OASIS

INTERVENTIONAL SPINE CARE

725 Skippack Pike, Suite #345
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 ☐ Widowed

EM Contact ______________________ Relationship __________ 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 ____

www.oasisspinecare.com
Tel: (267)462-4505 Fax: (267)462-4504

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.

OASIS INTERVENTIONAL SPINE CARE
FINANCIAL POLICIES

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 coverage and status.

I 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 any balance greater than $100 that is 60 days past due will incur a 20% service fee. Amounts that are past due for more than 90 days will incur a 30% fee.

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 if my account becomes delinquent and Oasis Interventional Spine Care incurs any collection charges, they will be my responsibility.

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 any co-payments, deductibles, coinsurances, and any other amount identified by the insurer are my responsibility. Any amount owed on my balance must be paid before I see the care provider.

I understand that I am responsible to present updated referral authorizations from insurance carrier when required.

I understand that when paying by credit card, a 4% charge will be applied to the transaction.
If paying by check, check should be made out to: Oasis Interventional Spine Care.

In the case of legal guardianship (such as for a minor), I consent to evaluation and treatment at Oasis Interventional Spine Care and 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.

____

Patient Name (Print) Date

____

Patient or Gardian Signature Date

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 $35.00 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): ______________________________

CONSENT FORM

1. I, ____________________________________ am suffering from a condition requiring outpatient care, hereby voluntarily consent to the rendering of such care at Oasis Interventional Spine Care, LLC, which may include such diagnostic procedures and medical treatment as my physician or other members of the medical staff of the facility or designees consider to be necessary or appropriate.

2. I understand that the practice of medicine and surgery is not an exact science and that the results cannot always be anticipated. I acknowledge that no guarantees have been made to me as a result of examination, procedures or treatment in this facility.

3. The undersigned authorizes the release of medical information to healthcare providers, insurance companies, federal and state agencies, which may be necessary for continuity of care, and completion of medical records.

4. I hereby authorize CMS or my insurance carrier to forward payment for medical benefits for all services provided directly to Oasis Interventional Spine Care, LLC of the insurance benefits otherwise payable to me, but not to exceed the balance due to the facility's regular charges for this period of treatment. I understand that I am financially responsible to Oasis Interventional Spine Care for charges not covered by this authorization. **I understand that there will be a $30.00 fee for any returned checks.**

5. In order to submit a claim for payment to Oasis Interventional Spine Care, LLC for services covered under your policy, we must have your authorization for release of medical records to your insurance carrier. I hereby authorize release of any information necessary to file a claim with my insurance company. I understand that I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

6. I understand that Oasis Interventional Spine Care, LLC will not be responsible for the loss or damage of valuables, including but not limited to money, jewelry, eyeglasses, dentures or other personal property. There is no insurance policy to cover these items. Understanding this policy, I relieve Oasis Interventional Spine Care, LLC of responsibility including financial liability of any personal holdings.

7. **I understand that if I do not call at least 24 hours in advance to cancel a scheduled appointment and fail to attend it, I will be charged a $35 no show fee. If I do not call at least 48 hours in advance to cancel a scheduled procedure at the Blue Bell Surgery Center and fail to attend it, I will be charged a $100 no show fee.** If I am 15 minutes late to an appointment, I will be asked to reschedule. If I fail to attend a scheduled appointment on three occasions I will not have the opportunity to schedule another appointment.

8. I give Oasis Interventional Spine Care, LLC consent to photograph or video record appropriate portions of my body, for medical and medical record documentation purposes, provided said photographs or videos are maintained and released in accordance with protected health information regulations.

This form has been fully explained to me, and I certify that I understand its contents.

Date____/____/____ Signature____

Witness (*If patient is unable to consent or is a minor, complete the following*)

*Patient (is a minor of _____years of age) (is unable to consent because)*________________________________

*Date ___/___/___ Signature of Legal Guardian or relative*____

Witness ____

Relationship to Patient ____

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