES NO

Do you currently have an attorney? (circle) YES NO If YES what is Attorney's name? _____

CONSENT FOR TREATMENT: I authorize Dr. Anthony Paglia, M.D. P.A. to perform such examination, treatments, laboratory tests and to administer such medications as, in his opinion, are necessary or advisable for me. I also acknowledge that no guarantee or assurance have been made in regards to the results of treatment.

INSURANCE AUTHORIZATION: I understand it is my responsibility to provide a referral/authorization for each visit for all services rendered. I acknowledge that I am personally responsible and liable for full payment of all non-covered services, and all medical or surgical fees billed by Dr. Anthony Paglia, M.D. P.A. Should Dr. Anthony Paglia, M.D. P.A. accept payment by direct assignment from Medicare or any other insurance company, I understand that I am responsible and liable for any and all deductible expenses and "co-insurance" not covered by Medicare or my primary insurance company. I authorize any holder of medical and other information about me to release to Medicare and its agents, any insurance company, and other third party payer, state medical assistance agency, or any other governmental or private payer responsible of paying such services. I authorize a copy of this authorization to be used in place of the original.

I hereby authorize my insurance company to pay directly to Dr. Anthony Paglia, M.D. P.A. any and all medical and/or surgical benefits otherwise payable to me for his professional services.

It is my responsibility to notify the physician's office of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by my health care insurer if the submitted claims or any part of them are denied for payment. I also agree to pay all reasonable and customary collection fees and/or attorney's fees that may be incurred due to any delinquent accounts I may have. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services received.

Signed By _____ _____ _____

Signature of Patient Or Legal Guardian **Date** **Relationship to Patient**

_____ _____

Print Patient's Name **Print Name of Legal Guardian, if applicable**

PLEASE NOTE: You Must Produce your Insurance Card to Front Desk at Every Visit

ATLANTIC PAIN MANAGEMENT SPECIALISTS
21110 Biscayne Blvd. Suite 205 Aventura, Florida 33180