CMH Pain Management Services, LLC

Dr. Manhal Saleeby, MD

413 Bracey Lane
P. O. Box 90
South Hill, VA 23970

Phone: (434) 447-3261
Fax: (434) 447-3307

Patient Information

Patient Name: _____ If Minor Parent: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Number: _____

Social Security Number: _____ - _____ - _____ Date of Birth:____/_____/____ Sex: ☐ M ☐ F

Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed Spouse's Name: _____

Primary Care Physician: _____ Phone Number of Physician: _____

Referred By: _____ Reason for Referral: _____

Employer Name: _____ Work Phone: _____

Contact Information

Emergency Contact Name: _____ Phone Number: _____ Relationship: _____

Name of Nearest Relative (who does not reside with you) _____ Phone: _____

Insurance Information

Is this a job related injury: ☐ Is this due to an accident: ☐ If yes, Claim/Case Number: _____

Primary Insurance: _____ Person on Account _____ Date of Birth _____

Person on Account Employer: _____

Secondary Insurance: _____ Person on Account: _____ Date of Birth _____

Person on Account Employer: _____

Authorization for Treatment, Guarantee of Payment and Assignment of Insurance Benefits

I, _____, patient of CMH Pain Management Services, LLC hereby authorize treatment. I authorize PMS, LLC to furnish to insurance carriers any information necessary to process this claim. Co- pays are due in full on the date of service. If your insurance company requires a referral, you are responsible for obtaining the referral. If the referral is not obtained, you are responsible for the payment in full on the date of services.

The undersigned understands that he/she is primarily responsible to CMH Pain Management Services, LLC for all charges incurred by him/her, his/her spouse and or his/her minor children and that Pain Management Services, LLC will file the patients insurance claim (if any) as a courtesy to the patient. The undersigned hereby guarantees payment to Community Memorial Health Center, all charges incurred by him/her, his/her spouse and or his/her minor children and if his/her account is turned over to an attorney for collection, he/she agrees to pay all costs of collection including attorney's fees equal to 33.3% of all sums due and payable. The undersigned hereby agrees to pay interest at a rate of 18% per annum (annual percentage rate) on all outstanding balances. The undersigned hereby assigns to Pain Management Services, LLC, any and all insurance benefits under any and all policies of insurance.

Patient: _____ Date: _____

Guantor (if not patient): _____ Date: _____