COMPREHENSIVE PAIN AND SPINE, LLC

PATIENT REGISTRATION

Patient's Name: _____ DOB: _____ Sex: ____ Marital Status: _____

Home Phone #: (_____) _____ Cell Phone #: (_____) _____ Email Address*: _____

Address: _____ City: _____ State: _____ Zip Code: _____

SSN: _____ Preferred Language: _____ Race: _____

Name of referring doctor: _____ Phone #: (_____) _____

Employer: _____ Work Phone #: (_____) _____

Spouse's Name: _____ Spouse's Employer: _____

Nearest relative not living with you: _____ Phone #: (_____) _____

HEALTH INSURANCE COVERAGE - *To be completed by all patients.* (In the case of workers' compensation, this information will only be used if your compensation is denied).

Health Insurance Company Name: _____ Phone #: (_____) _____

Address: _____ City: _____ State: _____ Zip Code: _____

Group #: _____ ID #: _____

Subscriber is: ☐ Self ☐ Spouse ☐ Parent ☐ Other Subscriber's Name: _____

Social Security # of Subscriber *(if other than self)*: _____ DOB of Subscriber: _____

Do you have secondary insurance? ☐ Yes ☐ No Carrier Name: _____ ID #: _____

LIABILITY - <u>ACCIDENT</u> *(AUTO or otherwise – but NOT work related). Please provide us with **YOUR** med-pay/PIP benefits of your policy.*

Insurance Company Name: _____ Date of Accident: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Policy Number: _____ Claim #: _____

Claims Adjuster: _____ Phone #: (_____) _____

Location of Accident *(State)*: _____

WORKERS COMPENSATION – *Please complete this section if your illness/injury is **WORK RELATED**.*

Insurance Company Name: _____ Date of Accident: _____ Claim #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Claims Adjuster: _____ Phone #: (_____) _____ When was the Report of Accident filed? _____

Employer at the time of the accident: _____ Contact Person: _____ Phone #: (_____) _____

Address: _____ City: _____ State: _____ Zip Code: _____

ATTORNEY – *Please complete if an attorney is representing you regarding this particular illness/injury.*

Attorney Name: _____ Phone #: (_____) _____

Address: _____ City: _____ State: _____ Zip Code: _____

PATIENT AUTHORIZATION AND ASSIGNMENT

I, _____, hereby authorize Comprehensive Pain and Spine Services, LLC., (hereby referred to as CPASS), to apply for benefits on my behalf for services rendered. I request that payment be made directly to CPASS. I certify that the information provided regarding insurance coverage is true and accurate. I further authorize the release of any necessary medical or other information for this or any related claim to my insurance companies. I permit a copy of this authorization an assignment to be used in place of original. This will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I agree to assume responsibility for all charges incurred should collection of this balance become necessary including court costs and attorney's fees. I understand that CPASS may refer me to a facility in which it has a financial interest. I am not obligated to use that facility and may make my appointment at another one of my choice.

Signature: _____ Date: _____

COMPREHENSIVE PAIN AND SPINE SERVICES, LLC

NEW PATIENT QUESTIONNAIRE

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

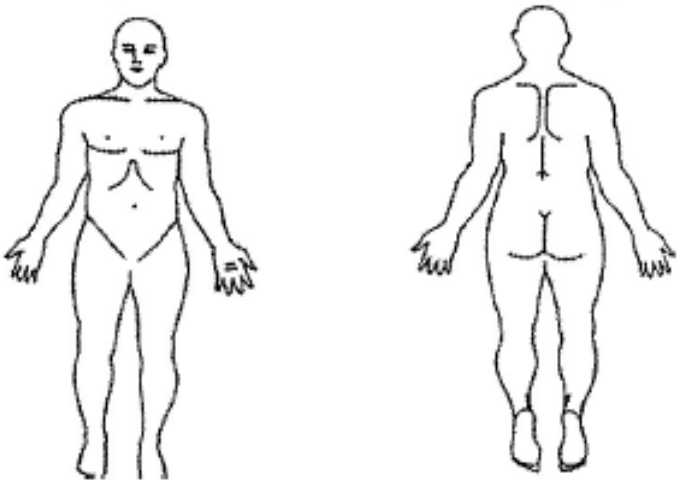
Primary Care Physician: _____ **Have you seen your PCP this calendar year?** ☐Yes ☐No

Referring Provider: _____

This visit is related to a: ☐ Workers' Compensation Injury ☐ Motor Vehicle Accident

Chief Complaint: _____

On the diagram, shade in the areas where you feel pain?



Right Left **Left Right**

Current Pharmacy

Name: _____

Address: _____

Phone: _____

Height: _____

Weight: _____

The onset of your pain was: ☐suddenly following an injury ☐suddenly without an injury ☐gradually following an injury ☐gradually without an injury ☐after a work related injury ☐after a motor vehicle accident

Your pain has been occurring for: _____ number of ☐days ☐weeks ☐months ☐years

Your pain occurs: ☐intermitent ☐continuous ☐occasional ☐rare

Describe your pain: ☐throbbing ☐dull ☐shooting ☐aching ☐stabbing ☐burning

Is your pain: ☐mild ☐moderate ☐severe ☐unbearable

Pain level today 0 1 2 3 4 5 6 7 8 9 10 (0 = no pain 10 = unbearable pain)

Over the last 2 weeks, please identify your pain levels below:

Severe pain level 0 1 2 3 4 5 6 7 8 9 10 (0 = no pain 10 = unbearable pain)

Average pain level 0 1 2 3 4 5 6 7 8 9 10 (0 = no pain 10 = unbearable pain)

Do you experience: ☐numbness ☐weakness ☐tingling ☐pins/needles ☐burning ☐swelling

What activities increase your symptoms:

☐sitting	☐lifting	☐bending to the right	☐cold/damp weather
☐standing	☐bending forward	☐bending to the left	☐coughing/sneezing
☐walking	☐bending backward	☐driving	

Please continue to the back of the form → / page 2

What activities decrease your symptoms:

☐nothing ☐rest ☐ice application ☐massage
☐sitting ☐avoiding strenuous activity ☐stretching ☐acupuncture
☐standing ☐lying with pillow between legs ☐pain medication ☐swimming
☐walking ☐heat ☐chiropractic manipulation

Medications tried:

☐Oral NSAIDS (Ibuprofen/prescription strength Motrin) ☐Prescription pain medications (Vicodin/Dilaudid)
☐Over the counter agents ☐Prescription nerve medications (Lyrica/Cymbalta)
☐Muscle relaxants (Flexeril/Skelaxin) ☐Prescription topical agents (Voltaren gel/Lidoderm)

Previous conservative measures:

☐physical therapy ☐surgical interventions ☐massage
☐chiropractic treatment ☐activity modification ☐acupuncture
☐cortisone injections ☐bracing

ALL CURRENT MEDICATIONS, INCLUDING OVER THE COUNTER (please list): _____

_____

ALLERGIES (include allergies/side effects to medications or seafood): _____

_____

PAST MEDICAL HISTORY: Please check any of the following conditions you have or have had:

☐headache ☐stroke ☐TMJ ☐thyroid disease ☐cancer ☐lung disease/asthma ☐blood clots
☐high blood pressure ☐ peripheral vascular disease ☐heart attack ☐coronary artery disease ☐diabetes
☐gastrointestinal disease ☐stomach ulcers ☐kidney disease ☐hepatitis A ☐hepatitis B ☐hepatitis C
☐fracture ☐arthritis ☐neurological disorders ☐pinched nerves ☐seizures ☐HIV/AIDS

Please list any other past or present conditions you have: _____
Please indicate any prior accidents or work injuries: _____

PAST SURGICAL HISTORY: ☐Arthroscopic Surgery ☐Caesarean Section ☐Carpal Tunnel Surgery ☐Hernia Repair
☐Hysterectomy ☐Joint Replacement ☐Pacemaker ☐Spine Surgery ☐Stent ☐Other:_____

_____

FAMILY HISTORY: ☐None ☐Unknown Please list all medical conditions that are common in your family:

Arthritis	☐Father	☐Mother	☐Brother	☐Sister	☐Other: _____
Back Problem	☐Father	☐Mother	☐Brother	☐Sister	☐Other: _____
Depressive Disorder	☐Father	☐Mother	☐Brother	☐Sister	☐Other: _____
Diabetes	☐Father	☐Mother	☐Brother	☐Sister	☐Other: _____
Cancer	☐Father	☐Mother	☐Brother	☐Sister	☐Other: _____
Hypertension/HBP	☐Father	☐Mother	☐Brother	☐Sister	☐Other: _____
Heart Attack/Disease	☐Father	☐Mother	☐Brother	☐Sister	☐Other: _____
Substance Abuse	☐Father	☐Mother	☐Brother	☐Sister	☐Other: _____

SOCIAL HISTORY: Occupation: _____ ☐Full-time ☐Part-time ☐Retired ☐Not Working

Marital Status: ☐S ☐M ☐W ☐D ☐P Tobacco use: ☐Yes ☐No Former smoker: ☐Yes ☐No

Alcohol use: ☐Yes ☐No Do you have problems with drug or alcohol use or dependency? ☐Yes ☐No

REVIEW OF SYSTEMS-PROBLEMS EXPERIENCING AT THE PRESENT TIME:

☐Fever ☐Dry Eye ☐Dry Mouth ☐Leg Swelling ☐Shortness of Breath ☐Rash
☐Constipation ☐Involuntary Urine loss ☐Poor Balance ☐Dry Skin ☐Joint Swelling ☐Anxiety
☐Depression ☐Unexplained weight loss ☐Sleep Disturbance ☐Easy Bleeding ☐Involuntary bowel incontinence

The above information is accurate to the best of my knowledge:

Patient Signature:_____ Date:_____

Comprehensive Pain and Spine Services, LLC

OPIOID RISK TOOL:
Have you been prescribed opiates for 6 weeks or longer?

O YES
O NO

If you answered NO to the above question, do not proceed.

Do you have a family history of substance abuse?
O Alcohol
O Illegal Drugs
O Prescription Drug

Do you have a personal history of substance abuse?
O Alcohol
O Illegal Drugs
O Prescription Drug

Are you between 16 and 45 years of age?
O YES
O NO

Do you have a history of preadolescent sexual abuse?
O YES
O NO

Have you been diagnosed with any of the following?
O Attention Deficit Disorder
O Obsessive Compulsive Disorder
O Bipolar
O Schizophrenia Depression

ADVANCED DIRECTIVE:
This section pertains for patient 65 or older:

In the event that you are incapacitated, who would you like to have make your medical decisions?

Provide name, phone number, and relationship. If none assigned, leave blank.

_____

Comprehensive Pain and Spine Services, LLC

Welcome and thank you for choosing Comprehensive Pain and Spine Services.
Please read the following guidelines which will help us care for you in an efficient and safe manner. Feel free to contact us with any questions.

GUIDELINES

- **Primary Care referrals**: Please obtain all of the necessary referral forms (if requested by your insurance) from your primary care physician in advance of your visit. Unfortunately, patients cannot be seen without the appropriate referral.
- **Co-payments**: Co-payments and deductibles must be paid upon the patient's arrival. We accept checks, debit cards, Visa and MasterCard.
- **Non-covered services**: Certain Services must be paid for at time of service if not covered by insurance or unless other arrangements are made.
- **Tardiness**: Please call if you're running late. Patients arriving more than 15 minutes late may be asked to reschedule. Obviously, we try to deliver the same respect for your time. If we are running late you will be seen and session will be completed entirely.
- **Cancellations**: We request that patients are unable to keep their appointments contact our office at least 24 business hours prior to the scheduled appointment time since there are other patients that could benefit from the treatment slots. Patients who do not contact the office been 24 hours to cancel their appointments will be charged $50 fee for missed appointments.
- **Repeated missed appointments**: we will be unable to schedule future appointments for patients having three missed appointments and or cancellations without appropriate notice or multiple cancellations per our discretion. this will happen particularly if we feel that these missed appointments are adversely affecting the treatment plan.
- **Medication refills**: to ensure that your medication needs are met in a timely manner we request that you notify us at least three days prior to the date your medication is scheduled to run out. There may be a $15 fee assessed when a prescription is obtained prior to a scheduled appointment.
- **Audio/ video recording prohibited**: please be advised that, in order to better enable us to ensure compliance with HIPAA policies and security laws and regulations, and in recognition of legitimate privacy concerns of our patients and staff, use of any video or video recording devices in this office by patients or other visitors, including but not limited to cell phones, is strictly prohibited. You reserve the right to terminate any patient as permitted under state law if the patient or anyone accompanying the patient is found to be in violation of this office policy. We appreciate your cooperation.

_____ _____

Signature of patient or responsible party Date

Comprehensive Pain and Spine Services, LLC

CLAIMS, PAYMENT AND REVIEWS POLICY

Thank you for selecting Comprehensive Pain and Spine Services(CPASS) as your healthcare provider. We are committed to providing you with the best possible medical care at the lowest possible cost. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our claims, payment and review policies which we require you to read and sign prior to any treatment.

Full payment for professional services is due at the time of service. We accept checks, Visa, MasterCard or Discover.

Our practice participates with most insurance carriers. As a courtesy, we will contact your carrier to confirm coverage and estimate their payment for services rendered. I agree to provide information regarding health insurance, workers' compensation, automobile, and other health care benefits which the patient may be entitled. Patient assigns payment(s), if any, from insurance carriers(s)/health benelit(s) plan to CPASS for services rendered. The direct payment assigned and authorized includes any medical insurance benefits entitled, including any Major Medical benefits otherwise payable to patient under the terms of the policy, but not to exceed the balance due for services rendered.

I understand that if my insurance company or health maintenance organization does not consider the services received as covered or has not authorized the services, then I will be fully responsible for the service provided. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay larger co-pay, co-insurance or other charges. In the event that the insurance does not reimburse these services provided, I acknowledge that I will be responsible for any balance that it declines to pay for such services .

(initials). _____

We require you to make your payment at time of service. Prompt payment allows us to control costs which ultimately keep our lees to a minimum. Patients with a standard co-payment (i.e. $10.00, $12.00 or $15.00 per visit) are required to pay this at the time of service. Patients whose co-insurance is based upon a percentage of the charge are required to pay an estimated percentage of their bill at the time of service. This payment will be applied toward your ultimate responsibility. If you have a deductible that has not been met, your insurance carrier will apply services to that deductible. We require you to pay your deductible at the time of service.

NOTICE TO TRICARE BENEFICIARIES II you are a TRICARE beneficiary, the prior two paragraphs do not apply to you. When you visit one of our physicians or physician's assistants, please identify yourself as a TRICARE beneficiary. If the services to be rendered to you are excluded from your TRICARE benefits, your payment options for these excluded services will be discussed with you at the time of your visit. If the services to be rendered to you are covered as TRICARE benefits, your only charge will be the applicable deductible, copayment and/or cost-sharing amount.

II you have insurance coverage, we are glad to help you receive maximum allowable benefits and will file your claim(s) for you. II your insurance carrier fails to process your claim within 45 days from the date of service, the balance becomes your responsibility. If an insurance problem occurs, you are asked to assist us in contacting your insurance carrier. Please be aware that few insurance companies attempt to cover all medical costs. Some companies pay fixed allowances for each procedure/service while others pay only a percentage of the costs. Our practice is committed to providing the best treatment to you, and we charge what is usual and customary for this area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates which may bear no relationship to the current standard and cost of care in this area.

As required by your insurance carrier, you are responsible for obtaining any necessary referral if your insurance policy mandates such paperwork. You will need to present a completed referral at the time of your appointment. As required by insurance mandates you are also responsible to obtain the appropriate authorizations for medical treatment. In the event that you are seen (by your acknowledgement) without the proper referral/authorization as required by your insurance carrier, you will be responsible for payment of all fees at the time of service. We will file a claim with your insurance carrier and reimburse you if they issue payment to us. We ask that you participate in any dispute with your insurance carrier regarding your policy guidelines and regulations.

| authorize release of information, including financial information and confidential health information and medical records for services rendered regarding my injury or any other services, which may include records related to treatment for substance abuse, to my insurance carrier(s), managed care plan or other pay or, including past or present employer(s), authorized private review entities or entities acting on their behall, authorized chart reviewers, the billing agents, collection agents, our attorneys or insurance companies, the Social Security administration, the Health Care Financing Administration, the Peer Review Organization acting on behalf of the federal government, and/or any other federal or state agency for the purpose of satisfying billed charges and/or facilitating utilization review and/or otherwise complying obligations of state or federal law.

There is a $15 charge for prescription refills prior to a scheduled appointment and a $50 charge for No Show or Call to Cancel appointments with less than a 24 business hour notice. Returned checks will be processed with a service charge of $35. Outstanding patient balances over 30 days will accrue a monthly 1.5% interest charge. Balances referred to collection services are subject to additional fees. In addition, patients whose accounts have been referred to collection agencies must pay any outstanding balance and pay for each visit in full at the time of the appointment before additional services/care will be provided.

Our staff is available to answer questions relating to how your claim was filed or any additional information the carrier may need to process your claim. However, coverage issues are best addressed by your employer or group plan administrator. Your insurance policy is a contract between you and your insurance carrier. CPASS is not a party to that contract and cannot act as a mediator with the carrier or your employer.

In my capacity as patient, legal representative or representative payee for the patient, I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered services. In the event my account must be placed with an attorney or collection agency to obtain payment, I agree to pay reasonable attorney's fees and other collection
costs.

Disclosure of Financial Relationships: CPASS may have financial relationships with other companies. If so, a separate sheet will be provided. All patients have a right to choose where and from whom they receive health care services. If you would prefer to use another health care provider for laboratory, durable medical equipment or otherwise, please let our staff know. We can recommend other health care providers and/or work with your preferred health care providers. Our practice believes that a good provider-patient relationship is based upon effective communications. If you have any questions, please feel welcome to call 410-575-3429

By signing below I certify that I have read and understand the Claims, Payment, and Reviews Policy, have had the opportunity to ask questions and have them answered and accept the above conditions and terms. I further certify that I am the patient or guardian, duly authorized representative, parent or other family m ember of the patient.

_____ _____

Patient Name (please print) Signature of Patient or Responsible Party & Date

_____

Witnessed by CPASS Representative & Date

Comprehensive Pain and Spine Services, LLC

You and the HIV Virus

We are all concerned with minimizing the risks of exposure to the HIV virus.

We're all very conscientious about this add Comprehensive Pain and Spine Services. We have very careful protocols that comply with government regulations for safety (monitored by the occupational health and safety administration.) we would like you to know that we use disposable needles, and you are at no time exposed to blood or bodily fluids of any other patient.

we are obligated to provide a safe workplace. This ensures a safe trip and environment for you. There may be an occasion when we are accidentally in contact with your blood or other bodily fluids. If such an incident occurs oh, we may obtain your informed consent to test your blood for HIV.

Again, these precautions are taken in the interest of safety for you and our staff members.

Please sign below that you understand this information.

_____ _____

Patient Signature Date

Comprehensive Pain and Spine Services, LLC

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of a separate document, entitled, "Notice of Privacy Practices" which sets forth CPASS's privacy practices and my rights regarding privacy of my protected health information.

PATIENT SIGNATURE (or Representative) _____DATE _____

FOR OFFICE USE ONLY

We have made every possible effort to obtain written acknowledgement of receipt of our notice of privacy practices from this patient but it could not be obtained because:

1. The patient refused to sign
2. Due to an emergency situation, it was not possible to obtain an acknowledgement
3. We were unable to communicate with the patient
4. Other (please provide specific details)

Employee Signature_____ Date _____

COMPREHENSIVE PAIN AND SPINE SERVICES, LLC

Patient Name: _____ DOB: _____

Patient Address: _____

Patient Home Number: _____ Patient Mobile Number: _____

By signing this authorization, I authorize _____ to use and or disclose medical information concerning my medical treatment including any reference or record relating to my mental and/or substance abuse to or for the individual and/or party listed below:

COMPREHENSIVE PAIN AND SPINE SERVICE, LLC

1919 SKINNERS TURN RD

OWINGS, MD 20736

Phone: 410-575-3429 Fax: 1-866-214-0466

Information to be released: (please check all that apply):

☐ Complete Medical Records

☐ Records with Specified Dates of: _____

☐ Other: _____

I understand that the medical records I authorized to be disclosed are privileged and confidential and may be disclosed only on my authorization, except when required by HIPAA and related laws other disclosures identified in the Notice of Privacy Practices.

Signature of Patient or Legal Guardian: _____ Date: _____

Print Patient's Name: _____

Print Name of Legal Guardian: _____ Relationship to Patient: _____