MAYS AND SCHNAPP PAIN CLINIC AND REHABILITATION CENTER REGISTRATION FORM

For treatment at Mays and Schnapp Pain Clinic & Rehabilitation Center, Pain Clinic Associates, PC and Pain Clinic Physical Therapy

First Name:_____ MI: _____ Last: _____
Date of Birth: _____ Social Security Number:_____ Sex: ☐ Male ☐ Female
Address:_____ City:_____
State:_____ Zip_____ Main Phone (_____)_____ Other Phone (_____) _____
Emergency contact (different phone #) _____ Phone_____
May we leave a message on your home or cell phone? ☐ Yes ☐ No
If you would like email contact, please provide this information. Email address: _____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
St of TN asks that you check the appropriate box for race: ☐ African American ☐ Asian ☐ Caucasian ☐ Unknown ☐ Other
St of TN asks that you check the appropriate box for ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown
Employer Name: _____ Student: ☐ Yes ☐ No
Address: _____ Work Phone_____

IS YOUR TREATMENT HERE IS THE RESULTS OF: (We file only your insurance, not any third party insurance)

1. A **work-related accident** for which you have an active or pending workers comp claim? ☐ Yes ☐ No
2. An **auto accident** (we bill your auto or health insurance) with a pending or active claim? ☐ Yes ☐ No
3. **Any other accident** with a pending or active claim? ☐ Yes ☐ No

If you answered yes to any of the three questions above, please complete the following:
DATE OF ACCIDENT: _____ **STATE WHERE ACCIDENT OCCURRED**: _____ **CLAIM #** _____
Name and address of WC employer:_____
Contact Name : _____ Phone # _____
Are you represented by an attorney for your treatment here? ☐ Yes ☐ No If Yes, please provide
Attorney Name/Firm: _____ Phone: (____)_____
Attorney Address: _____

INSURANCE INFORMATION **Insurance cards must be provided**

PRIMARY INSURANCE COMPANY:_____
Claims Address _____
Ins Phone: _____ Effective date: _____ Policy# _____ Group# _____
Are you the insured? ☐ Yes ☐ No If not, please list insured information:
Name: _____ Relationship to you:_____
Address:_____ DOB:_____ SS# _____
SECONDARY INSURANCE COMPANY:_____
Claims Address _____
Ins Phone: _____ Effective date: _____ Policy# _____ Group# _____
Are you the insured? ☐ Yes ☐ No If not, please list insured information:
Name: _____ Relationship to you:_____
Address:_____ DOB:_____ SS# _____
TERTIARY INSURANCE COMPANY: _____ Policy# _____ Group# _____

Depending on treatment here, you may receive three (3) bills from your treatment: Mays and Schnapp Pain Clinic & Rehabilitation Center (for the ASC Facility), Pain Clinic Associates, PC (for Physicians' services) and Pain Clinic Physical Therapy (for P.T. services)

With the exception of approved Worker's Compensation treatment or authorized Veteran's Administration claims, I understand that I am fully responsible for all charges incurred by me for any services provided to me by the providers of services at the above facilities, and that these charges are payable to the Providers. I understand that I am responsible for all collection and/or attorney fees and court costs incurred in the collection of my account. I further understand that it is my responsibility to obtain any precertification and/or preauthorization required by my insurance company.

As a service to me, I request, authorize and hereby assign the Providers of the above facilities any benefit due me under the above listed insurance policies, and request that these insurance companies pay any funds due me under the above contracts directly to the providers of the above facilities in Memphis, TN. I also request any payment of Medicare, Medigap, Medicaid or Champus benefits due me by made directly to the Providers of the above facilities for any service furnished to me by them. I authorize the release of any information applicable to me to any listed insurance company, Workers Compensation employer or carrier or attorney involved in litigation regarding me, as necessary in order to resolve any payment of benefits due to the provider of the above facilities.

Patient/Guarantor Signature_____ Date _____