



PAIN CONSULTANTS, PLLC

9800 Levin Road NW, Suite 201 P: 360-692-2330
Silverdale, WA 98383 F: 360-692-2329

www.painconsultantspllc.com

Christopher Merfield, MD

Fellowship: Interventional Pain Medicine
Diplomate of the American Board of Anesthesiology
Board Certified Interventional Pain Medicine

John Hache, MD

Fellowship: Interventional Pain Medicine
Board Eligible in Anesthesiology and Pain Medicine

Erin Henderson, ARNP

PATIENT INFORMATION

Last Name		First Name		MI	Alias or Maiden Name	
Date Of Birth	Sex	Social Security Number		Marital Status		
Mailing Address			City		State	Zip
Home Phone		Cell Phone		Work Phone		
Employer			Employed Full time or Part time?			
Preferred Language		Race	<input type="checkbox"/> Refuse to report		Ethnicity	<input type="checkbox"/> Refuse to report
Email address					<input type="checkbox"/> No Email/Elect not to disclose	
Referring Provider			Primary Care Provider			
Pharmacy Name and Location						
Emergency Contact Name and Relationship				Emergency Contact Phone #		

RESPONSIBLE PARTY INFORMATION *(if different from patient information)*

Last Name		First Name		MI	Alias or Maiden Name	
Date Of Birth	Sex	Social Security Number		Employer Name		
Street Address			City		State	Zip

INSURANCE INFORMATION - *Must be completed in order to bill your insurance.*

PRIMARY Insurance Company	ID Number	Group Number
Subscriber Name	Subscribers DOB	Relationship to the patient
SECONDARY Insurance Company	ID Number	Group number
Subscribers Name	Subscribers DOB	Relationship to patient
PRESCRIPTION COVERAGE		
If you have prescription benefits, please list your insurance carrier		ID Number

WORK RELATED INJURY OR MOTOR VEHICLE ACCIDENT		Is this an open claim? YES or NO
Insurance Company	Claim Number	Date of Injury
Insurance Address		Phone Number

Financial Agreement: I understand that I am responsible for all co-payments, deductibles and charges for services rendered to me not covered by my insurance company. I will pay my co-payments at the time of service per contractual obligation with my insurance company. In the event that legal action should become necessary to collect any unpaid balance due for medical services rendered to me, I agree to pay reasonable attorney fees or other such costs as the court determines proper. I agree that the venue for any legal action shall be in Kitsap County.

Release of Benefits and Information: I authorize my insurance benefits be paid directly to the provider of service. I am financially responsible for any balance due. I authorize **Pain Consultants, PLLC**, to release any information required for this claim.

Attendance Agreement: My signature acknowledges that I understand that Pain Consultants requires 24 hours notice for appointment cancellations. Missing multiple appointments without notice, or continually giving less than 24 hours notice for cancellations, may result in termination of care.

SIGNATURE: _____

Printed Name: _____ **DATE:** _____