Addison Pain
+ Regenerative Medicine

Patient Registration Form

PATIENT INFORMATION

_____ _____ _____
Legal First Name Middle Name Last Name
Date of Birth: _____/_____/_____ Age: _____ Sex: M / F
Social Security #: _____ Marital Status: Married / Single / Divorced / Widowed
Address: _____
Home/Work/Cell #: _____ Home/Work/Cell #: _____
Email: _____
Referring or Primary Care Physician: _____

INSURANCE POLICY

_____ _____ _____
Insurance Network Group Number Subscriber ID Number
Primary Policyholder Name: _____
Date of Birth: _____/_____/_____ **Social Security #:** _____
Relationship to patient: Spouse / Parent / Other: _____

LETTER OF PROTECTION COVERAGE

Law Firm: _____ Date of Injury: _____
Attorney's Name: _____ Phone & Fax #: _____

EMERGENCY CONTACT

Name: _____ Relationship to patient: _____
Home/Work/Cell #: _____Home/Work/Cell #: _____

AUTHORIZATION TO RELEASE INFORMATION I hereby authorize the above-named agency to release any treatment information requested by attorneys, physicians, insurance companies, employees, health care providers, or any other entity which may be concerned with the payment of charges incurred for the treatment services of East Rehabilitation, P.A. ASSIGNMENT OF INSURANCE BENEFITS I hereby do authorize payment directly to East Rehabilitation, P.A. I am responsible for payment of all services rendered not covered by insurance.

_____ _____
Patient Signature **Date**

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Authorization for Use and Disclosure Of Protected Health Information (PHI)

Addison Pain and Regenerative Medicine ("APRM") recognizes the patient's right to confidentiality of protected health information ("PHI"). This form obtains permission to discuss and/or release information regarding your care at our practice to a person whom you designate as an authorized representative. Authorization is optional- you may opt to not designate any authorized representatives.

Please bear in mind, if you intend for anyone else to schedule your appointments, manage your prescriptions, or receive billing/account/medical record information on your behalf, you must authorize them on this form.

PATIENT NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

I authorize APRM to disclose my PHI to the listed person(s):

NAME	PHONE NUMBER	RELATIONSHIP TO PATIENT

PROTECTED HEALTH INFORMATION DISCLOSURE OVER THE PHONE

The provider(s) and/or staff have my permission to:

☐ Leave a detailed message with the person(s) listed above
☐ Leave a detailed message on my primary voicemail: (_____) - _____ - _____
☐ Leave a detailed message on my business voicemail: (_____) - _____ - _____

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient if they are not a covered entity under the federal privacy rule. I understand that I may revoke this authorization at any time by notifying Addison Pain and Regenerative Medicine in writing, to be effective on the date notification is received. I agree that my authorization is voluntary.

_____ _____

Patient Signature **Date**

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Notice of Privacy Practices Acknowledgement

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

The protection of your health information is important to us. We have available to you a comprehensive version of our Notice of Privacy Practices if you wish to read it in its entirety. This notice can be found on our website (www.addisonpain.com/patient-forms) OR our front desk will give you a copy when you arrive for your visit. We ask that you acknowledge your opportunity to review a full copy of our Notice of Privacy Practices by signing below. The delivery of your health care services will in no way be conditioned upon your signed acknowledgement. If you have any questions about the Notice of Privacy Practices, please notify a staff member.

I acknowledge that Addison Pain and Regenerative Medicine provided me with a written copy of the office's Notice of Privacy Practices. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____

Patient Signature **Date**

_____ _____

Patient's Legal Guardian Signature (if applicable) Date

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Financial Policy

INSURANCE We will file your insurance claims. This office will accept your insurance company's maximum allowable reimbursement. The patient will be responsible for any deductible, coinsurance and co-payment amount. The patient is responsible for payment of any non-covered service. This includes, but is not limited to, deductibles, co-payments, non-covered charges, and "usual and customary" charges. We will supply factual information as necessary to supplement your claims. We cannot bill third party insurance. It is the responsibility of the patient to provide accurate and timely insurance information. Inaccurate or untimely information given to the staff that results in denial or non-coverage by your insurance company results in the guarantor being responsible for payment. While the filling of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from the date(s) services are rendered. Therefore, it is necessary for you to know what benefits your insurance plan provides for you.

REFERRAL If a referral is required for your insurance policy, it is your responsibility to obtain this referral from the primary insurance company prior to any appointments. Failure to obtain a referral may result in reduction or denial of benefits.

PAYMENT Co-pays and estimated patient responsibility are due at the time of service.Self-pay patients are responsible for all visits, treatment and other related services performed by their treating provider and agree to pay at time of service for the estimated cost of such services. While we make our best effort to accurately provide an estimate of patient responsibility based on ordered services and insurance benefits, please be advised any quote is merely an estimate and you may be responsible for additional amounts. Patients typically receive a statement from our office after the insurance company has processed the claims. This will include charges that the insurance company has not paid. Payment is due within 30 days of the statement date. Patients with financial hardship may apply for assistance and provide proof of income/assets to quality for hardship status with our practice.

FEES The charge for a returned check is $35.00 payable by cash or money order. This will be applied to your account in addition to the insufficient fund amount. The charge for no-showing or late cancellation of an appointment will be will be automatically applied to your account.

I authorize payment of benefits to my treating provider at East Rehabilitation, P.A. (Addison Pain and Regenerative Medicine) and authorize my provider to release any information requested by my insurance carrier. I have read and fully understood the above financial policy. I understand and agree the terms of this financial policy may be amended by the practice any time without prior notification.

_____ _____

Patient Signature **Date**

_____ _____

Patient's Legal Guardian Signature (if applicable) Date

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General Consent for Care and Treatment

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved.

At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment.

By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician or mid-level practitioner about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

This document is also a notification that your patient visit will involve the following: medical assistant and/or scribe, mid-level provider (Nurse Practitioner), and Physician. There will be other non-Physician employees involved in your care as deemed necessary, to perform reasonable and necessary medical examinations, testing and treatment for the condition(s) which has brought you to seek care at this practice.

If additional testing, invasive or interventional procedures are recommended, you will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

By signing below, you certify that you have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient Signature **Date**

_____ _____

Patient's Legal Guardian Signature (if applicable) Date

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Cancellation / No- Show Appointment Policy

We would like to thank you for being a patient in our office. We value all of our patients and our providers strive to provide the best pain management possible by working collaboratively and reserving time for your individual needs. **We kindly ask that if you must cancel or reschedule your visit, please call us at least 24 hours prior to your appointment date.** This courtesy makes it possible to give your reserved time to another patient who is needing treatment.

We will assess charges for appointments that are cancelled or missed without advance notice from the patient.

CANCELLATIONS

Cancelling your appointment with less than 24 hours' notice will result in a non-refundable fee of $35 that will be applied to your account.

MISSED APPOINTMENT

A "no-show" is defined as someone who misses an appointment without providing any notification to our office. No-showing a scheduled appointment will result in a non-refundable fee of $50 that will be applied to your account. If a patient accumulates multiple no-shows, they may be discharged from our practice.

Please check with our staff to ensure that your best contact number is on file with us so that you may receive automated phone calls and text message reminders for your appointments. Thank you for your understanding and courtesy.

_____ _____

Patient Signature **Date**

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Text Messaging Notification

With your approval, our providers may use their personal electronic devices to communicate with you to send messages regarding test results, scheduling future appointments, next steps in your treatment plan, and other personalized forms of communication.

This allows the provider to stay personally connected with you to improve communication, however, it is not considered a "secure" portal and therefore can risk your information being shared. If you opt to communicate via text message with our office, you agree to assume such risk and hold East Rehabilitation P.A. harmless in the event of any data breach in such transmission.

We understand the importance of keeping all patient information confidential while maintaining a personal relationship with you. We respect your choice if you do not wish to receive text messages (SMS) from your provider.

Please indicate your preference below:

- ☐ I DO NOT wish to communicate with my provider via text regarding my treatment.

- ☐ I DO wish to communicate with my provider via text regarding my treatment.

_____ _____

Patient Signature **Date**

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Medical Records Release Authorization

I hereby authorize the use of disclosure of information from the medical record of

PATIENT NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

PLEASE RELEASE THE FOLLOWING INFORMATION

☐ **Entire Record** ☐ Progress Notes ☐ Radiology Reports

☐ Laboratory Results ☐ Medication List ☐ Other: _____

TO THE FOLLOWING RECIPIENT

☐ Directly to patient

☐ Healthcare provider / facility: _____

Fax: _____ Email: _____

☐ Other: _____

Fax: _____ Email: _____

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse. I understand that I have a right to revoke this authorization at any time and must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already release in response to this authorization. I understand that any disclosure information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that my medical record may contain notes and results that only a physician can interpret. I understand and have been advised that I should contact my physician to prevent my misunderstanding the information contained in these entries. I will not hold East Rehabilitation P.A. liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____

Patient Signature **Date**

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Initial Patient Visit

Patient Name _____ **DOB** _____ **Sex** M / F

Referred by _____ **Phone** _____

Reason for visit _____

Primary Insurance _____ **Secondary Insurance** _____ ☐ **Self Pay**

☐ **Attorney** _____ **Pharmacy (cross streets)** _____

Please describe how your problems began, including <u>when</u> and <u>how</u> the pain started

_____

_____

_____

_____

_____

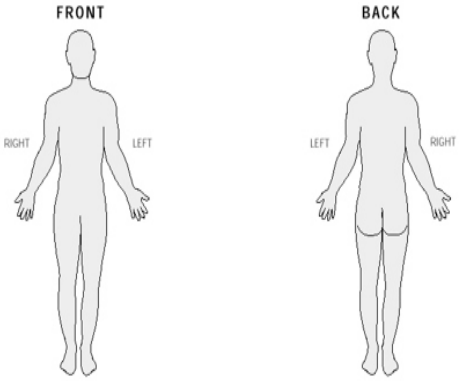
_____

_____

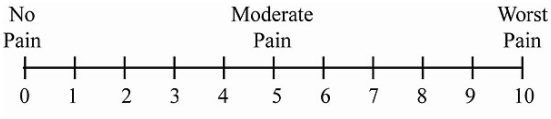
_____

_____

Indicate your pain location(s) by drawing on the figure below



Circle your current pain level



Pain started? ☐ < 2 weeks ☐ 1 - 3 months ☐ 3 – 6 months ☐ 6 months – 1 year ☐ > 1 year

Pain present? ☐ always ☐ usually ☐ occasionally ☐ rarely ☐ only when I _____

Type of pain? ☐ aching ☐ shooting ☐ sharp ☐ burning ☐ tiring ☐ numbing ☐ throbbing ☐ stabbing ☐ tender ☐ tightness ☐ other: _____

Pain lessens with: ☐ rest ☐ medication ☐ changing position ☐ massage ☐ heat or cold pack ☐ movement ☐ relaxation techniques ☐ other: _____

Pain worsens with: ☐ physical activity ☐ sitting ☐ standing ☐ walking ☐ other: _____

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Mood & sleep? □ normal □ daytime sleepiness □ insomnia □ depression □ anxiety

PLEASE COMPLETE ALL QUESTIONS, CIRCLING ITEMS BELOW THAT APPLY TO YOU

Prior imaging Back: MRI / CT / X-Rays Neck: MRI / CT / X-Rays Other:_____

Prior injections Trigger Point Injections Epidural Injection Joint Injection Rhizotomy Nerve Block

Prior therapies
Have you ever had physical therapy? □ No □ **Yes – for how long?** _____
Have you had chiropractic treatment? □ No □ **Yes – for how long?** _____
Exercises or stretching at home? □ No □ Yes Massage therapy? □ No □ Yes
Have you used orthotics, like a back or knee brace? □ No □ **Yes – for how long?** _____

Prior medicines Lortab/Lorcet/Vicodin Norco Darvocet Percocet Percodan Codeine Celebrex/ Vioxx Motrin/Advil Lodine Mobic Alleve/Naproxen Oxycontin MS Contin Methadone Duragesic Patch Morphine Actiq Neurontin Elavil Topamax/Zonegran Ambien Xanax Restoril Trazodone Robaxin Skelaxin Flexeril Zanaflex Baclofen Soma Prozac Celexa Lexapro Paxil Remeron Zoloft Other_____

Allergies _____

Medical conditions Arthritis Asthma Cancer Chronic pain Depression Diabetes Deep vein thrombosis Reflux Gastric ulcer High blood pressure Mental illness Migraines Neurological disorder Obesity Osteoporosis Muscle pain / inflammation Thyroid disorder Seizure Other: _____

Prior surgeries Appendectomy C-section Cholecystectomy Hernia repair Hysterectomy Tonsillectomy Tubal ligation Joint replacement Spinal fusion Back surgery Shoulder surgery Knee surgery Ankle surgery Vertebral fusion Laminectomy Hip surgery or replacement Knee replacement Other: _____

Family history Neck pain Lower back pain Alcohol abuse Substance abuse Cancer Heart disease Mental illness Bleeding problems Arthritis Other: _____

Functional Circle all the actions you are unable to perform without assistance
Dress Bathe Groom Toilet Walk Drive Perform sports

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Social history

Do you smoke? □ yes □ no How many packs per day? _____ For how long? _____

Do you use alcohol? □ no □ yes, socially □ yes, heavy consumption □ recovering alcoholic

Illicit drug use? □ no □ yes: _____

Diet and exercise habits _____

Marital status: □ married □ single □ divorced □ widowed

Describe your work: □ office □ heavy labor □ homemaker □ driver □ retired □ student

Do you drive yourself? □ yes □ no, because_____

Review of symptoms

Circle all the symptoms you are **currently** experiencing

Fatigue Fever Chills Night sweats Weight loss Weight gain Anxiety Excess sleeping Difficulty falling asleep Irritability Headache Sinus pain Migraine Chest pain Palpitations Increased heart rate Leg pain with exercise Limb swelling Snoring Difficulty breathing Shortness of breath Waking at night due to shortness of breath Cough Decreased appetite Anorexia Heartburn Nausea Vomiting Abdominal pain Diarrhea Constipation Muscle weakness Muscle aches Joint pain Joint swelling Joint stiffness Knee swelling Muscle cramps Dizziness Vertigo Fainting Confusion Memory loss Difficulty with balance Tingling Numbness Anxiety Depression