Dear New Patient: _____

Your New Patient appointment is scheduled for: _____

Location: **440 B High Street**, **Bowling Green, KY 42101**

Welcome to the Center for Pain Management. We look forward to your upcoming new patient appointment.

We have enclosed the new patient forms for your initial visit to our practice. Prior to your visit please fill out the following forms and bring them with you to your scheduled appointment. Completing the forms entirely will help us in serving you better.

Please bring any reports of diagnostic testing (MRI, CT SCAN, X-RAY, MYELOGRAM, EMG etc.) with you to your scheduled visit.

Please note, if you need to reschedule, or cancel your appointment, please do so at least 24-48 hours in advance. Failure to notify our office of your absence will result in a delay of rescheduling.

Directions to our Office:

Address: 440 B High Street
Bowling Green, KY 42101

From I-65:

Take exit 26 (Bowling Green/Cemetery Road) Turn Left off the exit ramp if on 65 North and turn Right off the ramp if on 65 South. Travel on Cemetery Road which turns into Fairview Avenue for about 3 miles till the intersection with US 31 W Bypass. After crossing the traffic light at US 31 W Bypass on Fairview, cross one more traffic light at Lehman Ave and look for a Hospital Sign on the Right side. Immediately after crossing the Hospital sign, make a Right onto High Street. After traveling for a block on High Street, make a Right onto 5th Ave and our building is on the Left Side. We are at the High Street Medical Plaza- 440 High Street, Suite B- the building at the intersection of High Street and 5th Ave.

From Medical Center of Bowling Green:

Turn onto High Street from US 31 W Bypass going toward Medical center. Pass the ER of the Medical Center on the Left and go underneath the walkway and proceed further on High Street. We are located on the left side at the High Street Medical Plaza- 440 High Street, Suite B-the building at the intersection of High Street and 5th Ave.

CENTER for PAIN MANAGEMENT

PATIENT INFORMATION

Name: _____ Birth Date: _____

Address: _____ Social Security #: _____ - _____ - _____

City: _____ Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Other

State: _____ Zip: _____ Sex: [ ] Female [ ] Male

Home Phone: _____ Referring Physician: _____

Mobile/Other: _____ Primary Physician: _____

Work Phone: _____

GUARANTOR (Person Statement will be mailed to)

[ ] Same as Patient

Name: _____ Birth Date: _____

Address: _____ Social Security #: _____ - _____ - _____

City: _____ Home Phone: _____

State: _____ Zip: _____ Work/Other Phone _____

PRIMARY INSURANCE

[ ] Same as Patient [ ] Same as Guarantor [ ] Other

Company: _____ Policyholder: _____

Phone Number: _____ Relation to Patient: _____

ID Number: _____ Social Security #: _____ - _____ - _____

Group Number: _____ Birth Date: _____

SECONDARY INSURANCE

[ ] Same as Patient [ ] Same as Guarantor [ ] Other

Company: _____ Policyholder: _____

Phone Number: _____ Relation to Patient: _____

ID Number: _____ Social Security #: _____ - _____ - _____

Group Number: _____ Birth Date: _____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Address: _____

City/State/Zip: _____

Home Phone: _____

Work/Other Phone: _____

PATIENT EMPLOYMENT

[ ] Employed [ ] Retired [ ] Unemployed [ ] Other

Employer: _____

Address: _____

City/State/Zip: _____

Work Phone: _____

Position: _____

IS YOUR CONDITION CONNECTED WITH WORKMAN'S COMPENSATION? □ YES □ NO
If so, please include the following:
Name of Employer: _____
Employer's Phone: _____ Date of Injury: _____
Contact: _____ Claim #: _____
How did accident occur? _____

IS THIS RELATED TO AN AUTO ACCIDENT? □ YES □ NO
If so, please include the following:
Insurance Company: _____ Address: _____
Phone #: _____ Contact: _____
Policyholder's Name: _____ Relationship to Patient: _____
Date of Accident: _____ Policy #: _____
Claim #: _____ How did accident occur? _____

INSURANCE AUTHORIZATION (All patients must sign authorizing us to bill your insurance carrier)
I understand and authorize Cumberland Brain & Spine to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company to be made directly to the above practice. I authorized any holder of medical information about me to release to the health financing administration and its agents any information needed to determine these benefits. I understand that I am financially responsible for any information necessary to secure payment of benefits, which includes providing current insurance information. Without this current information, I understand that I will be billed for any services that are rendered by the above practice.

Signature: _____ Date: _____

PAYMENT POLICY (All patients must sign acknowledging co-pay responsibilities and returned check fees)
Co-payment is due at the time of service. If you do not have your co-pay, please let the receptionist know so she can reschedule your appointment. There is a $25 returned check fee, and a $20 fee for missed appointments.

Signature: _____ Date: _____

ATTORNEY AUTHORIZATION (Only patients with attorneys must sign)
Who is your attorney:_____ Atty phone number: _____
I understand and authorize my medical bills and records to be sent to the above listed attorney to these dates of treatment. If my case is not settled, or if the amount settled does not cover my medical bills, I will pay for these services.

Signature: _____ Date: _____

RELEASE OF INFORMATION/COLLECTIONS POLICY
I authorize Ram Pasupuleti, MD, to release my insurance company any information required for services provided. I also assign any insurance benefits to Ram Pasupuleti, MD on any unpaid medical bills. I understand that I remain responsible to Ram Pasupuleti, MD for any and all charges not met by the insurance company. I , the undersigned, herby agree that in the event of default in payment of any amount due, and if his account is placed in the hands of an agency or attorney for collection or legal action, to pay an additional charge equal to the cost of the collection including the agency and attorney fees and court costs incurred and permitted by laws governing these transactions.

Signature: _____ Date: _____
By signing each of the above statements, I acknowledge that I fully understand the content, and agree to all of the above conditions.

NOTICE OF PRIVACY PRACTICES

TO OUR PATIENTS:

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by this Practice in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: Treatment, Payment and Health care operations:

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing, or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspect of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified to you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means of at alternative locations.
- The right to inspect and copy your protected health information (our normal copying fee will be required)
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

PATIENT ACKNOWLEDGEMENT

I have received, read and understand your Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information. I understand that this Medical Practice has the right to change its Notice of Privacy Practices from time to time and that I may contact the office at any time at the address noted in this notice to obtain a copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Signature: _____ Date: _____

CENTER for PAIN MANAGEMENT

NEW PATIENT HISTORY FORM

DATE:			PRIMARY CARE PHYSICIAN:			
NAME	LAST:	FIRST:	MIDDLE:	DATE OF BIRTH:	AGE:	SEX: ❑ F ❑ M
				REFERRED BY:		
STREET ADDRESS:		CITY:		STATE:	ZIP CODE:	
HOME PHONE:		EMPLOYER:		WORK PHONE:		

PAIN HISTORY

HOW AND WHEN DID YOUR PAIN START:

_____

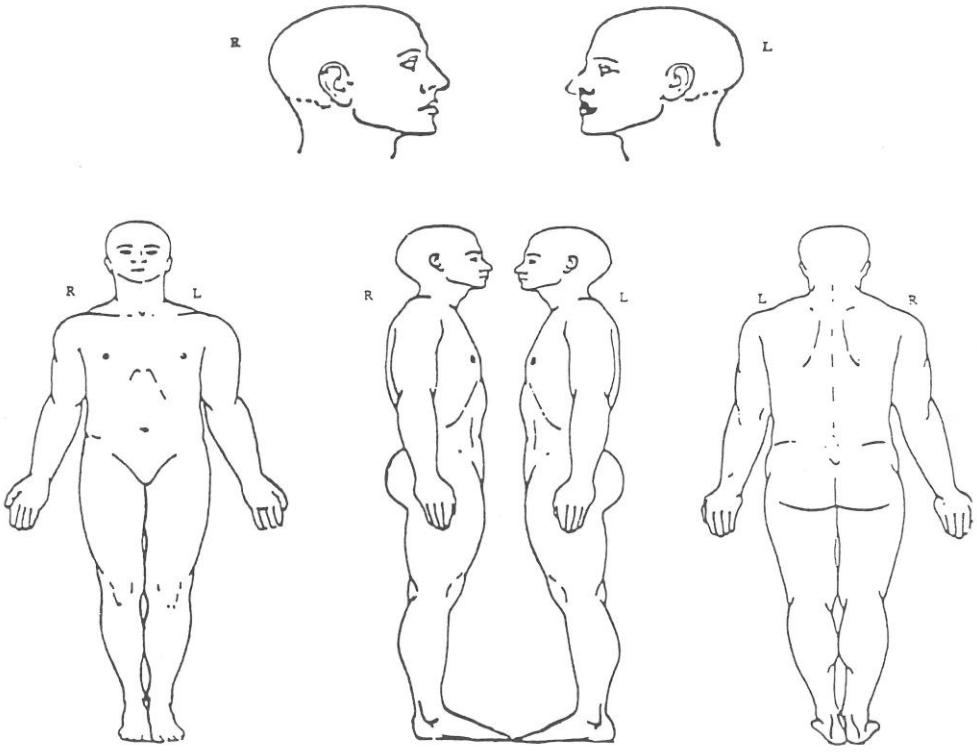
_____

DESCRIBE YOUR PAIN IN YOUR OWNWORDS (LOCATION, QUALITY, AGGRAVATING AND RELIEVING FACTORS ETC):

_____

IS YOUR PAIN FROM AN ACCIDENT/INJURY? ❑ YES ❑ NO IF YES, IS IT ❑ WORK RELATED ACCIDENT/INJURY ❑ AUTOMOBILE ACCIDENT ❑ OTHER DESCRIBE

PLEASE SHADE IN, ON THE DRAWINGS BELOW, THE AREA WHERE YOU FEEL PAIN.



CIRCLE THE NUMBER THAT BEST DESCRIBES YOUR PAIN:

PREVIOUS TREATMENT FOR PAIN

PLEASE CHECK ONE	YES	NO	HELPFUL YES	HELPFUL NO	
SURGERY					NAME OF SURGEON: DATE:
PHYSICAL THERAPY/ OCCUPATIONAL THERAPY					NAME OF THERAPIST:
CHIROPRACTOR					NAME OF CHIROPRACTOR:
TENS UNIT					COMMENTS:
COUNSELING					NAME OF THERAPIST:
PAIN MANAGEMENT					NAME OF PHYSICIAN: MEDICATIONS:
NERVE BLOCKS/EPIDURALS					NAME OF PHYSICIAN: DATE:

TESTS AND INVESTIGATIONS PERFORMED

TEST	DATE	FACILITY	ORDERING PHYSICIAN
X-RAY			
CT SCAN			
MRI			
MYELOGRAM			
OTHER LABS (EMG, BLOOD WORK, BONE SCAN)			

MEDICAL HISTORY

WEIGHT: _____ HEIGHT: _____

CHECK IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS PAST OR PRESENT:

CONDITION	DATE DIAGNOSED	CONDITION	DATE DIAGNOSED
❑ DIABETES		❑ EMPHYSEMA/LUNG PROBLEMS	
❑ HIGH BLOOD PRESSURE		❑ ARTHRITIS	
❑ HEART PROBLEMS		❑ SEIZURE DISORDER	
❑ BLEEDING DISORDER		❑ STROKE	
❑ CANCER		❑ PSYCHOLOGICAL DISORDERS ❑ ANXIETY ❑ DEPRESSION ❑ SCHIZOPHRENIA	
❑ ASTHMA		❑ KIDNEY PROBLEMS	
❑ ALLERGIES		❑ OTHER	

SURGICAL HISTORY

LIST ANY SURGERIES YOU HAVE HAD:

TYPE OF SURGERY	DATE

MEDICATIONS

ARE YOU ALLERGIC TO ANY MEDICAITONS ❑ YES ❑ NO
IF YES, WHICH ONES: _____

ARE YOU ALLERGIC TO LATEX PRODUCTS ❑ YES ❑ NO

ARE YOU TAKING ANY BLOOD THINNING MEDICAITONS ❑ YES ❑ NO
IF YES, WHICH ONES: _____

LIST ALL CURRENT MEDICATIONS BOTH PRESCRIBED AND OVER THE COUNTER (ATTACH LIST IF YOU HAVE ONE)

MEDICATION	WHY PRESCRIBED	DOSAGE	EFFECTIVENESS

SOCIAL & FAMILY HISTORY

MARITAL STATUS: ❑ MARRIED ❑ SINGLE ❑ DIVORCED ❑ WIDOWED

ARE YOU PREGNANT OR PLAN TO BECOME PREGNANT ❑ YES ❑ NO

DO YOU SMOKE? PRESENT ❑ YES ❑ NO PAST ❑ YES ❑ NO WHEN DID YOU QUIT_____
IF YES, HOW MUCH _____ HOW LONG_____

DO YOU DRINK ALCOHOLOIC BEVERAGES? ❑ YES ❑ NO IF YES, HOW MUCH _____

DO YOU USE ANY RECREATIONAL DRUGS? ❑ YES ❑ NO IF YES, WHICH ONES/ HOW MUCH _____

HAVE YOU EVER RECEIVED TREATMENT FOR ANY TYPE OF ADDICTION? ❑ YES ❑ NO IF YES, DESCRIBE: _____

OCCUPATION: _____ HOURS PER WEEK: _____

HOW MUCH WORK, IF ANY, HAVE YOU MISSED IN THE PAST MONTH DUE TO PAIN _____

EXERCISES/HOBBIES YOU LIKE : _____

DOES PAIN INTERFERE WITH YOUR HOBBIES /EXERCISES ❑ YES ❑ NO DESCRIBE _____

DO YOU HAVE ANY FAMILY MEMBER WHO HAS SIMILAR PAIN/CHRONIC PAIN ❑ YES ❑ NO DESCRIBE _____

RELEVANT FAMILY HISTORY _____

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE

SIGNATURE:_____ DATE:_____

NAME OF PERSON COMPLETING THE FORM (IF OTHER THAN PATIENT)_____