



Medical/Financial Release of Information Authorization

I, _____, hereby authorize Interventional Pain Consultants, LLC to release information regarding my:

Medical Information

Billing Information

Appointment Information

Other _____

If requested by my Primary Care Physician (please list) _____

And any of the following:

Name	Relationship	Phone Number
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Name	Relationship	Phone Number
------	--------------	--------------

Name	Relationship	Phone Number
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Patient Signature	Date
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Representative Signature	Relationship to patient	Date
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Acknowledgment & Consent

I understand that Interventional Pain Consultants, LLC (referred to below as “This Practice”) will use and disclose health information about me.

I understand that my health information may include information both created and received by this practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health related information.

I understand and agree that this practice may use and disclose my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative, and business functions that support my physician’s efforts to provide me with, arrange, and be reimbursed for quality, cost-effective healthcare.

I also understand that I have the right to receive and review written description of how this practice will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other office personnel of this practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or summary of the most current version of this practice’s Notice of Privacy Practices in effect will be posted in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that this practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of this Notice of Privacy Practices (if I have requested a copy).

By: _____ Date: _____
(Patient Signature)

OR

By: _____ Date: _____
(Patient Representative)



Financial Guidelines

Interventional Pain Consultants, LLC would like to welcome you. Please review the following policies and guidelines; if at any time you have questions or concerns please contact our office staff.

Insurance Co-Pays, Deductibles and Co-Insurances: Please remember our relationship is with you, and we will bill your insurance company as a courtesy. Any unpaid insurance balances (with the exception of contractual obligations) will be your financial responsibility. If we do hold a contract with your insurance company, our contract requires that we collect all co-pays and deductibles at the time of service. If you do not have your co-pay or deductible at the time of service, your appointment will be rescheduled. If you have a co-insurance due we request that you pay at the time of service. However; you may choose to pay your co-insurance when you receive your first billing statement.

Past Due Balances and NSF Fees: If you have not settled your past due balance with our office, you will not be rescheduled for any future appointments until the balance has been resolved. Any balances that have not been resolved within a timely manner will be turned over to collections. For all checks that are returned by the bank we will assess a \$25.00 returned check fee to your account.

Private Pay and Payment Options: Payments are due in full at the time of service. If you are not able to pay in full at the time of service, please contact our billing department for payment arrangements. If you pay in full at the time of service you will receive a 25% discount. We accept CASH, CHECK, and VISA, or MASTERCARD.

Cancellation Policy: If you are not able to keep your appointment we require a 24-hour notice of cancellation. If you do not show up for your appointment you will be assessed a no-show fee. Fees will be determined by the billing department and your physician.

Authorization to Release and Assign Insurance Benefits: I authorize release of any information required to act on any insurance claim, and permit photocopy or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to Interventional Pain Consultants, LLC the medical and/or surgical benefits I am entitled from my insurance company and/or Medicare.

This authorization is in effect for all future claims until I choose to revoke it in writing.

I, the undersigned, understand and agree to the above Financial Guidelines. I understand that I am financially responsible for all charges incurred for my medical treatment.

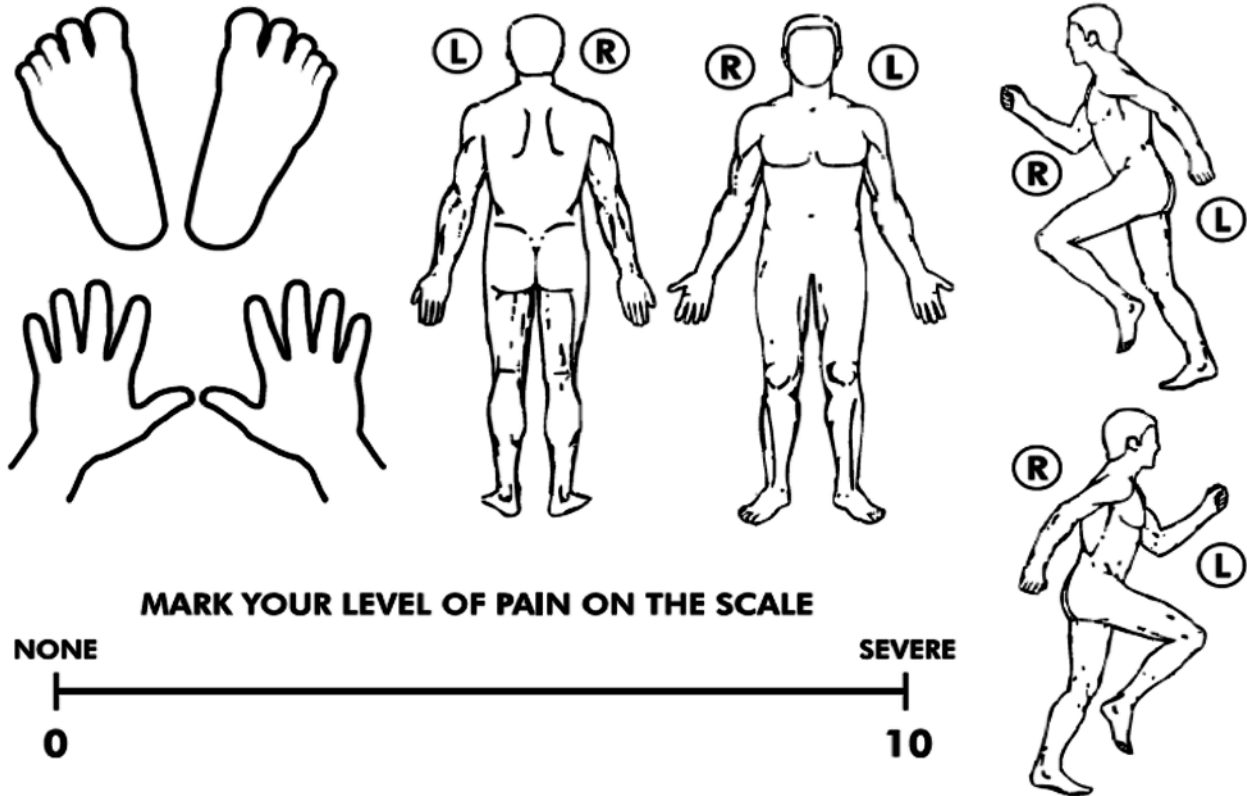
Patient Signature/Authorized Signature

Date

Printed Name of Patient

Relationship to Patient

Description of Pain



Circle a Few Words that Describe Your Pain

- | | | | | | |
|------------|------------|----------|-------------|-------------|-----------|
| Flickering | Pricking | Pinching | Crushing | Hot | Tingling |
| Quivering | Boring | Pressing | Tugging | Burning | Itchy |
| Pulsing | Drilling | Gnawing | Pulling | Scalding | Smarting |
| Pounding | Stabbing | Cramping | Wrenching | Searing | Stinging |
| Dull | Tender | Cool | Troublesome | Spreading | Tight |
| Sore | Tiring | Cold | Miserable | Radiating | Numb |
| Hurting | Exhausting | Freezing | Intense | Penetrating | Drawing |
| Aching | Nagging | Annoying | Unbearable | Piercing | Squeezing |

Patient Name: _____ Date: _____

Review of Systems

Have you recently experienced any of the following? *(Please circle YES or NO)*

General

Tire easily, weakness	YES	NO
Marked weight change	YES	NO
Night sweats	YES	NO
Persistent fever	YES	NO

Cardio/Respiratory

Chest pain	YES	NO
Palpitations	YES	NO
Shortness of breath	YES	NO

Digestive System

Nausea	YES	NO
Vomiting	YES	NO
Constipation	YES	NO
Diarrhea	YES	NO

Genitourinary System

Increased frequency	YES	NO
Feel the need to urinate	YES	NO
Incontinence	YES	NO
Pain with urination	YES	NO

Endocrine

Thyroid trouble	YES	NO
Adrenal trouble	YES	NO
Diabetes	YES	NO

Hematology

Abnormal bleeding	YES	NO
Abnormal bruising	YES	NO

Neurologic

Numbness	YES	NO
Weakness	YES	NO
Headaches	YES	NO

Eyes

Trouble seeing	YES	NO
Eye pain	YES	NO
Inflamed eyes	YES	NO
Double vision	YES	NO

Ears

Loss of hearing	YES	NO
Ringing	YES	NO

Skin

Rash	YES	NO
Change in color	YES	NO
Change in hair	YES	NO
Change in nails	YES	NO

Psychiatric

Anxiety	YES	NO
Depression	YES	NO
Bipolar Disorder	YES	NO

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Name: _____ Date: _____

DOB: ____/____/____

History of Present Illness

How long has your pain been present? _____

How did the injury take place? _____

Is there anything that relieves your pain? _____

Is there anything that worsens your pain? _____

Where in your body does your pain radiate to? _____

Associated Signs *(please circle)*: Numbness · Fatigue · Poor Sleep · Depression · None

Previous Therapies *(please circle)*: Physical Therapy · TENS · Acupuncture · Chiropractics · None

Injections *(please list)*: _____ Other: _____

Medicines Taken Regularly

Medication	Milligrams Daily	Dose

Patient Questionnaire · pg 2

Past Medical History

Arthritis	YES	NO	Other: _____
Back Trouble	YES	NO	_____
Asthma	YES	NO	_____
High Blood Pressure	YES	NO	_____
Heart Disease	YES	NO	_____
Hepatitis	YES	NO	_____
Diabetes	YES	NO	_____
Thyroid Trouble	YES	NO	_____

Medication Allergies

Tetanus Antitoxin	YES	NO	List: _____
Penicillin	YES	NO	_____
Sulfa	YES	NO	_____
Others	YES	NO	_____

Surgeries

Tonsils	YES	NO	YEAR_____	Thyroid	YES	NO	YEAR_____
Appendix	YES	NO	YEAR_____	Heart	YES	NO	YEAR_____
Gallbladder	YES	NO	YEAR_____	Hernia	YES	NO	YEAR_____
Stomach	YES	NO	YEAR_____	Back	YES	NO	YEAR_____
Breast	YES	NO	YEAR_____	Neck	YES	NO	YEAR_____
Uterus/Ovary	YES	NO	YEAR_____	Other: _____			
Hernia	YES	NO	YEAR_____	_____			

Hospitalizations *(Other than for surgeries):*

List: _____

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Family History

Leukemia	YES	NO	Other: _____
Heart Disease	YES	NO	_____
Lung Disease	YES	NO	_____
Tuberculosis	YES	NO	_____
High Blood Pressure	YES	NO	_____
Diabetes	YES	NO	_____
Thyroid Trouble	YES	NO	_____
Cancer	YES	NO	_____

Social History

Do you drink alcohol?	YES	NO	Amount per day: _____
Do you smoke cigarettes?	YES	NO	Amount per day: _____
History of substance abuse/addiction?	YES	NO	
Have you ever been through Detox?	YES	NO	

Explain: _____
