

BERNARD E. FILNER, M.D.

PAIN MEDICINE

Dear New Patient:

Welcome to Dr Bernard E. Filner's practice.

Before you come in, please follow the instructions noted below:

1. **Complete the enclosed New Patient Information Form.** Please bring it with you at time of appointment.
2. **We suggest you take the vitamins,** suggested on our web site, to ease muscle pain and soreness.
3. Ask your doctor to **mail or fax any reports** that pertain to your medical condition for which you are seeing us (X-rays, MRI's, laboratory tests, CT scans, etc.). Please have these at time of appointment.
4. Please bring in your **medical insurance card** or any pertinent **insurance information** related to this medical problem. We **do not participate** with any insurance. As a courtesy, we will file your medical claims with your insurance company. **Please be aware however, that you are responsible for any and all balances on your account.** We will provide you with any necessary documentation requested by your insurance company and appropriate letters to help with any appeal of your insurance company's payments.
5. We require payment of a minimum of **20% of your total bill at the time of service.** Checks, cash, Visa, MasterCard, Discover, or American Express are accepted.
6. Please keep your scheduled appointments. If you have any doubts, please call us **after** you have checked your calendar to schedule your appointment.
7. If you need to change or cancel your appointment please give us 2 business days notice (emergency or acute illness excepted). There is a fee (\$75.00) for any late or non-emergency cancellations.

If we can help with any question or information, please do not hesitate to give us a call. We have enclosed directions to our office in case they are needed. Thank you and see you soon.

Sincerely,
Wendi Bretner
Office Manager

BERNARD E. FILNER, M.D.
NEW PATIENT INFORMATION FORM

Patient Name _____ Home Phone: _____
Address: _____ Work Phone: _____
City/State/Zip: _____ Cell Phone: _____
SSN: _____ e-mail address: _____
Birthdate: ___/___/___ Marital Status _____ Sex: ___ Student? _____

Emergency Contact:
Name _____ Phone number: _____ Relationship _____

Occupation: _____ **Hobbies:** _____

Patient's Employer _____ Phone _____
Address: _____
City/State/Zip: _____

PRIMARY INSURANCE COVERAGE

Insurance company name: _____
Address: _____
City/State/Zip: _____
Policy ID No. _____ Group No. _____
Relationship to card insured person (self, spouse or child) _____

If relationship is other than Self, Please provide the following information for the insured person:

Insured Person name: _____ Home Phone No. _____
Address: _____
City/State/Zip: _____
Social Security No. _____ Birthdate: _____

PAYMENT AGREEMENT

I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Filner will prepare any necessary reports and forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to Dr. Filner will be credited to my account on receipt. However, I understand that if this balance is not paid in a timely fashion, that I will be responsible not only for the balance due, but for any collection and/or reasonable attorney fees that are incurred in the attempt to collect this debt. I AGREE THAT I AM ULTIMATELY RESPONSIBLE FOR MY ACCOUNT REGARDLESS OF INSURANCE COVERAGE. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered me will be immediately due and payable. I authorize the release of any medical or other information necessary to process any claims.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

Please list all current medications and dosages: _____

Please list any treatments you are having at the present time: _____

How did you hear about us? _____

Are you involved in litigation related to this problem? Yes No

Attorney's Name: _____ Phone No.: _____

Attorney's Address: _____

City/State/Zip: _____

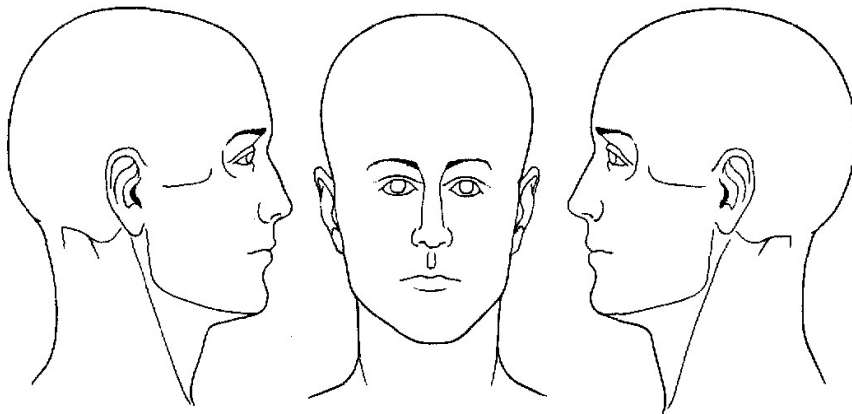
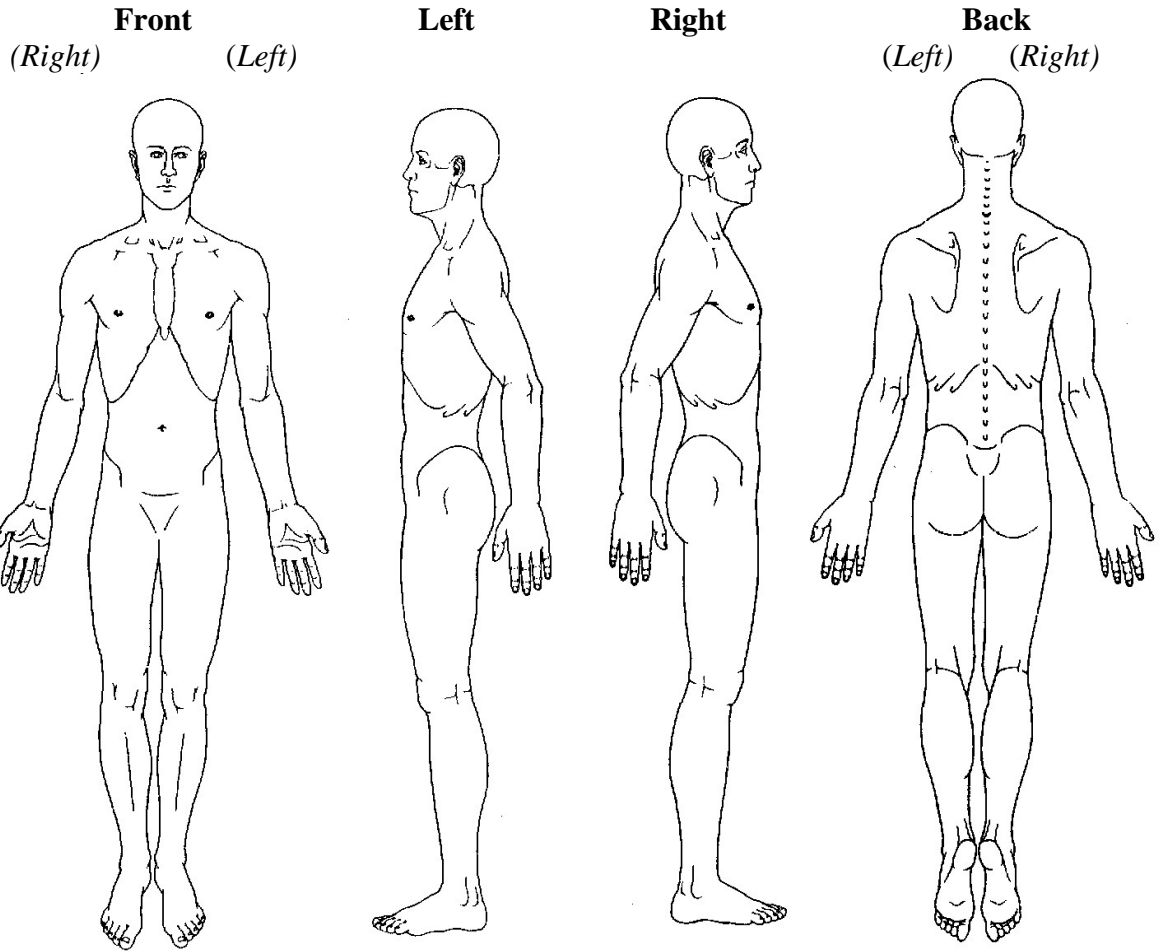
Is this problem work related? Yes No

Worker's Comp. Caseworker Name: _____ Phone No.: _____

Is this problem the result of a motor vehicle accident? Yes No

If "yes", please provide Case Number: _____

Mark the locations of your pain on the diagram using an "X":



Right

Front

Left