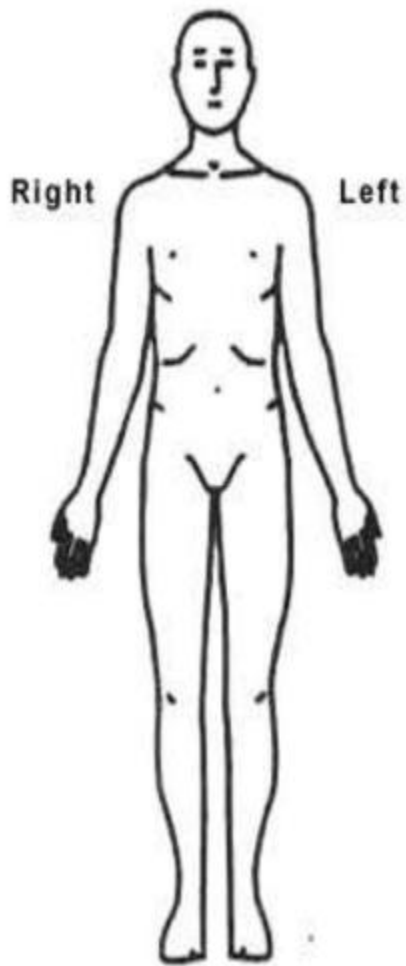
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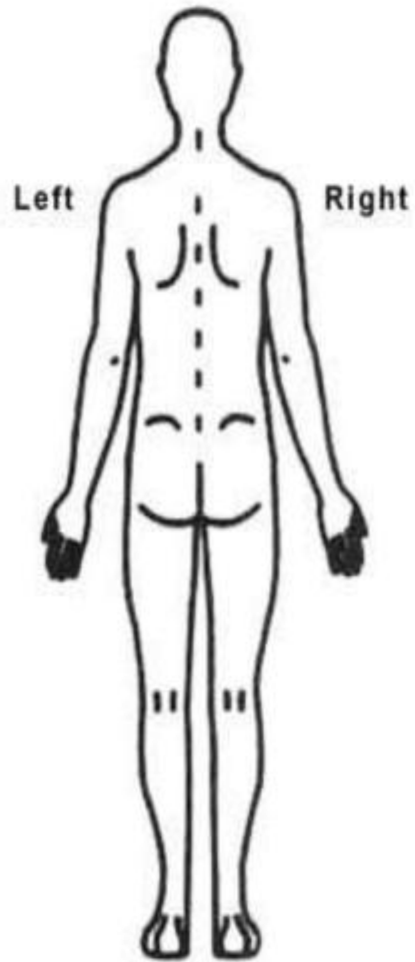
Left
Right

Name ____

OTHER INFORMATION

1. Any RELEVANT **SURGERIES** (i.e. spine surgery). If yes, give name and date of surgery.

2. Any RELEVANT **HOSPITALIZATIONS**. If yes, give place and date of hospitalization.

3. Any RELEVANT **FAMILY HISTORY**

4. List any **ALLERGIES**

5. List any **CURRENT MEDICATIONS**

VIKAS GARG, MD, MSA **ALEX J NELSON, MD**

BOARD CERTIFIED FELLOWSHIP TRAINED PAIN MANAGEMENT SPECIALISTS

Pain Clinic Patient Information Sheet

Patient Information:

REFERRING PHYSICIAN____________________PRIMARY CARE PHYSICIAN____________

LAST NAME ______________________ FIRST NAME _____________________M.I.__________

ADDRESS_______________________________CITY, STATE, ZIP__________ _____________

PHONE (________)______________________CELL (__ ____) ___________________________

SOCIAL SECURITY # _____________________ DATE OF BIRTH__________________

EMPLOYER____

ADDRESS_______________________________ PHONE (_____) __________________

MARITAL STATUS: M S D W SPOUSE NAME___________________

REASON FOR VISIT____

INJURY_______________________________________DATE OF SYMPTOMS ONSET_______

EMERGENCY CONTACT INFORMATION:

NAME__________________________________RELATIONSHIP TO PATIENT______________

PHONE (_________) _____________________CELL(__ __) _____________________ _______

ADDRESS_______________________________CITY, STATE, ZIP_________________________

INSURANCE INFORMATION:

PRIMARY INSURANCE________________________________POLICY#___________ ______

GROUP#______________________EFFECTIVE DATE____________________COPAY_______

INSURED NAME______________________________INSURANCE PHONE (_____) ________

If spouse - get DOB and SSN

Spouse's Social Security#__________________________Date of Birth______________________

SECONDARY INSURANCE______________________________POLICY #__________________

GROUP # _________________EFFECTIVE DATE ____________________COPAY ______

INSURED NAME______________________________Insurance Phone (________) _________

If spouse- get DOB and SSN

EMAIL:

PHARMACY:

VIKAS GARG, MD, MSA **ALEX J. NELSON, MD**

BOARD CERTIFIED FELLOWSHIP TRAINED PAIN MANAGEMENT SPECIALISTS

I hereby authorize the office of Interventional Spine and Pain Management to use, disclose or release information from the medical records of:

Patient Name____

Date of Birth__________________________Social security #_______________________

Release to

Name____

Address____

Phone________________________________Fax__________________________________

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or have copied the information to be used or disclosed, as provided in DFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact the HIM department or the Privacy officer at the Interventional Spine & Pain Management.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Department. I understand that the revocation will not apply to my insurance company when laws provide my insurer with the right to contest a claim under my policy. If I fail to specify an expiration date, event or condition, this authorization will expire in (12) months.

I understand that the information in my health record may include information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS),or Human Immunodeficiency Virus (HIV). It may also include information about the behavioral or mental health services, and treatment for alcohol and drug abuse. This information may be disclosed to and used by the individual or organization mentioned above.

_____________________________________ ______________________

Signature of patient, Parent or parent representative Date

_____________________________________ ______________________

If Signed by Legal Representative, state relationship Signature or Witness

VIKAS GARG, MD, MSA **ALEX J NELSON, MD**

BOARD CERTIFIED FELLOWSHIP TRAINED PAIN MANAGEMENT SPECIALISTS

Consent and conditions of Treatment

Thank you for choosing Interventional Spine and Pain Management to provide for your healthcare needs. We are committed to providing exceptional healthcare. The first step in this process is to provide information regarding patient rights, risks and responsibilities. The second step is to obtain your consent to treat the patient. The admitting staff can answer any questions may have in regards to the following agreement.
I agree to the following:

1. **CONSENT TO TREAT:** I consent to the treatment or admission of____ at Interventional Spine and Pain Management for services or supplies that have been or may be ordered by a licensed professional healthcare provider. I understand that treatment may include but is not limited to; radiological examinations, laboratory procedures, physical therapy, anesthesia, nursing care or medical and surgical treatment. I understand that all licensed professional healthcare providers that render service to the patient are responsible and liable for their own acts, orders and omissions. I acknowledge that the hospital has not made not can it make a guarantee of the outcome of treatment.

2. **FINANCIAL AGREEMENT:** I agree to pay for all services and supplies rendered to the patient in accordance with the rates and financial policies in effect at the time of service. I authorize any overpayment made on this account to be transferred to any other account balance for which I am responsible. I agree to pay interest fees on any unpaid balance after 60 days of discharge or date of service at a rate not to exceed 18% apr. If this account is assigned to an attorney or a collection agency for collection then I agree to pay all collection agency fees, court costs, and attorney's fees.
   - I am aware that financial counseling is available for any services that I may receive during my visit at Interventional Spine and Pain Management.

3. **ASSIGNMENT OF INSURANCE BENEFITS:** I assign and authorize payment to Interventional Spine and Pain Management directly of any healthcare benefits that the patient is entitled to receive. This assignment will not be withdrawn or voided at any time unless I pay the account in full. I understand that I am responsible for any and all charges not covered by my insurance policy(s). If the patient is entitled to Medicare or Medicaid benefits under Title XVIII of the Social Security Act, I request assignment of benefits directly to Spine and Pain Management Center.

4. **ASSIGNMENT OF PHYSICIAN BENEFITS:** I am aware that physician services by Radiologist, Pathologist, Anesthesiologist, as well as medical, surgical and emergency care are not billed by the hospital but are billed separately. I understand that I am under the same obligation to those providers as stated in this agreement unless otherwise agreed to in writing with those providers. I authorize payment of any medical benefits for such claims to the appropriate provider.

5. **RELEASE OF MEDICAL INFORMATION:** I authorize the hospital or any professional healthcare provider who rendered services to the patient to release any medical or other information necessary to process claims.

- I acknowledge that I have received a copy of the Privacy Notice.
- I decline to accept a copy of the Privacy Notice.

6. **PERSONAL VALUABLES AND BELONGINGS:** I agree that the Interventional Spine and Pain Center is not responsible for the loss or damage of any article or personal property.

7. **ADVANCE DIRECTIVE/LIVING WILL:** State Law requires that the hospital provide all adult patients with information about their right to make an Advanced Directive or Living Will. Please mark one of the following:

- I have provided a copy of my Advance Directive or Living will and request that it be put in my chart as part of my Medical Record.
- I have received information with regard to my right to make Advance Healthcare directives.
- I decline information regarding an Advance Directive or Living Will.
- I have not provided nor do I have an Advance Directive or Living Will.
- I understand if Advance Directive or Living Will **is not present** in my medical record its directives **will not** be followed.

Action taken by admission clerk:____

I understand and accept the terms of this agreement and certify that I am duly authorized by the patient or by law to execute the above agreement in their behalf.

Patient__________________________ Date ______ / _________ / ________ Time_________________________

FINANCIAL POLICY

The patient or their guarantor is responsible for full payment for services provided by our physicians at the time of service. The only exception is if our office has contracted with your insurance carrier to accept their payment in full after all deductibles, co-insurance and/ or co-pays have been paid by the patient. Our staff is required by insurance carriers, Medicare and Medicaid to collect deductibles, co-insurance and/or co-pay amounts at the time of service. To effectively submit your insurance claim and to determine your payment responsibility, we require a copy of your insurance, Medicare, Medicare supplement, or Medicaid card, and your current mailing address. If this information cannot be provided then full payment for services rendered will be required at the time of service.

If we are not contracted with your insurance carrier, we will provide you with a copy of your bill which contains all the information necessary for you to bill your insurance carrier. It will be your responsibility to bill and collect from your insurance carrier. Please be aware that your insurance carrier may not cover medical services provided by our office if we are not under contract. Consequently, if we are not contracted with your insurance carrier, full payment for all services rendered will be required at the time of service.

As a matter of general policy, all patient accounts over 60 days will be charged 1.5% monthly interest of a $3.00 minimum on the outstanding balance. In the event that your balance is not paid as agreed, the undersigned jointly and severally agrees to pay all costs charged to PMC by a collection agency, including but not limited to collection, attorney and court fees.

For your convenience, we accept cash, personal checks and credit cards in our office. If you have any questions regarding this policy or payment for services, please contact the receptionist or a representative of the accounts receivable department.

I have read all the information above and understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account and for any professional services rendered. In the event my insurance is billed, I authorize payment of medical benefits to be paid directly to Pain Management Center. A photocopy of this agreement shall be considered as effective as effective and valid as the original.

Non-covered medical services are the responsibility of the patient and payment is due at the time services are rendered.

ALL COPAYS ARE DUE AT THE TIME OF SERVICE.

THERE IS 100.00 USD CHARGE FOR ANY MISSED APPOINTMENT WITHOUT 24 HOUR NOTICE.

PATIENTS' SIGNATURE_________________________________DATE____________

RESPONSIBLE PARTY'S SIGNATURE
(IF PATIENT IS MINOR)____________________________________DATE____________