

PATIENT INFORMATION

Family Dr.: _____ Phone #: _____ Referring Dr.: _____ Phone #: _____

How did you hear about our practice? _____

Patient Name: _____ Email for Patient Portal: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

Social Security #: _____ Date of Birth: _____ Preferred Language: _____

Sex (please check one): M F Race: _____ Ethnicity: _____

Marital Status: (please check one) Married Single Divorced Widowed Other

Spouses Name: _____ Date of Birth: _____ Social Security #: _____

OCCUPATION INFORMATION

Employer: _____ Occupation: _____ Phone #: _____

PHARMACY

Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

EMERGENCY CONTACT INFORMATION (someone not living in the same household)

Name: _____ Relationship: _____

Home Phone #: () _____ Cell Phone #: () _____ Work Phone #: () _____

INSURANCE INFORMATION: IT IS YOUR RESPONSIBILITY TO KNOW IF YOU NEED A REFERRAL.

Primary Insurance Carrier: _____ Name of Policy Holder: _____

ID Number: _____ Group # _____ Relationship to Insured: _____

SS# of Policy Holder: _____ D.O.B of Policy Holder: _____

Secondary Insurance Carrier: _____ Name of Policy Holder: _____

ID Number: _____ Group # _____ Relationship to Insured: _____

SS# of Policy Holder: _____ D.O.B of Policy Holder: _____

Patient Signature: _____ **Date:** _____

AUTHORIZATION FOR TREATMENT & ASSIGNMENT OF BENEFITS

This will authorize the treatment of myself as well as filing of any insurance in force for all charges, which include anesthesia and pathology, if applicable and the direct payment to Gershon Pain Specialists of any amount due on my claim under the above stated policy. I understand that my insurance policy is a contract between me and my insurance company and that I am financially responsible to Gershon Pain Specialists for non-payment of any fees not covered by insurance. I understand and agree to pay in full any balance due after an insurance payment or to make payment arrangements with Gershon Pain Specialists. In consideration of services rendered, the undersigned patient, spouse, and/or responsible party agrees to pay all cost of collections including attorney's and/or collection agency's fees in the range of 28-33% plus court cost and any interest allowable by law, if incurred. I hereby authorize the release of any medical information necessary to process claims.

Patient Signature: _____

Date: _____

DEEMED CONSENT FORM

I understand that the laws of Virginia provide if my physician or any person employed by or under the direction and control of my physician(s) is directly exposed to my body fluids in any manner which may according to the then current guidelines for the Center of Disease Control transmit the Human Immunodeficiency Virus (HIV) or Hepatitis B or C viruses that I am deemed by law to have consented to testing for infection with HIV or Hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person(s) who is exposed to my bodily fluids.

Patient Signature: _____

Date: _____

ACKNOWLEDGEMENT OF HIPAA PRIVACY PRACTICES & OFFICE POLICY

1. _____ (initial) I hereby acknowledge that I have had the opportunity to review a copy of the Notice of Privacy Practices. Please list anyone you are authorizing to have access to your medical record below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

2. _____ (initial) I hereby acknowledge that I understand there is a **\$150.00** cancellation fee for procedures not cancelled within 72 hours, and a **\$25.00** fee for **No Show** office visits.
3. _____ (initial) I hereby acknowledge that I understand there is a **\$50.00** charge for each check that is returned for insufficient funds. If any balance is not paid in full within 3 business days, an additional **\$55.00** fee will be added, and we will forward your returned check to the Commonwealth Attorney-City of Virginia Beach for prosecution.
4. _____ (initial) I authorize Gershon Pain Specialists to leave testing reminders or results on my answering machine.
5. _____ (initial) I understand that Gershon Pain Specialists utilizes the Prescription Monitoring Program and routinely monitors controlled medication prescriptions. I also understand that Gershon Pain Specialists will report all controlled substance violations to law enforcement.
6. _____ (initial) I understand that it is the policy of Gershon Pain Specialists to provide and mandate urine Monitoring for all patients who are prescribed scheduled medication.



AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand if my record contains information related to substance abuse, HIV, and/or mental health, the information will be released with my medical record.

Patient Name: _____

Last 4 digits of SS#: _____ Date of Birth: ____/____/____ Account # _____

Person/Organizations providing information:

Person(s)/Organization(s) receiving information:

Information to be disclosed, covering the period of health care: From _____ To _____

- Complete Health Record OR, select from the following:
Office Notes Pathology Reports Procedure Reports Laboratory Tests Diagnostic Testing
Other (please specify) _____

This information is to be disclosed for the purpose of: _____.

The patient of the patient's representative must read and initial the following statements:

- I understand that unless earlier revoke, this authorization will expire 5 years from the date of signed below.
I understand that I may revoke this authorization at any time by notifying GPS in writing. If I do, it won't have any effect on any actions GPS took before it received the revocation.
I understand that GPS cannot require me to sign this authorization as a condition to receive treatment from Gershon Pain Specialists except:
i. When Gershon Pain Specialists provides me with research-related treatment; or
ii. When Gershon Pain Specialists provides me with health care solely for the purpose of creating protected health information for disclosure to someone else.

Gershon Pain Specialists, it's employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. Please be aware there is a charge for obtaining your records.

Signature of Patient or Representative

Date

Print Name

Relationship to Patient

PATIENT QUESTIONNAIRE

Name: _____

Age: _____ Referring Provider: _____

Where is your pain located? _____

Does the pain radiate throughout your body? If so, where? _____

What makes your pain better? _____

What makes your pain worse? _____

When did your pain begin? _____ Who have you seen for this? _____

What treatments/tests have you undergone for this pain? _____

Is your pain constant or intermittent? _____

Please describe your pain:(check all that apply)

- Numbness
- Weakness
- Tingling
- Pins & Needles
- Sharp
- Pulsating
- Dull
- Pressure
- Deep
- Aching
- Throbbing
- Stabbing
- Stinging

How severe is your pain?

- 0- No Pain
- 1-2 Mild Pain, requires no medication
- 3-4 Mild/moderate pain, requires mild medications
- 5-6 Moderate pain, requires stronger medications
- 7-8 Moderate/Severe, constant pain, requires narcotic or ER visit
- 9-10 Severe, constant pain, requires admission to hospital

Past Medical History: Please list any medical problems that you are being treated for or have been treated for in the past:

Please list your surgical history:

Do you have any allergies to medications? Y/N

If so, please list: _____

Social History:

Do you use Nicotine Products? Y/N

Do you drink alcohol? If so, how many drink per week? _____

Do you or your family have a history of illicit drug or prescription overuse/abuse? Y/N

Do you have children? Y/N If so, how many _____