Advanced Pain Modalities

NEW PATIENT REGISTRATION

Welcome to Advanced Pain Modalities. We have a few quick items we need you to complete before we see you today. If you have any questions, feel free to stop by and ask our front desk. We're always here to help you!

Today's date: _____/____/_____

Patient Information:
Last Name:_____First Name:_____ Middle: _____ Nickname: _____
Date of Birth: _____ Gender:_____ Height: _____ Weight: _____
Home Phone:_____ Cell Phone:_____ Email:_____
Preferred Contact Form: _____ Social Security Number: _____
Address:_____ City:_____State:_____Zip:_____
Race_____ Ethnicity_____ Primary Language_____
Preferred Pharmacy: _____Pharmacy Phone Number: _____
Pharmacy Address:_____
Height: _____ Weight: _____

Responsible Party (Guarantor) Information
Relationship to Patient: ❑ Self (If self, skip to Emergency/Next of Kin) ❑ Spouse ❑ Parent ❑ Other_____
Last Name:_____First Name:_____ Middle: _____ Nickname: _____
Date of Birth: _____
Home Phone:_____ Cell Phone:_____ Email:_____
Preferred Contact Form: _____ Social Security Number: _____
Address:_____ City:_____State:_____Zip:_____

In case of emergency, notify:
Emergency Contact Name:_____Relationship:_____Cell Phone #:_____

Primary and Secondary Insurance Information:
Primary Insurance:_____
Insured's Name:_____ Insured's DOB:_____
Ins. Address:_____ Insured's SS#:_____
Ins Phone:_____ Group #:_____
Policy/Subscriber ID:_____

Secondary Ins:_____ Ins Address:_____
Phone:_____ Insured's Name:_____ Insured's DOB:_____
Group #:_____ Policy/Subscriber#:_____

Physician Information:
Primary Care Physician:_____ Primary Care Physician Phone: _____
Referred by: _____
How did you hear about us? _____

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Last name: _____ First name: _____

List other physicians you have seen regarding your condition (specifically include any Rheumatologists, Neurologists, Orthopedic Surgeons, Spine Surgeons, or Chiropractic Physicians):

_____

Main pain complaint(s)	**Date started**	**Pain scale (0-10**
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Check whether you have had these treatments		**Approx last treatment**	**Approx relief %**
Chiropractic treatment	❑ YES ❑ NO	_____	_____
Physical therapy	❑ YES ❑ NO	_____	_____
Massage therapy	❑ YES ❑ NO	_____	_____
Psychology for pain	❑ YES ❑ NO	_____	_____

Check whether you have had these injections			
Epidural Steroid Injection	❑ YES ❑ NO	_____	_____
Facet Joint Injection or facet block	❑ YES ❑ NO	_____	_____
SI Joint Injection	❑ YES ❑ NO	_____	_____
Radiofrequency	❑ YES ❑ NO	_____	_____
Ablation	❑ YES ❑ NO	_____	_____
Trigger Point Injection	❑ YES ❑ NO	_____	_____

* List any other injections (joint, tendon, bursa, etc.): _____

Past Medical History (Check off the ones that apply)

❑ Diabetes
❑ Cancer
❑ High blood pressure
❑ High cholesterol
❑ Heart attack
❑ Asthma
❑ Pneumonia
❑ Stroke
❑ Epilepsy
❑ Anemia
❑ Thyroid problems
❑ Tuberculosis (+) skin test ___
❑ Depression
❑ Anxiety
❑ Glaucoma
❑ Fractures
❑ Headaches
❑ Neck problems
❑ Back problems
❑ Rheumatoid arthritis
❑ Osteoarthritis
❑ Osteoporosis
❑ Esophageal reflux (GERD)
❑ Kidney/Bladder disease
❑ Hepatitis
❑ Peptic ulcer
❑ Appendicitis
❑ Other: _____

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Surgical History (Check off the ones that apply)

- ❑ Spinal fusion
- ❑ Knee surgery
- ❑ Joint replacement
- ❑ Hip surgery
- ❑ Shoulder surgery
- ❑ Heart bypass
- ❑ Back surgery
- ❑ Thyroid surgery
- ❑ Prostate surgery
- ❑ Breast Surgery
- ❑ Breast Biopsy
- ❑ Other: _____

Allergies	**Reaction**

Have you had any problems with **surgery** or **anesthesia**? _____

Medication List:

Name	Dose	Times/day

Family History:

	Age	Alive/Deceased	Major Health Problems (heart disease, stroke, cancer, diabetes, arthritis, etc)
Mother			
Father			
Children			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Brother(s)			
Sister(s)			
Aunt(s)			

Social History:

1. Smoke: No ❑ Yes ❑. If yes, ____ packs/ day for ___ years. (If you have smoked in the past, quit date: _____ .)

2. Alcohol: No ❑ Yes ❑ If yes: rarely___ occasionally___ daily___.

3.Do you have a living will and medical POA? ❑ YES ❑ NO

3. Sleep Habits: Number of hours per day____. Do you rest well? Yes ❑ No ❑

Occupation: _____ Hobbies/activities: _____

Marital status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated: ☐

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First/Last Name: _____ **DOB:** _____

CONSTITUTIONAL:
FATIGUE **Yes** ❑ No ❑
LOSS OF APPETITE **Yes** ❑ No ❑
WEAKNESS **Yes** ❑ No ❑
WEIGHT LOSS/GAIN **Yes** ❑ No ❑
TROUBLE SLEEPING **Yes** ❑ No ❑

GENERAL:
SKIN RASH **Yes** ❑ No ❑
COLOR CHANGES **Yes** ❑ No ❑
HAIR/NAIL CHANGES **Yes** ❑ No ❑

HEENT:
VISION LOSS/CHANGE **Yes** ❑ No ❑
RINGING IN EARS **Yes** ❑ No ❑
LOSS OF SMELL **Yes** ❑ No ❑
TROUBLE SWALLOWING **Yes** ❑ No ❑

CARDIOLOGY:
CHEST PAIN **Yes** ❑ No ❑
IRREGULAR HEARTBEAT **Yes** ❑ No ❑
SHORTNESS OF BREATH **Yes** ❑ No ❑
DIZZINESS **Yes** ❑ No ❑
COLD EXTREMITIES **Yes** ❑ No ❑

RESPIRATORY:
COUGH **Yes** ❑ No ❑
WHEEZING **Yes** ❑ No ❑
PAINFUL BREATHING **Yes** ❑ No ❑

GI:
CONSTIPATION **Yes** ❑ No ❑
DIARRHEA **Yes** ❑ No ❑
NAUSEA/VOMITING **Yes** ❑ No ❑

HEMATOLOGICAL/LYMPH:
ABNORMAL BLEEDING **Yes** ❑ No ❑
ABNORMAL BRUISING **Yes** ❑ No ❑

PSYCHIATRIC:
ANXIETY **Yes** ❑ No ❑
DEPRESSION **Yes** ❑ No ❑
MEMORY LOSS **Yes** ❑ No ❑

ENDOCRINOLOGY:
EXCESSIVE THIRST **Yes** ❑ No ❑
FREQUENT URINATION **Yes** ❑ No ❑
EXCESSIVE SWEATING **Yes** ❑ No ❑
HEAT/COLD INTOLERANCE **Yes** ❑ No ❑

MUSCULOSKELETAL:
JOINT PAIN/STIFFNESS **Yes** ❑ No ❑
LEG CRAMPS **Yes** ❑ No ❑
MUSCLE CRAMPS **Yes** ❑ No ❑

NEUROLOGICAL:
HEADACHE **Yes** ❑ No ❑
SEIZURES **Yes** ❑ No ❑
TINGLING/NUMBNESS **Yes** ❑ No ❑
LOSS OF FEELING IN LEGS **Yes** ❑ No ❑

Disclosure of Health Information:

I hereby give consent for Advanced Pain Modalities to use and disclose my Protected Health Information (PHI) to implement Treatment, Payment, and Health Care Operations (TPO). By signing below, I agree to all of the terms and conditions discussed within the Notice of Privacy Practices. I acknowledge that I have reviewed the Notice of Privacy Practices prior to giving my consent to the terms of this document.

With my consent, Advanced Pain Modalities may contact me using the information above in reference to appointment reminders, insurance information, laboratory testing, my clinical care, AMA news & updates, and other implementing TPO. Advanced Pain Modalities may contact me in the following ways (mark options below):

☐ Via telephone (including message reminders & voicemail messages)
☐ Via mail (all classified information pertaining to my medical records will be marked "personal and confidential").
☐ Via email (including portal message notifications, reminders, and informational newsletters

I have the right to request that Advanced Pain Modalities restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. BY signing this form, I am consenting to allow Advanced Pain Modalities to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Release of Pertinent Information

I hereby give consent to Advanced Pain Modalities to relay any lab results, radiological testing results, billing information, or any other imperative information to:

☐ My preferred phone number — Okay to leave a message ❑ YES ❑ NO
☐ My alternate phone number — Okay to leave a message ❑ YES ❑ NO
☐ An alternate contact — Okay to leave a message ❑ YES ❑ NO

Contact Last Name, First Name (Printed)	Contact Phone Number	Relationship to Patient

Financial Policy
Payment is due at the time of service. For any portion of your balance not covered by insurance, or for our private pay patients, Advanced Pain Modalities accepts cash, check, American Express, Visa, MasterCard, and Discover.

1. Your insurance policy is a contract between the policyholder and the insurance carrier. Advanced Pain Modalities is not a party to that contract. Advanced Pain Modalities will not be involved with disputes between the policyholder and the insurance carrier regarding deductibles, copayments, covered or non-covered charges, secondary insurance policies and "usual and customary" charges.

2. Advanced Pain Modalities is contracted with most insurance plans. Advanced Pain Modalities will file a claim on your behalf and guarantee adherence to carrier guidelines for submission of claims, copay collection, and reimbursements. Any contractual provider discounts will be deducted.
3. All insurance policies are individual, therefore not all services are guaranteed a covered benefit. It is the insured's responsibility to be aware of their individual insurance benefits prior to the appointment.
4. Returned checks and balances over 90 days may be subject to collections and additional fees which will be charged to the responsible party. If Advanced Pain Modalities is forced to send your balance to a third-party collection agency, a fee of 25% will be added to your balance.
5. Please note that all appointment cancellations must be at least 24 hours in advance, which allows Advanced Pain Modalities to care for other patients in need. If you fail to cancel your appointment, you may be charged a $75 service fee which will not be covered by your insurance plan.
6. There will be a $75 no show fee charge on all returned checks
7. Advanced Pain Modalities understands that temporary financial issues may affect prompt payment for services. Please communicate with our office so that we can assist by managing your account balance with a payment plan.
8. After hours calls are subject to a $25 fee. This fee is intended to cover our costs but not discourage you from calling if you are concerned about anything important. Calls resulting in being referred to an emergency room by the provider or a follow up office visit are exempt from the fee.
9. I agree I am responsible for the allowed amount for services my insurance plan puts to patient responsibility. In the event I default on payment, I understand that I am responsible for all costs incurred on my account. If the debt is assigned to a third-party collection agency, I agree I am responsible for the full amount including collection fees.

Receipt of Notice of Privacy Practices:
The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

We have furnished you with a notice of privacy practices in your new patient folder, which provides information about how Advanced Pain Modalities and its employees and agents may use and/or disclose protected health information about you for treatment, payment, healthcare operations, and as otherwise allowed by law. By checking below and signing the form at the end, you acknowledge that you have received a copy of our Notice of Privacy Practices. I understand that I may refuse to sign this agreement.

__☐__ I have received a copy of the Notice of Privacy Practices for Advanced Pain Modalities
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Treatment consent:
I hereby authorize employees and agents of Advanced Pain Modalities
(including physicians, physician assistants, nurse practitioners, medical assistants, and other employees and staff members) to render medical evaluations and care to the patient indicated above. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in the case of an emergency.

If we feel that a referral or consultation with another healthcare provider is necessary, I authorize Advanced Pain Modalities
to discuss my health information with the provider we are referring to.

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☐ I have read, understand, and agree to this consent for treatment at Advanced Pain Modalities

I certify that I have correctly completed all the information on this form to the best of my knowledge. The duration of the consents and agreements contained on this form are indefinite and continue until revoked in writing.

_____ _____

Signature of Patient or Responsible Party | Printed Name of Patient or Responsible Party

_____ _____

Relationship to Patient (If Other Than Self) | Today's Date

Patient Rights

Advanced Pain Modalities will ensure that:

1. A patient is treated with dignity, respect, and consideration.
2. A patient is not subjected to:
    a. Abuse
    b. Neglect
    c. Exploitation
    d. Coercion
    e. Manipulation
    f. Sexual abuse
    g. Sexual assault
    h. Seclusion
    i. Restraint, if not necessary to prevent imminent harm to self or others
    j. Retaliation for submitting a complaint to the Department or another entity or
    k. Misappropriation of personal and private property by an outpatient treatment centers personnel
3. A patient or the patient representative:
    a. Except in an emergency , either consented to or refuses treatment
    b. May refuse or withdraw consent to treatment before treatment is initiated
    c. Except in an emergency, is informed os alternative to a proposed psychotropic medication or surgical procedure
    d. Is informed of the following
        i. The outpatient treatment centers policy on health care directives and
        ii. The patient's complaint process
    e. Consents to photographs of the patient before a patient is photographed except that a patient may be photographed when admitted to an outpatient treatment center for identification and administrative purposes and
    f. Except as otherwise permitted by law, provides written consents to the release of a patients
        i. Medical records, and
        ii. Financial records

You as a patient have the following rights:

1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis.
2. To receive treatment that supports and respects the patient's individuality, choices, strength, and abilities

3. To receive privacy and treatment and care for personal needs
4. To review, upon request, the patient's own medical records according to
5. To receive a referral to another Healthcare institution if the Outpatient Treatment Center is unable to provide physical health services or Behavioral Health Services for the patient
6. To participate or help the patient representative participate in the development of, or decisions concerning treatment
7. To participate or refuse to participate in research or experimental treatment and
8. To receive assistance from a family member, representative, or other individual and understanding protecting or exercising to patients rights

By signing below, I acknowledge that I have read and received the above.

Patients Signature _____ Date _____

Print Name: _____