GARRETT SPINE, NERVE & PAIN CENTER

90 Main Street

Westernport MD, 21562

Ph: 301-616-2550

Fax: 301-359-5057

Your appointment is _____ at _____.

Your arrival time on _____ is at _____.

Dear Patient,

Thank you for choosing Garrett Spine, Nerve, & Pain Center for your pain management needs. Bring the following items to your new patient consult:

- ✓ Drivers License (or other government issued form of identification)
- ✓ **ALL** Insurance cards (primary insurance, secondary insurance, etc)
- ✓ **ALL** attached new patient paperwork and consents **completed and signed.**

If you do not have the items listed above at the time of your appointment, you may be asked to reschedule.

It is important for all new patients to arrive 30 minutes prior to their scheduled appointment time to allow time for front office staff to obtain needed information as well as for the clinical staff to review and input the information from the attached paperwork. Please arrive at your appointment at the **highlighted arrival time** listed above.

If you are unable to make your scheduled appointment, please contact the office at 301-616-2550 at least 48 hours in advance and appointments cancelled or rescheduled less than 48 hours will result in a fee. All attendance policies and the fees associated with missed appointments are detailed within this packet**. Please carefully read ALL consents and policies** of Garrett Spine, Nerve, & Pain Center failure to adhere to policies outlined in this packet could result in discharge from the practice.

General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____

Phone Number: _____ SSN: _____

I authorize the custodian of records of: _____ or other person/entity (specifically describe) _____ to disclose/release the following information* (mark all that apply)

- ☐ All records
- ☐ Laboratory/Pathology Results
- ☐ X-Ray/Radiology/Imaging Records
- ☐ Billing
- ☐ Abstract/Summary
- ☐ Pharmacy/Prescription Records
- ☐ Other (describe specifically) _____

**Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, behavioral health, or sexually transmitted diseases, you are hereby authorizing disclosure of this information.*

These records are for services provided on the following date(s): _____

Please send the records listed above to (use additional sheets if needed)

Name: _____

Address: _____

Phone: _____

Fax: _____

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign this authorization will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have the authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize this use or disclosure of this protected health information.

_____ _____

Signature of patient or representative Date

_____

Printed Name

GSNPC
GARRETT SPINE, NERVE & PAIN CENTER

At GSNPC our goal is to simplify the billing and financial process of healthcare as much as possible by keeping you informed of your financial responsibility in statement form and through our secure web portal. Please read this carefully and if you have any questions, please do not hesitate to ask. We are committed to providing the best treatment for our patients and we charge what we believe to be reasonable and customary fees for our region and specialty. If your insurance company uses a different fee schedule, you will be responsible for any balance remaining.

PAYMENT:

- All applicable co-payments, co-insurance, deductibles, and personal balances, both current and prior are due at the time of service unless other payment arrangements have been made. In some cases, you may be asked to pay the balance of your account or make payment arrangements prior to making your next appointment.
- If you fail to meet the financial obligations agreed upon in this financial policy or other payment arrangements made you will be required to pay the entire balance due prior to being scheduled for any further appointments.
- If after billing your insurance plan the claim is denied for any reason, the charges then become the responsibility of the patient.
- There is a $25.00 service charge for returned checks.
- If you have questions regarding your charges/bill please contact the office manager at 301-616-2550 the office manager and the patient services coordinator are also the staff available to assist patients with setting up payment plans.

INSURANCE:

- Our office participates in a variety of insurance plans. GSNPC accepts assignment of insurance benefits. This means your insurance plan will pay GSNPC directly the amount due based on your plan coverage.

It is your responsibility to:

- Bring your insurance card to each visit and notify GSNPC of any changes to your coverage and personal information. If you do not have your insurance card at the time of your visit you will be responsible for providing your insurance card to GSNPC by the end of the business day or your visit will be marked as self-pay, and the patient will be responsible for the full balance.
- Know and understand your benefit plan. Please read and understand your insurance policy. Your policy is a contract between you and the insurance carrier.
- If GSNPC physicians do not participate in your insurance plan or you are a self-pay patient, payment in full is expected at the time of the services unless prior arrangements have been agreed upon with the office manager or patient services coordinator.

- We will work with your insurance plan to obtain payment. Your assistance in collection from your insurance plan may be required. Additional information may be needed from the patient to ensure the insurance claim is submitted properly.

Insurance Denials

- If any date of service is denied by the insurance carrier, the remaining balance will be turned over to the patient and become their responsibility.

Insurance Non-Payment

- If a claim is forty-five (45) days old and there has been no response from the insurance carrier, the balance due will be turned over to patient responsibility for payment.

Past Due Accounts

- Accounts over 30 days old from the billed date are considered delinquent.
- Overdue accounts will be referred to a collection agency. Legal fees that we pay to secure past due balance will be added to your account.
- Please notify GSNPC at least 48 hours in advance if you cannot keep your appointment. No shows and last-minute cancellations cost the practice a significant amount of lost revenue. As a private practice with significant overhead and salary, our practice must hold patients accountable for the keeping of their appointments. **Cancellations in less than 48 hours or no shows will result in fees being charged.**
- The following fees are based on the length of time we block out for various appointment types. Be aware patients may be discharged from the practice for nonpayment of these fees. Fees must be paid in full prior to scheduling next appointment or the patient must have an approved payment agreement on file.

MISSED APPOINTMENT/NO SHOW FEES:

New Patients - $150.00

EMG (Nerve Conduction Study) - $200.00

Procedures/Injections - $150.00

Follow Up Appointments - $50.00

I have read Garrett Spine, Nerve, & Pain Center Financial Policy. I understand and agree to this policy.

_____/_____

Printed Name of Patient or Responsible Party Date

_____/_____

Signature of Patient or Responsible Party Date

_____/_____

GARRETT SPINE, NERVE & PAIN CENTER

GSNPC Communication Policies

We receive a high volume of telephone calls each day, if the staff is busy assisting another patient or on another call your call will be returned in the order it was received. If the staff is unable to answer your call, please leave a detailed message. All calls and voicemails will be addressed and returned by the end of the business day. The information below provides answers to questions that are frequently asked. Please carefully review the information and policies listed below and sign at the end to indicate your agreement to the policies.

- **The only appropriate way of contacting the office and office staff is by calling the office phone number 301-616-2550**. **You should not contact the staff or provider on their personal Facebook accounts or personal cell phones for any reason.**

- The Garrett Spine, Nerve, & Pain Center (GSNPC) Facebook page is an informational page and allows us to post announcements regarding the office. ***Facebook messages to the GSNPC Facebook should be limited*** **and only requesting general information** such as hours or operation and services provided. Messages should not be sent regarding appointments, health conditions, referrals, etc**. Facebook messenger is not HIPAA compliant therefore those types of messages will not be answered**. If you cancel an appointment via a Facebook message and do not contact the office directly it will be considered a no show and the patient will be charged the no show fee.

- It is important to take your medications exactly as prescribed. If your medications are taken other than as directed and you run out of medication early, please do not call the office for an early refill, as we will not be able to honor that request.

- Medications prescribed by Dr. Soriano run on a *30-day cycle.* Each prescription that is sent to your pharmacy includes a "do not fill date" (DNF), indicating the date your prescription may be filled again. We are aware that some pharmacy policies allow the prescription to be filled after 28 days, however that is not our policy at GSNPC. **Please do not call the office requesting the do not fill date be changed or excluded from your prescription. If medication is taken as directed, you should have enough for the full 30 days**. Please do not call the office requesting the do not fill date be changed or excluded from your prescription because that request will not be honored.

- There are some medications that require prior authorizations (PA's) from your insurance company. The PA forms are faxed to our office from the pharmacy at which time a staff member will complete the form and submit it to your insurance company. *Typically, a response from the insurance company is received within 72 hours and is sent directly to the pharmacy.* Once the PA form has been submitted changes cannot be made to the prescription. If 72 hours have passed and you have questions regarding your prior authorization, please direct those questions to the nursing staff.

- **All refill requests are to be made 2-3 business days in advance to ensure the refill is sent into your pharmacy by the date your medication can be filled**. Due to Dr. Soriano working only 2 days a week at our location the approval for your medication may take up to 48 hours, which is why all requests must be made 2-3 business days in advance. If you fail to request your refill 2-3 days prior, please do not call stating it is an emergency, it is your responsibility to abide by the office policies and request refills in a timely manner.

- Dr. Soriano works here at GSNPC 3 days a week and, as most of our patients are aware, works at another facility 1-2 days a week. Patients seeing Dr. Soriano at GSNPC are **NOT to call his other place of employment for ANY reason.** If Dr Soriano has referred, you to be seen at the other facility you will receive instructions regarding that process and staff from the other facility will reach out to the patient once all information has been received and authorizations have been approved.

- Staff is available for patient calls and refill requests Monday-Thursday 830am-430pm. No calls or refill requests will be accepted after office hours, Fridays, weekends, or holidays. All calls and requests will be addressed the next business day.

- **Medication changes including dose and frequency will not be discussed or changed over the phone.** Questions about your medication regimen can be discussed at your next office visit.

_____ _____

Printed Name Date

_____

Patient Signature

GSNPC

GARRETT SPINE, NERVE & PAIN CENTER

As a user of electronic medical record, Garret Spine, Nerve, & Pain Center would like to include your medication history in your record. A medication history is a list of prescription medications that have been prescribed to you by a healthcare provider. The medication history is compiled of information from your pharmacy, your insurance health plan, and the use of electronic medical records by healthcare providers.

An accurate and up-to-date medication list is vital to the provider in order to make informed decisions regarding your care and to avoid potentially dangerous drug interactions. This tool also aids in the turnaround time for any necessary medication prior authorizations required by your insurance company.

By signing this consent form, you give us permission to collect, and give your pharmacy and your health plan permission to disclose, information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medications for the treatment of HIV/AIDS and any mental health conditions. This information will become a part of your medical record at Garrett Spine, Nerve, & Pain Center.

Medication history is a useful tool, but it may not always be completely accurate. Some pharmacies do not make drug history available to us, medications purchased without the use of your health plan may not be available, or any over the counter medications, supplements, or herbal remedies may not appear on the medication history list. It is very important for our staff to verify the information provided on the medication history list and for any errors to be addressed and corrected.

I give permission for Garrett Spine, Nerve, & Pain Center to obtain my medication history from my pharmacy, my health plans, and other health care providers.

This consent is valid for 12 months from the date of signing and will need to be renewed annually.

Patient Name: _____ Date of birth: _____

Patient Signature: _____ Date: _____

GARRETT SPINE,
NERVE & PAIN CENTER

Name: _____ Date of Birth: _____

Referring Provider: _____

Pharmacy: _____

Chief Complaint: _____

Circle all that apply regarding your pain:

chronic acute sudden gradual trauma related intermittent constant sharp
shooting stabbing radiating aching dull throbbing numbness & tingling

Please list TWO activities that aggravate your pain.

1. _____ 2. _____

Have you had any recent imaging completed? (Xray, CT Scan, MRI) NO YES If yes, when was the imaging performed and which facility was the imaging completed at? _____

Have you previously attended Pain Management? NO YES If yes, please provide the following information:

Name of Pain Management/Provider: _____ Date of last visit: _____

Reason for leaving: Discharged due to noncompliance Transportation Issues No longer accepting insurance/cost Ineffective treatment plan Other: _____

PREVIOUS TREATMENT FOR PAIN

Physical Therapy	Heat/Ice	Accupuncture	Chiropractor	TENS Unit
Home Exercise	Injections	Dry Needling	Medication	Other

If other, please explain _____

Did any of the previous treatments for your pain provide you with adequate pain relief? NO YES

If yes, please indicate which treatment _____

ALLERGIES – Please list all medication allergies and reactions.

Medication Name	Reaction

Are you allergic to latex? No Yes

CURRENT MEDICATIONS – if you have a medication list please provide a copy at your appointment. If you do NOT have a current medication list please list all medications including dose and frequency below.

Are you currently taking a blood thinner? NO YES _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

SURGICAL HISTORY:

_____ _____

_____ _____

_____ _____

PAST MEDICAL HISTORY (circle all that apply)

Anxiety	Heart Attack	Stroke
Depression	COPD	Asthma
Arthritis	Diabetes	Allergies
HTN	Edema	Migraines
GERD	Hypothyroidism	Coronary Artery Disease
Hepatitis	Kidney Disease	Liver Disease
Neuropathy	Osteoporosis	Seizures
Cancer _____	Alcoholism	Substance Use Disorder

Other: _____

FAMILY HISTORY

	Alive or deceased	Cancer	Diabetes	Alcoholism Substance Use	Heart Disease	HTN	Stroke	Thyroid Disease	Mental Illness
Father									
Mother									
Siblings									

Other Notable Family History/Explanation of checked boxes if needed:
_____
_____

SOCIAL HISTORY:

- Tobacco Use - current _____packs per day former smoker never/nonsmoker
  - If former smoker please list quit date _____
- Alcohol Use - NO YES if yes, how many drinks per day _____.
  - _____ cans of beer _____ glasses of wine _____ shots of liquor
- Substance Use - current use former use never
  - Substances used and frequency of use _____

    _____

    If former substance use, please list quit date _____

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	o o o o o	^ ^ ^ ^ ^	**x x x x**	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^ ^	**x x x x**	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^ ^	**x x x x**	⊗ ⊗ ⊗ ⊗