REGISTRATION

Patient Information (PLEASE PRINT)

Date: _____

Name: _____
(Last Name) (First Name) (Middle Name)

Date of Birth: _____ Sex: ❑ **M** ❑ **F** Patient's Social Security #: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

In case of emergency, who should be notified? Name: _____ Phone: _____

If pain/injury is related to Automobile Accident or Worker's Compensation, please provide all claim numbers, case manager's name, attorney name and phone numbers in order for our office to verify this information. Each service will be authorized prior to treatment.

Primary Insurance:
Name of Primary Insurance _____
Policy Holder's Name _____
Phone # _____
Policy/Claim # _____
Group # _____

Secondary Insurance:
Name of Primary Insurance _____
Policy Holder's Name _____
Phone # _____
Policy/Claim # _____
Group # _____

Referral Information
How did you learn of our practice?
_____

Assignment and Release

I hereby authorize North of Atlanta Pain Clinic L.L.C., to release any information concerning treatment of the undersigned patient to any insurance company for the purpose of determining eligibility for payment of insurance benefits and to secure those payments. This includes information on substance abuse and/or HIV. I authorize assignment of group insurance, hospital, surgical, medical and any other insurance benefits payable directly to North of Atlanta Pain Clinic L.L.C. I understand that I am financially responsible for any charges not paid by insurance. Interest will be charged on all unpaid balances at the rate of 1.5% per month. Should the account be referred to an attorney or collection agency, I shall pay reasonable attorney's fees and collection expenses. I certify that the information I have given in applying for payment under Title V, XVIII, and XIX of the Social Security Act is complete and correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries any information needed for this or any related Medicare/Medicaid claim.

_____

Signature of Insured **Date**

PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I acknowledge that I have received a copy of the "Notice of Privacy Practices", and I have been provided an opportunity to review it.

Name: _____
Date of Birth: _____
Signature: _____
Date: _____

FINANCIAL POLICY

Insurance coverage is a contract between you, the patient, and your insurance company; therefore, any questions about policy coverage or claims payment should be directed to your carrier.
Your insurance carrier will determine the insurance reimbursement.
You will receive a statement each month if your account has a balance due.
While the filing of the insurance is a courtesy that we do extend to our patients, all charges are the patient's responsibility from the day the services are rendered. We realize that temporary financial problems may, at times, affect timely payment of your account.
Upon request, special considerations may be extended. To avoid any misunderstanding, we ask that you make these arrangements with the financial counselor prior to services being rendered.

I understand from time to time I may incur services that my insurance company considers to be not medically necessary and/or non-covered. I agree and warrant that in such an event, I will pay for those charges incurred in connection with this determination. I have read, understand and agree to the financial policy as stated above.

_____ _____
Patient's Signature **Date**

PATIENT'S BILL OF RIGHTS

1) The patient has the right to considerate and respectful care.
2) The patient has the right to obtain complete current information concerning diagnosis, treatment, and prognosis in terms they can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person on their behalf. A patient has the right to know by name the physician responsible for coordinating their care.
3) The patient has the right to receive from their physician any information necessary to give informed consent prior to the start of any procedure and /or treatment. Except in emergencies, such information for informed consent should include, but not necessarily be limited to, the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient also has the right to know the name of the person responsible for the procedure and/or treatment.
4) The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of this action.
5) The patient has the right to expect all communications and records pertaining to their care should be treated as confidential.
6) The patient has the right to every consideration of privacy concerning their own medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discretely. Those not directly involved in treatment must have the permission of the patient to be present.
7) The patient has the right to expect that within its capacity, an office must make reasonable response to the request for services. Medical facilities must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medical permissible, the patient may be transferred to another facility only after receiving complete information and explanation concerning the needs for an alternative to a transfer.
8) The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, who are treating them.
9) The patient has the right to expect reasonable continuity of care, as well as the right to know in advance what appointment times and physicians are available.

PATIENT'S CONSENT TO PHOTOGRAPH

I, the undersigned, do herby authorize North of Atlanta Pain Clinic L.L.C. to photograph, _____ (Name) while under the care of the above institution. I understand that this is solely for identification purposes, and will not be used for any other reason.

_____ _____
Patient Signature **Date**

Authorization for Release of Confidential Medical Information

Patient Name _____ S. S. # _____

Date of Birth _____

Faulty Name(Clinic) _____

Physician Name _____

Telephone _____ Fax _____

This information is to be released to:

North of Atlanta Pain Clinic Attn: _____

3473 Satellite Blvd. Suite 120N Purpose of disclosure: Continuing Care

Duluth, GA 30096

T: 770-559-8385 F: 770-674-7367

Portions of Record needed – Check applicable sections: ❑ Entire Record ❑ Visit History Only

❑ Face Sheet	❑ ER Record	❑ Consultations
❑ Consent Form	❑ Therapy Records	❑ Physician's Progress Notes
❑ Discharge Summary	❑ Radiology Report	❑ Physician's Orders
❑ History & Physical	❑ Radiology Films/CD	❑ HIV Testing / Information
❑ Operative Report	❑ Mammogram	❑ Drug/Alcohol Test Results
❑ Pathology Report	❑ EKG	❑ Other _____

I understand that this consent is revocable by me, in writing, at any time except to the extent that action has been taken in reliance on it. I also understand that this consent will expire either ninety (90) days after the date of the signature or automatically when the records requested on this from have been mailed/faxed to the requestor.

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by law. Any further disclosure is strictly prohibited.

Patient's Signature _____ Date _____

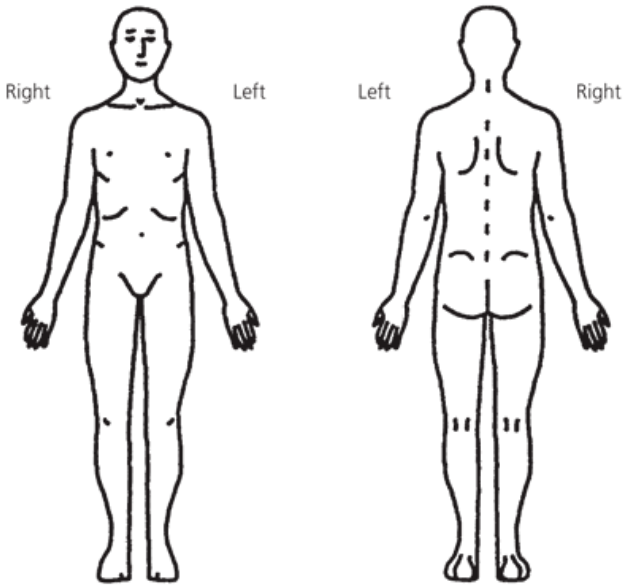
Patient's Representative _____ Date _____

NORTH OF ATLANTA PAIN CLINIC L.L.C.
3473 Satellite Boulevard Suite #120 North
Duluth, Georgia 30096
Tel: 770-559- 8385 Fax: (770) 674-7367
www.noapainclinic.com

NEW PATIENT PAIN HISTORY

1. Today's date: _____
2. Date pain began:_____
3. Where is your pain:_____
4. What caused your pain? ❑ Work Injury ❑ Auto Accident ❑ Home Injury ❑ Unknown
5. Description of Injury:_____
6. Rate your pain on a scale from 1 to 10 (10 being the worst pain) _____
7. What type is your pain? ❑ Sharp/Stabbing ❑ Shooting ❑ Burning ❑ Electric ❑ Dull/Aching
8. How frequent is your pain? ❑ Constant ❑ Sometimes How often? _____
9. Do you experience the following? ❑ Pins & Needles ❑ Numbness ❑ Weakness
10. If you answered yes to #9 where do you feel it? _____
11. Is your pain related to activity? ❑ Yes ❑ No
12. What makes your pain better? ❑ Nothing ❑ Lying on your back ❑ Lying on your side ❑ Sitting ❑ Bending
13. What makes your pain worse? ❑ Sitting ❑ Standing ❑ Walking ❑ Lifting ❑ Coughing ❑ Sneezing
14. Which do you have? ❑Trouble sleeping ❑ Urine Leakage ❑ Bowel Leakage ❑ Sexual dysfunction
15. Does your pain cause you to feel any of these symptoms? ❑ Depressed ❑ Anxious ❑ Angry

Please mark the area(s) of injury or discomfort as shown in the example below.



On a scale of 0 (least intense) to 10 (most intense), I rate my discomfort as follows:

What is your pain RIGHT NOW?	0	1	2	3	4	5	6	7	8	9	10
What is your TYPICAL or AVERAGE pain?	0	1	2	3	4	5	6	7	8	9	10
What is your pain AT ITS WORST?	0	1	2	3	4	5	6	7	8	9	10

HISTORY YES NO COMMENT HISTORY YES NO COMMENT

Do you smoke? ❑ Yes ❑ No *High Blood Pressure?* ❑ Yes ❑ No *Do you drink?* ❑ Yes ❑ No

Chest Pain/Angina? ❑ Yes ❑ No *Headaches?* ❑ Yes ❑ No *Heart Attack(s)?* ❑ Yes ❑ No

Osteoporosis/Arthritis? ❑ Yes ❑ No *Bleeding Disorder?* ❑ Yes ❑ No *High Cholesterol?* ❑ Yes ❑ No

Thyroid Problems? ❑ Yes ❑ No *Jaundice/Hepatitis?* ❑ Yes ❑ No *Diabetes?* ❑ Yes ❑ No

Liver Problems? ❑ Yes ❑ No *Hiatal Hernia/Ulcers?* ❑ Yes ❑ No *Fever?* ❑ Yes ❑ No

Kidney Problems? ❑ Yes ❑ No *Stroke?* ❑ Yes ❑ No *Convulsions/Epilepsy?* ❑ Yes ❑ No

Loss of Weight? ❑ Yes ❑ No *Night Pain?* ❑ Yes ❑ No

History of Cancer in Patient ❑ Yes ❑ No _____

Problems with bladder or bowel control ❑ Yes ❑ No _____

Height _____ Weight_____

Pain Management Procedures:

Helped pain? ❑ Yes ❑ No

_____

Dr.'s Name: _____ Type: _____ Phone: _____

MEDICATIONS

Current Medications	Dosage	Frequency	How Long

Past Medications:	Dosage	Frequency	How Long

Doctors Currently Treating Patient:

Dr.'s Name: _____ Type: _____ Phone: _____

Previous Surgeries: ❑ Yes ❑ No

Date of Surgery: _____

Dr.'s Name/hospital/type of surgery: _____

ALLERGY Profile

Please check any of the following symptoms/diseases **your family** has experienced and/or are currently experiencing

❑ Irregular Heart Beat	❑ Heart Attack	❑ Heart Failure
❑ Thyroid Disease/Goiter	❑ Diabetes	❑ Hepatitis
❑ Osteoporosis	❑ Dementia	❑ Bleeding Disorder
❑ Anemia	❑ Emphysema/Asthma	❑ High Blood Pressure
❑ Convulsions/Seizures	❑ Stroke/TIA	❑ Cancer
❑ HIV/AIDS	❑ Others	

I understand that the information I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in the information stated above (Address, Phone, Insurance, Medication, Allergy, and Etc.)

_____ _____

Patient's Signature Date

No Show/Late Cancellation Policy

Our office strives to see our patients on time and work in patients the same day if necessary. No shows for appointment are disruptive to the flow of the office, prevents other patients from accessing our medical care and are disrespectful to us.

While we do not want to cause any undue financial burden, we will assess a $30 no show fee for missed office visits and $150 no show fee for missed procedure appointments or if not provided with 24 hour notice to cancel or reschedule.

- We require 24 hours advance notice to cancel or reschedule an appointment.
- No show fee will be collected before scheduling any future appointments.
- Multiple no shows are grounds for dismissal from practice.

By signing below you attest that this policy has been explained to you, that you have read and understand your personal responsibilities, that you have had adequate time to review the policy and that all question pertaining to the policy have been answered. Further, you attest that you have been provided with a copy of this form. The original will be filed in your medical record.

_____ _____

Patient's Signature Date

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Medicare Advance Beneficiary Notice of Non-Coverage (ABN)

Medicare/Medicare advance plans do no pay for everything, even some care that your health care provider has good reason to think you need.

If your Medicare/Medicare advantage plan does not pay, you may have to pay.

You are responsible for making certain that NOA receives the following from Medicare or your Medicare advantage plan (if applicable). As a courtesy NOA staff may help you with this process, but it is your responsibility to be certain the following have been obtained:

- A proper referral number if necessary prior to your visit.
- Any prior authorization of treatment and /or tests ordered by your health care provider including but not limited to labs, drug screens, MRI, CT, X-Ray, EMG/NCS, Trigger point injections, Epidurals steroid injections, PT.
- Ensuring that you have not exceeded the authorized number of visits included in your benefits.

If you have exceeded the number of authorized visits and have not informed NOA and you receive services from NOA, you are responsible for payment in full for the visit(s) exceeding the authorized visits.

Should you have any questions about the cost of any services that we expect will not be paid for by Medicare/Medicare advantage please contact our business office (770-559-8385) and the cost of any services will be provided for you. If NOA provides services allowed by Medicare that are not paid for by your Medicare/Medicare advantage plan, you are personally responsible for payment.

By signing below you attest that this policy has been explained to you, that you have read and understand your personal responsibilities, that you have had adequate time to review the policy and that all question pertaining to the policy have been answered. Further, you attest that you have been provided with a copy of this form. The original will be filed in your medical record.

_____ _____

Patient's Signature Date

Note: **This notice gives our opinion, not an official Medicare decision.** If you have any questions about Medicare call (800-633-4227) or contact your Medicare advantage plan.

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Medicaid Advance Beneficiary Notice of Non-Coverage (ABN)

Medicaid/Medicaid advance plans do no pay for everything, even some care that your health care provider has good reason to think you need.

<u>If your Medicaid/Medicaid advantage plan does not pay, you may have to pay.</u>

You are responsible for making certain that NOA receives the following from Medicaid or your Medicaid advantage plan (if applicable). As a courtesy NOA staff may help you with this process, but it is your responsibility to be certain the following have been obtained:

- A proper referral number if necessary prior to your visit.
- Any prior authorization of treatment and /or tests ordered by your health care provider including but not limited to labs, drug screens, MRI, CT, X-Ray, EMG/NCS, Trigger point injections, Epidurals steroid injections, PT.
- Ensuring that you have not exceeded the authorized number of visits included in your benefits.

If you have exceeded the number of authorized visits and have not informed NOA and you receive services from NOA, you are responsible for payment in full for the visit(s) exceeding the authorized visits.

Should you have any questions about the cost of any services that we expect will not be paid for by Medicaid/Medicaid advantage please contact our business office (770-559-8385) and the cost of any services will be provided for you. If NOA provides services allowed by Medicaid that are not paid for by your Medicaid/Medicaid advantage plan, you are personally responsible for payment.

By signing below you attest that this policy has been explained to you, that you have read and understand your personal responsibilities, that you have had adequate time to review the policy and that all question pertaining to the policy have been answered. Further, you attest that you have been provided with a copy of this form. The original will be filed in your medical record.

_____ _____

Patient's Signature Date

Note: **This notice gives our opinion, not an official Medicaid decision.** If you have any questions about Medicaid call (866-211-0950) or contact your Medicaid advantage plan.

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