

(fka..Georgia Pain Clinic)



David W. Gale, MD
Thomas E. Hurd, MD

Marvin D. Tark, MD

New Patient Information Form

Last Name: _____ First Name: _____ MI: _____

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

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SSN: _____ Date of Birth: _____ Male _____ Female _____

Employer: _____ Occupation: _____ E-Mail _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Referring Physician _____ Primary Care Physician: _____

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

Spouse's Name: _____ Date of Birth: _____

Spouse Employer: _____ Employer Phone: _____

Primary Insurance Carrier
Subscriber Name: _____ DOB: _____ Mailing Address for Claims
SSN: _____

Secondary Insurance Carrier
Subscriber Name: _____ DOB: _____ Mailing Address for Claims
SSN: _____

NOTE: We will bill your secondary insurance as a courtesy. If claims are not paid within 60 days the balance will transferred to patient responsibility.

Is your condition the result of a work related injury? _____ Date of Injury: _____

Is your condition the result of a motor vehicle accident? _____ Date of Injury: _____

State where accident occurred: _____

Insurance Name: _____ Claim Number: _____

Adjustor's Name: _____ Phone: _____

I, _____ agree that the above information is true and I authorize Pain Solutions Treatment Center (formally known as: Georgia Pain Clinic to use this information to obtain financial reimbursement.

Patient's Signature: _____ Date: _____

Reviewed and Updated by: _____ Date: _____



FINANCIAL POLICY, CONSENT FOR TREATMENT, AND RELEASE OF MEDICAL INFORMATION

Thank you for choosing us as your pain management provider. Please understand that payment of your bill is considered part of your treatment. All patients must complete the registration sheet and provide proper insurance information prior to seeing a physician. Full payment is expected as services are rendered. We accept cash, check, Visa, and Mastercard. Payment terms can be arranged with prior approval from our billing department. Co-payments are due at the time of service.

If you have insurance, as a courtesy to you, we will file your primary insurance form and wait no more than 45 days from them to pay. If your account has reached 45 days, you will receive a letter from our office. The letter requests that you contact your insurance company and check on the status of your claim and call our office with the results, within 10 days. We will also file your secondary insurance claim once the primary carrier has paid.

The Pain Solutions treatment centers is committed to providing the highest quality care for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of your insurance company's arbitrary determination of usual and customary rates. Your insurance policy is a contract between you and your insurance company. Any disagreement you have concerning the amount your insurance pays should be directed to your insurance company. We will follow the rules of the agreement for the insurance companies with whom we are contracted. At no time will co-insurance, co-payments, or deductibles be waived.

If you have an HMO, PPO, or equivalent policy, it is your responsibility to inquire with the insurance company to see if Pain Solutions treatment centers is a contracted provider. We try to become contracted providers for as many policies as we can. It is also the patients' responsibility to keep track of referral and referral dates and number of visits.

If your treatment is based on an accident or injury claim, our office will complete your paperwork at a minimum cost of \$25 per form depending on the time required. Payment must be received, as the forms are prepared.

Authorization: I hereby authorize the Pain Solutions Treatment Centers to administer treatment and perform procedures as may be deemed necessary or advisable in my diagnosis. I further authorize the release of any medical information necessary to process my insurance claim and request payment of medical services to be assigned directly to Pain Solutions Treatment Centers. In the event my insurance does not cover services rendered, I agree to be personally and fully responsible for payment. I have read the office policy and understand and agree to its terms. This authorization is to remain in full force unless I revoke the same in writing.

Signature

Printed Name

Date

Authorization to Discuss or Disclose Health Information

I authorize Pain Solutions Treatment Center to discuss and/or disclose my health information with the following person/persons listed below:

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

I understand that this information may include any and all treatment plans, medication issues, history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care and evaluations; treatment for alcohol and/or drug abuse; or similar conditions.

The following information should not be released: _____

Patient's Name: _____

SSN# _____ DOB: _____

Patient's Signature: _____

Date: _____

Witness: _____ Date: _____

This form is valid for one year from patient signature date.

Phone: (770) 590-1078 / Fax: (770) 422-7306
400 Tower Rd, Suite 350, Marietta, GA 30060
645 Molly Lane, Suite 110, Woodstock, GA 30189
15 Medical Drive, Building A, Cartersville, GA 30121



PATIENT ACKNOWLEDGMENT FORM

Patient's Name: _____ **Date of Birth:** _____

SSN: _____ **Previous Name:** _____

I understand that the patient's health information is private and confidential. I understand that Georgia Pain Clinic works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Pain Solutions treatment centers may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that there may be situations where Pain Solutions treatment center is required by law to release this information without my permission. One example would be if a patient threatened to hurt someone.

Pain Solutions treatment center has a detailed document called the *Notice of Privacy Practices*. It contains more information about the policies and practices protecting the patient's privacy including other potential disclosures and uses of patient's health information. I understand that I can receive a copy of this document at any time of my choosing. One example would be disclosure of health information for research purposes. I understand that I have the right to read the *Notice of Privacy Practices* before signing this Acknowledgment.

Pain Solutions treatment center may update this Acknowledgment and *Notice of Privacy Practices*. If I ask, Pain Solutions treatment centers will provide me with the most current *Notice of Privacy Practices*.

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but are not limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative locations.

Pain Solutions treatment center has established procedures that help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist Pain Solutions treatment center by following these procedures if I choose to exercise any of my rights described in the *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review a current copy of Pain Solutions treatment center's *Notice of Privacy Practices* at my discretion.

Patient or Legally Authorized Signature

Date

Relationship to patient : _____

Medication Agreement & Refill Policy

As part of your treatment, our medical staff may prescribe medications for you. As you know, medications can have serious side effects if they are not managed properly. Your health and safety are very important to us, and we need your help to make sure your treatment follows the prescribed guidelines. No prescriptions will be written for you unless you accept the following agreement.

1. I agree to follow the dosing schedule prescribed to me by my doctor.
2. I will never share, sell or exchange my medications with anyone for any reason.
3. I understand that I am solely responsible for the safekeeping of my medications. I will treat my medications as I would any valuable possession. I know that Pain Solutions Treatment Centers does not replace LOST OR STOLEN prescriptions or controlled medications.
4. I understand that I should not drive or operate heavy machinery while I am taking medications that may cause drowsiness or impaired cognitive function.
5. I agree to notify Pain Solutions Treatment Centers if I experience any adverse effects or dosage problems with my prescribed medications. I may be asked to bring any unused medication to Pain Solutions Treatment Centers for disposal.
6. I agree that if I receive a controlled substance prescription from Pain Solutions Treatment Centers, I am not allowed to accept controlled substance prescriptions from any other physician without my doctor's consent.
7. I agree to use only one pharmacy for my pain-related medications. In the event, that circumstances require the use of another pharmacy, I will notify Pain Solutions Treatment Centers of this immediately and provide them with all pertinent contact information
8. I understand that medication refill prescriptions involving narcotic pain medicine require a scheduled appointment with my primary doctor in the office. **Narcotic pain medication refills will not be called into a pharmacy. Narcotic dosages will not be increased by phone.**
9. **I agree to keep all scheduled appointments. I understand that no medications will be given for canceled or no-show appointments.** I understand that if I am more than **15** minutes late to my scheduled appointment time, I will have to reschedule for another time.
10. I know that I can not be seen at the office without a scheduled appointment for ANY reason.
11. The Pain Solutions Treatment Centers phone triage hours are 9:00 am to 4:00 pm, Monday through Friday for Non- Emergency medication questions and refill requests. I know that I can not call this line more than two times in any day.
12. I know that I can be asked to bring any or all of my prescribed medications to my office appointment or at a random time for a prescription compliance check (Pill Count).
13. I understand that Pain Solutions Treatment Centers will write and dispense narcotic medication prescriptions on a 30 day basis. In order to receive another narcotic medication prescription I must schedule another office visit within 30 days of the date on my current prescription so my doctor can properly evaluate my progress.
14. I understand that abusive behavior or harassment toward any Pain Solutions Treatment Centers Staff can not be tolerated. The Doctor's will determine what actions can be considered harassment on a case-by-case basis and, if warranted, I can be dismissed from the practice.
15. I understand that dealing with a forged, falsified or altered prescription will result in my immediate dismissal from the Pain Solutions Treatment Centers.
16. I understand the Pain Solutions Treatment Centers reserves the right to PERFORM A URINE DRUG SCREEN AT ANY TIME WHILE I AM BEING TREATED WITH PRESCRIBED CONTROLLED SUBSTANCES. If the results of the urine drug screen do not reflect medicine prescribed by my doctor, or test positive for illegal drugs, I understand that I can be dismissed immediately from the practice.

By signing this agreement, you affirm that you have the full right and power to be bound by this agreement and that you have read, understood, and accepted these terms. Non-compliance with this agreement will be terms for dismissal from the practice.

PHARMACY NAME

PHARMACY PHONE NUMBER

(Revised 4/18/07)

PATIENT NAME *Please Print and Sign Name

DATE

Pain Solutions

treatment centers

Name: _____ Date: _____ PCP: _____ D.O.B: _____

Referring Physician: _____ Ht: _____ Wt: _____

Please fill out the following form to help us learn more about your condition so that we can better assist your needs.

- When did your pain begin?

- What caused your pain to begin?

- Was your injury work related? If so, what date?

- Have you pursued legal action for an injury?

- Who diagnosed the problem?

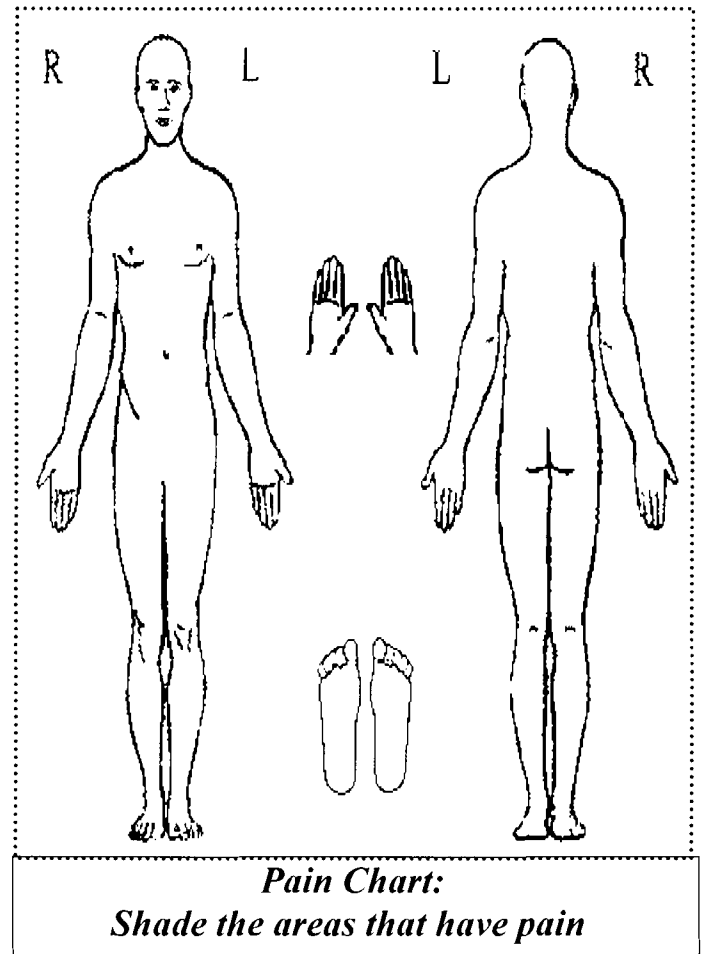
2. Where is your worst pain located?

3. Circle any of these to describe your pain **quality**:
Aching Burning Gnawing Sharp Shooting Spasm
Other: _____

4a. **Severity of Pain Scale**
Place an X on the line below to answer:
1 is best and 10 is the worst

What is the level of your pain?
0-----10

How does the pain affect your activity?
0-----10



4b. Does pain affect your sleep?
Yes _____ No _____

History of Present Illness Form

5. **(Timing)** When you have pain, how long does it last?

Is it "constant" _____ or "come and go" _____

6. Circle the correct answer:

When is your pain best? AM Afternoon Night

When is your pain worst? AM Afternoon Night

7. Circle what **aggravates** or makes your pain worse:

Sitting standing walking bending lying down

Other: _____

8. Circle what **relieves** or makes your pain better:

Sitting standing walking bending lying down

Other: _____

9. Is your pain **associated** with the following?

Weakness? ___ Where? _____

Numbness? ___ Where? _____

Tingling? ___ Where? _____

Skin color or temperature change? ___ Where? _____

Bowel or bladder problems? ___ How? _____

Skin sensitive to touch? ___ Where? _____

Skin sensitive to heat or cold? ___ Where? _____

10. What **tests** have you had done?

X-Rays: _____ Date: _____ Results: _____

MRI: _____ Date: _____ Results: _____

Cat scan: _____ Date: _____ Results: _____

Myelogram: _____ Date: _____ Results: _____

EMG/NCS: _____ Date: _____ Results: _____

Treatments/ Surgeries

11. Circle any **previous treatments** you have tried. List how they helped.

Doctors: _____

Pain Specialists: _____

Epidurals/ Injections: _____

Physical Therapy: _____

Chiropractor: _____

Ice/Heat: _____

History of Present Illness Form

Tens unit: _____

Medications

12. List all the medications you are **currently** prescribed for pain, **and all other** prescription and non-prescription medications that you also take:

Allergies and Blood Thinners

13. Are you taking any blood thinners? _____
List any medication you are allergic to: _____

Previous Surgeries

14. Previous surgeries and year performed: No surgeries

Neck Surgery: _____ Gallbladder: _____ Broken Bones: _____
Back Surgery: _____ Heart surgery: _____ Chest/Lung Surgery: _____
Hysterectomy: _____ Stomach/hernia: _____ Appendectomy: _____

List any additional surgeries: _____

Past Medical History

15. Are you currently, or have you in the past, been treated for any medical conditions?
Please Explain:

Social History

16. Most recent occupation: _____

Circle the correct answer:

Current employment status: Full-time Part-time Retired Disabled

Marital Status: Single Married Divorced Legally Separated Widowed

Children living at home? Yes No **Ages:** _____ **Do you live alone?** Yes No