Pain & Rehabilitation Consultants

Welcome to Pain & Rehabilitation Consultants.
We provide our patients with management of chronic pain and many other challenging pain problems utilizing a multidisciplinary approach.

We hope that you will be pleased with our thorough efforts to reduce your pain and provide you a better quality of life.
The first step in getting treatment for your chronic pain will be a medical evaluation with a thorough exam to establish the source of your pain.

Please complete the attached paperwork to include the medical questionnaire and bring to your initial visit.
For our providers to better understand some of your pain complaints, please bring any previous medical records, diagnostic studies, lab work, or any other information pertaining to your pain to your evaluation.

Please contact our office with any further questions you may have:
For our Madison location: 256-464-7855
For our Albertville location: 256-660-1315.

We look forward to working with you!

Pain & Rehabilitation Consultants

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How did you hear about PRC?_____

Doctor Referral:_____PCP Name:_____

Patient Information:

Last Name:_____First Name:_____Middle:_____

D/O/B:_____SSN:_____Marital Status:_____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____Cell phone:_____

Employer:_____Occupation:_____

Emergency Contact:_____Phone Number:_____

Relationship:_____

Insurance Information:

Name of Primary Insurance:_____Member ID:_____

Group #:_____Copay:_____Relationship to Insured:_____

Primary Name of Insured:_____D/O/B:_____

Name of Secondary Insurance:_____Member ID:_____

Group #:_____Relationship to Insured:_____

Primary Name of Insured:_____D/O/B:_____

Patient Condition Information:

Reason for visit:_____

Job Related: YES or NO Auto Accident: YES or NO

Are you represented by an attorney: YES or NO Attorneys Name:_____

(Please see front desk if you answered yes to either of the previous two questions)

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Statement of Patient Financial Responsibility

Patient Name: _____ **DOB:** _____

Pain & Rehabilitation Consultants appreciates the confidence you have shown in choosing us to provide your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. Please be aware of your insurance carrier coverage for Nurse Practitioner /Physician Assistant, as this is part of your treatment staff. Also, please be aware of your insurance carrier coverage for urine drug screens as they also are a part of your treatment. ***You are responsible for any amounts not covered by your insurer.*** If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full. **You are responsible for notifying our billing department of any coverage changes**. If you fail to update our office in a timely manner your claim may be denied for timely filing and you will be responsible for the balance in full.

I have read the above policy regarding my financial responsibility to, Pain & Rehabilitation Consultants LLC., for providing services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Pain & Rehabilitation Consultants the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature _____ **Date** _____

Guarantor Signature _____ **Date** _____
(If guarantor is not the patient)

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature _____ **Date** _____

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Consent for Treatment and Authorization to Release Information

I hereby authorize Pain & Rehabilitation Consultants through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize Pain & Rehabilitation Consultants to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment. A photocopy will be as valid as the original. I authorize the release of any information to insurance carriers concerning my diagnosis and treatments and I assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance for this authorization.

If the patient has Medicare: I certify that all the information given to me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request payment of authorized benefits be made on my behalf and assign the benefits payable for physician services to Pain & Rehabilitation Consultants.

If the patient has Tricare: I hearby agree to accept full responsibility for any co-pays or cost shares that are considered part of my other health insurance (OHI) plan even though making these payments may result in PRC being paid an amount in the excess of the 115% balance billing limit set by Public Law 102-396. I also understand that Pain & Rehabilitation Consultants may bill me for any cost share or co-payment that is not paid at the time of service.

I acknowledge I have been given the opportunity to read Pain & Rehabilitation Consultants Notice of Privacy Practices.

Patient/Guarantor Signature _____ **Date** _____

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Patient Information & Policies

*_____**Privacy Notice:** I hearby acknowledge that I have received the Notice of Privacy Practices from Pain & Rehabilitation Consultants.

*_____**Consent to Treat:** I hearby authorize and consent to the performance of examinations, diagnostic procedures, and treatments which my physician and I agree are necessary. I understand that no guarantee has been made as to the results of the care, treatment, and/or medications given to me.

*_____**Patient Financial Responsibility:** I understand that as a courtesy to me, Pain & Rehabilitation Consultants will submit charges related to my care to my primary and secondary insurance carriers. It is my responsibility to resolve any question regarding coverage, benefits, or payments for services provided. I am financially responsible for any covered or non-covered services which are not paid by my primary or secondary insurance and any charges over sixty days will be considered delinquent, and become my responsibility with payment due from me plus a processing fee of 3% of the outstanding balance per month. **My outstanding balance may be submitted to small claims court if I fail to pay my bill or have not made acceptable payment arrangements. In addition, I will be responsible for all court costs, filing fees, and attorneys fees should this account require litigation. Pain & Rehabilitation Consultants may place any delinquent account with a collection agency and I am responsible for all collection agency fees.** I authorize Pain & Rehabilitation Consultants to verify my employment with my employer in accordance with federal law.

*_____**Non-Covered Services:** I understand that there may be treatments necessary to be a patient at Pain & Rehabilitation Consultants that are not covered by my insurance and these services will be my financial responsibility. Services include but not limited to: urine drug screens, lab work, durable medical equipment, and injection therapy. I am aware these services will be used in my treatment as my physician believes it will be an effective form of treatment.

*_____**Payment Options:** I understand that Pain & Rehabilitation Consultants accepts, cash, credit card, debit card, money orders, and cashier checks as a form of payment. We **do not** accept personal checks.

*_____**No Insurance Coverage:** I agree to pay Pain & Rehabilitation Consultants the full and entire amount of $450.00 for treatment given to me or the above name patient at the initial visit (urine drug screen included) and pay the fee of $185.00 for each follow-up visit. I also understand that urine drug screens will be performed according to the practice policies and I will be prepared to pay the fee of $85.00 when required.

Pain & Rehabilitation Consultants

Patient Information & Policies Continued

*_____**Injuries and Accidents Involving Legal Litigation:** We will not accept third party billing if your injury or accident involves litigation. Our services are provided to you, the patient, not to your attorney. If you are involved in current litigation, services will not be provided unless the case is closed. Once your case has been closed a written letter from your attorney will be required prior to services being rendered.

*_____**Cancellation/No Show Policy:** We understand that there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24 hours prior to your scheduled appointment to cancel. Any office or procedure no show or cancellation less than 24 hours in advance will incur a fee of $100.00 to be paid prior to your next office visit. I understand that if I no show for two consecutive appointments or cancel three times in one year I will be discharged from Pain & Rehabilitation Consultants.

*_____**Medication Refills:** I understand that if I cancel or no show my monthly follow-up visit, my medications will not be refilled until I am seen in office again. I understand that if my medications or lost or stolen, I am not guaranteed a medication refill. Proper paperwork will have to be shown and refill of my medication will be at the discretion of the provider. If I do pick up a prescription for any time other than my scheduled monthly follow-up visit, I will incur a $25.00 fee to be paid prior to receiving my prescription. **Please be aware that a 24 hour notice for a prescription refill is required by calling the office.**

*_____**Paperwork Completion:** I understand that if I need any paperwork completed, I will incur a $25.00 fee per paperwork request. Paperwork completion includes but not limited to: prior authorizations, letters, and certain forms.

*_____**Interventional Procedure Policy:** I understand that if I am advised to schedule for an interventional procedure as a part of my plan of care and choose not to participate in my plan of care as ordered by my physician, a decrease in pain medication will occur at my next scheduled office visit.

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Patient Information & Policies Continued

*_____**Inconsistent Urine Drug Screen Policy:** I understand that if I am prescribed medications by the physician at Pain & Rehabilitation Consultants and have a urine drug screen that is considered inconsistent I will be placed on a probation. The first offense includes a two week prescription with a fee of $25. The second offense includes a two week prescription with a fee of $25 and $150 fee to be paid prior to my next office visit. **Please be aware that a 24 hour notice for a prescription refill is required by calling the office.** If I have three inconsistent urine drug screens, I will be discontinued from my pain medication and offered injection therapy or released from care. At any point in time, I am aware that my physician may discontinue my medication and release me from care due to inconsistent urine drug screen.

*_____**Plan of Care Policy**: I understand that if I am advised to have an imaging study to include but not limited to: MRI, CT Scan, X-ray, EMG, or Punch Biopsy; physical therapy, or a referral to another provider for treatment and choose to not participate as a part of my plan of care as ordered by my physician, a decrease in pain medication will occur at my next scheduled office visit.

*_____**Telephone Call Policy:** I understand that if I have an issue or question to discuss with my nurse regarding my healthcare or current treatment plan that my nurse will return my call within 24 hours. Please be aware that frequent calls to the office within a 24 hour period will result in my release from care.

*_____**Authorization to Verify PDMP**: I understand and give authorization to Pain & Rehabilitation Consultants (providers) to request and verify all pharmacy records from the pharmacy and state database as deemed necessary.

_____	_____	_____
Patient Print Name	Patient Signature	Date

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Chief Complaint (reason for visit):_____
_____

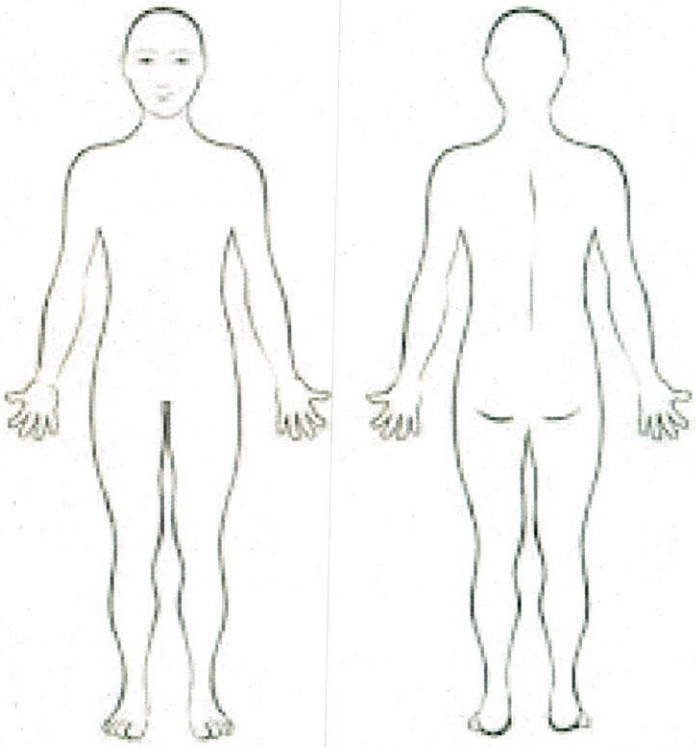
When did your pain begin and was it related to any specific injury?_____
_____
_____

What is your current pain level? 0(no pain) 1 2 3 4 5 6 7 8 9 10 (worst you ever felt)

How low does your pain level get on a daily basis? 0(no pain) 1 2 3 4 5 6 7 8 9 10 (worst you ever felt)

How high does your pain level get on a daily basis? 0(no pain) 1 2 3 4 5 6 7 8 9 10 (worst you ever felt)

Please mark the areas where you have pain in the diagram below:



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Please circle the description of your pain:

Ache Burning Sharp Stabbing Numbness Stinging Tingling Throbbing Nagging
Pressure Soreness Tightness Shooting Heaviness Crushing Electrical Sensation

Injection therapy- please circle if you have ever had any of the following injections:

Cervical Medial Branch Block Thoracic Facet Injections Lumbar Medial Branch Block
Cervical Epidural Injection Lumbar Epidural Injection Lumbar Sympathetic Block
Cervical Radiofrequency Ablation Lumbar Radiofrequency Ablation
Trigger Point Injection Sacroiliac Joint Injection Sciatic Nerve Block

Medication Management- please circle if you have dosed any of the following medications:

*Anti-inflammatory: Ibuprofen Motrin Aleve Advil Naproxen Diclofenac Mobic Celebrex
*Neuropathic: Neurontin Gralise Horizant Lyrica Topamax Trileptal Elavil Cymbalta
*Muscle Relaxer: Flexeril Skelaxin Robaxin Baclofen Zanaflex Soma
*Opiates: Codeine Tramadol Tramadol ER Nucynta Nucynta ER Norco Lortab Vicodin
*Opiates Continued: Oxycodone Percocet Roxycodone Oxycontin Xtampza ER
*Opiates Continued: Oxymorphone Oxymorphone ER Hyrdromorphone
*Opiates Continued: Hydromorphone ER Morphine MS Contin Kadian
*Opiates Continued: Suboxone Butrans Patch Fentanyl Patch Methadone

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Please list any and all medical problems that you have:_____
_____
_____
_____

Please list any surgeries that you have had:_____
_____
_____

Are you currently under a pain contract with another clinic? (Yes or No)_____

Have you been in pain management in the past? (Yes or No)_____

If yes to the above question, what clinic(s) have you been to and the reason for discharge?
_____
_____

Do you use tobacco? (Y or N)_____Type:_____QTY:_____day week month

Do you drink alcohol? (Y or N)_____Type:_____QTY:_____day week month

Do you or have you ever used illicit drugs? (Y or N)_____Type:_____

Do you currently work? (Y or N)_____Full time:_____Part time:_____

Are you disabled? (Y or N)_____How long have you been on disability?_____

Please be aware this paperwork must be completed prior to your initial evaluation. If help is needed with these forms, please arrive 1 hour prior to your appointment for assistance. If the paperwork is not completed, your appointment will be rescheduled.

_____ _____
Patient Print Patient Signature