Coastal Pain and Spine Center

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Street Address (No PO Box): _____

City: _____ State: _____ Zip Code: _____

E-Mail Address: _____

Telephone: (Home) _____ (Mobile) _____

Social Security Number (necessary for insurance filing): _____

Date of Birth: _____ Sex: Male Female Marital Status: S M W D

Spouse Name: _____ Spouse Date of Birth: _____

Spouse Social Security Number:_____ Spouse Employer:_____

Referring Doctor: _____ Phone: _____

Reason For Visit: _____

Was this a work injury? Yes No
Was this a result of an auto accident? Yes No
Are there any lawsuits pending? Yes No Attorney: _____

Primary Care Information: _____
(Physician, NP, PA) (Practice Name)

Preferred Pharmacy: _____
(Name) (City/Street)

Employer Information

Employer: _____

Employer Address: _____ Phone: _____

Employment Status (circle one): Full Time Part Time Retired Not Employed Disabled

Emergency Notification

Name: _____ Phone: _____ Relationship: _____

POLICY HOLDER INFORMATION

Name: _____ Relationship: _____

Social Security Number (needed for filing claims): _____- _____-_____

Date of Birth: _____/_____/_____

PLEASE BRING YOUR INSURANCE CARDS TO THE APPOINTMENT

Medical Release Authorization and Insurance Agreement

I hereby authorize this office to apply for benefits on my behalf for covered services rendered. I request payment from my insurance to be made to Coastal Pain and Spine Center. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account.

I request that payment for authorized Medicare benefits be made either to me on my behalf or on my behalf to Coastal Pain and Spine Center. I authorize the holder of medical information about me to release the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I certify that the information I have reported to my insurance coverage is correct and further authorize the release of any necessary information, including medical information to my insurance company in order to determine insurance benefits to which I may be entitled. I may revoke this authorization at any time in writing.

I authorize Coastal Pain and Spine Center to release and/or send medical information regarding my case to other consulting and/or referring physicians.

Print Name: _____

Signature (required): _____ Date: _____

Financial Responsibility Agreement

As a courtesy to you, our office will file a claim to your insurance carrier for your medical charges. You will be responsible for any balance remaining after your insurance carrier paid. Insurance companies do not always pay what you expect them to pay. If there is a question or problem with the amount paid, this should be discussed with your insurance carrier.

We will not bill you for your medical charges that are not eligible for insurance payment until 60 days after the claim has been filed. If no payment has been made at that time, we ask that you notify your carrier that your claim has not been paid and that your doctor has requested payment from you.

Our office will be happy to assist you as best as we can. The bill, however, is your responsibility. If you have questions or problems, we will try to help. You may call our billing department to answer questions or arrange a payment schedule for large balances. Should timely payments of this account not be made, Coastal Pain and Spine Center may retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance. Any expense incurred by such action shall become an additional liability for you may be responsible.

I HAVE READ YOUR POLICY, UNDERSTAND AND IT, AND WILL COMPLY WITH ITS PROVISIONS.

Print Name: _____

Signature (required): _____ Date: _____

Medical Release Form

Please sign ALL that apply

1. Authorization to release information: I hereby authorize Coastal Pain & Spine Center to release any information required in the course of my examination or treatment, to my insurance company.

Signature of patient: _____

2. Authorization to release information: I hereby authorize Coastal Pain & Spine Center to release any information in the course of my examination or treatment, to the referring physician.

Signature of patient: _____

3. Authorization to release information: I hereby authorize the requested medical records to Coastal Pain & Spine Center (Fax: 866-502-2928)

____ Progress Notes
____ MRI Report
____ Operative Reports
____ Radiology Reports (CT Scan, DEXA Scan, X-Rays)
____ Lab Results
____ Other: _____

Signature of patient: _____

4. I hereby give my permission for the staff of Coastal Pain and Spine Center to leave messages regarding my treatment on my voicemail. By Consenting below, I also authorize the release of medical information, appointments, medical records, and/or claims information to the person(s) listed below

Authorized Individual	Relationship
_____	_____
_____	_____
_____	_____

Print Name: _____

Signature of patient: _____

No Show/Late Cancellation Policy

This policy has been established to help us better serve you.

It is necessary for us to make appointments in order to see our patients as efficiently as possible. No-shows and late cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No-shows and late cancellations delay the delivery of healthcare to other patients.

A " no-show" is missing a scheduled appointment. A" late cancellation" is defined as canceling an appointment within 24 hours of an office appointment or 48 hours in advance of a procedure appointment.

We understand that situations such as medical emergencies occasionally arise. These situations will be considered on a case-by-case basis. A charge of $50.00 will be assessed for each no-show or late cancellation OFFICE appointment if less than 24 hours notices are given. A charge of $100.00 will be assessed for each no-show or late cancellation PROCEDURE appointment if less than 48 hours notice is given. Please understand that insurance companies consider discharge to be entirely the patient's responsibility.

To cancel or reschedule an appointment please call 843-757-6744 ext 101 for Bluffton or ext 201 for Hilton Head. This policy is in effect to ensure that all of our patients have the opportunity to be seen in a timely manner.

_____ _____

Patient Acknowledgement (Please sign) Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain right to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that directly and indirectly.
Conduct normal healthcare operations such quality assessments and physician certifications.

I am aware that your Notice of Privacy Practices containing a more description of the uses and disclosures of my health information is available in the reception area. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to address the above to obtain a current copy of its Notice of Privacy Practice.

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 restriction, but if you do not agree then you are bound to abide by such restrictions.

I have received a copy of the Notice of Privacy Practices for Coastal Pain and Spine Center, Inc.

_____ _____

Name of Patient Date of Birth

_____ _____

Signature Date

_____

Signature of Patient Representative (Required if the patient is a minor)

OFFICE USE ONLY

I attempted to obtained the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: **Initials:** **Reason:**

Pain Symptoms History

Tell Us About Your Symptoms: _____

_____

When did pain start: _____

Where is pain located and radiate: _____

Constant or Intermittent: _____

What Improves/Worsens Symptoms: _____

Any weakness in arms/legs: _____

Have you had prior tests (Circle): MRI CT Scan Xray EMG

If yes, when and Where: _____

Have you had prior neck, back, or joint surgery (Circle): Yes No

If yes, when and by who? _____

Have you been to physical therapy (Circle): Yes No

If yes, the last time you went and for how long? _____

Have you had prior injections (Circle): Yes No

If yes, when and by who? _____

What medications have you tried to help with pain? Side effects or benefits? _____

_____

_____

_____

_____

Do you currently have any of the following (Circle):

Heartburn	Constipation	Diarrhea
Weight loss	Weight Gain	Sleep disturbance
Blurry vision	Vision Changes	Headaches
Balance Problems	Chest Pain	Heart Palpitations
Cough	Shortness of breath	Memory Problems

Medical History

List Any Allergies: _____

Height: _____ **Weight:** _____

Medical History (Circle)

Respiratory:	COPD or Asthma	Sleep Apnea	Pulmonary Embolism (PE)
Cardiac:	Hypertension	Heart Attack	Coronary Artery Disease
	Pacemaker	Defibrillator	High Cholesterol
GI:	GERD	Stomach Ulcer	Ulcerative Colitis/Crohn's
	Hepatitis	Liver Disease	Gastric Bypass
Renal:	Kidney Stones	Incontinence	Chronic Kidney Disease
Neurologic:	Stroke	Seizures	Migraines
Psych:	Depression	Anxiety	Substance Abuse
Hematology:	Thrombocytopenia	Anemia	DVT
Endocrine:	Diabetes	Osteoporosis	Low Thyroid
Rheum:	RA	Ehlers-Danlos	
Cancer:	_____		
Other:	_____		

Please List Prior Surgeries:

_____

_____

_____

Social History:	Tobacco Use:	Yes	No	Former
	Cannabis Use:	Yes	No	Former
	Alcohol Use:	Yes	No	Former

Family Medical History:

Parents_____

Children_____

Siblings_____

Other_____

Please list any **Blood Thinners** you are taking: _____

Please list all **Prescription Medications** you are taking (Name, Dose, & Frequency)

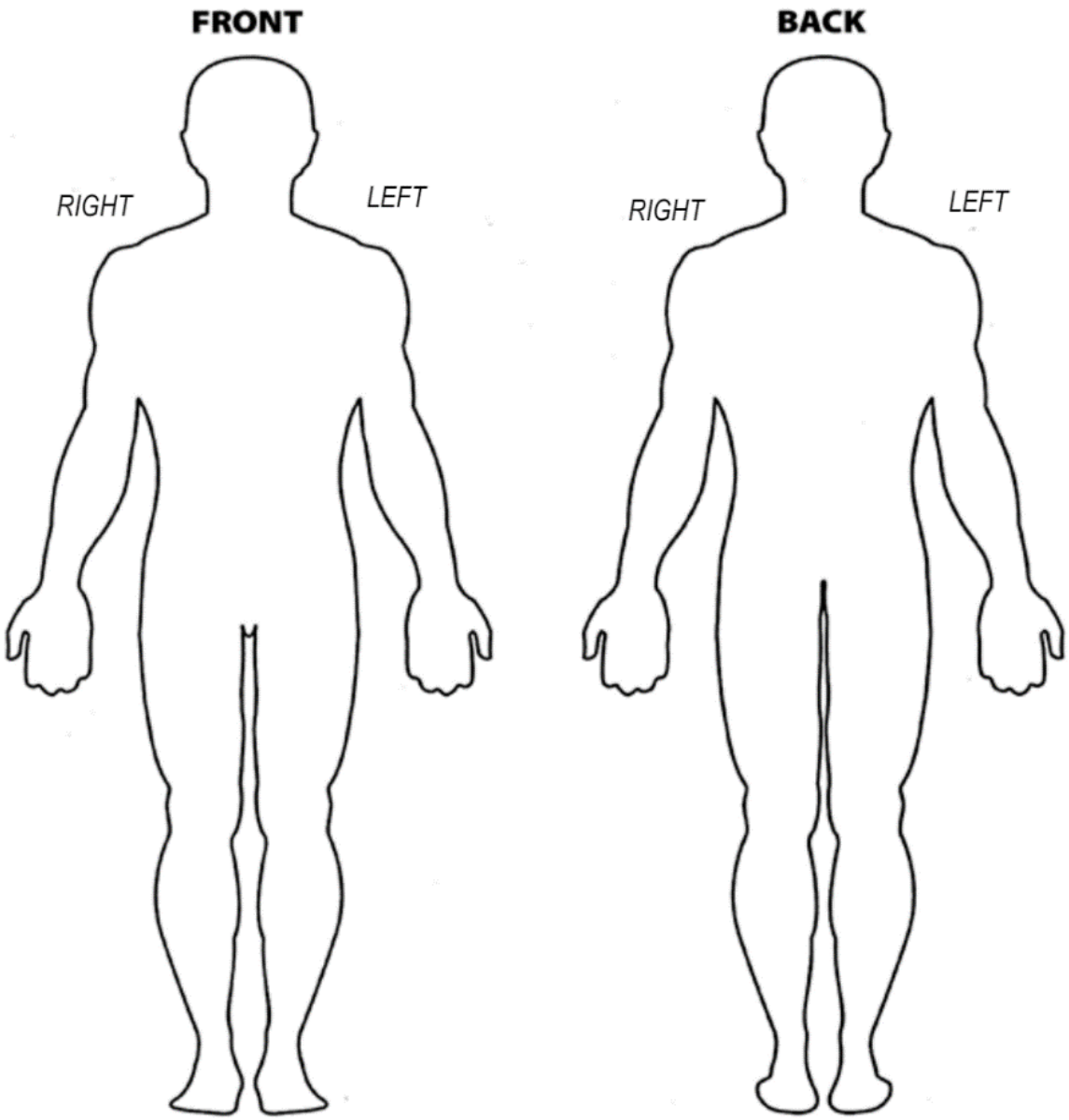
_____

_____

_____

_____

WHERE IS YOUR PAIN?



Burning	ooooo
Aching	xxxxxx
Pins/Needle	///////////
Numb	+++++