Even though we are committed to compassionate care, we must exercise proper due diligence when prescribing opioid analgesics for chronic pain in order to follow state and federal guidelines. Therefore, our clinic policy is that an appropriate workup must be completed prior to the dispensing of any controlled prescription. This workup will include review of previous pharmacy/clinic records, evaluation by diagnostic and laboratory tests, and acceptable completion of a urine drug screen yielding expected results. Our clinic policy is to never co-prescribe benzodiazepines and opiate pain medications.

- Please bring your driver's license and insurance cards along with your **completed** new patient paperwork to your scheduled appointment. Payment for services is expected at the time of service (co- pays, co-insurance, private pay). We accept check, money order and credit cards (Visa, American Express, MasterCard, and Discover).
- **If you have been instructed to obtain <u>imaging reports and/or films</u> by our staff, please bring them to your appointment. Our office requires these as part of your consultation. If we do not have your films at the time of your appointment, you may be rescheduled.**
- Your initial visit at the Practice is a consultation. If a doctor referred you for an injection, you must be seen for an office visit first. Procedures are scheduled after the initial consultation.
- If English is your second language, please make arrangements for someone to accompany you to your visit who can translate in order to provide you with the best healthcare service. We want you to fully understand your diagnosis and prognosis and have any questions you may have answered.

Patient Acknowledgement Statement

Patient Name & DOB: _____

I understand that services or items that I have requested be provided to me by The Painsmith may not be covered under my insurance as being reasonable or medically necessary for my care. I understand my health plan determines the medical necessity of the services or items I request and receive. I also understand I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable or medically necessary for my care.

Advanced Practitioner Consent for Treatment

The Practice has on staff physician assistants, nurse practitioners, or advanced practice nurses to assist in the delivery of medical care of pain management.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. A nurse practitioner or advanced practice nurse is not a doctor. A nurse practitioner or advanced practice nurse is a registered nurse who has received advanced education and training in the provision of health care. Under the supervision of a physician, a physician assistant, a nurse practitioner, or an advanced practice nurse can diagnose, treat and monitor acute and chronic disease as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of the supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

A physician assistant, a nurse practitioner, or an advanced practice nurse may provide such medical services that are within his/her education, training and experience.

I have read the above and hereby consent to the services of an advanced practitioner for my health care needs. I understand that at any time I can refuse to see the advanced practitioner and request to see a physician.

Acknowledgment of Urine Testing Policy

I understand that the Practice reserves the right to perform random urine testing on any patient. I have the right to refuse the urine test but may then not be prescribed any medications or given refills of medications.

Acknowledgment of External Rx History

I understand that the Practice reserves the right to obtain an external Rx history and randomly verify past medications through the Prescription Drug Monitoring Database and insurance/pharmacy records in order to progress my care.

Acknowledgment of Late Arrival Policy

If you are unable to make an appointment, please call within 24 hours prior to your appointment time to reschedule. If you fail to notify our office less than 24 hours prior to your scheduled appointment or are more than 15 minutes, you may be charged a NO SHOW fee of $50. Frequent NO SHOWS may result in a release from the Practice.

Permission to Leave Messages

I give permission for the Practice to leave appointment information, test results, and/or pre-operative instructions on voice message for the following phone numbers or with the following individuals:

_____

_____

PATIENT SIGNATURE & DATE: _____

Communication Consent

We want to stay connected with our patients. Patients in our Practice and all our affiliated clinics may be contacted via email and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. If you provide an email or phone number to the Practice, you understand that you may receive these communications from the Practice.

You may opt out of these communications at any time. The Practice does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan. Email and standard text messaging are not confidential methods of communication and may be insecure.

Select below to opt-out of communication via text and/or email regarding various aspects of your medical care, which may include, but shall not be limited to, reminders, feedback, and general health reminders/information, test results, prescriptions, appointments, and billing.

Opt-out:

☐ I decline/revoke to receive communication via **text**.

☐ I decline/revoke to receive communication via **email**.

_____ _____

Patient Name | Date of Birth

_____ _____

Patient/Patient Representative Signature | Date

NAME: _____ DATE OF BIRTH: _____

Clinic Policies

Initials ____Payment is due at the time services are rendered. I understand that if I have insurance that I am the responsible party, having insurance does not guarantee payment of the services rendered to me. I authorize submission of my claim to the insurance company listed above.

Initials____ I understand that I can elect to not use my health insurance for any care received and elect to self-pay. I understand that if I elect to self-pay for any care, that I am unable to change this election after the fact as certain documentation parameters may prohibit the Practice from submitting my claim to insurance.

Initials ____Permission for treatment: I hereby authorize physician and assistants for the care of the patient named on this record to administer treatment as may be deemed necessary including examinations of treatments that may be ordered to be performed by the clinical personnel. I acknowledge that no guarantees have been made to me to the result of examinations or treatments to be performed.

Initials ____ Pain Medication Contract: I understand that if I request any controlled substances be prescribed to me that I will need to agree to a pain medication contract and that failure to abide by this contract may result in cessation of prescription medication and/or dismissal from the practice. I further understand that any refill request must be made a minimum of 3 business days prior to my fill date.

Acknowledgement of Review of Notice of Privacy Practices

Initials ____ I have been given the chance to review the privacy practices.

Medicare/Insurance Assignment of Benefits/Rights

Initials ____ I request that payment of authorized Health Insurance or Medicare benefits be made on my behalf to The Painsmith for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Signature and Date

New Patient Medical History

Pain Complaint: _____

Secondary to: Illness ☐ Accident ☐ Work ☐ Other: _____

Date of the onset of pain: _____ How often do you have pain: Constant ☐ Intermittent: ☐

Type of Pain: Aching ☐ Throbbing ☐ Sharp ☐ Shooting: ☐ Stabbing: ☐ Burning: ☐

(Using a scale of 1 to 10) How bad is your pain on average? _____ At its worst _____

What makes your pain better?

_____

What makes your pain worse?

_____

Please list any treatments you have had in the **PAST YEAR**. (Physical Therapy, Injections, Acupuncture)

1._____ 3._____
2._____ 4._____

Please list any hospitalizations and surgeries you have had in the **PAST YEAR**.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Are you currently taking aspirin? Yes: ☐ No: ☐ if so, what dosage? _____
Are you currently taking a blood thinner? Yes: ☐ No: ☐ If so, what? _____

Pharmacy _____ Pharmacy # _____

Address _____ Phone _____

Please list any medications you are currently taking:
Name of Medication / Dosage/ how often

1._____/_____/_____ 7. _____/_____/_____
2._____/_____/_____ 8. _____/_____/_____
3._____/_____/_____ 9. _____/_____/_____
4._____/_____/_____10. _____/_____/_____
5._____/_____/_____11. _____/_____/_____
6._____/_____/_____12. _____/_____/_____

Please list any Medication Allergies/Adverse Reactions

1._____/_____ 4. _____/_____
2._____/_____ 5. _____/_____
3._____/_____ 6. _____/_____

Are you pregnant? Yes: ☐ No: ☐ If so how many months: _____

TOBACCO & ALCOHOL QUESTIONAIRE

Tobacco

Type	Usage Status *(i.e. Never, Former, Current)*	Last Used	Light	Occasional	Social	Heavy	Never
Cigarettes			◯	◯	◯	◯	◯
Cigars			◯	◯	◯	◯	◯
Pipe			◯	◯	◯	◯	◯
Chewing Tobacco			◯	◯	◯	◯	◯
Dipping Tobacco			◯	◯	◯	◯	◯

Light smoker is understood to mean less than 10 cigarettes per day or an equivalent

Heavy smoker is understood to mean greater than 10 cigarettes per day or an equivalent

Alcohol

Type	Usage Status *(i.e. Never, Former, Current)*	Last Used	Light	Occasional	Social	Heavy	Never
Beer			◯	◯	◯	◯	◯
Wine			◯	◯	◯	◯	◯
Hard Liquor			◯	◯	◯	◯	◯

Heavy use is defined as:

For women and persons greater than 65 years of age:
more than 7 standard drinks per week or more than 3 drinks per occasion
For men under 65 years of age:
more than 14 standard drinks per week or more than 4 drinks per occasion.

New Patient Registration Form

Demographics

Name _____ _____ _____
(First) (MI) (Last)

Male ___ Female___ Date of Birth _____ Social Security # _____-_____-_____

Marital Status ___ single ___ married ___ divorced ___ widowed ___ separated

Address _____ City _____

State _____ Zip Code _____ Email Address _____

Home Phone (_____) _____ - _____ Cell Phone (_____) _____ - _____

Work Phone (_____) _____ - _____

Emergency Contact/Relationship_____ (Spouse Parent Sibling Other:)

Emergency Contact Phone (_____) _____ Other:

Billing & Insurance Information

1.) Primary Insurance _____

Policy Holder Name _____ DOB _____ Phone (_____) _____

2.) Secondary Insurance _____

Policy Holder Name _____ DOB _____ Phone (_____) _____

Guarantor's Name (if different from above) _____ DOB _____

Referral Information

Primary Care Dr. (First & Last Name) _____ Phone (_____) _____

Were you referred by a Physician ☐ Yes ☐ No

Referred By (First & Last Name) _____ Phone (_____) _____

Language ☐ English ☐ Spanish Other _____
Interpreter Needed? ☐ Yes ☐ No

Ethnicity ☐ Hispanic or Latino _____ Other ☐ Decline

Race ☐ White ☐ Black or African American ☐ Asian ☐ Decline
☐ American Indian ☐ Hawaiian or Other Pacific Islander _____ Other

Financial Policy

1. Proof of Insurance:

Payment is due at the time of service, which includes applicable co-pays, deductibles and co-insurance. Please bring your insurance card(s) with you to every appointment. It is your responsibility to inform the front desk when a change of insurance has occurred, or when the cause for treatment should be billed to a liability insurance company or worker's compensation instead of your regular primary insurance. Verification of benefits is required. If benefits are unable to be verified, you are responsible. All charges are your responsibility whether your insurance company pays or does not pay. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, etc.

2. Payment is due at time of service:

We accept cash, checks, debit and credit cards. All deductibles, copays, and non-covered services are due at time of service unless payment arrangements have been made in advance. If you have Medicare, and Medicare deems the treatment as "medically unnecessary" (according to HCFA payment guidelines), you will be required to sign a waiver (advanced beneficiary notice) prior to treatment and the service is due at the check-out counter. All Medicare patients will be required to pay the 20% copay based upon the current Medicare Fee Schedule at upon checking-in for an appointment, unless proof of a secondary policy is evident. Pre-determined copays are due when you check-in for your appointment. If your copay is based on a percentage (example 20% is patient responsibility) and you do not have a secondary policy, please be prepared to pay. Insurance claims are filed as a courtesy; you are ultimately responsible for the rendered services.

3. Our responsibility to report non-compliance:

It is our obligation under many of the managed care contracts to report patients who repeatedly refuse to pay copays and deductibles at time of service or who repeatedly "No-Show" for appointments. Please know that if you are reported, you could possibly lose your health care benefits. Contact human resources with your employer for further clarification of your benefits and obligations.

4. Financial Assistance:

Our office treats patients regardless of financial status. If you have no insurance, have maximized your benefits, have a high deductible or you are currently medically indigent or financially indigent but not eligible for Public Assistance or Medicaid, please ask to speak with the Office Administrator.

5. Billing, Payments, Over Payments, and Miscellaneous Fees:

If an overpayment is made by you on the account, a refund will only be issued in a timely fashion if there are no other outstanding debts on the other accounts containing the same guarantor or financial responsible party. Patient balances unforeseen at time of service will be billed to the address you have provided for billing purposes. It is your responsibility to inform us of any changes in your address, phone, or employment. All balances are due in full within 14 days of the billing date. Miscellaneous applicable fees include, but are not limited to: $50 for Appointments "No-Shows" without 24 hour notice or Appointments in which you arrive more than 15 beyond the scheduled time, $50 for returned checks and designated document requests. For further details, please contact our administrative staff.

6. Past Due and Delinquent Accounts:

Failure to meet your financial obligations may result in: reporting your account to our contracted collections agency, who in turn may report you to the credit bureau; a filing for a judgment in small claims court or other collection action against you and may lead to you being discharged as a patient from this facility. We will make every effort to assist you in maintaining your account in good standing. If you have been advised of a past due or delinquent account, please ask to speak with our billing or administrative staff immediately.

I understand and agree that I am absolutely responsible for the balance on my account for professional services rendered. I also understand that I should direct all insurance and/or financial concerns to the administrative staff.

Signature _____ Printed Name _____ Date: _____

Tel: 210-963-7493 Fax 888-464-0947

Authorization to Disclose Protected Health Information (PHI)

Patient Name:_____ DOB: _____

Address: _____

Phone: _____ Email: _____

I hereby authorize The Painsmith, PLLC located at 731 Carnoustie Dr, Suite 102, San Antonio, TX, 78258 to obtain medical records including, but not limited to: lab reports, progress notes, consultation notes, imaging reports or films, operative reports for the purposes of continuity of care. It is my request that this notice serve as appropriate records release under HIPAA guidelines for any provider I have previously seen.

I understand that this release shall be effective for a period of one year following my signature or a shorter timeframe that I request in writing. I also understand that I can revoke this permission at any time giving writing notice to this organization. I also understand that by refusing to release my records I will not be denied care, but that my Physicians ability to properly care for me may be adversely affected.

Signature _____

Date _____