Interventional Pain Center

Office # 615-972-1100 | Fax # 615-537-4950

Hendersonville Medical Center location
353 New Shackle Island Rd Suite 101-A
Hendersonville, TN 37075

Skyline Medical Center location
3443 Dickerson Pike Suite 730
Nashville, TN 37207

Your appointment is scheduled on:_____ arrive at time:_____
(if your 15 minutes or later for your appt, you maybe asked to reschedule)

Dear Patient,

Thank you for choosing Interventional Pain Center for your pain needs. In order for our providers to serve you best, we require the following items on your first visit.

- ☐ New patient paperwork
- ☐ Insurance card(s)
- ☐ Current driver's license or state identification (you will not be seen without valid identification).
- ☐ Please bring a list of your current medications.
- ☐ Please call us 24 hours in advance if you are unable to make your appointment.
- ☐ If you need assistance via wheelchair, please bring someone to assist you along with a wheelchair, we do not provide this service.

Directions once arriving at the Hendersonville Hospital: The easiest way to find our office is to enter through the front door of Medical Office Building A and go along the right hallway beside Mendoza Podiatry. You will then take an immediate left down a long hallway, where we are at the end of the hallway in Suite 101-A. See attached campus map.

Directions once arriving at the Skyline Medical Center: The easiest way to find our office is to enter through the front door of Medical Office Building and take the evaluator to the 7th floor Suite 730. See attached campus map.

Only the patient will be allowed in the exam room, family and friends must wait in the waiting area.

For patients with small children:

We understand that you may not be able to find someone to watch your child/children while you are here with us. It is important that you are able to give your undivided attention while seeing our providers. We ask that you try to make the proper arrangements for someone to watch your children in order for us to best serve you at your visit with us.

Our hours of operation are 8am to 5pm, Monday through Thursday. If you have any questions, please give us a call at the number listed above. We look forward to participating in your care.

Interventional Pain Center Patient Information

Patient Name:_____Date of Birth:_____/_____/_____Age:_____ M F

Address:_____City/State/Zip:_____
Mailing Address (if different from above):_____
Home Phone:_____ Work Phone:_____
Cell Phone:_____ Email Address:_____

May we leave messages?: (Please circle all that are acceptable)
At home: Yes/No At Work: Yes/No Cell: Yes/No Email: Yes/No

May we send text appointment reminders to your cell phone? Yes/No

Emergency Contact:_____Phone:_____
Primary Care Physician:_____Phone:_____

Primary Insurance Information

Primary Insurance Name:_____ Policy #:_____
Policy Holder's Name:_____Policy Holder's Date of Birth:_____
Policy Holder's Social Secuity #:_____
Group Number:_____ Insurance phone #:_____

Secondary Insurance Information

Secondary Insurance Name:_____ Policy #:_____
Policy Holder's Name:_____Policy Holder's Date of Birth:_____
Policy Holder's Social Secuity #:_____
Group Number:_____ Insurance phone #:_____

IS THIS RELATED TO AN AUTOMOBILE ACCIDENT? _____

Employment Information

Employer Name: _____ Employer's Phone #:_____
Employment status: ___FT ___PT ___Retired

Is this a worker's comp or auto insurance claim? Yes or No
If yes, please answer the following questions:
Company Name: _____ Claim #:_____
Contact Person: _____ Contact Person's Phone #: _____
Date of Injury: _____

Consent for Insurance Assignment/Payment: I hereby authorize the assignment of benefits (payments) directly to Interventional Pain Center for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-pays, deductibles and non-covered services are due at the time of service. I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Signature of Responsible Party:_____ Date: _____
Relationship if not patient:_____

Interventional Pain Center Authorization for the Release of Medical Records

Patient's Name: _____Date of Birth: _____

Social Security Number: _____Phone: _____

FAX RECORDS TO: _____615-537-4950_____
REASON FOR DISCLOSURE: Continuity of Care

I authorize _____to release or disclose to the above-named entity all of my medical records, including any specially protected records, such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle-cell anemia, or HIV infection for the purpose of medical treatment. If you do not want certain portions of your medical records released, please read this section carefully and identify the information you do not want released below:

Please circle all that apply: Past Dates of Service Present Dates of Service Future Dates of Service
Specific Records Needed (to be completed by the provider/nurse):
□ Imaging of _____ □ Operative Report _____
□ Discharge Letter □ Recent Progress Notes □ Other _____

* I understand that I may revoke the Authorization at any time prior to the expiration date or event, but that my revocation will not have any effect on actions taken by Interventional Pain Center (IPC) or its physicians, employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to Interventional Pain Center.
* I understand that I am not required to sign this Authorization. IPC will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this Authorization.
* I understand that my records may be subject to disclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that this Authorization does not limit IPC or its physicians', employees' or agents' ability to use or disclose my information for treatment, payment, or health care operations, or as otherwise permitted by law.
* I authorize IPC to request records pertinent to my treatment from providers and other healthcare entities, as needed, within the time this authorization is valid. This Authorization will expire a year from date of signature.

Signature of Patient/**Representative**:_____

Printed Name: _____Date Signed: _____

Relationship, if not Patient: _____

**If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative MUST accompany this request (i.e. court appointed guardian, durable power of attorney for health care, etc.). For a deceased patient, a death certificate coupled with executor or administrator of estate paperwork must accompany this request. Exception: Parents signing for a patient under the age of 18.

Financial Responsibility

Patient's Name: _____Date of Birth: _____

As your medical provider, our relationship is with you. Your insurance is a contract between you and your insurer, which may not cover 100% of your care. As a courtesy to you, we may obtain eligibility and/or benefit information from your insurance company and communicate this to you as well as file a claim for any services rendered. You are financially responsibility for the services rendered by Interventional Pain Center and agree to pay at the time of service. To protect your identity, you must present a valid insurance card and photo ID at each visit. You are also responsible to pay any applicable co-payments or past due balances at each visit.

Payments that you are responsible for include, but are not limited to any and all co-payments, co-insurances, and deductibles. You have agreed with your insurance company to pay these at each doctor's office visit. Additional diagnostic and therapeutic procedures may be subject to separate co-payments, co-insurances, and deductibles than your office visit. Check with your insurance carrier to determine how your benefits apply. Though Interventional Pain Center will attempt to determine and collect your payment responsibility at the time of service, you are responsible for any additional payment responsibilities determined after any claims are processed by your insurance company.

Referrals-HMO and POS Plans

You are responsible for obtaining an authorization for examinations and treatments if required by your insurance company. Often separate referrals will be required for examinations, diagnostic tests, and procedures. Though we may attempt to assist you in obtaining a referral as a courtesy, it is your responsibility to have authorization on file with us before your visit. Without this the insurance company will not pay for your visit. Without a referral you have the option to receive services on a fee for service basis.

Keeping Your Account Up to Date

It is your responsibility to inform us of any changes in your insurance, telephone numbers, and address. Please have your insurance card available at all office visits. Insurance companies give us ninety (90) days to file a claim. Therefore, if we bill the wrong insurance carrier because you failed to provide the correct information, the visit will be your responsibility.
Accounts ninety (90) days or older may be turned over to a collection agency. You may also be given notice legally dismissing you from our practice and be asked to find another physician. You agree to pay all reasonable attorney fees and collection costs in the event of default of payment.

Forms

Insurance covers only your medical care. It does not cover submitting forms that may assist you in collecting disability benefits or maintaining employment. Our fee for these services ($20.00/page) reflects the resources diverted to the effort.

Returned checks: There will be a **$50.00 charge** for all returned or cancelled checks.
Release of Medical Records: There is a **$20.00 charge** for copies up to forty (40) pgs, each additional page is **$0.25** cents.

I have read and understand all the information on this financial policy. I agree to its terms and to the assignment of benefits and release of information described above. With my signature I am also authorizing medical treatment to be performed by Interventional Pain Center.

Responsible Party Signature:_____Date:_____
Relationship if not patient:_____

Authorization for the Use and Disclosure of Protected Health Information

Patient's Name: _____Date of Birth: _____

Federal law states that we cannot share your health information without your permission except in certain situations. If you sign this form you are giving us permission to share the information you indicate below. If you decide later that you do not want us to share your information, you may revoke this authorization at any time in writing.

Phone Number:_____Social Security Number:_____
Street Address:_____
City/State/Zip:_____

I give Interventional Pain Center permission to share the health information below with the following person or group:

_____

Purpose for which disclosure is authorized (Examples are: for my health condition or at the request of the individual):

_____

Describe the specific information that you want to be disclosed and the time period that this authorization should cover (Examples are: information on my back surgery in April 2006):

Information:_____
Time Period:_____To:_____

If you do not enter a date, then this authorization will not expire until you inform us otherwise.
I understand that the information described above may be re-disclosed by the person or group that I hereby give Interventional Pain Center permission to share my information with, and that my information would no longer be protected by the federal privacy regulations. Therefore, I release Interventional Pain Center and its workforce members from all liability arising from the disclosure of my health information pursuant to this agreement.
I understand that I may request copies of any information disclosed by this authorization. I understand that I may revoke this authorization by notifying Interventional Pain Center in writing, with the understanding that previously disclosed information would not be subject to my revocation request.
I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.

Responsible Party Signature:_____Date:_____
Relationship if not patient:_____

(Attach documentation that you are a personal representative, for example: authorization form, durable power of attorney, court order, guardianship documents).

Notice of Privacy Practices Acknowledgement

I have read and may request a copy the notice of privacy practices and I have been provided with an opportunity to review it. The Notice of Privacy Practices is displayed in the waiting room and beside the check in and check out desk.

Signature:_____ Date:_____

No Show Policies and Procedures

Patient's Name: _____Date of Birth: _____

The medical staff at Interventional Pain Center is here to provide a comprehensive approach for your spine and musculoskeletal problems with use of physical therapy, therapeutic spinal procedures, orthotics, and medication management. It is our intention to assist with rehabilitating every area of physical injury by utilizing our professional and experienced providers to care for your entire being and not just treating the symptoms. Our goal is to improve your ability to function independently and also to increase your quality of life. It is your responsibility to comply with our facility's policies and procedures by keeping all of your scheduled appointments.

*Our policies and procedures **require <u>24 hours of advanced notification</u> to be given prior to the cancellation of your scheduled appointment or it is considered a "no show"**. Not showing up to your appointment as scheduled represents a cost where other patients could have been seen at that time. **A <u>$25.00 fee</u> will be charged for the first missed follow-up appointment. A <u>$50 fee</u> will be charged for the second missed follow-up appointment. A <u>$75 fee</u> will be charged for the third and all subsequent missed follow-up appointments. A <u>$100 fee</u> will be charged for any procedure appointments**.

*We will not prescribe any controlled substances, especially narcotics, as policy if you are non-compliant with any aspect of your treatment plan.
*Your referring physician and insurance company may be notified of non-compliance.
*Non-compliance with this policy may result in immediate discharge.

Payments

Co-Pays: Are to be paid on the day services are rendered.

Self-Pay Patients: Payments must be made in full at time of service, unless arrangements have been made. ***Per Tennessee State guidelines, we are <u>not allowed</u> to accept cash from self-pay patients so your payment must be made in the credit/debit card or prepaid credit card.***

Payments: Payments are due on or before your next scheduled appointment. If your account is sent to collections, you will not be re-scheduled for future appointments until your balance has been paid in full.

Prescription Refills

Call your pharmacy and have them fax a request for refills on non-narcotic medication. Narcotics/opiates can only be refilled at office visits and at the discretion of the provider. **Lost or stolen narcotics/opiates will not be replaced**. Losing your prescription or having your medication stolen is not considered an emergency. Your signature is an acknowledgement of your understanding and agreement with these policies.

Your signature is acknowledgement of your understanding and agreement with the policies listed above.

Responsible Party Signature:_____Date:_____
Relationship if not patient:_____

IPC Pain Management Treatment Agreement

Patient's Name: _____Date of Birth: _____

The purpose of this consent is to comply with the law regarding controlled pharmaceuticals and to prevent any misunderstanding about any controlled medication you may be given for pain. When other traditional and usually helpful treatments for pain have not worked, or assumed may not work, controlled substance medications are prescribed. Controlled substance pain medications (i.e. opioids/narcotics, tranquilizers, and barbiturates) are very useful, but have a high potential for misuse and therefore are closely controlled by the local, state, and federal government. They are intended to relieve pain, to improve function, to improve the ability to work, and to increase independence. They are not used to simply feel good. Because providers at Interventional Pain Center (IPC) may prescribe such a medication for me to help manage my pain, I agree to the following conditions:

PLEASE HAVE READ AGREEMENT BELOW.

I agree to submit to a blood, urine, or saliva test, if requested by my Provider, to determine compliance with my program of pain medication. Refusal to submit a sample is reason for discontinuation of these medications or dismissal from care.

I understand that I may be called at any time to bring all prescribed medication for a mandatory pill count within a specified time period (usually 24 hours). Message maybe left on an after-hours voicemail if cancellation is needed.

I understand that I am to bring my medications prescribed by IPC in their original bottles to EVERY appointment. I am to bring the bottle even if it's empty. Due to scheduling, your next appointment may be less than 30 days. For example, if you are prescribed medications for thirty (30) days and your next appointment is 28 days later, you are expected to have two (2) days of medications for your pill count.

I understand that **lost or stolen medication or unfilled prescriptions WILL NOT be replaced**, and I will safeguard my medication from theft.

I will not attempt to obtain controlled medication from any other provider, nor will I borrow or buy medication from any other person. Receiving a pain shot from an ER is acceptable, but obtaining a narcotic prescription from an ER is not acceptable. I will not sell, trade, or share my medications with anyone else.

I will notify IPC of any change in name, address or phone number. I understand that I must at all times have an updated phone number with my provider. I agree to return any phone call from IPC within 24 business hours.

I understand that the combination of controlled substances and alcohol are contra-indicated; the combination may result in serious harm or even death. I agree to not use alcohol while receiving narcotic/opiate pain medications.

I understand that non-professional or inappropriate behavior toward any IPC staff, affiliate, or provider will not be tolerated. I agree to be respectful to other patients I may encounter in the waiting room, lobby, hallways, etc. **I understand that children under the age of 18, cell phone usage or smoking electronic cigarettes are not allowed in the clinic.**

I have read, understand, and agree to follow the terms of this agreement:

Responsible Party Signature:_____Date:_____

Pain Management Treatment Consent (cont.)

Patient's Name: _____Date of Birth:_____

I agree that I will use my medications ONLY as instructed by my provider. I understand that any change to my prescriptions will require an office visit. I understand that self-medicating is not tolerated. No refills will be made during evenings or weekends.

I will not use any illegal substances, including marijuana, cocaine, etc. I will not participate in the sale, illegal possession, or transport of controlled substances (narcotics, sleeping/nerve pills, pain medication, etc.).

I authorize my provider to investigate fully any possible misuse of my pain medication using any city, state, or federal law enforcement agency.

I understand that with any controlled substance, there are inherent risks, which include (but are not limited to) the following: loss of efficacy over time, withdrawal symptoms, addiction, respiratory distress or failure, loss of function/impairment, sedation, constipation, allergic reaction, itching, nausea, dry mouth, decreased hormone levels, suppressed immune system, and/or death. It is my responsibility to report to my physician at Interventional Pain Center any side effects immediately.

It may be deemed necessary by my physician for me to see a behavioral health specialist at any time while I am receiving controlled substance medications. I understand that if I do not attend this appointment, my medications may not be continued or renewed beyond an amount needed to fulfill ethical and medical standards of care. I understand that if this specialist feels that I am at risk for psychological dependence, my medications will no longer be renewed and my treatment plan will be re-evaluated.

I authorize physicians at IPC and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency in the investigation of any possible misuse, sale, or other diversion of my controlled substance pain medications. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I will agree to allow my physician at IPC to communicate with my referring physician, other relevant treating physicians, and pharmacists regarding my use of controlled substance pain medications. I will follow the instructions of the physicians at IPC relating to reducing my use of opioids/narcotics, should that be necessary.

I agree that the goals of pain management have been explained to me as to what is considered appropriate and reasonable and that alternative treatment plans, outside of use of controlled pain medications, have been made available to me. I have agreed to proceed with pain management after a full explanation of the risks and benefits. I understand if I break this agreement, it will result in a change in my treatment plan, including safe discontinuation of my opioid medications when applicable or complete termination of the provider/patient relationship.

I understand that I am only to use the pharmacy listed below for all my medication needs with IPC. If I choose to use another pharmacy, I will notify my provider within 24 hours.

Pharmacy Name: _____Phone #: _____*or* Pharmacy Address: _____

I have read, understand, and agree to follow the terms of this agreement:

Responsible Party Signature:_____Date:_____

Provider Signature:_____Date:_____

Interventional Pain Center - **Patient History**

Patient's Name: _____Date of Birth: _____

Marital Status: (Circle one) Single Married Separated Divorced Widowed **Primary Language:**_____

Patient's Race:_____ **Patient's Ethnicity:** _____

Who do you live with:	☐	spouse	☐	spouse & children	☐	children	☐	parents	☐	alone	☐	friend
Work status:	☐	employed full time	☐	employed part time	☐	unemployed	☐	retired	☐	short term disability	☐	long term disability
Tobacco use:	☐	no	☐	yes	_____years		_____ packs per day					
Alcohol use:	☐	no	☐	rarely	☐	occasionally	☐	regularly				
Street drug use:	☐	no	☐	yes								

Medical History and Family Medical History (Please check all that apply):

Disease	**SELF**	**Mother**	**Father**	**Sister(s)**	**Brother(s)**	**Moms Mom**	**Moms Dad**	**Dads Mom**	**Dads Dad**	**Comments**
No significant history known										
Addiction										
Alcoholism										
Anxiety										
Arthritis OA/RA										
Asthma										
Bowel Disease										
Cancer										
Cirrhosis										
Coronary Artery Disease										
Depression										
Diabetes										
Emphysema										
Gallbladder Disease										
Head Injury										
Heart Arrhythmia										
Heart Attack (MI)										
Hepatitis										
Hiatal Hernia										
High Blood Pressure										
High Cholesterol										
Kidney Disorder										
Migraine Headaches										
Multiple Sclerosis										
Muscle Disorder										
Osteoporosis										
Pancreatitis										
Peripheral Nerve Disease										
Prostate Disorder										
Reflux										
Seizures										
Sleep Apnea										
Spine Disorder										
Stroke										
Ulcers										
Vascular Disease										
Other										

Patient's Name: _____Date of Birth: _____

Past Surgical History (Please list all surgeries you have had and date it was performed):

_____

_____

_____

Medications: List ALL of your current medications: If no medications, check here: ☐

Medication Name:	Dosage: (ie. mg)	Frequency: (times per day)	Route: (i.e. Pill, Patch)

Allergies: If no known allergies, check here: ☐

_____

_____

_____

Review of Systems (Please check all that you are currently experiencing):

Cardiac:	☐ Abnormal EKG ☐ Irregular heartbeat	☐ Congestive failure ☐ High blood pressure	☐ Chest pain	☐ Murmur
Endocrine/ Hematological:	☐ Abnormal blood sugars	☐ Bruising easily	☐ Bleeding	
Gastrointestinal:	☐ Bowel control loss ☐ Chronic nausea	☐ Appetite loss ☐ Heartburn	☐ Constipation	☐ Diarrhea
General:	☐ Night sweats	☐ Weight loss ☐ Weight gain	☐ Fevers	☐ Fatigue
Genitourinary:	☐ Painful urination ☐ Bladder control loss	☐ Irregular bleeding ☐ Enlarged prostate	☐ Testicular pain ☐ Blood in urine	☐ Pregnancy
Head:	☐ Teeth/gum problems ☐ Headaches	☐ Hearing loss ☐ Facial pain	☐ Vision loss	☐ Sinusitis
Musculoskeletal:	☐ Joint pain	☐ Muscle spasms	☐ Neck pain	☐ Back pain
Neurological:	☐ Vertigo/dizziness ☐ Seizures	☐ Drowsiness ☐ Weakness	☐ Blackouts ☐ Numbness	☐ Tremors
Psychiatric:	☐ Depression	☐ Panic attacks	☐ Anxiety	☐ Insomnia
Respiratory:	☐ Shortness of breath ☐ Home oxygen use	☐ Chronic cough ☐ Sleep apnea	☐ Wheezing	☐ C-Pap
Skin:	☐ Rash			
Vascular:	☐ Poor circulation	☐ Current clot	☐ Swelling in legs	

Interventional Pain Center – O.R.T.

Date:_____Patient Name:_____Date of Birth:_____

Patient should choose their gender column below:

Family History of Substance Abuse:	Female	Male
Alcohol	☐ 1	☐ 3
Illegal Drugs	☐ 2	☐ 3
Prescription Drugs	☐ 4	☐ 4
Personal History of Substance Abuse:		
Alcohol	☐ 3	☐ 3
Illegal Drugs	☐ 4	☐ 4
Prescription Drugs	☐ 5	☐ 5
Age (mark box if you are between 16 and 45)	☐ 1	☐ 1
History of Preadolescent Sexual Abuse	☐ 3	☐ 0
Psychological Disease		
Attention deficit disorder, obsessive compulsive disorder, bipolar, schizophrenia	☐ 2	☐ 2
Depression	☐ 1	☐ 1
If you are a female, are you pregnant?	☐ Yes	☐ No
Scoring totals	_____	_____

Do you have any problems with your liver? YES or NO Kidney Problems? YES or NO

****

Below this line - Office staff use only

FOLLOW UP: **DR WILSON** **or** **Peggy** **DR PRIETO**

ASAP Next Med Refill 1 Week 2 Weeks 4 Weeks 5 Weeks As Needed

PROCEDURE: RFA MBB TFESI MID-ESI SIJ Other:_____

RIGHT LEFT BILATERAL Levels:_____

Precert needed? Y N Appointment Date and Time: _____

Tobacco Use - Yes No