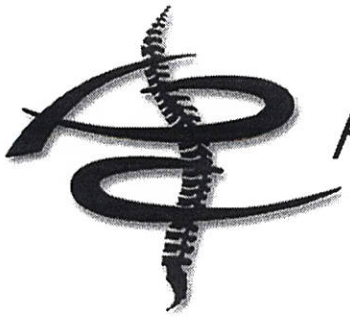

Advanced Pain Care

PATIENT INFORMATION

LAST_____FIRST_____M.I._____

DATE OF BIRTH_____SSN_____

HOME ADDRESS_____CITY_____ST_____ZIP_____

MAILING ADDRESS_____CITY_____ST_____ZIP_____

PHONE: HOME_____CELL_____WORK_____

WHICH PHONE NUMBER ABOVE IS BEST TO REACH YOU?_____

MAY WE LEAVE A MESSAGE?_____

EMAIL ADDRESS_____

PRIMARY CARE PHYSICIAN_____REFERRING PHYSICIAN_____

EMERGENCY CONTACT_____

RELATIONSHIP_____PHONE_____

INSURANCE

PRIMARY

INSURANCE COMPANY NAME_____

SUBSCRIBER'S NAME AND DATE OF BIRTH_____

RELATIONSHIP TO PATIENT_____

POLICY NUMBER_____GROUP NUMBER_____

SECONDARY

INSURANCE COMPANY NAME_____

SUBSCRIBER'S NAME AND DATE OF BIRTH_____

RELATIONSHIP TO PATIENT_____

POLICY NUMBER_____GROUP NUMBER_____

ADDITIONAL BILLING INFORMATION

ARE YOU TREATING WITH DR. GREENBERG FOR AN AUTO ACCIDENT___ON THE JOB INJURY___

IF SO, INFORM THE OFFICE IMMEDIATELY AND PROVIDE THE FOLLOWING FORMATION:

PATIENT'S MOTOR VEHICLE OR WORKER'S COMP CO NAME_____

BILLING ADDRESS_____CITY_____ST____ZIP_____

CLAIM NUMBER_____DATE OF INJURY OR ACCIDENT_____

ADJUSTOR OR CASE MANAGER'S NAME_____

CONTACT NUMBER FOR ADJUSTOR OR CLAIM MANAGER_____

AUTHORIZATION TO PAY AND RELEASE INFORMATION

I HEREBY ASSIGN ADVANCED PAIN CARE ALL PAYMENTS TO WHICH I AM ENTITLED FOR EXPENSES RELATED TO THE SERVICES PERFORMED AND DIRECT THAT PAYMENT FOR SUCH SERVICES BE MADE TO ADVANCED PAIN CARE. I ALSO AUTHORIZE ADVANCED PAIN CARE TO RELEASE SUCH INFORMATION AS MAY BE REQUIRED TO SECURE SUCH PAYMENT. I RECOGNIZE MY FINANCIAL OBLIGATION FOR ANY CO-INSURANCE OR DEDUCTIBLE, AND NON-COVERED SERVICES THAT MAY BE REQUIRED. THIS AGREEMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS DOCUMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.

SIGNATURE_____DATE_____