MRHS™

COMPREHENSIVE SPINE AND PAIN CENTER

295 Madison Avenue, Suite 407 NY, NY 10017

LAST NAME ______________________ FIRST NAME ______________ DOB______/_____/________

SS#______________ Marital Status: M___S___D__W___ EMAIL: ______________________________

ADDRESS______________________________ APT#_______ CITY______________ STATE______ ZIP________

HOME PHONE________________ MOBILE_______________ WORK______________________

EMERGENCY CONTACT______________ PHONE___________ RELATIONSHIP______________________

REFERRING PHYSICIAN__________________ REFFERED BY____________________________

PATIENT PHARMACY/LOCATION________________________ SEX M F Oher (Please Specify)____________

RACE__________________ ETHNICITY_______________ PRIMARY LANGAUGE ________________

PRIVATE INSURANCE INFORMATION

INSURANCE COMPANY____________________ ADDRESS________________________________

CITY________________ STATE_____________ ZIP___________ PHONE_______________

NAME OF INSURED____________________ RELATIONSHIP TO INSURED__________________________

MEMBER ID ______________________ GROUP NUMBER____________________________

PRIMARY CARE PHYSICIAN NAME____________________________ PHONE____________________

Assignment of Benefits

As a courtesy to the patient and their families, Tim Canty M.D., NYAA and Interventional Spinal Pain does submit claims to many third party payers. I request that payment of authorized Medicare or private or private benefits to be made to Tim Canty M.D., NYAA and Interventional Spinal Pain for any covered services furnished by Tim Canty M.D., NYAA and Interventional Spinal Pain does If my insurance carrier pays me directly, I agree to forward agree to forward any such funds to Tim Canty M.D., NYAA and Interventional Spinal Pain within 10 days.

Disclosure of Information

I understand that my medical records and billing information are made and retained by retained by Tim Canty M.D., NYAA and Interventional Spinal Pain and are accessible to Tim Canty M.D., NYAA and Interventional Spinal Pain personnel, who may use disclosure medical information for Tim Canty M.D., NYAA and Interventional Spinal Pain operations and functions and share with any other health and care personnel involved in my continuum of care for this treatment course.

Release of Records

I authorized Tim Canty M.D., PLLC to release any governmental health care program and its agents, or to any private insurance company or its agents any information to determine my benefits payable to Tim Canty M.D., NYAA and Interventional Spinal Pain. I hereby authorize my prior attending physicians to release all medical records pertaining to my healthcare information to Tim Canty M.D., NYAA and Interventional Spinal Pain

Acknowledgement of Notice of Private Practice

A complete description of how my medical information will be used and disclosed by Tim Canty M.D., NYAA and Interventional Spinal Pain used and disclosed by Tim Canty M.D., NYAA and Interventional Spinal Pain NOTICE OF PRIVATE PRACTICES has been made available to me. I have been given the opportunity and have been advised to read the notice prior to signing this consent form. If I have any questions, I know to contact the Compliance Officer whose information is provided to me in the Notice of PRIVATE PRACTICES.

Consent and Disclosure for Care Treatment

I the undersigned, do hereby agree and given consent to Tim Canty M.D., NYAA and Interventional Spinal Pain to furnish medical care and treatment to the patient listed below that is considered necessary and proper in diagnosing or treating his/her physical and/or mental condition. This facility (NY Ambulatory and Anesthesia, PC and Allcare Medical PC) is owned in part by the physician(s). The physician(s) who referred you to this center and who will be performing your procedure may have a financial and ownership interest. Patients have the right to be treated at another healthcare facility of their choice. I acknowledge the understanding of this disclosure which was made in accordance with regulatory guidelines.

Release Information

I hereby authorize the physician to release any information acquired in the course of my treatment, to my primary and/or referring physician and my insurance company (ie's). I also authorize all prior treating physicians, physical therapy, radiology, other care providers and attorney to release all medical records pertaining to my healthcare information to Tim Canty M.D., NYAA and Interventional Spinal Pain.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that in the event that insurance benefits are paid directly to me, I will forward the payment to Tim Canty M.D., NYAA and Interventional Spinal Pain with the understanding that if I do so within 90 days, it may be determined that the services of a collection agency and/or attorney may be necessary to facilitate the collection of all past due charges. I agree to be responsible for all reasonable collection fees and costs associated with the collection of said past and due balance(s). I also authorize Tim Canty M.D., NYAA and Interventional Spinal Pain or insurance company to release any information required to process my claims.

Patient Name____________________ Parent/Guardian or Representative____________________

Patient Signature__________________ Witness Signature______________________

DATE:______________________ DATE:____________________________

This authorization permits Tim Canty M.D., NYAA and Interventional Spinal Pain to disclose identifiable health information about you. List any relatives / personal representatives who are authorized access to your medical records / treatment plans: