**Southeastern Interventional Pain Associates**
**NEW PATIENT INTAKE**

Name: _____ Date: _____

Birthdate: _____ Age: _____ Referring Physician: _____

**CHIEF COMPLAINT:** Low Back Pain (Lumbar) Mid Back Pain (Thoracic) Neck Pain
Headaches Shoulder Pain Leg Pain Hip Pain Arm Pain Wrist Pain Ankle Pain

**TYPE of PAIN:** Throbbing Sharp Burning Numbness Dull Radiating Other

When did pain start? _____ Did you have an injury? Yes No If so date_____

Other Explain: _____

What makes the pain worse? Walking Standing Sitting Lying down Other

Does pain interfere with sleep? Yes No When is pain the worst? AM fternoon Evening

| **Have you ever tried any of the following for your pain?** | | | | **How much pain relief?** |
|---|---|---|---|---|
| NSAIDS (Motrin, Aleve, etc) | __No | __Yes | | __Good __Moderate __Minimal __Poor |
| Physical Therapy | __No | __Yes | How long: _____ | __Good __Moderate __Minimal __Poor |
| Anti-depressants | __No | __Yes | | __Good __Moderate __Minimal __Poor |
| Oral Steriods | __No | __Yes | | __Good __Moderate __Minimal __Poor |
| Home Exercise | __No | __Yes | | __Good __Moderate __Minimal __Poor |
| Electrical Stimulation | __No | __Yes | | __Good __Moderate __Minimal __Poor |
| Massage Therapy | __No | __Yes | | __Good __Moderate __Minimal __Poor |
| Trigger Point Injections | __No | __Yes | | __Good __Moderate __Minimal __Poor |
| Epidural Steriods | __No | __Yes | | __Good __Moderate __Minimal __Poor |
| Other_____ | | | | __Good __Moderate __Minimal __Poor |

**SURGERY HISTORY:** Please list any surgery. If you have had a fusion on your spine please list the levels.

Surgery: _____ Date: _____
Surgery: _____ Date: _____
Surgery: _____ Date: _____
Surgery: _____ Date: _____

**PAST INJURIES:**

Type: _____ Date: _____ Type: _____ Date: _____
Type: _____ Date: _____ Type: _____ Date: _____

**FAMILY HISTORY:** (Check all that applies) __Heart Attack __Heart Disease __High Blood Pressure

__Diabetes __Cancer __Depression __Other_____

Have you ever had a bad reaction to anesthesia? __Yes __No

**SOCIAL HISTORY:** Marital Status __Married __Divorced __Single __Widowed

Do you exercise? _None __Less than 1-3 x per week __4 or more times per week

Occupation: __Employed __Unemployed __Homemaker __Retired __Disabled __Student

Smoking: __Yes __No Packs per day____ Number of years____

Recreational Drug Use: __Yes __No Kind: _____

Alcohol: __Yes __No Drinks per day _____ Drinks per week _____

**MEDICATIONS:** Please list **ALL** current medications and dose

Medication: _____ Dose: _____ Qty/per day: _____

Medication: _____ Dose: _____ Qty/per day: _____

Medication: _____ Dose: _____ Qty/per day: _____

Medication: _____ Dose: _____ Qty/per day: _____

Medication: _____ Dose: _____ Qty/per day: _____

Medication: _____ Dose: _____ Qty/per day: _____

Medication: _____ Dose: _____ Qty/per day: _____

Medication: _____ Dose: _____ Qty/per day: _____

Medication: _____ Dose: _____ Qty/per day: _____

**ALLERGIES:** __Yes __No (If yes please list)

_____

_____

_____

_____

_____

**REVIEW OF SYSTEMS:**

**Constitutional:** Weight_____ Height: _____ __Fever/Chills __Night sweats __Weight loss (past year) _____ lb __Weight gain (past year) _____ lb

**HEENT: __None** __Hearing loss __Hearing aid: R / L __ Sinus Problem __Loose Teeth

**Endocrine: __ None** __Diabetes __Insulin Dependent __Oral Diabetic Medication __Hypothyroidism __Addison's Disease __Excessive thirst or urination __Awaken to urinate

**Gastrointestinal: __None** __Change in appetite __History of Hepatitis __Liver Disease __History of Ulcer __Heartburn __Diarrhea __ Constipation __ Gallbladder Disease __ Nausea/Vomiting __Ostomy __Signs of GI Bleeding (blood in stool, dark/tarry stool, vomiting blood) __Bowel incontinence

**Respiratory: __None** __ COPD __Emphysema __Asthma __Shortness of breath __Chronic Cough __Sleep Apnea __Cough Secretions Regularly __Snoring __Airway Obstruction __History of TB __Nasal Septal Deviation __Home breathing Treatment __Home Oxygen

**Cardiovascular: __None** __Hypertension __Angina: Last Episode ___/___/___ __Palpitations __Heart Murmur __Heart Attack: When ___/___/___ __Chronic Heart Failure __Shunts/Stents __Rheumatic fever __Pacemaker __Artificial Valve __Coronary Artery Disease

**Neurological: __None** __Dizziness __Headaches __Seizures __Stroke When ____/____/____ __Weakness of extremities _____ __Fainting __ Numbness _____ __Paralysis __Multiple Sclerosis Other _____

**Musculoskeletal: __None** __Back Pain __Arthritis __Cast __Osteoporosis __ Neck Pain __Joint Pain __Rheumatoid arthritis __Joint Replacement _____ __Artificial Limb

**Genitourinary: __None** __Kidney Problem __Burning while urinating __Blood in Urine __Frequency __Bladder or Kidney Infections __Ostomy __Dialysis __Catheter __Difficulty urinating __Urinary incontinence

**Skin: __None** __Sores __Rash __Bruises __Cuts __Burns __Incision __Itching

**Hematological: __None** __Easy Bruising __Low platelets __On coumadin, lovenox, or other blood thinner __On aspirin/non-steroidal anti-inflammation __History of cancer __History of Radiation Therapy __History of Chemotherapy

**Gynecological: __N/A** Last Period _____ __Menopausal __Hysterectomy

**Psychological** During the past month have you been tense or anxious? (Please circle one) __Never __Seldom __ Sometimes __Frequently __Always
During the past month have you been depressed or discouraged? __Never __Seldom __Sometimes __Frequently __Always
During the past month have you been irritable or upset? __Never __Seldom __Sometimes __Frequently __Always

**Acknowledgement of Medical Information**

I attest that the medical information completed on this questionnaire is current, complete, true, and accurate. I accept full responsibility for any information not updated or shared with my physician.

_____ _____
Patient Signature or Authorized Person if not Patient Date

# Southeastern Interventional Pain Associates

## I. Patient Demographic Form (ALL SECTIONS MUST BE FILLED)

**Patient's Information:**

LAST NAME: _____FIRST NAME: _____ MI: _____

BIRTHDATE_____ SEX: __M __F

MARITAL STATUS: __MARRIED __ SEPARATED __ DIVORCED __WIDOWED __SINGLE

ADDRESS_____

CITY_____STATE_____ZIP_____

HOME PHONE#_____CELL#_____S.S._____

EMAIL ADDRESS: _____

**Race:** __ African/American __ American Indian __ Asian __ White
__ Multi-racial __ Pacific Islands __ Other __ Decline

**Ethnicity:** __ Hispanic/Latino __ Non-Hispanic/Latino __ Decline

## II. Insurance Information:

PRIMARY INSURANCE: _____ SECONDARY INSURANCE: _____

POLICY NUMBER (ID): _____ POLICY NUMBER (ID): _____

GROUP NUMBER: _____ GROUP NUMBER: _____

INSURED NAME: _____ INSURED NAME: _____

RELATIONSHIP TO PATIENT: _____ RELATIONSHIP TO PATIENT: _____

## III. Guarantor Information:

LAST NAME: _____FIRST NAME: _____ MI: _____

ADDRESS_____

CITY_____STATE_____ZIP_____

HOME PHONE#_____CELL#_____S.S._____

NAME OF EMPLOYER: _____ OCCUPATION: _____

## IV. Emergency Contact:

LAST NAME: _____FIRST NAME: _____ MI: _____

ADDRESS_____CITY_____

STATE_____ZIP_____ RELATION TO PATIENT:_____

HOME PHONE#_____CELL#_____

## V. Pharmacy Information:

PHARMACY NAME: _____ PHONE NUMBER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

Patient Signature: _____ Date:_____

# Southeastern Interventional Pain Associates

## Responsibility for Payment / Assignment of Benefits / Contact

In consideration of the treatment provided at Southeastern Interventional Pain Associates (SIPA) to me I agree to pay SIPA for such treatment. If private health insurance, Medicare, other governmental or other insurance programs cover the treatment, I authorize SIPA to bill any such insurer for all charges incurred in connection with the diagnosis, care and treatment. My insurance coverage may provide that some amount of the bill will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered by my health insurance, Medicare, or any other programs for which I am eligible.

I understand that some payments such as co-payment, deductible, and coinsurance is required at the time of service, or in advance of, services being provided. I also understand I will be billed for any charges not paid by my insurer, and I will be responsible for paying them. I understand and acknowledge that:

- If I elect to pay for medical treatment in cash, in full before services are provided, I can request that my health insurance, in any form, not be billed for that service or be notified that the service was provided.
- I understand that I may be responsible for notification to my insurance company to obtain authorization before service is rendered, and if I am not pre-certified for such services, my benefits may be reduced or lost, but I will still be responsible for paying SIPA for the services.
- Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan and my certificate of coverage.
- If I do not consent, or later revoke my consent, to the release of my information to any insurer that I have identified, I will be responsible to pay all billed charges for the treatment and services received.

I hereby assign to SIPA and the professionals involved in my care, all my rights and claims for reimbursement under private health insurance, Medicare, or other programs that I identify for which benefits may be available to pay for the services provided to me, and authorize payment for such services to be made directly to SIPA.

If I default or do not pay for treatment provided, I acknowledge and agree that SIPA is entitled to recover the full amount of the debt owed for medical services and is entitled to the right of recovery of a ll collection expenses, including litigation, garnishment of wages or arbitration costs, and reasonable attorney's fees incurred for the purpose of securing payment. Collection expenses and/or attorney fees include the fee charged to SIPA to complete the collection. For example, if a collection agency or law firm charges 20% of the amount collected as their fee, SIPA will add 20% to my bill and the collection agency or law firm will then earn 20% of the amount collected.

I agree that in order for SIPA to service my account or to collect any amounts I may owe, SIPA or a vendor acting on its behalf, may contact me by telephone at any telephone number associated with my account

I agree that SIPA or a vendor acting on its behalf may also contact me by sending text messages or e-mails, using any e-mail address I have provided.

I acknowledge and agree that methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Further information concerning SIPA financial practices and expectations can be found in the Patient Financial Policy, which has been offered to me.

## Patient Rights and Responsibilities

I understand that I have the right, and the responsibility, to participate in my care and treatment.

I understand that I have the right to be informed about the treatment being recommended, and the responsibility to ask questions if I do not understand it. I agree to provide accurate and complete information about my health history and presenting complaint, to agree upon a treatment plan, and follow that plan.

I understand that my health care providers will treat me with respect, and I agree to do the same for them.

Patient Signature: _____ Date:_____

# Southeastern Interventional Pain Associates

## Use and Disclosure of Health Information

I understand that SIPA will use and disclose my health information for the purposes of treatment, payment, and healthcare operations, as permitted by law. Further information can be found in the Notice of Privacy Practices, which has been offered to me.

I understand and acknowledge that SIPA may record medical and other information related to my treatment in paper, electronic, photographic, video and other formats and that such information will be used in the course of my treatment, for payment purposes and to support healthcare operations.

I give SIPA, its employees and agents consent to exchange information with other health care professionals and providers (for example physicians, hospitals, nursing homes, home health agencies and pharmacies) about my prior and current health conditions to facilitate treatment, or to facilitate discharge planning.

## Communication Preferences

I agree that SIPA may communicate with me in writing to any address I have provided, may communicate with me orally or by text message to any telephone number I have provided, and may communicate with me electronically to any email address I have provided.

**My preferred method of communication is (check one):**

__ Home Phone __ Cell Phone __ Other (Specify) _____

If our office cannot reach you personally, may we leave protected health information, (i.e. test results, appointment dates, returned messages, etc.) by the following methods? (Check all that apply)

| | |
|---|---|
| With a family member: | Yes _____ No _____ |
| Home Answering machine: | Yes _____ No _____ |
| Cellular Phone voicemail: | Yes _____ No _____ |
| By mail to home address: | Yes _____ No _____ |
| By email: | Yes _____ No _____ |

## Protected Health Information Contacts

I give SIPA authorization to release information regarding my health to the following people: (i.e. spouse, siblings, parents, etc.) Please note that anyone not listed on this form, including immediate family members and/or relatives, **will not** have access to any information in your medical file.

Name_____ Relation_____

Name_____ Relation_____

Name_____ Relation_____

Name_____ Relation_____

If our office cannot reach you personally, may we leave protected health information, (i.e. test results, appointment dates, returned messages, etc.) by the following methods?:

Patient Signature: _____ Date_____

# Southeastern Interventional Pain Associates

## PATIENT FINANCIAL POLICY

**Patient: _____ _____ _____**
**LAST NAME FIRST NAME MI**

**Southeastern Interventional Pain Associates, LLC believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.**

1. **Payment** *is expected at the time of your visit.* We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of you visit. We do ask for a copy of an ID card due to the many cases of identity theft in the news lately. (Please do not be offended!)

2. **Insurance** We are participating providers with the majority of insurance plans. We will file all of these insurance claims. A list of these insurance plans is available upon request. Please remember that insurance is a contract between the patient and the insurance company and the ultimate financial responsibility for any services provided by a physician and /or medical provider is the patient' regardless of who is listed as the holder of the medical insurance.

   If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due at the time of service. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

   Note: After 60 days, any unpaid insurance claims will be transferred to the patient's financial responsibility for payment and/or follow-up with their insurance carrier.

3. **Referrals:** For those plans that require prior authorizations and/or written referrals for coverage, the patient is responsible to obtain and present this information prior to your office visit/treatment. Please be advised that if we do not have the referral prior to your visit you will be charged for the full amount and you insurance will not be billed for the charges.

4. **Self-Pay:** For patients who are not covered by medical insurance, or have a medical insurance that the physician does not participate with, we require full payment at the time of the service.

5. **Returned Checks:** will incur a $40.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $40 service charge and the full balance must be paid prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $40 service fee and collections action. Our office will not accept any further checks if you have a returned check. You must pay with cash, credit card or money order.

6. **Forms, Medication Authorization, Admin Fees:** completing disability forms, writing jury excuse letters, medical summary letters etc., requires office staff time and time away from patient care for our medical providers. We require pre-payment for completing these forms, letters or extra communication outside normal patient treatment communication. The charge is determined by the complexity of the form, letter, or communication. Base charges for letters are $10 per occurrence plus any applicable postage. Postage is additional and payment is required in advance. Base fees for forms are $45 per occurrence plus any applicable postage.

7. **Medical Records:** Pursuant to O.C.G.A §31-33-3, effective July 1, 2016 the State of Georgia's Department of Community Health (DCH) set the cost for paper medical record retrieval as follows:

| | |
|---|---|
| Search, Retrieval and Other Direct Administrative Costs Up to: | $25.88 |
| Certification Fee Up to Per Record: | $9.70 |
| Copying Costs for Records in Paper Form: Per page for pages 1-20: | $0.97 |
| Per page for pages 21-100:$0.83 Per page for pages over 100: | $0.66 |

The average cost of a patient's medical record on paper form can be approximately $140.98

***SIPA will put medical records in electronic format and the charge is $60.00 (mailing costs will be calculated separately).***

# Southeastern Interventional Pain Associates

8. **Missed Appointments/Late Cancellation:** If you miss your appointment or fail to cancel your appointment within 24 hours you may be charged a $75.00 fee. Maintaining scheduled appointments allow us to continue to provide the best possible medical care for our patients.
9. **Payment Arrangements:** If you are unable to pay your outstanding balance please notify the office to set up a payment arrangement prior to you next office visit or any services you may require.
10. **Billing Office:** If you have questions in regard to any of your billing statements, our accounts receivable staff is available to assist you. **CALL 770-558-8501.**

**PATIENT ACKNOWLEDEMENT**

*My signature below affirms that I have read, understand and agree to the above terms and conditions of the Patient Financial Policy of Southeastern Interventional Pain Associates. I understand that charges not covered by my insurance company, as well as applicable copayments, coinsurance and deductibles, are my financial responsibility.*

*I authorize my insurance benefits be paid directly to Southeastern Interventional Pain Associates.*

*I authorize Southeastern Interventional Pain Associates to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.*

*I understand if my account is delinquent, I agree to pay all expenses incurred by this office to collect the account. This includes, but is not limited to, items such as collection agency fees, garnishment of wages cost, court costs, and attorney fees.*

_____ _____

Patient's Signature (Patient or Guardian) Date

# SOUTHEASTERN INTERVENTIONAL PAIN ASSOCIATES

## Pain Management Treatment Agreement

***If you are not prescribed Opioids (Narcotics) you do not need to fill out this treatment agreement.***

*PLEASE READ CAREFULLY*

Southeastern Interventional Pain Associates (SIPA) understands that your pain is a significant hindrance to the quality of life you desire. *Opioid (narcotic) and Interventional treatment for chronic pain is used to reduce pain and improve what you are able to do each day.* In order to help you achieve your goals and improve your ability to do daily activities, the SIPA Physicians may prescribe interventional alternatives, including nerve blocks, injections, neurolytic procedures, conservative therapy including physical therapy, non-narcotic analgesics, exercises or other interventions based on the individual's specific presentation. ***In accordance with the DEA, and Georgia Composite Medical Board's Pain Management requirements, 360-3-06 this practice will not manage Chronic Pain with only Opioids (narcotics) SIPA is licensed as a Pain Management Clinic by the State of Georgia and we must abide by the state guidelines, which means we must use an interventional approach for the treatment of Chronic Pain.*** I, _____ understand that compliance with the following guidelines is important in continuing pain treatment with Southeastern Interventional Pain Associates.

1. **I understand that I have the following responsibilities:**
   a. I will take medications only at the dose and frequency prescribed.
   b. I will not increase or change medications without the approval of my provider
   c. If I alter my prescriptions or sell my medication I understand it is a violation of the law.
   d. I will actively participate in efforts and alternative treatment designed to improve function (including interventional procedures and other treatment prescribed by my provider).
   e. I will not request opioids or any other pain medications from providers other than this one. Only this provider will prescribe all pain medication.
   f. I will inform the provider of ***All*** other medications I am taking.
   g. I will obtain all medications from one pharmacy, when possible. By signing this agreement, I give consent to SIPA to talk to my pharmacist.
   h. I will protect my prescriptions and medications. I understand that lost prescriptions or medications may not be replaced. I will keep all medications from children.
   i. I agree to participate in psychiatric or psychological assessments, if necessary.
   j. If I have an addiction problem, I will not use illegal or street drugs or alcohol. My provider may ask me to follow through with a program to address this issue. By signing this agreement I give consent for a designated family member to speak with my provider should any drug abuse be suspected.

2. **I understand that in the event of an emergency I will go to the nearest emergency room.** I am responsible for signing a consent form to request record transfer to my provider.
3. **I understand I will consent to random drug screening as required by the GA. State Pain Management Guidelines.** The drug screen is a urine test to check to see what drugs I am taking and to see if they are metabolizing properly.
4. **I will keep my scheduled appointments and/or cancel my appointment a minimum of 24 hours prior to the appointment.**
5. **I understand that my provider may stop prescribing opioids or change the treatment plan if:**
   a. I do not show any improvement in pain or my physical activity has not improved.
   b. My behavior is inconsistent with the responsibilities outlined #1.
   c. I give, sell or misuse my opioid medications.
   d. I develop rapid tolerance or loss of improvement from the treatment.
   e. I obtain opioids from another provider.
   f. I refuse to cooperate when asked to provide a drug screen.
   g. I refuse to have interventional treatment prescribed by my physician.
   h. If I am unable to keep follow-up appointments.
   i. If I am cited for DUI.
   j. If I am abusive to medical staff or administrative staff .

| | |
|---|---|
| **Patient Signature:** | **Date:** |
| **Print Patient Name:** | **Date of Birth:** |
| **Pharmacy:** | **Pharmacy Phone**: |