NARAYANA
HEALTHCARE ALLIANCE

For Staff Use
Reviewed: Y / N
Date: _____
Initialed: _____

New Patient Information Packet

Patient Demographics

First Name: _____ Middle: _____ Last: _____

Patient's Address:_____

City: _____ St: _____ Zip:_____ Email: _____

Home Phone: _____ Work Phone: _____ Cell: _____

SSN: _____--____--_____ Gender: M F Date of Birth: _____/_____/_____

Marital Status: Single Married Divorced Widowed Legal Separated

Employment Status: Employed Self-Employed Unemployed Disabled Retired
Part-time Student Full-time Student

If employed, where?_____

Insurance Information

Insurance Carrier: _____

Group #: _____ Start Date: _____ Member ID: _____

Is the patient the subscriber/policy holder: Y / N

If no, patient's relationship to subscriber: Child Wife Husband Parent Special Dependent
Grandparent Aunt Uncle Grandchild Niece Other

If no, subscriber's name: _____ SSN: _____--____--_____

Gender: M F Date of Birth: _____/_____/_____

Marital Status: Single Married Divorced Widowed Legal Separated

Employment Status: Employed Self-Employed Unemployed Disabled Retired
Part-time Student Full-time Student

If employed, where?_____

Subscriber's Address (if different from patient): _____

City: _____ St: _____ Zip:_____ Email: _____

Home Phone: _____ Work Phone: _____ Cell: _____

For Staff Use
Reviewed: Y / N
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Initialed: _____

Emergency Contact

Emergency Contact Name: _____ Gender: ☐ M / ☐ F

Home Phone: _____ Work Phone: _____ Cell: _____

Relationship to patient: _____

Parent/Guardian (If patient is minor, please complete)

Parent/Guardian same as Emergency Contact: ☐ Y / ☐ N

Parent/Guardian Name: _____

Relationship to patient: _____

SSN: _____ Gender: ☐ M / ☐ F

Home Phone: _____ Work Phone: _____ Cell: _____

Pharmacy

Preferred Pharmacy: _____ City: _____ Phone: _____

I understand that I am requesting to receive care from Narayana Healthcare Alliance LLC. I also authorize the clinic to contact my emergency contact in case of emergency. Also, by leaving my contact numbers I am consenting to leaving messages regarding my care and appointments. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

_____

Patient Printed Name

_____ _____

Patient's Signature Date

Patient Medical History

Patient Name: _____ Chart #: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: _____ Primary Care Physician: _____

How were you referred to us? ☐ Self ☐ Work Comp ☐ Chiroprator ☐ Primary Care Physician

What is the main reason for this visit? _____

On a scale of 0 to 10 what number would you give your pain today? _____ (0 no pain, 1-3 mild, 4-6 moderate, 7-10 severe)

PAST HEALTH HISTORY OF PATIENT - Please check **Y** or **N** for each condition listed below. **Do not leave any blanks.**

Metabolic Disease
- Diabetes ☐Y☐N
- High Blood Pressure ☐Y☐N
- Thyroid Disease ☐Y☐N
- Osteoporosis ☐Y☐N

Pulmonary Disease
- Pneumonia ☐Y☐N
- Asthma ☐Y☐N
- COPD ☐Y☐N
- Tuberculosis ☐Y☐N

CNS Disease
- Stroke ☐Y☐N
- Seizure ☐Y☐N

Cardiac Disease
- Heart Attack ☐Y☐N
- Angina ☐Y☐N
- Heart Murmur ☐Y☐N
- Arrhythmia ☐Y☐N
- Valve Problems ☐Y☐N

Psychiatric Disease
- Depression ☐Y☐N
- Schizophrenia ☐Y☐N
- Bipolar Disorder ☐Y☐N

GI Disease
- Ulcer ☐Y☐N
- Gall Bladder ☐Y☐N
- Hernia ☐Y☐N
- GI Bleed ☐Y☐N
- Obstruction ☐Y☐N

Urologic Disease
- Urinary Tract Infection ☐Y☐N
- Kidney Stone ☐Y☐N
- Dialysis ☐Y☐N

Cancer
- Location _____
- Year Diagnosed _____
- Reoccurrence ☐Y☐N
- Current Treatment ☐Y☐N

Infections
- After Surgery ☐Y☐N
- Venereal Disease ☐Y☐N
- Hepatitis ☐Y☐N
- AIDS ☐Y☐N
- HIV Positive ☐Y☐N
- Osteomyelitis ☐Y☐N

Blood Disorders
- Anemia ☐Y☐N
- Clotting Problems ☐Y☐N
- Hemophilia ☐Y☐N

Arthritis ☐Y☐N
- Rheumatoid ☐Y☐N
- Osteoarthritis ☐Y☐N
- Gout ☐Y☐N

Miscellaneous
- Blood Clots ☐Y☐N
- Thrombophlebitis ☐Y☐N
- Prior Blood Transfusion ☐Y☐N

Explain any other conditions not listed above that you have been diagnosed with: _____

_____

SURGICAL PROCEDURES (include approximate dates): ☐ **NONE**

_____ _____

_____ _____

_____ _____

_____ _____

Have you ever had a problem with anesthesia? ☐ No ☐ Yes If yes, explain _____

ALLERGIES: ☐ **NONE**

Medication / Other	Reaction	Severity of Allergy - circle level of severity
_____	_____	Mild ☐ Moderate ☐ Severe ☐ Intolerant ☐
_____	_____	Mild ☐ Moderate ☐ Severe ☐ Intolerant ☐
_____	_____	Mild ☐ Moderate ☐ Severe ☐ Intolerant ☐
_____	_____	Mild ☐ Moderate ☐ Severe ☐ Intolerant ☐
_____	_____	Mild ☐ Moderate ☐ Severe ☐ Intolerant ☐

Reaction Examples: *Unknown, Breathing Difficulty, Nausea, Rash, Anaphylaxis, Vomiting, Diarrhea, Hives, Dizziness*

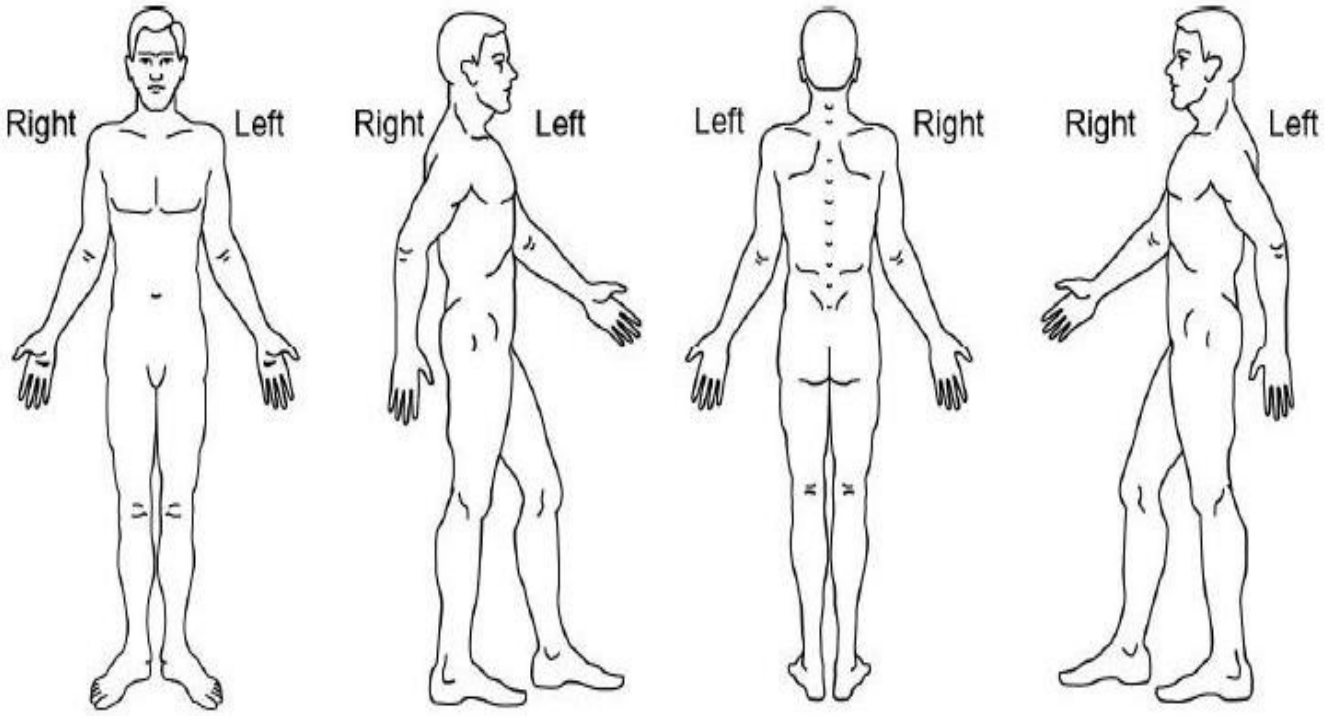
CURRENT MEDICATIONS: ☐ **NONE** *Include medications prescribed by a physician, Over-the-Counter (OTC), Herbal Supplements and Vitamins.*

Medication & Dosage	Prescribing Physician	Medication & Dosage	Prescribing Physician
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	

PAIN RATING

On a scale of 0 to 10, "0" being no pain and "10" being the worst pain imaginable, circle the number below that describes your level of pain:

No pain = 0 1 2 3 4 5 6 7 8 9 10 = Worst pain imaginable.



SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

HIPAA Acknowledgement Form

This notice describes how our practice may use/or disclose your protected health information (PHI). PHI is the individual identifiable health information including actual medical information, your name, address, phone number, identification number, insurance information, or other identifiers. Please review this notice carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandates that patients be provided with advance written notice of the practice's policies regarding the use and/or disclosure of protected health information. The notice takes effect April 14, 2003.

A patient's information may be used and/or disclosed for the following reasons:

Treatment- we may use PHI to provide you with medical treatment or services. This includes communications between other health care professionals, other healthcare facilities, and other providers for administering treatment.

Payment - we may use and/or disclose your PHI so the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third-party. This includes typical payment activities such as verification of coverage, pre-certification, referrals, and claims processing.

Administrative or Healthcare Operations Activities - we may use and or disclose medical information about you for certain administrative, healthcare and management activities, such as compliance monitoring, quality improvement, and business planning. These uses and or disclosures are necessary to run the practice and to ensure that our patients receive quality care and services.

For Communicable Diseases/Public Health Safety - we may disclose your PHI if Authorized by law, if the public may have been exposed to a communicable disease.

For Legal Proceedings - we may disclose PHI in response to a court order.

The patient reserves the right to request restrictions on the policies listed in this notice, and receive a copy of all information used and or disclosed. Request for patients own PHI will be provided only with a photo proof of identification from the patient. You have the right to designate a personal representative to authorize the disclosure of protected health information.

We reserve the right to contact patients regarding appointments. Also, please be advised we have open adjusting areas. If you wish any discussion to be confidential please request a private room. If you believe your privacy rights have been violated with respect to our protection of your PHI please contact us in writing.

I hereby verify that I have read and understand this notice of privacy practices.

Patient/Representative Signature_____Date_____

Financial Policy

Patient Name: _____ Date:_____

Thank you for choosing Narayana Healthcare Alliance LLC. We strive to offer the best healthcare services to our patients. Part of that service is providing transparency regarding any financial responsibilities. If at any time during your visit you have questions or concerns regarding your potential costs of services, please alert one of our team members.

Please review the following.

1. Narayana Healthcare Alliance LLC verifies your benefits with your insurance company prior to each visit. Verification of your benefits with your insurance company is not a guarantee of benefits or payment. You are responsible for paying any out-of-pocket expenses as part of your benefit coverage. Copayments, deductibles, and coinsurance for clinic visits are due at the time of the service, in accordance with the carrier 's plan. If you are unable to pay at the time of services, NHA reserves the right to reschedule your appointment. Be advised having more than one insurance policy is not a guarantee that all of your out-of-pocket expenses will be covered.
2. Assignment of Benefits: In consideration of the treatment being rendered, you hereby irrevocably assign any and all insurance benefits you have to Novus Spine & Pain Center for services provided to you. You understand you remain personally financially responsible for any services not covered by your insurance benefits or plan.
3. Your insurance policy is a contract between you and your insurance cerrier. You are ultimately responsible for payment, in full, for all medical services provided. Any charges not paid by the carrier will be your responsibility, except as limited by the Practice's specific network agreement with your insurance carrier, if such an agreement is in place.
4. Coverage changes and timely submission. Is it your responsibility to timely inform us of any change to your billing or insurance information. Your insurance carrier places a time limit within which a claim can be submitted on your behalf. If NHA is unable to process your claim within this period due to incorrect insurance information or not responding to insurance carrier inquiries, you will be responsible for all charges.
5. Insurance Plan Participation. NHA has specific network agreements with many insurance carriers, but not all. It is your responsibility to contact your insurance carrier to verify that your assigned provider participates in your plan. Your insurance carrier may have out-of-network charges that have higher deductibles and copayments, which you will be responsible for. If your insurance plan requires you to have a referral, it is your responsibility to obtain this referral. Without a referral, you will hold financial responsibility for the visit and subsequent services rendered. NHA, as a courtesy to our patients, will make a good-faith effort to obtain prior authorization, if needed. Ultimately, it is your responsibility to ensure that the service provided to you is covered in your benefits and authorized by the insurance carrier.
6. If your insurance carrier does not pay for services within a reasonable time, we may transfer the balance to your sole responsibility. Plesae follow up with your carrier for non-payment issues. If you have an outstanding balance of over 90 days and have failed to make payment arragements we may turn your balance over to a collection agency and/or an attorney for collection.
7. Medication refill requests are to be approved by the provider. A fee of $50.00 will be charged for any of the following requests: lost prescription, urgent refill/office visit (same day or next); and refills processed after a missed appointment.
8. For Self-Pay patients with no active insurance coverage, Narayana Healthcare Alliance LLC offers a flat rate of $300.00 for the initial office visit and $250.00 for each follow-up office visit. Please note separate fees apply for Urine Drug Screens. Additional charges apply for services not included in the office visit (examples procedures, injections, etc.). Payment is required prior to services being rendered.
9. If your balance is not paid or a payment arrangement has not been made after two (2) attempts to collect, a $25 service charge, may be assessed as a late fee on your account.
10. There is a charge for completing individual medical forms, disability, work restriction, employer forms, school forms, etc. Please allow five (5) business days to process all form requests.

PRACTICE CODE OF CONDUCT

We are pleased to serve you and glad you chose us for your pain management care. We will always strive to provide exceptional care for you. Reasons that NHA may ask you to seek health care services elsewhere include: rude or violent behavior to staff via phone or in-person, repeat no shows or cancellations or continued late arrivals, refusal to adhere to the plan of care, failure to adhere to the opioid contract and unwarranted requests for disability paperwork.

By signing below I understand and accept the financial policy for Narayana Healthcare Alliance.

_____ _____

Printed Name Date

_____

Signature

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I consent to medical examination and treatment for myself or for the patient for whom I am the parent or legally authorized representative. (If a patient is a minor, the parent having legal custody, a legal guardian, or a person authorized by them in writing must sign. If a patient is incompetent, a legal guardian or conservator must sign.)

I consent to the use or disclosure of my protected health information by Narayana Healthcare Alliance LLC (NHA) for the purpose of diagnosing and/or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations for NHA. I understand that diagnosis and/or treatment of me by NHA may be conditional upon my consent, as evidenced by my signature on this document.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, and my employer or a health care clearinghouse. This protected health information relates to my past, present, and/or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. NHA is not required to agree to the restrictions that I may request; however, if NHA agrees to a restriction that I request then the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that NHA has taken action in reliance on this consent.

I understand I have the right to review NHA's Notice of Privacy Practices, which has been made available to me, prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, and in the performance of health care operations of the NHA. The Notice of Privacy Practices for NHA is also posted at each office location. This Notice of Privacy Practices also describes my rights and NHA's duties with respect to my protected health information.

NHA reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

I hereby authorize the release of my Protected Health Information to the following individuals (Please Print):

_____

_____

_____

Release of information authorization

Type of authorization: Release of Protected Health Information to a designated person / entry.

Patient Name: _____ **Date of Birth:** _____

Maiden name, if applicable: _____

Address: _____

I authorize (from): _____ to release medical information, about me, to **N**arayana Healthcare Alliance.

Description of information to be disclosed: I authorized a physician/facility noted above to disclose the following protected information about me to the person identified above.

Information requested: _____for the dates of/from _____ to _____. I understand that information in my medical records concerning HIV treatment/status, depression, mental, social, health issues, and drug/alcohol use will be released unless initialed below:

_____ Mental health _____ HIV _____ Drug/Alcohol

Purpose of disclosure: (please circle choice below)

1. Further treatment 2. Personal Records 3. Transfer Care 4. Other: _____

Expirations of Termination of Authorization: This authorization will expire upon completion of this transaction. You have the right to terminate this authorization at any time. This request will be honored except to the extent of any action already taken on this authorization prior to revocation.

Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by requesting so.

Re-disclosure: We have no control over the person(s) you have listed to receive your protected in health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirement to the Privacy Rule and will no longer be the responsibility of Narayana Healthcare Aliance LLC. **I understand that if I refuse to sign and agree with this release, but in doing so, I will not have access to my records.**

Patient Signature: _____ **Date**: _____

Witness Signature: _____ **Date**: _____

OPIATE CONTRACT

The long term use of opioid therapy (narcotic analgesics) is somewhat controversial because of uncertainty regarding the extent to which this treatment usually improves the patient's quality of life. There is the potential risk of an addictive disorder. The extent of this risk is not certain. These drugs all have potential for abuse diversion and, accordingly, rather strict accountability is necessary when use is prolonged. In addition to clinical monitoring to determine the benefits of this treatment, accountability is a necessity. For this reason, the following policies are agreed to by treatment recipient as indicated by the signature below.

1. All narcotics must come from the one physician or, during his or her absence, by the covering physician.
2. All narcotics must be obtained by the same pharmacy.
3. The prescribing physician has complete liberty to discuss fully all diagnostic and treatment details with the pharmacists at the dispensing pharmacy for purposes of maintaining accountability.
4. Routine or random urine and/or saliva toxicology screens may be requested at any time.
5. Prescriptions and bottles of narcotic tablets may be sought by other individuals with chemical dependency and should be closely safeguarded. In addition, they may be hazardous or lethal if a person who is not tolerant to their effects, specifically a child, should inadvertently take them. It is expected that the patient will take as much care with the medication and the prescription as would be taken with a Driver's License or a large amount of cash. Early medication will not be given. If the patient uses a month's supply of medication in three weeks, the last week has to be endured without medication. In an event that the medication is not controlling the pain and/or side effects occur, the patient is to bring the medication to be disposed in our office so it may be documented in our records.
6. Medication will not be replaced if they are lost, fall into the toilet, are eating by pets, left in a plane, or for any other reason. If your medication has been stolen and you complete a police report regarding the theft, an exception can be made.
7. Prescriptions may be issued early, for example, if the treating physician is going to be out of town, or the patient will be out of town when a refill is due. However, these prescriptions will contain instructions to the pharmacist not to be filled prior to the appropriate date.
8. If the responsible legal authorities have question concerning the patient's treatment as might occur, for example, if a patient were obtaining medications at several pharmacies, all records of narcotic administration.
9. It is understood that failure to adhere to these policies will result in permanent cessation of narcotic prescribing by this physician.

_____
Patient Name (Printed)

_____ _____
Physician Signature Patient Signature

48 Hour Cancellation & "No Show" Fee Policy for Office Visits

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, our office reserves the right to charge a fee of $75.00 for all missed appointments ("no shows"), or appointments cancelled without 24 hour advanced notice.

It is every patient's responsibility to remember their scheduled appointments. Patients will receive a printout of their appointments after they are scheduled. Reminder calls are an office courtesy and should not be solely relied on.

These fees will be the patient's responsibility. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "no shows" in any 12 month period may result in termination from our practice.

Medication Refill / Procedure Consultation and Imaging Review / Follow- Ups
Late Cancellation / No Show : $75.00

48 Hour Cancellation Policy for Office Procedures

In order for us to maintain our efficiency in the Office, the Procedure Room, as well as giving full consideration to the staff, it is necessary for us to implement a cancellation policy. It is important that when you schedule your procedure you have thoroughly checked your personal calendar to make sure that your scheduled date is ideal for you. Cancelling or rescheduling your procedure requires multiple phone calls to the insurance company and patient.

If you need to cancel your procedure we ask that you do so in a timely manner.
Cancellations less than 48 hours before procedure will be charged a $250 fee.
This fee will not be applied toward your procedure and will be your responsibility. This fee is not billable to insurance. This fee must be paid prior to procedure being rescheduled.

If you do not show up for a scheduled procedure you will be charged a $250 fee.

We thank you in advance for your cooperation and understanding of the procedure scheduling process.

By signing below, you acknowledge that you have received this notice and understand this policy.

Procedure Late Cancellation / No Show : $250.00

_____ _____

Print Name **Sign and Date**