REGISTRATION INFORMATION

Date: _____ Home Phone: _____

Social Security No.:_____ Cell Phone: _____

Email: _____ Work Phone: _____

PATIENT:

_____

Last Name First Name Middle Initial

_____

Street Address

_____

City State Zip Code

Gender: ❑ M ❑ F **Age:** _____ **Birthdate:** _____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Spouse's Name: _____ Birthdate: _____

Spouse's Phone Number: _____ Spouse's SSN: _____

EMPLOYMENT:

❑ Employed ❑ Disabled ❑ Full-Time Student ❑ Part-Time Student

Patient Employed by/Occupation: _____

Business Address & Phone: _____

INSURANCE:

Do you have Medical Insurance? ❑ Yes ❑ No

If yes, Name of Primary Insurance: _____

ID #:_____ Group #:_____ Insured's Name: _____

Name of Secondary Insurance (if any): _____

ID #:_____ Group #:_____ Insured's Name: _____

Are you covered under Worker's Compensation? ❑ Yes ❑ No

If yes, Adjuster's Name:_____ Claim #: _____

Address to send claims to: _____

Adj's Phone #:_____ Adj's Fax # _____ Date of Injury: _____

Is your condition related to an auto accident? ❑ Yes ❑ No Which state?_____ Date of Injury: _____

Other reason for injury? Please describe:_____

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IN CASE OF EMERGENCY, who should be notified?

_____

Emergency contact's number:_____ Relationship to patient: _____

Primary care provider:_____ City/State: _____

Please list other doctors you have seen in the past 5 years:

_____

_____

_____

How did you learn of our practice? _____

Whom may we thank for referring you? _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
Name of Insurance Company

and assign directly to Dr. Buzzanell all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____(SEAL) _____
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Buzzanell for any services furnished by my physician. 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. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____(SEAL) _____
Signature of Benificiary Date

MEDICATION HISTORY CONSENT

I give my permission for Blue Ridge Pain Management to access my pharmacy history electronically.

_____(SEAL) _____
Signature Date

NEW PATIENT EVALUATION

Patient: _____ DOB: _____ Date: _____

Referring Physician: _____ Primary Care Physician: _____

Surgeon: _____ Psychiatrist: _____

PAIN ASSESSMENT:

Do you suffer from headaches more than 3 days/week? ❑ Yes ❑ No

Cause of pain: _____

If accident, date: _____ Is this an open case? ❑ Yes ❑ No

How long have you had the pain: _____

Location of pain: _____

Description of pain: *(Check the ones that apply to you)*

❑ Sharp ❑ Stabbing ❑ Burning ❑ Stinging
❑ Dull, aching ❑ Numbness ❑ Pressure ❑ Electrical/Shooting
❑ Throbbing ❑ Pins & Needles ❑ Cramping

Is the pain: ❑ Rarely ❑ Occasionally ❑ Frequently ❑ Always Present

Is the pain always the same? ❑ Yes ❑ No

What makes your pain worse?

❑ Carrying ❑ Bending ❑ Sitting ❑ Twisting ❑ Changing position
❑ Walking ❑ Lying down ❑ Standing ❑ Weather ❑ Stress

What makes your pain better?

❑ Lying down ❑ Standing ❑ Ice
❑ Sitting ❑ Walking ❑ Heat

What pain treatments have you had? *(Check what applies to you)*

❑ Epidural Steroids ❑ Spinal cord stimulation ❑ Acupuncture ❑ Narcotic pain medication
❑ Chiropractor ❑ Physical therapy ❑ Intrathecal pump ❑ Steroid injection Where? _____
❑ Trigger points ❑ TENS unit ❑ Back brace
❑ Other _____

Past Medical History/ Problems: *(Check what applies to you)*

❑ Heart Attack ❑ Kidney disease ❑ Depression ❑ Anxiety
❑ Emphysema ❑ High blood pressure ❑ Asthma/bronchitis ❑ Arthritis
❑ Hepatitis/liver disease ❑ Cancer ❑ Infection-TB_AIDS ❑ Sleep apnea
❑ Seizures ❑ Heart Surgery ❑ Bleeding tendency
❑ Angina ❑ Stroke ❑ Diabetes
❑ Other _____

(Please fill out the back)

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Past Surgical History: *(Please include dates)*

_____

_____

Special studies to diagnose the cause of your pain: *(X-Ray, MRI, CT Scan, Myelogram, EMG)*

_____

_____

Family History: *(Check what applies to your family)*

❑ Migraine	❑ Seizures	❑ Stroke	❑ Heart Attack	❑ DM
❑ Back Problems	❑ Depression	❑ Anxiety	❑ Cancer	❑ HTN

Social History:

Smoking habits: _____ packs per day for _____ years

Alcohol intake: _____ Amount & Frequency _____

Have you been treated by another pain management center? ❑ Yes ❑ No

If yes, where? _____

Have you been treated for addiction? ❑ Yes ❑ No

REVIEW OF SYSTEMS:

I have suffered from the following:

❑ Decreased appetite	❑ Breathing difficulty	❑ Long-standing surgical scars	❑ Anxiety
❑ Increased appetite	❑ Constipation	❑ Change in skin, hair or nails	❑ Nervousness
❑ Fatigue	❑ Diarrhea	❑ Jerkiness	❑ Confusion
❑ Excessive sweating	❑ Nausea/vomiting	❑ Headaches	❑ Hallucinations
❑ Sleepiness/sedation	❑ Bladder problems	❑ Light headed	❑ Forgetfulness
❑ Daytime sleepiness	❑ Urinary retention	❑ Dizziness	❑ Inability to concentrate
❑ Blurred vision	❑ Itching	❑ Pain to light touch	❑ Change in libido
❑ Double vision	❑ Swelling		❑ Feeling hopeless
❑ Dry mouth	❑ Flushing		❑ Nightmares

Medication Allergies?: _____

Are you on a blood thinner? ❑ Yes ❑ No if so, which one? _____

List all medications (prescribed and over-the-counter) including strength and how often you take it:

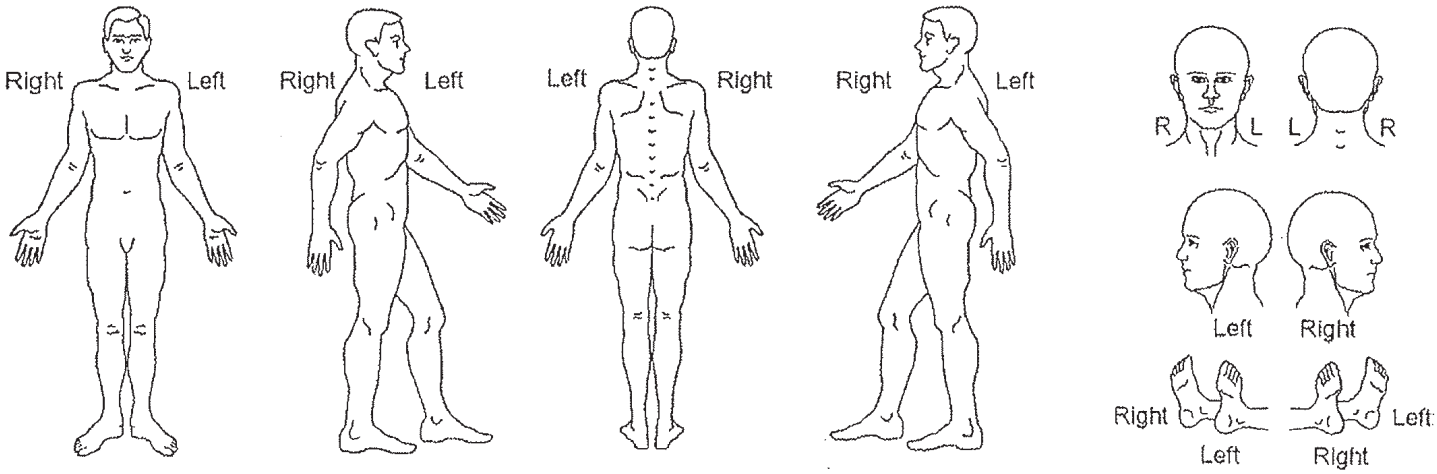
I am CURRENTLY taking the following for PAIN and PAIN RELATED issues:

Name *(e.g.: Advil 200 mgs)*	Pill strength *(e.g. 2 to 3 tablets)*	Amount at a time / How often? *(e.g. 3 times a day)*

PAIN INDICATOR

Patient: _____ DOB: _____ Date: _____

Please mark the painful areas in the pictures below.



Comments: _____

_____

_____

_____

My **WORST** Pain score: 0 1 2 3 4 5 6 7 8 9 10

My **LEAST** Pain score: 0 1 2 3 4 5 6 7 8 9 10

My Pain score **Today:** 0 1 2 3 4 5 6 7 8 9 10

My Pain score **Average:** 0 1 2 3 4 5 6 7 8 9 10

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MY MEDICATION LIST

Patient: _____ DOB: _____ Date: _____

Allergies and reactions: _____

_____

DATE	MEDICATION/DOSE	PURPOSE	TIMES TAKEN	PRESCRIBED BY	DATE CHANGED OR STOPPED/REASON

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HIPAA PATIENT CONSENT FORM

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient’s consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations. Our employees continually undergo training so that they may understand and comply with government rules and regulations regarding Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the “Privacy Rule”.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all that we can to secure and protect your privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information and information about treatment, payment, or health care operations, in order to provide health care that is in your best interest.

We may have indirect treatment relationships with you such as laboratories, which may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain personal consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any questions regarding this form, please ask to speak to our HIPAA Compliance Officer.

We will be happy to provide you with a copy of this form upon your request.

This Consent was signed by:

Printed Name- Patient or Representative	Relationship to Patient (If other than patient)
Signature	Date
Signature	Date

AUTHORIZATION FOR RELEASE OF INFORMATION (HIPAA)

Patient: _____ DOB: _____ Date: _____

_____ is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
❑ Voice Mail	❑ Results of lab tests/x-rays Other:
❑ Spouse (provide name & phone number)	❑ Financial ❑ Medical
❑ Parent (provide name & phone number)	❑ Financial ❑ Medical
❑ Email communication (provide email address)* _____	❑ Financial ❑ Brreach notification ❑ Medical ❑ Appointment reminder

**For email communication, I understand that if email is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email communication for the checked items.*

❑ Our appointment reminders can go out by text 2 days prior to your appointment and by phone the day before your appointment. Please provide a cell phone number for text*:_____.

**Text messaging is not secure as it is transmitted over wireless networks which may or may not be secure. We are not responsible for extra costs from your phone carrier.*

❑ Communication about treatment alternatives even if this office is being compensated for making the communication.

Patient rights:

- I have the right to revoke this authorization at any time.
- I have the right to inspect or copy the protected health information to be disclosed as described in this document.
- Revocation may not be effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority *(attach necessary documentation)*

_____

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FINANCIAL POLICY

A. MEDICAL AND SURGICAL CONSENT. I, the undersigned, consent to the treatment and procedures which may be performed during this and any further service, and which may include but are not limited to any medical/surgical treatment or procedures. I have the right to refuse any treatment and to be informed of the possible medical consequences of refusal. My signature on this document indicates my general consent to be treated. My physician may request that I sign a more specific form relative to any procedure that may be performed.

B. RELEASE OF INFORMATION. The physician(s) may disclose any or all parts of these medical records to my insurance carrier(s) and any organization(s) contractually responsible for purposes of satisfying all charges billed by the physician(s). This includes but is not limited to all claim filings, appeals, and correspondence in regard to the charges billed.

C. FINANCIAL RESPONSIBILITY. I, the undersigned, hereby understand and acknowledge that it is the policy of this office that payment is made at each visit and I am responsible for payment of all services rendered in my behalf.

Financial Balance Policy: If you have established a balance that is 45 days or older and have not made arrangements to pay it, you will be discharged 30 days from the date the practice notifies you in writing. You must pay any balance owed before you are a patient of the practice again. If the balance is not paid within the 30 days, the account will be turned over to collections and reported to the credit bureaus.

D. SCHEDULING AND NO SHOW POLICY. If you are more than five minutes late for your scheduled appointment time, you will be rescheduled to the next available slot. This includes time for filling out the necessary paperwork for your appointment. Example: Your appointment time is 10:00. You arrive at 10 and don't have your paperwork completed, handed in and in the queue until 10:06. In this scenario, you will be rescheduled.

You will be given reminder calls about your appointment and are asked to be here 15 - 30 minutes early to fill out your paperwork so that the schedule does not get behind. The clock we go by is at our front desk station. We are endeavoring to stay on schedule and abiding by this policy will make that happen so you won't have to wait unreasonably long.

Our appointment reminders go out by text and email 2 days prior to your appointment and by phone the day before your appointment. Please provide a cell phone number for text: _____ and email: _____ to get these reminders. This is a service to you. We are not responsible for forgotten appointments. By providing us with these communication venues you are giving consent to receive reminders from us in this way.

If you do not cancel or reschedule your appointment 24 hours before your appointment time, this will be considered a no show and you will be charged $35. If you are sick, please call the office and talk with the medical assistant to determine whether or not this appointment will be rescheduled without a charge. If you do not pay this charge, you will be subject to our Financial Balance Policy described above. Inclement weather falls under our inclement weather policy and no charges will be assessed.

E. AUTHORIZATION FOR MEDICAL PAYMENTS. I hereby authorize payment of medical benefits to any physician or supplier for services rendered.

F. INSURANCE MATTERS. I understand the following concerning insurance:

- We will file your insurance claim, however we **MUST** have a copy of your insurance card in order to file. At the time of service, you will be responsible for any and all copays, deductibles and co-insurance amounts.
- All insurance changes must be given to us at the time of service. If your insurance changes and we are not notified in writing, you will be responsible for all charges and we will be unable to bill your insurance for any services before the change notification.
- **IN Network Insurance Office Policy:** If we are contracted with your insurance company, you will only be responsible for your co-pays and co-insurance as outlined on your EOB (Explanation of Benefits). See the front desk for a current list of payers.

- **OUT of Network Insurance Office Policy:** If we are not in contract with your insurance company, we will file the insurance on your behalf and accept assignment of the payments. Any balance will be patient responsibility. We are not obligated to write off amounts your insurance company recommends to us. We will give a remaining insurance balance discount of 20% as a courtesy to our patients.
- **Self Pay Policy:** Patients with no insurance are given a 20% discount on Office Visits and a 50% discount on Procedures. Payment is mandatory at time of visit. You will not be permitted to carry a balance and if a balance remains you will not be able to come back for another visit until the balance is paid in full.
- As a courtesy, we will file your secondary insurance provided that all information is given at the **time of service**. If no payment is received from the secondary carrier within forty-five (45) days of filing, the unpaid balance becomes your responsibility. In the event of duplicate payment by the insurance and/or patient, refunds will be sent to the appropriate party as soon as possible.
- All patient balances become due and payable immediately upon your benefits determination or our receipt of the payment or denial notice from your insurance carrier.
- For those patients who are members of an insurance plan that requires a referral, please verify with our front desk staff that current authorization has been received prior to your visit. If we do not have a completed authorization, you will be responsible for your visit.
- The patient, not our office or the insurance company, is responsible for all charges incurred in regarding to all medical/surgical care. We advise you to know your insurance plan and your covered benefits. You will be billed directly for all non-covered services and supplies.

G. MEDICARE AND/OR MEDIGAP PATIENTS. I hereby request that payment of authorized Medicare and/or Medigap Benefits be made on my behalf to Blue Ridge Pain Management for any services rendered to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits payable for related services.

H. RETURNED CHECKS. A service charge of $35 will be applied to your account for all returned checks. Once a returned check has been received, all future payments must be made with cash, money order or cashier's check.

I. RESPONSIBILITY FOR SERVICES PROVIDED TO MINORS. The responsibility for payment of services rendered to any dependent children rests with both parents. The responsibility for payment of services rendered to any dependent children of divorced parents rests with both parents as well. Any court ordered responsibility judgment must be determined between the individuals and/or the court system without the inclusion of our office.

J. DISABILITY FORMS. If a disability form is needed, there will be a thirty-five dollar ($35.00) fee for the initial completion of your form and a twenty-five dollar ($25.00) fee for any subsequent form. Our office requires five to seven (5-7) business days to complete all forms.

I, the undersigned, further state that the foregoing Financial Policy has been carefully read, and that I understand the contents thereof, and have signed of my own free and voluntary act, and have not been influenced in executing this Financial Policy by any representative of BLUE RIDGE PAIN MANAGEMENT or its agents. I hereby acknowledge the continuing nature of this agreement unless or until withdrawn by me in writing.

_____ [SEAL] Dated: _____/_____/_____

Patient Signature (or Parent if Patient is a Minor)

_____ Copy Provided to Patient

Witness