# Pain Care, LLC Billing Policy

We would like to take the time to welcome you to Pain Care, LLC. Pain Care is committed to providing exceptional quality, cost effective, comprehensive, and ethical pain management programs that exceed your expectations.

When you are scheduled for a procedure, your procedure will be performed at Pain Care Center of Georgia, 1365 Rock Quarry Road, Suite 301, Stockbridge, Georgia, 30281; Center for Pain and Spine, 2401 Newnan Crossing Boulevard, Suite 130, Newnan, Georgia, 30265; Griffin Center for Pain and Spine, 619 South 8th Street, Suite 300, Griffin, Georgia, 30224; or Johns Creek Center for Pain and Spine, 6300 Hospital Parkway, Suite 425, Johns Creek, Georgia, 30097. Depending on your insurance coverage, your procedure may be billed as office based or facility based. Please be advised, there may be two or three financial components to each procedure: the physician's fee, the fee for the facility, and the fee for anesthesia services. The physician's fee is billed by Pain Care, LLC; the facility fee is billed by Pain Care Center of Georgia, Center for Pain and Spine, Griffin Center for Pain and Spine, or Johns Creek Center for Pain and Spine and the fee for anesthesia is billed by Perimeter Anesthesia.

Some insurance carriers require precertification for your procedure. Pain Care will make every effort to verify your benefits and obtain any necessary precertification prior to your appointment, however, precertification is not a guarantee of payment.

Primary, secondary, and tertiary claims will be submitted on your behalf so long as the information needed to process the claim is on file and verified prior to your procedure.

Based on your insurance coverage, our Financial Counselor will determine the portion of the procedure charge you are responsible to pay at the time of the procedure. This amount will be based on the Ambulatory Surgery Center fees only and you will most likely receive a statement for additional charges. Depending upon your insurance plan, deductibles, and how your insurance carrier adjudicates the claim, you may be responsible for additional charges. Our Financial Counselor will attempt to contact you prior to your scheduled procedure regarding any payment due at the time of service. If you have any questions regarding your insurance coverage prior to a scheduled procedure, please contact our Financial Counselors at 770-771-6580.

Anesthesia services are provided by Perimeter Anesthesia and billed separately to your insurance company by Perimeter Anesthesia. Your insurance carrier will determine the payment and coverage for these services based on their guidelines. Please be advised if you have any questions about anesthesia services, you may contact Perimeter Anesthesia at 888-408-0200, Ext 2.

**Pain Care accepts cash, all major credit cards, and money orders. We do not accept personal checks or Care Credit as a form of payment.** If you have a balance due with Pain Care, Pain Care Center of Georgia, Center for Pain and Spine, Griffin Center for Pain and Spine, or Johns Creek Center for Pain and Spine, we reserve the right to apply your payment to the oldest balance first. In the event your account has a credit with one entity and a balance for another, we reserve the right to transfer the credit to any outstanding balances prior to issuing a refund.

## FOR BILLING RELATED QUESTIONS:

We encourage you to reach out to your insurance company as a first point of contact for any questions related to how any services are adjudicated and/or covered.

If you have any questions regarding charges incurred for Pain Care, LLC, Pain Care Center of Georgia, Center for Pain and Spine, Griffin Center for Pain and Spine, or Johns Creek Center for Pain and Spine please call 770-771-6585.

For billing related questions related to anesthesia services, please contact Perimeter Anesthesia at 888-408-0200, Ext 2. Please be advised, Pain Care cannot provide any information related to anesthesia services billing or statements.

**MISSED APPOINTMENTS:**

If you are unable to keep your procedure appointment, please reschedule at least 48 hours prior to your appointment time. Failure to reschedule for any reason will result in a $75 missed appointment charge.

If you are unable to keep your follow up appointment, please reschedule at least 24 hours prior to your appointment time. Failure to reschedule for any reason will result in a $50 missed appointment charge.

Missed appointment charges must be paid at or prior to your next appointment.

_____ _____

Patient Signature Date

_____ _____

Patient Name Date of Birth

Revised 6/19/2020

**Date**: _____ **Patient Name**: _____ **Patient DOB**: _____

**Where is the primary location of your pain? _____**

**When did your pain first begin? Please tell us how many days, weeks, months or years.**

Days: ____ Weeks: ____ Months: ____ Years: ____

**What is the frequency of your pain?**

◯constant ◯ intermittent

**Rate your pain on a scale of 1-10 _____**

**What best describes your pain?**

◯ dull ◯ aching ◯ throbbing ◯ sharp ◯ burning ◯ stabbing

**Do you have numbness, tingling, or weakness? If so, where**

◯ right leg ◯ left leg ◯ right arm ◯ left arm

**What makes your pain worse?**

◯bending ◯ lifting ◯ sitting ◯standing ◯lying down

**What makes your pain better?**

◯rest ◯medication ◯standing ◯sitting ◯laying down ◯heat ◯ice

**What does your pain interfere with?**

◯sleep ◯physical activities ◯relationships ◯ emotions ◯ appetite

**Are you experiencing any bowel/ bladder issues?** ◯ yes ◯no

If yes, please explain: _____

**Have you had any of the following completed to assist with the pain?**

◯ MRI ◯ CT ◯ XRAY ◯ EMG/Nerve Conduction Study

**Have you had any of the following therapies for your current pain?**

◯ injections ◯Physical Therapy ◯Chiropractic Therapy ◯ NSAIDS ◯ Pain Medications

**Have you had any of the following surgeries? Spine**: ◯Cervical ◯Lumbar ◯Thoracic

**Joint**: ◯Knee ◯Shoulder ◯Hip If so, please explain: _____

**Please list all current medications:**

| MEDICATION | DOSAGE | INSTRUCTIONS |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

If additional space is needed please let the front desk know.

**Please list all allergies: _____**

**Past Medical History (please select all that apply):**

◯Addiction
◯Alcoholism
◯Anxiety
◯Arthritis OA/RA
◯Asthma
◯Bowel disease
◯Cancer
◯Cirrhosis
◯Coronary artery disease
◯Depression
◯Diabetes
◯Fibromyalgia
◯Gallbladder
◯Head injury
◯Heart arrhythmia
◯Heart attack (MI)
◯Hepatitis
◯High blood pressure
◯High cholesterol
◯HIV
◯Kidney disorder
◯Migraine headaches
◯Multiple sclerosis
◯Neuropathy
◯Osteoporosis
◯Pancreatitis
◯Peripheral nerve disease
◯Reflux
◯Seizures
◯Sleep apnea
◯Stroke
◯Tuberculosis
◯Ulcers

**Date**: _____ **Patient Name**: _____ **Patient DOB**: _____

**Family Medical History (please check all that apply):**

◯Addiction
◯Alcoholism
◯Anxiety
◯Arthritis OA/RA
◯Asthma
◯Bowel disease
◯Cancer
◯Cirrhosis
◯Coronary artery disease
◯Depression
◯Diabetes
◯Fibromyalgia
◯Gallbladder
◯Head injury
◯Heart arrhythmia
◯Heart attack (MI)
◯Hepatitis
◯High blood pressure
◯High cholesterol
◯HIV
◯Kidney disorder
◯Migraine headaches
◯Multiple sclerosis
◯Neuropathy
◯Osteoporosis
◯Pancreatitis
◯Peripheral nerve disease
◯Reflux
◯Seizures
◯Sleep apnea
◯Stroke
◯Tuberculosis
◯Ulcers

**Please mark any of the following symptoms/problems that you currently have (mark all that apply):**

HEENT
◯Headache
◯Facial pain
◯Sinusitis
◯Loss of vision
◯Hearing loss
◯Teeth/gum problems

Respiratory
◯Chronic cough
◯C-PAP
◯Home oxygen use
◯Shortness of breath
◯Sleep apnea
◯Wheezing

Cardiology
◯Abnormal EKG
◯Chest pain
◯Congestive failure
◯Murmur

Gastroenterology
◯Appetite loss
◯Bowel control, loss
◯Chronic nausea
◯Constipation
◯Diarrhea
◯Heartburn

Skin
◯Rash

Genitourinary
◯Bladder control loss
◯Blood in urine
◯Enlarged prostate
◯Irregular bleeding
◯Painful urination
◯Pregnancy
◯Testicular pain

Endocrine/Hematological
◯Abnormal blood sugars
◯Easy bruising/bleeding

Vascular
◯Current blood clot
◯Poor circulation
◯Swelling in legs

Musculoskeletal
◯Back pain
◯Joint pain
◯Muscle spasms
◯Neck pain

Neurology
◯Blackouts
◯Dizziness
◯Drowsiness
◯Numbness
◯Tremors

Psychiatric
◯Insomnia
◯Panic attacks

**Social History:**

Occupation: _____
Marital Status: _____
Alcohol Use: ◯Y ◯N
Tobacco Use: ◯Y ◯N
Recreational Drug Use: ◯Y ◯N
History of Alcohol Abuse: ◯Y ◯N
History of Prescription or Illicit Drug Abuse: ◯Y ◯N

**Date**: _____ **Patient Name**: _____ **Patient DOB**: _____

## ORT

Family History of Substance Abuse

Alcohol ◯Y ◯N
Illegal Drugs ◯Y ◯N
Prescription Drugs ◯Y ◯N

Personal History of Substance Abuse

Alcohol ◯Y ◯N
Illegal Drugs ◯Y ◯N
Prescription Drugs ◯Y ◯N

Age between 16-45? ◯Y ◯N

History of Preadolescent Sexual Abuse: ◯Y ◯N

ADD/OCD/Bipolar/Schizophrenia: ◯Y ◯N

# COMM

Please answer each question as honestly as possible. Keep in mind that we are only asking about the **past 30 days**. There are no right or wrong answers. If you are unsure about how to answer the question, please give the best answer.

| **Please answer the questions using the Following scale:** | **Never** | **Seldom** | **Sometimes** | **Often** | **Very often** |
|---|---|---|---|---|---|
| | **0** | **1** | **2** | **3** | **4** |
| 1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems? | ○ | ○ | ○ | ○ | ○ |
| 2. In the past 30 days, how often do people complain that you are not completing necessary task? (i.e. going to class, work or appointments). | ○ | ○ | ○ | ○ | ○ |
| 3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e. another doctor, emergency room, friends, street sources). | ○ | ○ | ○ | ○ | ○ |
| 4. In the past 30 days, how often have you taken your medications differently from how they are prescribed? | ○ | ○ | ○ | ○ | ○ |
| 5. In the past 30 days, how often have you seriously thought about hurting yourself? | ○ | ○ | ○ | ○ | ○ |
| 6. In the past 30 days, how much of your time was spent thinking about opioid medications? (i.e. having enough, taking them, dosing schedule, etc.) | ○ | ○ | ○ | ○ | ○ |
| 7. In the past 30 days, how often have you been in an argument? | ○ | ○ | ○ | ○ | ○ |
| 8. In the past 30 days, how often have you had trouble controlling your anger? (i.e. road rage, screaming, etc.) | ○ | ○ | ○ | ○ | ○ |
| 9. In the past 30 days, how often have you needed to take pain medications belonging to someone else? | ○ | ○ | ○ | ○ | ○ |
| 10. In the past 30 days, how often have you been worried about how you are handling your medications? | ○ | ○ | ○ | ○ | ○ |

## COMM (continued)

| Please answer the questions using the Following scale: | Never | Seldom | Sometimes | Often | Very often |
|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 |
| 11. In the past 30 days, how often have others been worried about how you are handling your medications? | ○ | ○ | ○ | ○ | ○ |
| 12. In the past 30 days, how often have you had to make an emergency phone call or show up at a clinic without an appointment? | ○ | ○ | ○ | ○ | ○ |
| 13. In the past 30 days, how often have you gotten angry with people? | ○ | ○ | ○ | ○ | ○ |
| 14. In the past 30 days, how often have you had to take more of your medication than prescribed? | ○ | ○ | ○ | ○ | ○ |
| 15. In the past 30 days, how often have you borrowed pain medication from someone else? | ○ | ○ | ○ | ○ | ○ |
| 16. In the past 30 days, how often have you used you pain medicine for symptoms other than your pain? (i.e. to help you sleep, improve your mood, or relieve stress.) | ○ | ○ | ○ | ○ | ○ |
| 17. In the past 30 days, how often have you had to visit the emergency room? | ○ | ○ | ○ | ○ | ○ |