

Advance Pain Management, LLC

2950 Stone Hogan Connector Rd
Building A Suite B
Atlanta, GA 30331

Phone: 404-781-2800 Fax: 404-844-2903

Patient Information

Last Name: _____ First Name: _____ MI: _____

Address: _____ City/State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security #: _____ Date of Birth: _____ Male/Female: _____

Employer: _____ Title: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Referring Physician: _____ Primary Care Physician: _____

Marital Status: _____ Spouse: _____

Primary Insurance

Primary Insurance Carrier: _____

Mailing Address for Claims: _____

Subscribers Name: _____ DOB: _____ SSN: _____

Insured ID #: _____ Group #: _____

Insured Employer: _____

Secondary Insurance

Note: Advance Pain will bill your secondary insurance as a courtesy. If claims are not paid within 60 days, the balance will be transferred to patient responsibility.

Secondary Insurance Carrier: _____

Mailing Address for Claims: _____

Subscribers Name: _____ DOB: _____ SSN: _____

Insured ID #: _____ Group #: _____

Insured Employer: _____

MVA or Personal Injury

Is your condition the result of a work related injury? _____ Date of injury: _____

Is your condition the result of a motor vehicle accident? _____ Date of injury: _____

State where the accident occurred: _____ was a seat belt worn? _____

Insurance Name: _____ Claim #: _____

Adjustor's Name: _____ Phone #: _____

Authorization

I, _____ agree that the above information is true and I authorize **Advance Pain Management LLC**; to use this information to obtain financial reimbursement on my behalf.

I hereby authorize Advance Pain Management to administer treatment and perform procedures as may be deemed necessary or advisable in my diagnosis. It is my full understanding that I must adhere to the provider's recommendations regarding my care to include a multidisciplinary approach which consists of pharmacological treatment, physical therapy, and various types of patient procedures provided by Advance Pain Management, LLC. I understand that if I fail to comply with the recommended therapies, I may be considered non-compliant which can potentially result in being dismissed from the practice.

I further authorize the release of any medical information necessary to process my insurance claim and request payment of medical services to be assigned directly to Advance Pain Management LLC. In the event that my insurance does not cover services rendered, I agree to be personally and fully responsible for payment. I have read the office policy and understand and agree to its terms. This authorization is to remain in full force unless I revoke the same in writing.

Lastly, I acknowledge the receipt of the Notice of Privacy Practices of Advance Pain Management, LLC on this day.

Patient Signature: _____ Witness: _____

Printed Name: _____ Printed Name: _____

Date: _____ Date: _____

History of Present Illness:

Age: _____ Height: _____ Weight: _____

Where is your pain located? _____

Date your pain began? _____

What caused your pain to begin? _____

Was your pain gradual or sudden? _____

What makes your pain better or worse? _____

Was your injury work related? If so, what date? _____ Where? _____

Describe the occurrence? _____

Was anyone at work notified? _____

Have you pursued legal action for an injury? _____

Who first diagnosed the problem? _____

Where is your worst pain located? _____

Describe your pain quality (circle all that apply): Aching, Burning, Gnawing, Sharp, Shooting, Spasm,
Numbness, Tingling, Pins and needles

Other _____

Severity of pain: On a scale of 1 to 10: what is your pain level? _____

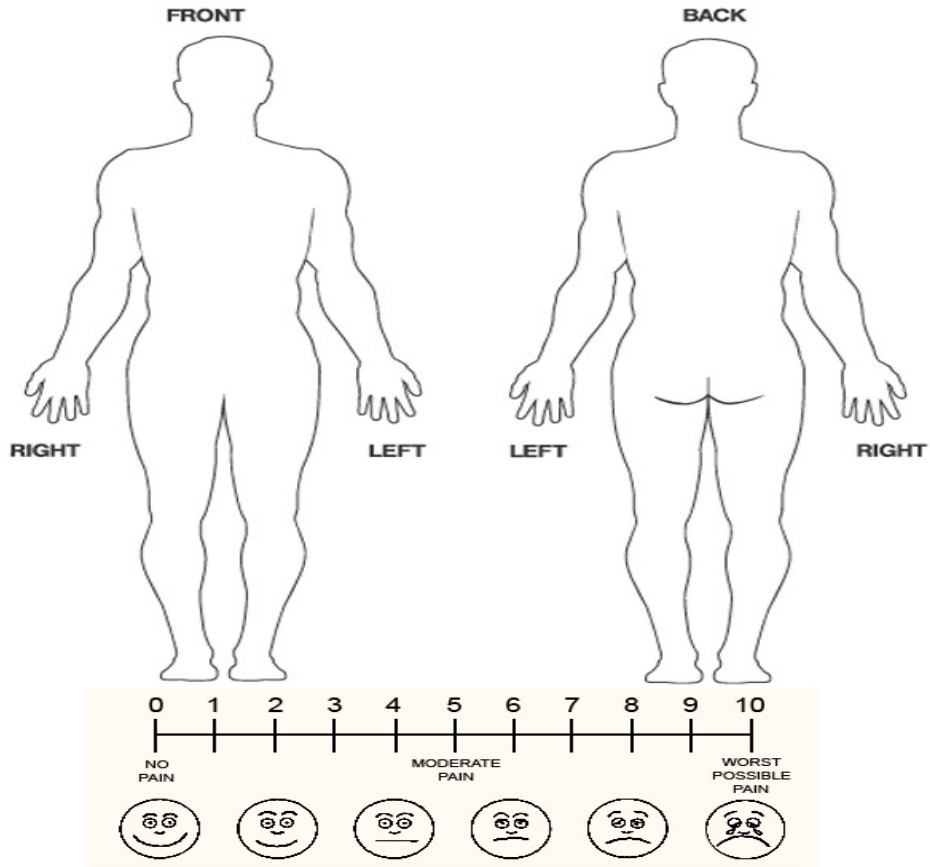
History of loss consciousness? Yes/No _____

If Yes, How long? _____

Any Nausea/Vomiting? _____

Any Headaches? _____

Draw the location of your pain on the body outlines and mark how bad it is on the pain line at the bottom of the page.



How does your pain affect your daily activity?

Does it affect your marital life? Yes/No _____

Does your pain affect your sleep? Yes/No: _____

When you have your pain, how long does it last? _____ is it constant? _____

Or does the pain come and go? _____ Does the pain wake you at night? _____

When is your pain in the least? AM _____ Afternoon _____ Night _____

When is your pain the worst? AM _____ Afternoon _____ Night _____

What aggravates or makes your pain worse? (Circle all that apply): Sitting, Standing, Walking, Bending, Lifting,

Lying Down, Other: _____

What relieves or makes your pain better? (Circle all that apply): Sitting, Standing, Walking, Bending, Laying Down,

Ice, Heat, and TENS unit, Massage Therapy, Other: _____

Is your pain associated with any of the following? :

- Weakness: _____ Where? _____
- Numbness: _____ Where? _____
- Tingling: _____ Where? _____
- Skin color or temperature change: _____ Where? _____
- Bowel or Bladder problems: _____ Where? _____
- Skin sensitive to touch: _____ Where? _____
- Skin sensitive to heat or cold: _____ Where? _____

What tests have you had? _____

- X-Rays: _____ Date: _____ Results: _____
- MRI: _____ Date: _____ Results: _____
- CT Scan: _____ Date: _____ Results: _____
- Myelogram: _____ Date: _____ Results: _____
- EMG/NCV/NCS: _____ Date: _____ Results: _____
- Labs: _____ Date: _____ Results: _____

What treatments have you tried? When/Where? Has it helped with your pain?

- Other Pain Specialists seen: _____
- Steroid Injections: _____
- Radiofrequency Ablation: _____
- Physical Therapy: _____
- Chiropractor: _____
- Ice/Heat: _____ TENS Unit: _____
- Trigger Point Injections: _____ Acupuncture: _____
- Other treatments tried: _____

Medications:

List all of the medication that you are currently prescribed and any non-prescription medications, or supplements that you take; include dose, frequency:

Allergies:

(list any medication that you are allergic to and what reaction you had):

Anticoagulants (Blood Thinners):

Are you taking any blood thinners? Yes/ No: _____

If yes; name, dose, frequency: _____

Date of last INR/PT/PTT result: _____

Previous Surgeries

(list any surgery you have had, date, performing physician):

Past Medical History:

Are you currently, or have you in the past, been treated for any medical condition? Yes/No_____

Please list any medical condition(s) that you have been diagnosed with:

Family History: (list all conditions your immediate family has been diagnosed with and state who)

Social History:

Most Recent Occupation: _____

Current Employment Status: Full-Time Part-Time Retired Disabled

Children living at home? Yes/No _____ Age: _____ Do you live alone? _____

How many hours of sleep do you have nightly? _____

Smoke: Yes/No _____ How much alcohol do you drink? _____

Use illicit drugs? Yes/No _____

Review of Systems:

Do you now or have you had any problems related to the following systems? Circle Yes or No

Constitutional Symptoms

Fever Y N _____
Chills Y N _____
Headache Y N _____
Others _____

HEENT

Blurred vision Y N _____
Glaucoma Y N _____
Cataracts Y N _____
Difficulty hearing Y N _____
Ringing in the ears Y N _____
Sinus problems Y N _____
Nose bleeds Y N _____
Bleeding gums Y N _____
Others _____

Cardiovascular

Chest pain Y N _____
High blood pressure Y N _____
Swelling in legs Y N _____
Murmur Y N _____
Rheumatic Fever Y N _____
Others _____

Respiratory

Wheezing Y N _____
Shortness of breath Y N _____
Frequent cough Y N _____
Asthma Y N _____
Night Sweats Y N _____
Emphysema Y N _____
Sleep Apnea Y N _____
Others _____

Gastrointestinal

Abdominal pain Y N _____
Nausea/Vomiting Y N _____
Heartburn Y N _____
Constipation Y N _____
Reflux Y N _____
Diarrhea Y N _____
Ulcers Y N _____
Hiatal Hernia Y N _____
Diverticulosis Y N _____
Blood in stool Y N _____
Others _____

Genitourinary

Painful urination Y N _____
Frequent urination Y N _____
Urgent urination Y N _____
Urination at night Y N _____
Blood in urine Y N _____
Stones Y N _____
STD Y N _____
Genital infections Y N _____

Hematological/Lymphatic

Swollen glands Y N _____
Clotting problems Y N _____
Easy bruising Y N _____
Easy bleeding Y N _____
Anemia Y N _____
Others _____

Endocrine

Tired/Sluggish Y N _____
Too hot/cold Y N _____
Excessive Thirst Y N _____
Others _____

Integumentary

Skin rash Y N _____
Persistent itch Y N _____
Boils Y N _____
Skin Cancer Y N _____
Psoriasis Y N _____
Moles/warts Y N _____
Others _____

Musculoskeletal

Joint Pain Y N _____
Neck Pain Y N _____
Back Pain Y N _____
Muscle weakness Y N _____
Joint Stiffness Y N _____
Arthritis Y N _____
Gout Y N _____
Others _____

Neurological

Stroke Y N _____
Seizures Y N _____
Tremor Y N _____
Loss of sensation Y N _____
Headaches Y N _____
Numbness Y N _____
Tingling Y N _____
Paralysis Y N _____
Loss of balance Y N _____
Memory loss Y N _____
Dizziness Y N _____
Others _____

Vascular

Varicose Veins Y N _____
Swelling legs/ankles Y N _____
DVT Y N _____
Claudication Y N _____
Others _____

Psychiatric

Anxiety Y N _____
Depression Y N _____
Suicidal thoughts Y N _____
Stress Y N _____
Mood swings Y N _____

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible to for any charges not covered by my health insurance or health care benefits. I understand that if Advance Pain does not accept my health insurance, I am financially responsible for all charges incurred on my behalf. It is my responsibility to notify Advance Pain Management LLC of any change in my health insurance coverage or contact information immediately. I am responsible for the entire bill or balance of the bill as determined by Advance Pain Management, LLC and/or my health insurance if the submitted claims or any part of them are denied payment. I understand that there may be times that the exact insurance benefit cannot be determined until after the insurance company receives the claim.

I will be responsible for all outside collection charges, attorney fees and/or court costs associated with collection of my outstanding balance. It is my understanding that by signing this form I am accepting financial responsibility as explained above for all payment for services received on my behalf. **A 24 hour cancellation notice is mandatory for my scheduled appointment. If I do not notify the office within the 24 hour period, I agree to pay the following for my missed appointment:**

- \$125.00 for a medication or follow- up visit
- \$175.00 for a non-fluoroscope procedure appointment
- \$275.00 for a fluoroscope procedure appointment

I agree to pay a \$30.00 for a returned check fee plus the amount of the check prior to the next scheduled appointment.

Patient Signature: _____

Patient Printed Name: _____

Witness: _____

Date: _____

Pain Management Agreement

The purpose of this Agreement is to prevent misunderstanding about certain medications you will be taking for pain management. This is to both help you and your Doctor to comply with the law regarding controlled pharmaceuticals and provide each patient with the best overall care in regards to managing your pain.

- I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.
- I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.
- I will **never** share, sell, or exchange my medications with anyone for any reason.
- I understand that I am **solely** responsible for the safekeeping of my medications. I will treat my medications as I would any valuable possession. I know that **Advance Pain Management does not replace LOST OR STOLEN prescriptions or controlled medications.**
- I understand that I should not drive or operate heavy machinery while I am taking medications that may cause drowsiness or impaired cognitive function.
- I agree to notify **Advance Pain Management LLC** if I experience any adverse effects or dosage problems with my prescribed medications. I may be asked to bring any unused medication to **Advance Pain Management, LLC** for disposal.
- I agree that if I receive a controlled substance prescription from **Advance Pain Management, LLC** I am **NOT** allowed to accept controlled substance prescriptions from any other physician without my doctor's consent.
- I agree to use only **ONE** pharmacy for my pain-related medications. I will notify Advance Pain in the event that I must change my pharmacy. **I agree to use the following pharmacy: (Name, location, telephone)**

- I understand that medication refill prescriptions involving narcotic pain medicine require a **scheduled appointment** with my Doctor in the office.
**** Narcotic Pain medication refills WILL NOT be called into pharmacy. Narcotic dosages WILL NOT increase by phone.**
- **I agree to keep all scheduled appointments. I understand that no medications will be given for canceled or no-show appointments.** I understand that if I am more than **15 MINUTES LATE** for my scheduled appointment time, I will have to reschedule for another time.

- I cannot be seen at the office **WITHOUT** a scheduled appointment **for any reason.**
- I know that I can be asked to bring **ALL OF MY PRESCRIBED MEDICATIONS** to my office appointment or at a random time for prescription compliance check (**PILL COUNT.**)
- **I understand that abusive behavior or harassment toward any Advance Pain Management LLC staff will not be tolerated. The Physician and Practice Administrator will determine what action may be considered harassment on a case-by-case basis and, if warranted, I may be dismissed from the practice.**
- I understand that dealing with a forged, falsified or altered prescription will result in my immediate dismissal from facility and criminal charges will be pressed to the fullest extent.
- **I understand that Advance Pain Management LLC reserves the right to PREFORM A URINE DRUG SCREEN AT ANY TIME WHILE I AM BEING TREATED WITH PRESCRIBED CONTROLLED SUBSTANCES. If the results of the urine drug screen test negative for the prescribed medicines prescribed by my doctor or test positive for illegal drugs, I understand that I may be dismissed from the practice.**

I authorize the physician and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the State's Board of pharmacy, DEA in the investigation of possible misuse, sale, or other diversion of my pain medicine. I authorize my physician to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy of confidentiality with respect to these authorizations.

This Agreement is entered into on this _____ day of _____, _____

Patient signature _____

Witnessed by _____

Physician signature _____

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MEDICAL RECORDS REQUEST FORM

_____	_____
Patient Name	DOB

Mailing Address	City, State, Zip Code

Release to:

This medical release form authorizes all physicians, hospitals and medical attendants to furnish any and all of my medical reports, history and information to:

Advance Pain Management, LLC
2950 Stone Hogan Connector Rd
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PHONE: 404-781-2800 FAX: 404-844-2903

Any representative of **Advance Pain Management**, concerning my medical condition. This authorization also includes examination of all hospital records, x-ray film and furnishing of any information including opinions. You are further requested not to disclose such information to any other person without written authority to do so. **ALL PRIOR AUTHORIZATION IS HEREBY CANCELLED.**

Please fax documents to:

_____ **404-844-2903**

Physician/Practice name

Complete address

City, State, Zip

Phone

Fax

(Patient's Signature)

(Date)

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To all Advance Pain Management patients:

If there is an issue with ongoing and perceived to be non compliance with the recommended and agreed upon plan of care by you (the patient) and your provider (Attending Physician and Mid-Level) this may result in a **DISCHARGE** from the practice. Patient will receive a 25-day supply of medications as well as a list of other pain management physicians. As a part of our company policy, as well as the DEA, and Georgia Medical Boards, this practice does not and will not manage Chronic Pain with only narcotics and no interventional treatments, or a multi-disciplinary approach. All patients are to comply with the plan of care set by the Attending Physician of which is agreed upon to continue to receive treatment at this facility.

As you well know, each and every patient's care is periodically reviewed by the above listed agencies in order to assure that the standard of care and ongoing compliance is upheld.

If you have any specific questions or concerns please consult with your provider or staff member. The impact of continuously having to review and consult with each patient has a direct impact on the practice as well as other patients whom are compliant and are here to receive the standard of care treatment.

Sincerely,

G. Manchireddy, MD

Patient Signature: _____

Date: _____

