PREMIER PAIN CENTERS
You will see we Care

403 W Campbell Rd,
Suite#305
Richardson TX 75080

4040 McDermott Rd,
Suite#100
Plano, TX 75080

Rao K Ali, MD
Board Certified Interventional Pain Management
Board Certified Physical Medicine & Rehabilitation

NEW PATIENT OFFICE INFORMATION

PATIENT INFORMATION

Legal First Name	Middle Initial	Last Name
Date of Birth:_____/___/_____	Age: _____	Sex: M / F
Marital Status: Married / Single / Divorced / Widowed		
Address:_____		
Home #:_____	Work #:_____	Cell#_____
Email:_____		
Primary Care Physician:_____		
Referred By: Physician/Friend/Internet _____		

INSURANCE POLICY

Insurance Network	Group Number	Subscriber ID Number
Claims Mailing Address:		
Subscriber Name: _____		
Date of Birth: ___ /___ /_____		
Employer Name & Address: _____		
Relationship to patient: Spouse / Parent / Other:		

EMERGENCY CONTACT

Name: _____	Relationship to patient: _____
Address: _____	
Home/Work/Cell #: _____	Home/Work/Cell #: _____

LETTER OF PROTECTION COVERAGE

LOP: Attorney's Name: _____	Phone #: _____
Attorney Address:_____	Fax #: _____

AUTHORIZATION TO RELEASE INFORMATION I hereby authorize the above-named agency to release any treatment information requested by attorneys, physicians, insurance companies, employees, health care providers, or any other entity which may be concerned with the payment of charges incurred for the treatment services of Rao K Ali MD and associates.

_____ _____

PATIENT SIGNATURE **DATE**

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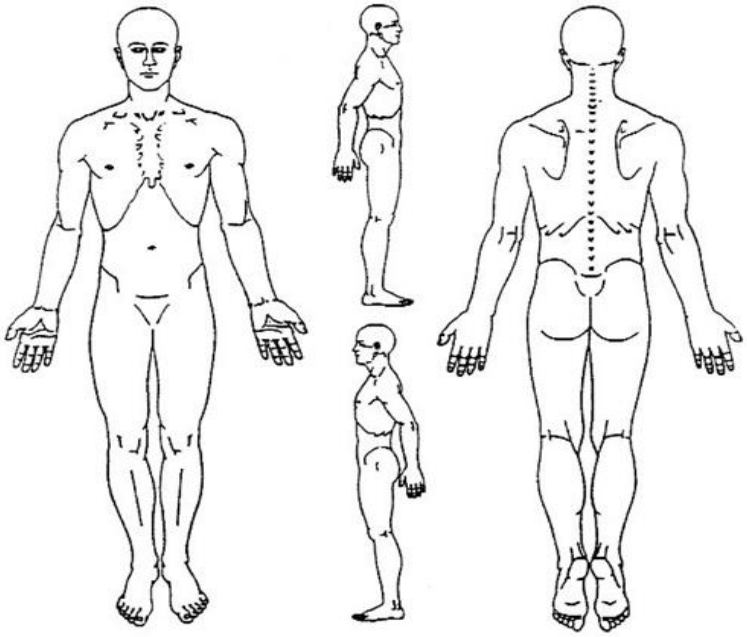
INITIAL PATIENT VISIT

PATIENT NAME: _____ **DATE:** _____

REFERRED BY: _____ **AGE:** _____ **SEX: M / F**

PRIMARY CARE DOCTOR: _____ **REASON FOR VISIT:** _____

Indicate your pain location(s) by drawing on the figure below:



Please mark the area of discomfort by using the appropriate letter(s).

X= pain **B**= burning

T= tingling **W**= weakness

Please describe how your problems began: how the pain started, and events until now

_____

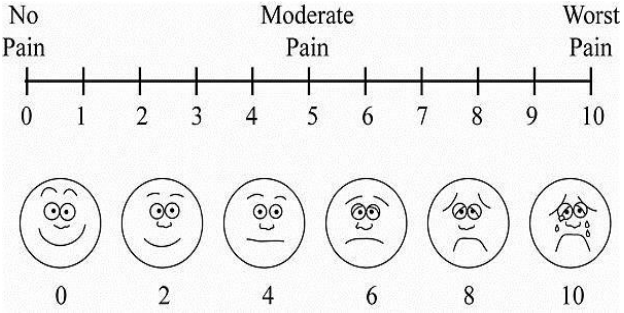
_____

_____

_____

_____

What is your current pain level?



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Most Painful area you want to be addressed first
Neck/Middle Back/Low Back/Hip/Knee/Shoulder/Arm/Leg

When the pain first start? □ 1 week □ 2 weeks□ 1 month □ 3 months □ 6 months □ 1 year □ > 1 year

Describe the pain: □ Aching □ Burning □ Tingling □ Sharp □ Dull □ Throbbing □ Band like

What is the frequency of the pain? □ Comes and goes □ Always present □ Only when I _____

_____

When is the pain the worst? □ Morning □ Evening □ After significant activity □ All the time

What makes the pain better? □ Rest □ Ice □ Heat □ Motrin/Aspirin, etc. □ Lortab/narcotics, etc. □ Massage □ Lying flat □ Bending forward

Any other Painful area you want to be addressed
Neck/Middle Back/Low Back/Hip/Knee/Shoulder/Arm/Leg

When the pain first start? □ 1 week □ 2 weeks□ 1 month □ 3 months □ 6 months □ 1 year □ > 1 year

Describe the pain: □ Aching □ Burning □ Tingling □ Sharp □ Dull □ Throbbing □ Band like

What is the frequency of the pain? □ Comes and goes □ Always present □ Only when I _____

When is the pain the worst? □ Morning □ Evening □ After significant activity □ All the time

What makes the pain better? □ Rest □ Ice □ Heat □ Motrin/Aspirin, etc. □ Lortab/narcotics, etc. □ Massage □ Lying flat □ Bending forward

PLEASE COMPLETE ALL QUESTIONS, CIRCLING ITEMS BELOW THAT APPLY TO YOU

MEDICAL PROBLEMS HTN, Diabetes Heart Disease Cancer/Tumor Stroke Osteoarthritis Osteoporosis Depression Fibromyalgia Migraine Previous Car Accident Work Injury Other: _____

PRIOR SURGERIES Fusion, (Neck, Back), Disc Surgery, Laminectomy, Joint replacement (Knee, Hip, Shoulder) Cardiac bypass, vascular surgery _____

FAMILY HISTORY Rheumatoid Arthritis Lupus/Connective Tissue Disease Heart Trouble Diabetes Cancer Stroke Depression/Suicide Other: _____

SOCIAL HISTORY Whom do you live with? _____
Do you smoke? □ yes □ no How many packs per day?__For how long? _____
Do you use alcohol regularly? □ yes □ no Any Illicit drug use? □ yes
□no Are you: □ married □ single □ divorced □ widowed

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Describe your work: □ office □ heavy labor □ homemaker □ driver □ retired □ student
□ Other: _____
Do you drive yourself? □ yes □ no because_____

FUNCTIONAL

Circle all the actions you are unable to perform:
Dress Bathe Groom Toilet Walk Run Climb Stairs Perform Sport: _____

REVIEW OF SYMPTOMS

Circle all the items you currently suffer from:

Anxiety/Depression Headaches Irritability Lack of Energy Trouble Sleeping Weight Gain Stiffness Falls Poor Balance Bowel/Bladder Changes Numbness/Tingling Weakness Cramps Memory Problems Fevers/Chills Night Sweats Shortness of Breath Other: __

IMAGING STUDIES

MRI_____ CT SCAN_____ XRAYS_____ BONE SCAN_____
OTHER_____

THERAPY

Have you ever had physical therapy? □ yes □ no If yes, when was the last time? _____
Have you had occupational therapy? □ yes □ no If yes, when was the last time? _____
Have you had chiropractic treatment? □ yes □ no If yes, when was the last time? _____
For what condition(s)? _____

PRIOR PROCEDURES

Trigger Point Injections Epidural Injection Nerve Blocks Joint Injection

Rhizotomy/RFA_others

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PATIENT MEDICATION FORM

Premier Pain Centers is dedicated to providing the highest quality medical care to our patients. Please assist us in our efforts to ensure your complete, accurate electronic medical record by providing us with a list of your known allergies, as well as all medications you are currently taking.

ALLERGIC TO:	DESCRIBE REACTION:

PRIOR PAIN MEDICINES Celebrex Ibuprofen/Advil Mobic Aleve/Naproxen

Neurontin Lyrica, Elavil Topamax C o d e i n e , Lortab/Vicodin Norco Percocet Percodan Oxycontin MS Contin Methadone Duragesic Patch Morphine Actiq /Zonegran Ambien Xanax Restoril Trazodone Robaxin Skelaxin Flexeril Zanaflex Baclofen Soma Prozac Celexa Lexapro Paxil Remeron Zoloft
Other_____

OTHER MEDICATIONS: PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING, PRESCRIPTION AND OVER-THE- COUNTER. PLEASE INCLUDE MEDICATIONS THAT YOU TAKE ON AN AS-NEEDED BASIS.

DATE STARTED	NAME OF MEDICATION	DOSE	HOW OFTEN DO YOU TAKE IT?

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I, _____, understand that that services or items that I have requested be provided to me by **Premier Pain Centers** may not be covered under my insurance as being reasonable or medically necessary for my care. I understand the health-insuring agent determines the medical necessity of the services or items I request and receive. I also understand I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable or medically necessary for my care.

Advanced Practitioner Consent for Treatment

This facility has on staff a physician assistant and/or a nurse practitioner to assist in the delivery of medical care of pain management.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. A nurse practitioner is not a doctor. A nurse practitioner is a registered nurse who has received advanced education and training in the provision of health care. Under the supervision of a physician, a physician assistant and a nurse practitioner can diagnose, treat and monitor acute and chronic disease as well as provide health maintenance care.

***"Supervision" does** not require the constant physical presence of the supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.*

A physician assistant and a nurse practitioner may provide such medical services that are within his/her education, training and experience.

I have read the above, and hereby consent to the services of an advanced practitioner for my health care needs. I understand that at any time I can refuse to see the advanced practitioner and request to see a physician.

Acknowledgement of Drug Screening Policy

I understand that **Premier Pain Centers** reserves the right to perform random drug screening on any patient. I have the right to refuse the drug screen, but may then not be prescribed any medications or given refills of medications.

Acknowledgement of Investigational Treatment

I am being informed that in certain circumstances the treatment being recommended maybe considered investigational, experimental, and not FDA approved. By signing this document I am giving consent to such treatments.

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AGREEMENT OF FINANCIAL RESPONSIBILITY

Thank you for choosing Premier Pain Solutions as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

Insurance

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company. The patient will be responsible for any deductible, coinsurance and co- payment amount. The patient is responsible for payment of any non-covered service.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.

Referrals

- If a referral is required for your insurance policy, it is your responsibility to obtain this referral from the primary insurance company prior to any appointments. Failure to obtain a referral may result in reduction of benefits.

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Self-Pay

- Patients are responsible for all visits, treatment and other related services covered by the treating provider at Premier Pain Solutions. While our office can try to estimate cost of services, the patient agrees in advance to pay for all services, tests and fees the providers feel are necessary for the patient's care.

Unpaid Balances

- Patients typically receive a statement from our office after the insurance company has processed the claims. This will include charges that the insurance company has not paid. Payment is due within 30 days of the statement date. An account is considered past due if not paid by due date listed on billing statement, unless prior arrangements have been made with our billing office.

Returned Checks

- The charge for a returned check is $35.00 payable by cash or money order. This will be applied to your account in addition to the insufficient fund amount.

No Show/Cancellation Policy

- No Show/Cancellation Policy: A charge of $50 will be applied to your account if notification of cancellation is not made within 24 hours of the appointment time.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full. I authorize payment of medical benefits to my treating provider at Premier Pain Solutions and authorize my provider to release any information requested by my insurance carrier. I understand and agree that the terms of this financial policy may be amended by the practice at any time without prior notification to the guarantor.

_____ _____

Signature of Patient /Responsible Party **Date**

_____ _____

Name of Patient/Responsible Party (please print) **Relationship to Patient**

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AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

PREMIER PAIN CENTERS recognizes the patient's right to confidentiality of protected health information ("PHI"). This form obtains permission to discuss and/or release information regarding your care at our practice to a person whom you designate as an authorized representative. Authorization is optional- you may opt to not designate any authorized representatives.

Please bear in mind, if you intend for anyone else to schedule your appointments, manage your prescriptions, or receive billing/account/medical record information on your behalf, you must authorize them on this form.

PATIENT NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

I AUTHORIZE PREMIER PAIN CENTERS TO DISCLOSE MY PHI TO THE LISTED PERSON(S):

NAME	PHONE NUMBER	RELATIONSHIP TO PATIENT

LIMITATIONS ON DISCLOSURE

I understand that by leaving this section blank, I am allowing all of my PHI to be disclosed to my authorized representative(s).

Limitations:

_____

I UNDERSTAND THAT INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT IF THEY ARE NOT A COVERED ENTITY UNDER THE FEDERAL PRIVACY RULE. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFYING PREMIER PAIN SOLUTIONS IN WRITING TO BE EFFECTIVE ON THE DATE NOTIFICATION IS RECEIVED. I AGREE THAT MY AUTHORIZATION IS VOLUNTARY.

_____ _____

PATIENT SIGNATURE **DATE**

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN SET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other

Individually identifiable health information used or disclosed by us 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; **"HIPPA" provides**

Penalties for covered entities that misuse personal health information.

As required by "HIPPA," 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 aspects 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 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.

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

- The right to request restriction 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 by 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 or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to receive an accounting of disclosure of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of January 1, 2013 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you filing a complaint.

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Please call us or contact following website for more information. https://www.hhs.gov/hipaa/index.html

NOTICE OF PRIVACY PRACTICES AKNOWLEDGEMENT

Patient Name: _____

Date of Birth: _____

I acknowledge that PREMIER PAIN CENTERSS provided me with a written copy of the office's Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____

Patient **Date**