Advanced Pain Management

EVANS: 404 Town Park Blvd., Suite 101 • Evans • Georgia • 30809 **THOMSON:** 315 Fluker Street • Thomson • Georgia • 30824
PHONE 706.922.7246 • FAX 706.922.7247 • apmaugusta.com

APM PATIENT INFORMATION

Date: _____/_____/_____

Name: _____/_____/_____
(Last) *(First)* *(MI)*

Date of Birth_____/_____/_____ SS# _____-_____-_____ Sex: ❑ Male ❑ Female

Address: _____ City_____ State _____ Zip _____

Home Phone # (_____) _____ - _____
Work Phone # (_____) _____ - _____
Cell Phone # (_____) _____ - _____
Circle preferred number for communication

Email : _____
(If you want patient portal access from practice website)

Martial Status ❑ S ❑ M ❑ D ❑ W ❑ P Ethnicity_____

How did you hear about us? _____

Employer _____ Phone # (_____) _____ - _____ Occupation _____

Emergency Contact _____Relationship_____Phone # (_____) _____ - _____

INSURANCE INFORMATION

Primary Insurance_____ ID# _____Group#_____

Subscriber Name _____ Date of Birth_____/_____/_____ Relationship _____

Subscriber SS# _____-_____-_____ Subscriber Address _____
(If different from patient address)

Secondary Insurance_____ ID# _____Group#_____

Subscriber Name _____ Date of Birth_____/_____/_____ Relationship _____

Subscriber SS# _____-_____-_____ Subscriber Address _____
(If different from patient address)

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WORKERS COMPENSATION/AUTOMOBILE ACCIDENT INFORMATION

Date of Injury: _____/_____/_____

Insurance Carrier Name_____ Contact Person _____

Policy#_____Claim# _____ Group#_____

Insurance Co. Address: _____City_____ State _____ Zip _____

Insurance Co. Phone # (_____) _____ - _____

Attorney Name _____

Attorney Address _____ City_____ State _____ Zip _____

Attorney Phone# (_____) _____ - _____

Employer (If WC)_____ Employer Phone # (_____) _____ - _____

Employer Contact Name _____

Employer Address _____ City_____ State _____ Zip _____

Patient Signature or Legal Representative_____ Date _____/_____/_____

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CONSENT TO TREATMENT

I desire to be treated at Advanced Pain Management. I understand that I may discontinue treatment at any time.

1. I consent to the rendering of medical care by the APM physicians, Nurse practitioner, Physician Assistants and staff.
2. I hereby authorize all professional staff to release any information acquired in the course of the examination and treatment to referring physician, insurance company, workers compensation carrier, the center's attorneys and consultants in accordance with the privacy laws.
3. As part of the medical procedures or tests, I understand that I may be tested for H.I.V. infection and/or hepatitis, or any other blood- borne infectious disease if the doctor orders the test for diagnostic purposes.
4. Guarantee of Payment: I agree to be responsible to the APM for charges resulting from services and supplies rendered at the prevailing rates unless I qualify for discount. I agree all bills are due in full upon demand. Should I fail to honor this agreement I agree to pay any collection cost or attorney fees resulting from the collection of my account.
5. Pre- Certification Requirements: If my insurance company or third –party requires precertification, then I understand that it is my responsibility to contact them to obtain such certification. Exception: Medicare.
6. Assignment of Benefits (other than Medicare and Medicaid): I hereby assign all rights and privileges and authorize payment directly to the center for any claim filed on my behalf or on the behalf of the person for whom I am duly authorized to sign for insurance benefits. I also understand that I am financially responsible to the center for co-pays, deductibles, co insurances and charges not covered by this assignment or by my insurance plan.
7. Assignment of Benefits (Medicare and Medicaid): I request that payment of authorized Medicare and/or Medicaid benefits to be made to the center or on my behalf for any services or supplies furnished by the center, including physician services. I authorize any holder of medical or other information about me to release it to the center for Medicare and Medicaid services and its agents, as appropriate, any information needed to determine these benefits for related services. I understand that I am responsible for any coinsurance, unmet deductibles and services not covered by Medicare and/or Medicaid.
8. Grievance Appeal Consent: I hereby authorize APM to act on my behalf in requesting a reconsideration of medical determination made by my managed care plan or utilization review entity regarding my medical care.
9. It is the policy of the physicians and staff of the APM to honor Advance Directives presented to them by their patients. However, should an untoward event happen to a patient while he or she is in our Facility, it is our policy to stabilize the patient and transport him or her to the hospital of his or her choice with a copy of the Advance Directive (if available).
10. Complaints, concerns, grievances regarding treatment, service, damaged or lost articles or billing should be directed to the Director of Nursing/Administrator for investigation and appropriate response

_____ HIPPA Acknowledgement and Consent - I acknowledge that I have reviewed/received a copy of Advanced Pain Management's Privacy Notice.

Patient Signature or Legal Representative _____ Date _____

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FINANCIAL POLICY FOR PATIENT CARE SERVICES

To help provide the most efficient and reasonable health care services, it is necessary for us to have a Financial Policy stating our requirements for payment of services provided to our patients. Patients are responsible for the payment of all services provided by our office. It is our policy to file for insurance as a courtesy to you if we have **accurate and complete** insurance information. The balance due is still your responsibility if we have not received payment from the insurance company within 30 days.

If you have insurance and we file with your carrier, we ask that you pay ahead of time on the balance which is your responsibility according to your plan, i.e., any **deductible, co-pay, co-insurance** amounts. We accept cash, personal checks and credit cards for payments. For Medicare patients, we will wait until we have received payment and then bill the patient for any remaining balance due. Since we are not a party to the agreement between you and your insurance company, we ask that you assist us in contacting them in the event that services are not paid within 30 days.

For Worker's Compensation claims, it is our policy to bill your employer or the Worker's Compensation carrier for services rendered. If you are covered, we will accept the payment made by Worker's Compensation as payment in full. If Worker's Compensation denies payment or goes into litigation, the entire balance will become your responsibility and will be due within 30 days from the date of the denial.

All insurance is verified prior to the patient's initial visit. If you do not have insurance and are not covered by either Medicare or Medicaid, you will be considered a **"SELF PAY"** patient. Payments at a discounted rate for these accounts are accepted if the balance is paid promptly with cash, personal check or credit card at the time of your visit. This assists us in cutting down on billing and operating expenses.

Patient "no shows" and cancellations are a tremendous loss for a practice. Please help our office reduce those losses by cancelling within 24 hours if you are unable keep your appointment. If you do not call 24 hours in advance to cancel your appointment, you will be responsible for a **$25.00 No Show** fee for any missed office visit and a **$50.00 No Show** fee for any missed procedure in which you (the patient) will be billed for and will have to pay before you can come for your next appointment. Please note we charge **$25.00** to fill out various forms and paperwork and please allow 7-14 days for completion.

We ask that you read this policy and aid us in keeping our costs down by ensuring that we are able to be reimbursed for our services on a timely basis. We welcome the opportunity to discuss any aspect of our financial policy.

To help in this policy we ask that you assist us by:

1. Providing us with current and updated information on yourself and your insurance company and to keep all changes up to date.
2. Make payment at the time of service for the balance if you are a **"SELF PAY"** patient, or for the amount of any **deductibles** or **co-pays** that may be due.
3. Discuss your account balance only with the check-out or business staff or contact the billing department of the hospital and /or physicians. **Please do not discuss the financial aspects of your care with the physician(s)**. It is important for them to be allowed to practice medicine and provide patient care. Please work with the rest of the office staff on any account questions or problems you may have. If they cannot help you or answer your questions to your satisfaction, then please, do not hesitate to contact the office manager.

Patient Signature or Legal Representative _____ Date _____

Witness _____ Date _____

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HEALTH HISTORY QUESTIONNAIRE

Full Name: _____ DOB: _____ Age: ____ Date: ____/____/_____

Referring Physician _____ Specialty: _____

Primary Care Physician Information / Name: _____

Address: _____ Phone # (_____) _____ - _____

Chief Complaint: What is your most bothersome pain problem? _____

_____

History of Present Illness: How long have you had this problem? _____

_____

Precipitating event: ❑ work injury ❑ auto accident ❑ unknown ❑ other _____

Is your pain: ❑ dull ❑ achy ❑ constant ❑ sharp ❑ shooting ❑ other _____

Do you experience: ❑ burning ❑ cramping ❑ tingling ❑ numbness ❑ other _____

Pain increased on: ❑ sitting ❑ standing ❑ walking ❑ lying down ❑ other _____

Pain decreased on: ❑ sitting ❑ standing ❑ walking ❑ lying down ❑ other _____

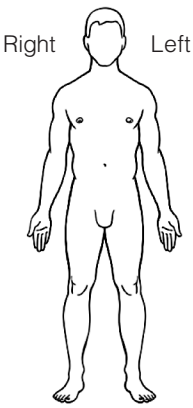
How long can you: sit _____ ❑ no limit stand _____ ❑ no limit walk _____ ❑ no limit

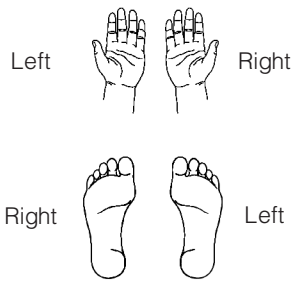
Does your pain radiate to: **leg/foot** ❑ right ❑ left **arm/hand** ❑ right ❑ left

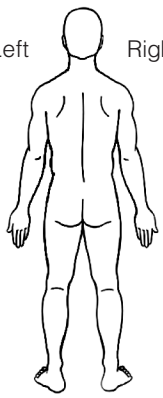
Previous treatment: Please list all treatments even if they did not help

Medication: _____
Injections: Dates/Type _____
Surgery: Dates/Surgeon _____
Other: _____

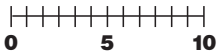
Please use the diagram below to indicate the are of the most significant pain.
Use XXX for the location, ::: for areas of numbness and /or tingling.
Use ⟶ to show if the pain travels from one area to another.







Mark Current/Best/Worst Levels of Pain
0 = No Pain **10** = Unbearable Pain



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HEALTH HISTORY QUESTIONNAIRE

Past Medical/Surgical History: if YES please explain on the spaces provided

	Past	Current		Past	Current
headaches	❑	❑ _____	GERD/ulcers	❑	❑ _____
stroke	❑	❑ _____	kidney disease	❑	❑ _____
thyroid disease	❑	❑ _____	hepatitis	❑	❑ _____
cancer	❑	❑ _____	racture	❑	❑ _____
lung disease/asthma	❑	❑ _____	joint replacement	❑	❑ _____
blood clots	❑	❑ _____	arthritis	❑	❑ _____
high blood pressure	❑	❑ _____	neurological disorders	❑	❑ _____
depression	❑	❑ _____	pinched nerv	❑	❑ _____
heart disease	❑	❑ _____	seizures	❑	❑ _____
diabetes	❑	❑ _____	psychiatric treatments	❑	❑ _____
gastrointestinal disease	❑	❑ _____	HIV/AIDS	❑	❑ _____

Other (please explain) _____

Surgeries (please include dates) _____

_____

Family History: (please list all known medical conditions present/past in parents, siblings, grandparents)

_____

_____

Social History:

Marital Status: ❑ single ❑ married ❑ separated ❑ divorced ❑ widowed ❑ other _____

Occupation: _____ ❑ full-time ❑ part-time ❑ retired ❑ disabled ❑ not working

Education: highest grade completed_____ Hobbies:_____

Smoking: ❑ yes ❑ no if yes: how many packs per day? _____ how long?_____

Alcohol: ❑ yes ❑ no if yes: how many drinks per day?_____ how long?_____ ❑ socially/occasionally

Street Drugs (illegal or abused prescription): ❑ yes ❑ no if yes, explain_____

Have you ever had an alcohol or drug abuse problem in the past? ❑ yes ❑ no if yes, explain _____

_____

Radiological Tests: Please include all tests applicable to current pain problem performed in the last 5 years

❑ X-Ray _____

❑ CT scan _____

❑ MR I _____

❑ Myleogram _____

❑ Other _____

Treatment Goals:

❑ Be more active and functional
❑ Return to work
❑ Improve relations with family
❑ Other _____

I certifiy that I have truthfully answered all questions to the best of my ability, without knowingly withholding any information concerning problems either past or present.

Patient signature _____ Date _____

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MEDICATION LIST

Patient Name: _____ Date: ____/____/_____

Date of Birth: ____/_____/_____ Phone# (_____) _____ - _____ Cell # (_____) _____ - _____

Pharmacy Name: _____ Pharmacy Phone # (_____) _____ - _____

Instructions: Patients should complete items **A-F** and return form to office staff.
Please Write "NONE" if You Do NOT Take Any Medications

A: **B:** **C:** **D:** **E:** **For Office Use Only:**

All Medications *(including over the counter, herbs, & vitamins)*	**Dosage** (mg)	**Frequency**	**Date Began**	**Prescribing Physician**	**Date/ Initials**	**Date/ Initials**	**Date/ Initials**	**Date/ Initials**	**Date/ Initials**
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									

F:
Drug Allergies:

_____ _____ _____

_____ _____ _____

_____ _____

Patient Signature Date

Initials	**Signature**