1715 N. George Mason Dr #102 ~ 14904 Jefferson Davis Hwy #401 ~ 450 Garrisonville Rd #109 ~ 1499 Chain Bridge Rd #101 ~ 11230 Waples Mill Rd #114C ~ 3500 Boston St #J2
Arlington, VA 22205 Woodbridge, VA 22191 Stafford, VA 22554 McLean, VA 22101 Fairfax, VA 22030 Baltimore, MD 21224

Phone #: 703–522–2727 **Thomas J. Raley, MD** **Fax #: 703–542–3753**

James Huang, MD **Vipul Mangal, MD** **Galadriel Pastor, PA-C**

ADVANCED SPINE AND PAIN

PATIENT REGISTRATION

Personal Information

Name: _____

DOB: _____

Male: _____ Female: _____ Age: _____

Marital Status: S M D W

Address:

_____

_____

Phone #: _____

SSN: _____

Email address:_____

Referring Doctor (First & Last Name):

_____

Phone#: _____

Insurance Information

Primary Insurance: _____

Subscriber: Self: _____ Other: _____

If Other, Subscriber Name: _____

Subscriber DOB: _____ SSN: _____

Secondary Insurance: _____

Subscriber: Self: _____ Other: _____

Subscriber Name: _____

Did this injury occur at work? Yes/No

If YES, do you have an active claim? YES/NO

Pharmacy (Name, Address, Phone Number):

_____

Employment Information:

Employer: _____

Employer Phone #: _____

Spouse Name: _____

Spouse's #: _____

Emergency Contact Information

Contact Name: _____

Relationship: _____

Phone #: _____

Address: _____

Signature On File:

By signing below, I agree to the following:
I allow ASAP to participate in the treatment of my health
I authorize the release of this information to my insurance company
I understand I am responsible for my account
I authorize my doctor to act as my agent in helping me to obtain payment from the insurance
I authorize payment directly to ASAP
I permit a copy of this authorization to be used in place of the original

_____ _____

Patient/Responsible Party Signature Date

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ADVANCED SPINE AND PAIN
FINANCIAL POLICY

Name: _____ Date: _____

Thank you for choosing us as your medical provider. Please read the following for a complete understanding of our *Financial Policy*. If you have any questions, please call our billing department at **703–522–2727**.

- Payment for services is due at the time services are rendered or upon receipt of the patient billing statement.
  ******ALL SELF-PAY PATIENTS MUST PAY AT THE TIME OF VISIT******
- We accept cash or credit cards only (***Visa and MasterCard***).
- Failure to cancel your appointment with 24 hour notice results in a $50 no show/same day cancellation fee for follow-up appointments and a $100 no show/same day cancellation fee for injections. These fees **MUST** be paid before your next appointment.
- Any forms that need to be filled out or written by a provider will be $20 per page.
- There will be a $15 fee for any and all prior authorizations on medications this office handles.
- For patients with insurance, we will submit the appropriate claim to your provider. You may be responsible for a copay the day of your appointment.
- We are a provider for the following insurance companies: ***Medicare, Tricare (Prime & Standard), Blue Cross Blue Shield, Aetna, Cigna (PPO), United Healthcare (PPO), PHCS, Coventry, & Workers Compensation.*** Please be advised that our services are Out of Network for ***every other*** policy, which could result in you having to meet an additional deductible or coinsurance.
- If you are out of network, your insurance company may submit a check for our services directly to you. It is then your responsibility to endorse the check to us immediately. Failure to do so may result in further penalty, including reporting to a collection agency and criminal prosecution.
- After our office has received payment from your insurance company, and the appropriate adjustments have been made, your remaining balance will be billed to you and is due and payable upon receipt of the bill.
- All prior balances must be paid before any new appointment can be made.
- ***Workers Compensation:*** If you are here as a result of a work related injury, we will require information regarding both your health insurance and your employer's Workers' Compensation insurance. WE will also need to verify that your employer assumes responsibility for charges incurred. If we cannot verify responsibility, or we are unable to obtain information on employer's Workers' Compensation insurance, we will bill your private/personal insurance carrier. In the case that you have no other insurance and we have not received payment from any third party, we will bill you directly.

I understand that if the office agrees to bill insurances as a courtesy, I must submit information as needed to ensure payment for services rendered to me. I understand that I am ultimately responsible for payment of all services.

In the event that a delinquent account is place in the hands of a collection agency, or attorney for collection, or suit is instituted on this account, I agree to pay, in addition to the amount of the delinquent account plus interest, reasonable collector's or attorney's fees.

_____ _____
Patient/Responsible Party Signature Date

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James Huang, MD **Vipul Mangal, MD** **Galadriel Pastor, PA-C**

ADVANCED SPINE AND PAIN
PATIENT CONSENT FORM

Name: _____ Date: _____

Advanced Spine and Pain, Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our office may change. If we change our notice, you may obtain a revised copy from our website or front desk receptionist at ASAP.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing this form you consent, to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent. You also allow our office to contact you by phone or by mail to provide appointment reminders or information about treatment alternatives or other health benefits and services that may be of interest to you. We may also contact you to raise funds for covered entity.

_____ _____
Patient/Responsible Party Signature Date

I give permission for **Advanced Spine And Pain** to discuss my care, appointments, and financial information with the following person(s):

_____ _____ _____
Name Relationship Date of Birth

_____ _____ _____
Name Relationship Date of Birth

_____ _____
Patient/Responsible Party Signature Date

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ADVANCED SPINE AND PAIN
AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ DOB: _____

SSN: _____

By signing this form, I hereby authorize _____ to disclose the health information described below to the office of **ADVANCED SPINE AND PAIN**.

CHECK ALL THAT APPLY:

- o All health information
- o Last (3) office visits, MRI, or X-ray notes, Injection procedure notes
- o Health information relating to the following treatment or condition

  _____

- o Health information for the date(s)

  _____

- o Other specific health information or dates

  _____

REASONS FOR THIS AUTHORIZATION:

- o At my request
- o Other (specify)

This authorization expires upon: _____ (date or description of event)

I understand that I may refuse to sign this authorization. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on signing an authorization if to do so would be prohibited by federal or state law. I understand an authorization may be required to participate in research or where health services are provided solely for the purpose of creating health information for a third party, and that if I refuse to sign an authorization those services may be denied.

I may revoke this authorization in writing. If I do, it will not affect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may revoke this authorization by writing a letter and mailing it by certified mail, return receipt requested, to the Privacy Office at the health care provided listed above. Once health information is disclosed pursuant to the authorization, it may be re-disclosed and may no longer be protected by privacy laws.

_____ _____

Patient/Responsible Party Signature Date

ASAP

ADVANCED SPINE AND PAIN

To: All Insured Patients

From: Advanced Spine and Pain, PLLC
Billing Department

Please be aware that some insurance plans require all labs to be sent to a specific laboratory. The Urine Screens utilized in our offices must be processed at our facility so that we may obtain immediate results to assist the provider in proper treatment planning. Per federal regulation, all drug screening results must also be confirmed by a third party facility and are sent to Alere Laboratories due to the specific testing that is required.

All patients are required to sign this document that represents an insurance waiver stating they have been notified the Urine Screen testing may not be covered by their insurance company and they understand they may be charged our self-pay fee of **$125.00**. *This fee is subject to change at any time and patients will be notified accordingly.*

Patient Waiver:

I have read the above statement and understand its contents. I also understand that if I receive a bill for any Urine Screen processed by my insurance company as non-covered, I am responsible for the balance.

Patient Name:_____

Patient Signature:_____

Date:_____

Tel: 703.522.ASAP (2727) www.asapspine.com Fax: 703.542.3753

Stafford Office
450 Garrisonville Rd, Suite 109
Stafford, VA 22554

ASAP

ADVANCED SPINE AND PAIN

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New Patient Medical History Form

Patient Name	
Date of Birth	
Gender	

Primary Care Physician:
Office Location of this Physician:

Pain History Background

What is your age?

What is your main pain complaint?

If pain is located in the neck or back, does it radiate into your arms or legs? ☐ Yes ☐ No

How long has this pain been present? *(Indicate number of months or years)*
Months _____ Years _____

Is the pain associated with any other symptoms?
☐ None ☐ Difficulty walking
☐ Numbness, where _____
☐ Weakness, where _____
☐ Sexual dysfunction _____
☐ Other _____

What words best describe how the pain feels?
☐ Sharp ☐ Burning ☐ Shooting ☐ Deep
☐ Stabbing ☐ Throbbing ☐ Aching ☐ Pressure
☐ Dull ☐ Tingling ☐ Other _____

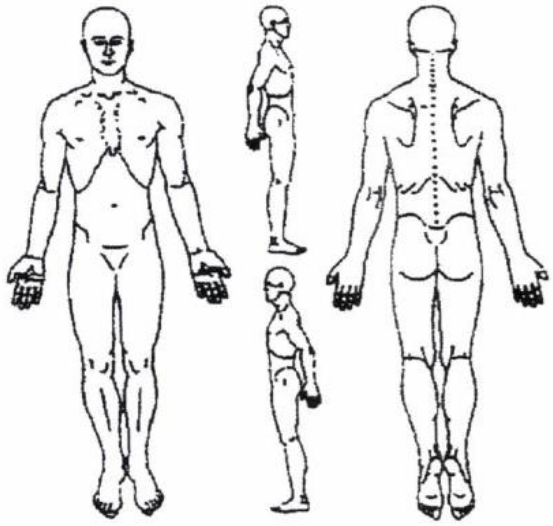
How often is the pain present? ☐ Constant
☐ Frequent (several times per hour) ☐ Sporadic (several times per day)
☐ Occasional (several times per week) ☐ Rare (several times per month)

What makes your pain better?
☐ Rest ☐ Heat ☐ Cold ☐ Medication
☐ Exercise ☐ Other _____

What makes your pain worse? ☐ Heat ☐ Cold ☐ Walking
☐ Bending/Twisting ☐ Sitting ☐ Standing ☐ Lying ☐ Stress
☐ Coughing/Sneezing ☐ Standing from sitting

Since your pain began, have you experienced any of the following?
☐ Bowel incontinence ☐ Bladder incontinence ☐ Neither

Has the pain affected your sleep? ☐ Yes ☐ No



Please shade the areas where you are having pain

For the scales below, circle a number using 0 to indicate none up to 10 to indicate most extreme/severe

Please indicate your ***current*** pain										
0	1	2	3	4	5	6	7	8	9	10
Please rate your ***worst*** pain in the last week										
0	1	2	3	4	5	6	7	8	9	10
Please rate your ***least*** pain in the last week										
0	1	2	3	4	5	6	7	8	9	10

Pain History

Is this a workmen's compensation injury? YES / NO

If YES, please explain what happened and when:

☐ Motor Vehicle accident Date: _____ ☐ Fall or other trauma Date: _____ ☐ Following surgery Date: _____ ☐ Following illness Date: _____ ☐ Unknown reason ☐ Other _____	How did your main pain complaint begin? *Please give details* _____ _____ _____ _____ _____
☐ No diagnosis has been given	What diagnosis, if any, have you been given for your current pain? _____

Treatment History

Have you ever been treated by another pain management physician or clinic? ☐ Yes ☐ No

Name of physician/clinic	Location	Dates of treatment	Reason for leaving
Name of physician/clinic	Location	Dates of treatment	Reason for leaving

Have you ever been evaluated by a surgeon for your main pain complaint? ☐ Yes ☐ No

Name of Surgeon	Date	Was surgery recommended? ☐ Yes ☐ No
Name of Surgeon	Date	Was surgery recommended? ☐ Yes ☐ No

Have you had **surgery** intended to treat your current pain complaint? ☐ Yes ☐ No

Surgery #1	Procedure name	Date	Surgeon
Surgery #2	Procedure name	Date	Surgeon

Have you seen any other specialists related to your main pain complaint? ☐ Yes ☐ No

Name of specialist	Specialty	Date seen
Name of specialist	Specialty	Date seen

Have you had an **Electromyography** or **EMG** test to evaluate nerve function? ☐ Yes ☐ No

Performed on arms/legs/both?	Physician performing test	Date
Performed on arms/legs/both?	Physician performing test	Date

Have you had **Radiologic Imaging** for your current pain complaint? ☐ Yes ☐ No

Please bring actual films or CD containing the images to your initial appointment

Study type	**Body part imaged**	**Date of study**	**Where study was performed**
X-ray			
MRI			
CT			
Ultrasound			
Bone Scan			
Other			

Past Medical History

Have you been diagnosed with any of the following conditions at any point in your life?

☐ Abnormal heart beat	☐ Depression	☐ Heart Attack	☐ Rheumatoid Arthritis
☐ Stomach ulcer or GI bleed	☐ Anxiety	☐ Emphysema/COPD	☐ Osteoarthritis
☐ Heartburn/Acid Reflux	☐ Insomnia	☐ Cancer	☐ Peripheral Neuropathy
☐ Diabetes	☐ Seizures	☐ Stroke	☐ Multiple Sclerosis (MS)
☐ Liver Disease	☐ Fibromyalgia	☐ Asthma	☐ Irritable bowel
☐ Kidney Disease	☐ Migraine Headaches	☐ Hypothyroid/Hyperthyroid	☐ HIV/AIDS
☐ Bleeding Disorder	☐ Psychiatric Conditions	☐ High Blood Pressure	☐ Vascular disease
☐ Sleep Apnea	☐ Alcoholism	☐ Hepatitis	☐ Broken Bones

Other conditions not listed above:

Past Surgical History

Surgery	Date (month/year)	Surgeon

Current Medications

Name of Medication	Dose	Frequency	Prescribing Doctor

Allergies

Do you have any known allergies? ☐ Yes ☐ No	Are you allergic to shellfish? ☐ Yes ☐ No
If yes, please list your allergies below	Are you allergic to IV contrast dye? ☐ Yes ☐ No
	Are you allergic to local anesthetics? ☐ Yes ☐ No
	Are you allergic to latex? ☐ Yes ☐ No

Family History

Please list medical problems of your immediate family such as diabetes, high blood pressure, heart disease, etc.

Relation	**Medical Condition**	**Relation**	**Medical Condition**
Father		Sister	
Mother		Sister	
Brother		Daughter	
Brother		Son	

Additional Siblings or Children:

Please check here if you are adopted ☐

Social History

Are you currently working? ☐ Yes ☐ No ☐ Unemployed ☐ Homemaker ☐ Student

If working, what is your present work status? ☐ Full Time ☐ Part Time ☐ Retired ☐ Disability ☐ Workers Compensation

If not working, what was your last job?	How long have you ben out of work?
Did you stop working due to your pain? ☐ Yes ☐ No	Is one of your goals to return to work? ☐ Yes ☐ No

What is your marital status? ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you have children? ☐ Yes ☐ No How many? What age?

What is your highest education level? ☐ Did not graduate High School ☐ High School ☐ GED ☐ Vocational Degree ☐ Some College ☐ College Degree ☐ Graduate Degree

Do you use tobacco? ☐ Never ☐ Occasional ☐ Smokeless ☐ Cigarettes __ packs/day ☐ Cigars __ /day

Do you use alcohol? ☐ Never ☐ Rarely ☐ Socially ☐ Regularly ____ drinks/day

☐ Yes ☐ No	Have you ever used recreational (street) drugs within the past 5 years? *If yes, please list what and when in the space below*
☐ Yes ☐ No	Do you have any history of recreation or street drug addiction?
☐ Yes ☐ No	Do you have any history of alcohol dependence or alcoholism?
☐ Yes ☐ No	Have you ever been enrolled in a drug or alcohol treatment program?
☐ Yes ☐ No	Do you have any history of prescription drug abuse?
☐ Yes ☐ No	Do you have any history of physical or sexual abuse?
☐ Yes ☐ No	Are you receiving workers compensation?
☐ Yes ☐ No	Are you receiving disability payments?
☐ Yes ☐ No	Have you applied, or do you plan to apply for workers compensation or disability?
☐ Yes ☐ No	Do you have a pending lawsuit related to your pain?

Review of Symptoms

Please check any of the following symptoms or problems you have experienced in the past 6 months

Constitutional	**Cardiovascular**	**Gastrointestinal**	**Respiratory**
☐ No Problems	☐ No Problems	☐ No Problems	☐ No Problems
☐ Weight Loss	☐ Chest Pain/Pressure	☐ Constipation	☐ Chronic Cough
☐ Weight Gain	☐ Rapid Heart Rate	☐ Diarrhea	☐ Wheezing
☐ Trouble Sleeping	☐ Poor Circulation	☐ Nausea/Vomiting	☐ Shortness of Breath
☐ Fever	☐ Swelling in Legs/Feet	☐ Blood in Stool	☐ Coughing up Blood
☐ Fatigue	☐ Irregular Heart Rate	☐ Abdominal Pain	☐ Home Oxygen Use
Other:	Other:	Other:	Other:
Musculoskeletal	**Neurological**	**Skin**	**Psychiatric**
☐ No Problems	☐ No Problems	☐ No Problems	☐ No Problems
☐ Joint Pain	☐ Headache	☐ Rashes	☐ Frequent Sadness
☐ Joint Stiffness	☐ Recent Falls	☐ Itching	☐ Excessive Worry
☐ Muscle Spasms/Cramps	☐ Poor Memory	☐ Color Change	☐ Depression
☐ Stiffness of Joints	☐ Fainting	☐ Nail or Hair Change	☐ Feeling Hopeless
☐ Muscle Weakness	☐ Seizures	☐ Easy Bruising	☐ Excessive Stress
Other:	Other:	Other:	Other:
Ear, Nose, Throat	**Eyes**	**Genitourinary**	**Endocrine**
☐ No Problems	☐ No Problems	☐ No Problems	☐ No Problems
☐ Snoring	☐ Blurred Vision	☐ Blood in Urine	☐ Heat Intolerance
☐ Hearing Loss	☐ Double Vision	☐ Painful Urination	☐ Cold Intolerance
☐ Dizziness	☐ Eye Pain	☐ Incontinence of Urine	☐ Changes in Appetite
☐ Ringing in Ears	☐ Redness and Drainage	☐ Frequent Urination	☐ Abnormal Sweating
☐ Nosebleeds	☐ Excessive Watering	☐ Kidney Stone	☐ Hair Loss
Other:	Other:	Other:	Other:

Name:_____ DOB:_____

Advanced Spine and Pain

PATIENT RESPONSIBILITY FOR CHRONIC OPIOID (NARCOTIC) THERAPY

This document represents patient expectations regarding the use of opioid (narcotic) pain medications for treating my pain. Opioid medications are only one part of an overall treatment plan; therefore, I will regularly attend and participate in all prescribed therapies. By signing this, I understand and agree to the following risks and conditions, which may be associated with long-term use of opioid medications.

RISKS:

1. Constipation (which may be severe enough to require medical treatment)
2. Urinary retention (difficulty with urination)
3. Change in appetite and/or in weight
4. Drowsiness or confusion which may affect thinking abilities or emotions
5. Itching
6. Nausea
7. Problems with coordination or balance that may make it unsafe to operate motor vehicles or heavy equipment
8. Depressed respiration (breathing too slowly, overdose can lead to respiratory arrest, coma or death)
9. Physical dependence (which means that quickly stopping opioids may lead to withdrawal symptoms)
10. Psychological dependence (which means that quickly stopping opioids may lead to drug cravings)
11. Sexual difficulties
12. If I become pregnant, my baby might be born physically dependent on opioids. This can be treated successfully. There may be other, unknown risks to unborn children (female patients only)
13. Other, rare side effects may occur

Initial _____

Conditions

1. I am not currently using any illegal pain medication. I have fully informed my physicians of any current, previous use, sale or diversion of legal or illegal drugs. (i.e. cocaine, cannabis, heroine, etc.)
   *****We also ask that you please inform your physician if you are on probation*****

   Are you on Probation: _____Yes _____No

   If yes, reason:

   _____

   _____

   Name of Probation Officer: _____ Ph#:_____

2. I am not currently abusing alcohol, and have fully informed my physicians about any previous alcohol abuse.

3. I will obtain all prescriptions for opioids only from ASAP physicians. I am not permitted to obtain similar medication from any other doctor or clinic without the expressed authorization of ASAP physicians. If an emergency occurs and opioid medications are prescribed from another doctor, I will notify ASAP physicians as soon as possible.

4. Prescriptions will not be mailed, unless otherwise specified.

5. I will take opioids only as prescribed by ASAP physicians and under no circumstances will I allow other individuals to use these medications, nor will I obtain these medications from other individuals.

6. The use of these medications will be ***strictly*** monitored.

7. Extra medication will not be given if the prescription runs out early due to excessive use. Lost, stolen, or misplaced prescriptions or medications will not be replaced.

8. No unplanned or emergency refills will be allowed. ***No prescriptions will be filled or renewed over weekends, after 4 pm on weekdays, or on holidays***.

9. Patients needing refills must call the office at least 5 days before current supply of opioid pain medications run out.

10. Prescriptions and refills ***Will Not*** be telephoned into pharmacies, and must either be picked up by patients, or mailed to pharmacy via standard delivery mail

11. Only on pharmacy will be used to fill prescriptions. ASAP physicians have my permission to communicate with the pharmacist about my use of medications. If I change pharmacies, I will notify ASAP in advance

Pharmacy Name:_____ Ph#:_____

Initial _____

12. I will be required to have unannounced blood or urine tests, or pill counts in order to assess the effect of the opioid as well as my abstinence from illegal drug use. By signing this patient responsibility form, I give permission for and agree to cooperate with any such test if I am asked to do so; failure to comply may result in discharge from the practice.

13. Before receiving any opioids, a psychological evaluation with follow up therapy may be required by the physicians at ASAP. Other medical evaluations and/or treatments nay also be required.

14. Due to known and unknown risks to unborn children, which include physical dependence, I will notify my physician if I am pregnant or if I become pregnant in the future.

15. I understand that opioid medications will be slowly reduced and safely stopped if I violate any aspect of this patient responsibility form (at the discretion of the provider), or if the ASAP physicians feel that opioids are not effective in controlling my pain. It may be necessary for me to enter a chemical dependence program in order to completely stop the medication.

16. I must visit the ASAP physicians at ***least every four to eight weeks*** for monitoring my medications. I understand that if I don't show for my regular scheduled appointment, I may not receive my refill medications. After three No Show appointments, I may be subject to discharge due to noncompliance.

17. I give ASAP physicians permission to communicate with any of my other physicians regarding my use of controlled substances.

18. I take all responsibility for the cost of medication, urine/blood tests, which insurance may not cover.

19. I understand that any violation of the above terms may lead to my immediate discharge from the office.

20. Other conditions: _____

I have read and understand this agreement, and I agree to all of the above. I will be given a copy of this form and I give permission for a copy to be sent to my other treating physicians, caregivers, pharmacists, and insurance providers.

Patient: _____ Date: _____

Physician: _____ Date: _____

Witness: _____ Date: _____

INTERPRETER'S STATEMENT: I have translated the information and advice presented orally to the individuals giving consent by the person obtaining this consent. To the best of my knowledge and behalf, he/she understood this explanation.

Interpreter: _____ Date: _____

ATTENTION PATIENTS

Please be aware that we are a Specialist office. This means that your insurance plan may require you to obtain a referral from your Primary Medical Doctor in order to be seen. The most common plans that require referrals are HMO policies, and Tricare Prime. If you are unsure of the type of policy you have, or whether a referral is required, you may call the Customer Service number on the back of your insurance card. If you have Tricare Prime, you can call 877-874-2273 for this information.

Please note that it is your responsibility to know your insurance. If you fail to obtain the proper authorization for your appointments, you may receive a bill. Be aware that this is for office visits only, as we will request authorization on your behalf for all other services or care you may require.

By signing below, you acknowledge that you have read and understand this policy

Patient Name:_____ Date:_____

Patient Signature:_____