Premier Pain Consultants

Advanced Solutions For Pain Relief

Eligibility Guarantee Form

I, _____, hereby certify that I am eligible with the following health insurance company _____ under the subscriber _____ through his or her employer _____. I also certify that I have chosen Premier Pain Consultants to be my medical provider. I understand that if the above is not true or I am not eligible under the terms of my Medical and Hospital Subscriber Agreement, I am liable for any and all charges for services rendered. Also, if the above is not true, I agree to pay in full for all services rendered within thirty days of receiving a bill from the above noted medical group/physician.

_____ _____

Print Patient Name Patient D.O.B. or SS #

_____ _____

Patient Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have read and received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____Date: _____

Print Name: _____

If not signed by the patient, please indicate:

Relationship:

Parent or guardian of minor patient
Guardian or conservator of an incompetent patient
Beneficiary or personal representative of deceased patient

Name of Patient: _____

You may share information about my condition with: