OASIS
INTERVENTIONAL SPINE CARE
725 Skippack Pike, Suite #130
Blue Bell, PA 19422

PATIENT INFORMATION

Name (last) _____ (First) _____ (M.I) _____

Address _____City_____State_____Zip_____

(M/F) _____ Social Security No. _____ Date of Birth _____ Age _____

Home Phone # _____ Cell Phone # _____ Other Phone # _____

Which is the best contact #? _____ Can messages be left? ☐ Yes ☐ No

Email _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Minor ☐ Other _____

Emergency Contact & Relation _____ Emr Contact Phone#_____

Do you give us permission to discuss your personal health information with your Emergency Contact? ☐ Yes ☐ No

Preferred Language _____Race _____ Ethnicity _____

How did you hear about us? ☐ Internet ☐ Directory (Specify) _____ ☐ Referral ☐Other_____

Referring Physician _____

BILLING INFORMATION

Name of Responsible Party (If other than self) _____

Address_____City_____State_____Zip _____

Relationship to Patient _____ Employer _____

Date of Birth _____ (M/F) _____

PRIMARY INSURANCE

Name of Insurance Company _____

Subscriber's ID# _____ Group # _____

Subscriber's Name: _____Patient Relation to Subscriber: _____

Subscriber's Date of Birth: _____ (M/F) _____ Insurance Phone # _____

Insurance Address _____

SECONDARY INSURANCE

Name of Insurance Company _____

Subscriber's ID# _____ Group # _____

Subscriber's Name: _____Patient Relation to Subscriber: _____

Subscriber's Date of Birth: _____ (M/F) _____ Insurance Phone # _____

Insurance Address _____

EMPLOYER INFORMATION

Employed: Full Time____ Part Time____ Retired____

Company Name _____Work Phone #_____ Ext_____

Address _____City _____State_____ Zip_____

PRIMARY CARE PHYSICIAN

Primary Care Doctor's Name _____

Address _____City _____State_____ Zip_____

Office Phone # _____ Office Fax #_____

PHARMACY INFORMATION

Whenever possible, Oasis Interventional Spine Care will electronically transmit your prescription(s) directly to your pharmacy. Please provide us with your preferred pharmacy information in the space below

Pharmacy Name: _____ Phone Number: _____

Pharmacy Address: _____ City_____ State_____ Zip _____

Do you give us permission to verify your prescription history from external sources (ex. Pharmacy or PCP)? ☐ YES ☐ NO

NOTE: Answering "No" to this question may affect our ability to safely prescribe you medications and manage your condition

PERSONAL REPRESENTATIVE

In addition to myself, I designate the following individual(s) as my personal representative and grant Oasis Interventional Spine Care permission to disclose (written and verbal) my protected health information with the individual(s) named below:

Name of Representative: _____ Relation to Patient: _____

Name of Representative: _____ Relation to Patient: _____

To change my personal representative(s) at any time a new form or written document will need to be completed.

"I, the undersigned, understand and agree that regardless of my insurance coverage, I am responsible for the balance of this account for any professional services rendered. I certify that the above information is true and correct to the best of my knowledge. I will notify the office of any changes in my insurance status. I also agree that if I am unable to pay my bill promptly, I will call the billing department to make timely payment arrangements. I understand that if my account becomes delinquent and Oasis Interventional Spine Care incurs any collection charges, they will be my responsibility. I UNDERSTAND THAT IF THE BALANCE ON MY ACCOUNT IS OUTSTANDING FOR MORE THAN 90 DAYS, MY ACCOUNT WILL BE SENT TO A COLLECTION AGENCY. I understand that as a courtesy, Oasis Interventional Spine Care will attempt to verify my insurance benefits, but it is ultimately my responsibility to know my coverage. Verification of benefits is not a guarantee of payment. Oasis Interventional Spine Care strongly encourages me to reaffirm my plan particulars with my insurance company. I understand that I am responsible for payment of the co-payment, deductible, coinsurance and all amounts identified by the insurer as the patient's responsibility at each visit to the office BEFORE I see the care provider. I understand that I am responsible to present updated referral authorizations from my insurance carrier when required."
If the patient is a minor: **"By consenting to care at Oasis Interventional Spine Care I am agreeing that I will take responsibility for the payment of the medical bills. I will provide the office with all information necessary and will communicate with the office regarding any changes in responsibility."**

"I acknowledge that I have received the Notice of Health Information Practices Policy."

Patient or Guardian Signature_____ Date_____

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Patient Policy for Missed Appointments

If you know that you will be unable to keep your appointment, please notify us within 24 hours of your scheduled appointment so that we may accommodate other patients that may require our services. This will assist us in meeting the medical needs of the community that may require immediate attention.

You will be charged a $30.00 fee for missed new patient and follow-up appointments when you do not provide a 24-hour notice.

If you know that you will be unable to keep your appointment for a scheduled procedure at the Blue Bell Surgery Center, please notify us within 48 hours of your scheduled appointment so that we may accommodate other patients that may require our services.

You will be charged a $100.00 fee for missed procedure appointments when you do not provide a 48-hour notice.

We appreciate your business and look forward to serving you and your medical needs in the future.

Patient Signature: _____ Date ____/____/____

Patient Name (PRINT): _____