SUMMIT PAIN ALLIANCE

Date of Visit: _____/_____/_____

INITIAL PAIN ASSESSMENT

Patient Name: _____ Date of Birth: _____/_____/_____

Primary Care Physician: _____ Referring Physician: _____

Marital Status: Single Married Divorced Widowed # of Children: _____

Currently Working: Yes No Occupation: _____ Last day of work: _____

Height: _____ Weight: _____ Date Pain Began: _____ Average Pain Score (0-10): _____

Location of Pain: Upper Back Lower Back Head Neck Arms Hands Feet Other_____

Pain Radiates To: Left Arm Right Arm Left Leg Right Leg Other_____

Pain Quality: Constant Intermittent Sharp Dull Burning Throbbing Shooting Tingling Other_____

What makes the pain worse?

_____

What makes the pain better?

_____

Numbness: Yes No Where:_____ **Weakness:** Yes No Where:_____

What imaging studies have you had?

MRI Date: _____ Where: _____

CT Scan Date: _____ Where: _____

EMG/NCS Date: _____ Where: _____

History of Treatment (list the dates next to each):

Acupuncture_____	Aquatic Therapy_____	Biofeedback_____	Chiropractic_____
Back Brace_____	Physical Therapy_____	Occupational Therapy_____	Massage Therapy_____

Medical History:

High Blood Pressure	High Cholesterol	Heart Attack	Heart Failure	Cancer
Recent Cough/Cold	Asthma	Bronchitis	Liver Problems	Hepatitis
Kidney Problems	Diabetes	Thyroid Problems	Seizure	Stroke
Prolong Bleeding	Other_____			

Drug and/or Food Allergies: _____

Smoke History: Yes No How many packs per day: ____ How many years: ____ Date when quit: _____

Alcohol History: None Socially Excessive # of drinks per week: ____

Substance Abuse: Yes No What Type: _____ Date when quit: _____

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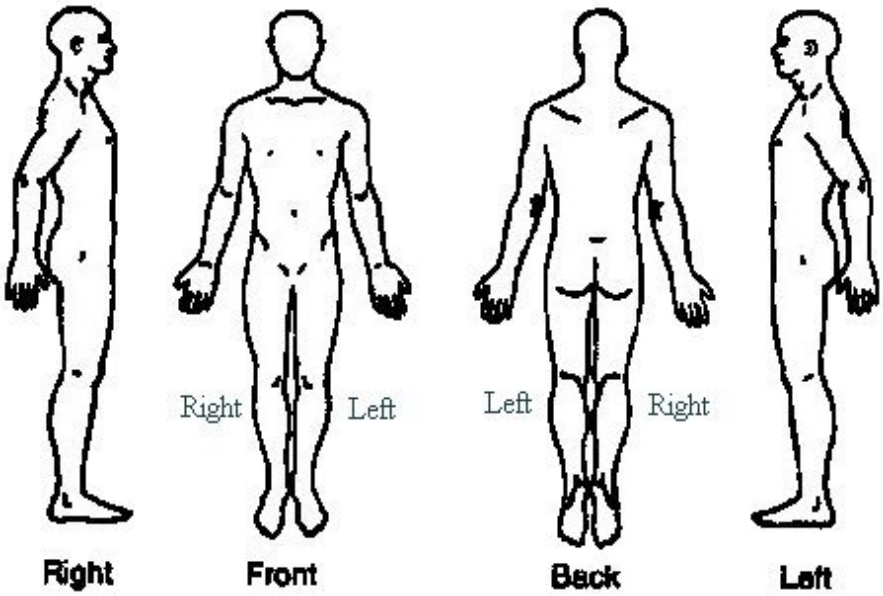
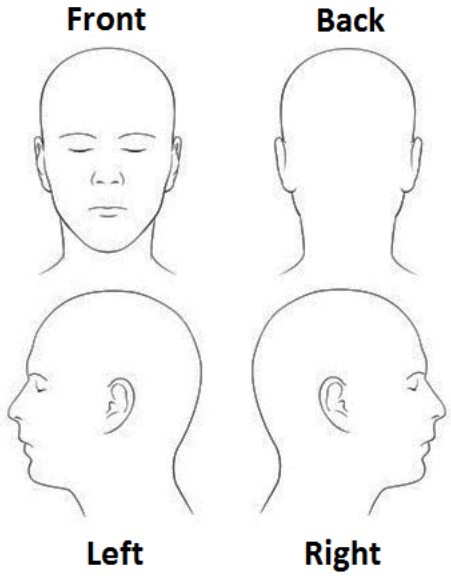
Location of Pain(s): (shade or drawn in where your pain is located on the figures)





Current Medications:

Name of Medication	Dose	Frequency

Surgery, Nerve Blocks, Trigger Point or Epidural Injections

Surgery / Procedure	Date

Patient Signature: _____ **Date:** _____

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REVIEW OF SYMPTOMS

Fevers	Yes	No	Nausea	Yes	No
Chills	Yes	No	Vomiting	Yes	No
Recent Weight Gain	Yes	No	Diarrhea	Yes	No
Recent Weight Loss	Yes	No	constipation	Yes	No
			Heartburn	Yes	No
Visual Disturbances	Yes	No	Liver Disease / Hepatitis	Yes	No
Hearing Loss	Yes	No	Signs of GI Bleeding	Yes	No
Glaucoma	Yes	No			
Cataracts	Yes	No	Hematuria	Yes	No
			Dysuria	Yes	No
Heat Intolerance	Yes	No	Recent Urinary Tract Infection	Yes	No
Cold Intolerance	Yes	No		Yes	No
Diabetes	Yes	No	Back Pain	Yes	No
Thyroid Dysfunction	Yes	No	Neck Pain	Yes	No
			Arthritis	Yes	No
Asthma	Yes	No	Osteoporosis	Yes	No
Cough	Yes	No			
Wheezed	Yes	No	Dizziness	Yes	No
Emphysema	Yes	No	Headaches	Yes	No
Shortness of Breath	Yes	No	Fainting	Yes	No
History of Tuberculosis	Yes	No	Numbness	Yes	No
			Paralysis	Yes	No
High Blood Pressure	Yes	No	History of Stroke	Yes	No
High Cholesterol	Yes	No	Vertigo	Yes	No
Bleeding Disorders	Yes	No			
Chest Pain	Yes	No	Anxiety	Yes	No
Coronary Artery Disease	Yes	No	Depression	Yes	No
Heart Murmurs	Yes	No	Mood Disorders	Yes	No
Palpitations	Yes	No			
History of Heart Attack	Yes	No	Cancer	Yes	No

If you answered “yes” to any of the questions, please provide a brief description & when it occurred:

_____

_____

_____

_____

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Date of Visit: _____/_____/_____

PAIN CENTER PRESCRIPTION AGREEMENT

I, _____ understand that in order to receive any prescription medications for the treatment of pain from the pain center physicians, I must comply with the following rules and expectations of the pain center:

1. **All** medications prescribed by a physician at the pain center will be used only as ordered and for the reason ordered. Stopping a medication suddenly, using a medication for a reason other than that for which it was prescribed, or increasing a medication without medical advice is not acceptable behavior and can also be dangerous. **Any prescription changes must be addressed at the time of your appointment.** Early refills will generally not be given.
2. Triplicate medications will be refilled **ONLY** at the scheduled pain center appointments. I am expected to make and keep all the appointments. Prescriptions will **NOT** be mailed or called to the pharmacy.
3. I will not request or receive pain medications nor controlled substances from any physician who is not from the pain center (or their designee).
4. I will not use illegal drugs or medications - if I am on medical marijuana I must provide a copy for my chart, with the understanding that no opioids will be prescribed from the pain center.
5. I will comply with a random blood, urine or oral swab test when requested. I may be asked to provide a blood, urine or oral swab test during my initial consultation.
6. Out of town refills will not be processed, if leaving town for emergencies, please make arrangements before leaving, and itineraries may be requested.
7. It is my responsibility to protect my prescriptions from loss, selling, theft, or damage. A police report will be required if medications are stolen. Any stolen or lost medications may not be replaced. If a second loss, theft, or damage of medications should occur, you may be dismissed from the practice.
8. I will fill all prescriptions under one pharmacy.
9. I understand that I am not to drive while under the influence of medications (i.e. narcotics/opiates), nor should I operate heavy machinery nor serve in any capacity related to public safety.
10. I am aware that the risks of opiates/benzodiazepines/muscle relaxants may include: addiction, sedation, physical dependence, nausea/vomiting, drowsiness, hypogonadism, tolerance, depression, decrease bone density, slowed reflexes and response time, and constipation.
11. Violation of any points in this agreement may result in dismissal from the practice at the discretion of the physician.

_____ _____

Patient Signature Date

Date of Visit: _____/_____/_____

PATIENT REGISTRATION FORM

Patient Name: _____ Date of Birth: _____/_____/_____
(Last Name, First Name, Middle Initial)

Social Security: _____-_____-_____ Gender: Male _____ Female _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Summit Pain Alliance may contact you by: Cell/Home Phone_____ Text Message_____ Email_____

Employer Name: _____ Address: _____

Marital Status: Single_____ Married _____ Divorced _____ Widowed _____ Other _____

****

EMERGENCY CONTACT

Name: _____ Relation to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Phone: _____

****

PHYSICIAN & PHARMACY INFORMATION

Primary Care Physician & Phone: _____

Referring Physician & Phone: _____

Pharmacy: _____ Location: _____ Phone: _____

****

As required by the Patient Protection & Affordable Care Act, please provide the following:

Race:

_____ American Indian or Alaska Native

_____ Asian

_____ Black or African American

_____ Native Hawaiian or other Pacific Islander

_____ Caucasian

_____ Other

_____ I prefer not to answer

Ethnicity:

_____ Hispanic or Latino

_____ Not Hispanic or Latino

_____ I prefer not to answer

Preferred Spoken Language:

_____ English _____ Spanish

_____ Other_____

SUMMIT
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INSURANCE INFORMATION

Primary Insurance: _____

Claim Mailing Address: _____

ID#: _____ Group #: _____

Insured Name (if different from the patient):_____

Date of Birth: _____/_____/_____ Social Security: _____-_____-_____

Secondary Insurance: _____

Claim Mailing Address: _____

ID#: _____ Group #: _____

Insured Name (if different from the patient):_____

Date of Birth: _____/_____/_____ Social Security: _____-_____-_____

****

GUARANTOR INFORMATION
(Individual responsible for payment, if different from the patient)

Name: _____

Patient Relationship to Guarantor: Self _____ Spouse _____ Child _____ Other _____

Date of Birth: _____/_____/_____ Social Security: _____-_____-_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Guarantor's Employer: _____

****

NOTICE OF PRIVACY PRACTICE

You may share health information about the patient's condition with:
(List the names of individuals to whom you wish to grant authorization to share medical information.)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

SUMMIT
PAIN ALLIANCE

WORKER'S COMPENSATION OR AUTO ACCIDENT

****

ATTORNEY INFORMATION

Attorney Name: _____ Phone: _____

Firm Name: _____

Address: _____

City: _____ State: _____ Zip: _____

****

WORKER'S COMPENSATION

Accepted Body Part: _____ Date of Injury: _____

Adjuster Name: _____ Phone: _____

Insurance Name: _____ Claim #: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Employer Name: _____

Employer Address: _____

****

AUTO ACCIDENT

Date of Injury: _____ Passenger _____ or Driver _____

Patient's Auto Insurance: _____ Claim #: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Adjuster Name: _____ Phone: _____

Policyholder Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Name of **Liable Party** (At Fault Driver): _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Liable Party's Auto Insurance: _____ Claim #: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Adjuster Name: _____ Phone: _____

Policyholder Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

RELEASE OF INFORMATION & FINANCIAL POLICY

Thank you for choosing Summit Pain Alliance as your health care provider. The following is a statement of our Release of Information/Financial Policy which we require you read and sign prior to any treatment.

RELEASE OF INFORMATION / MEDICAL RECORDS
By signing this form, you authorize Summit Pain Alliance or his/her designee(s) to release and disclose such medical records, information and documentation as may be necessary or appropriate in order to process insurance claims and to obtain payment on your behalf. You also authorize the release of information acquired in the course of your examination or treatment and all information pertaining to your history and progress in your case. This includes any alcohol or drug abuse data that may be protected by Federal Regulations - 42CFR Part 2. You agree that a photocopy your original authorization shall be considered equally authentic.

IDENTIFICATION AND INSURANCE
It is our policy that prior to being seen, you provide us with a picture identification card (i.e. driver license or passport) to verify your identity. We also need your insurance card(s) and any special claim forms required by your insurance company. We cannot bill your insurance company unless you provide us with your appropriate insurance information. We accept assignment of insurance benefits. That means your insurance will pay us directly the amount due based upon your benefit coverage. By signing this form, you authorize assignment of your benefits to Summit Pain Alliance for treatment and related services. However, we do require, as your insurance benefits require, payment of co-pays, co-insurance and deductibles at the time of service. Your insurance policy is a contract between you and your insurance company. *Please know your benefits. Please be aware that only your insurance company can tell you if the services provided are covered under your benefit plan.*

While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. In the event that your account is turned over to an outside collection agency, you will be responsible for an additional 30% of the balance owed and/or all the attorney fees and costs incurred to collect the unpaid debt.
Those Insurance Plans in which we are a Participating Provider.

All co-pays and deductibles are due at the time of treatment. Prior to seeking payment from you, we will work with these plans to obtain payment. In the event that your insurance coverage changes to a plan in which we are not a participating provider, refer to the paragraph below.
Those Insurance Plans in which we are NOT a Participating Provider.

If your insurance company has not paid your account in full within 45 days of the billed date, the balance is your responsibility. Your assistance in collection from your insurance company may be required.

WE ACCEPT PAYMENT IN THE FORM OF CASH, CHECK, VISA OR MASTERCARD
(THERE WILL BE A $25.00 FEE FOR RETURNED CHECKS)

(CONTINUED ON NEXT PAGE)

USUAL AND CUSTOMARY RATES
Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. The federal government agency that administers the Medicare and Medicaid programs, has determined that except for certain circumstances, the discounting or waiving of a patient's co-pay or deductible is unlawful. Additionally, under the new HIPAA regulations, we are now not allowed to discount or waive patient's co-pays or deductibles as outlined by benefit plans offered by other third party payers. You are responsible for payment unless we are a participating provider for your insurance company.

PATIENT BALANCES
Patients are responsible for full payment at the time of service if not covered by some other third party such as Medicare, Medicaid or private insurance.

CASES INVOLVING AN ATTORNEY
If you are receiving services for an auto accident, worker's compensation case or personal injury and you are working with an attorney, we will also require information relating to your group health coverage. Both your group health and the appropriate auto carrier will be billed at the same time. This procedure is necessary in order to have a claim on file with the group health in case the auto carrier does not pay or is exhausted at some point during your treatment. This procedure not only protects Summit Pain Alliance, but you as the patient.

MISSED APPOINTMENTS
Please help us serve you better by keeping scheduled appointments. We recognize there are times when it is not possible to keep appointments. If you are not able to keep an appointment, please call our office at least 24 hours prior to the appointment time. If you consistently miss scheduled appointments, our policy is to charge **$50.00 for missed appointments** and you will be held responsible for payment.

DISCLOSURE OF FINANCIAL INTEREST
Our physicians are currently staffed at several hospitals and outpatient surgery centers. They have financial interest at some of the facilities that your procedure may be performed. They are also consultants and paid national speakers for various device companies.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)
HIPAA is a protective measure safeguarding patient privacy and confidentiality. By signing this agreement I acknowledge that I have received information pertaining to my rights as covered under the Health Insurance and Portability and Accountability Act of 1996.

I have read and understand the above statements in the Release of Information/Financial Policy concerning my payment responsibility.

_____	_____	_____
Signature of Patient or Responsible Party	Print Name	Date
_____	_____	_____
Signature of Co-Responsible Party	Print Name	Date