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: _____________________

Martial 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____

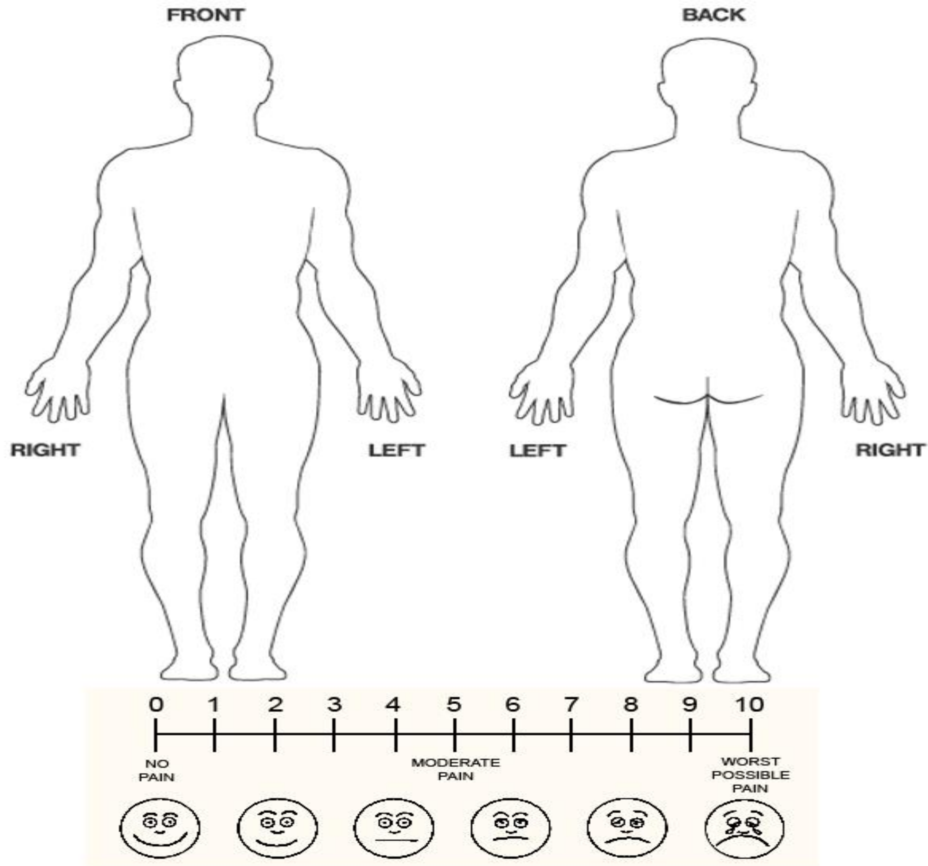
Severity of pain: On a scale of 1 to 10: what is your pain level? __________________________________

History of loss consciousness? Yes/No____

If Yes, How long? _____________________________

Any Nausea/Vomiting? _________________________

Any Headaches? _______________________________



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: ____

<u>**Pain Management Agreement**</u>

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 then the prescribed rate and that use of my medicine at a greater rate will result in my being with out medication for a period of time.
- I will <u>**never**</u> share, sell, or exchange my medications with anyone for any reason.
- I understand that I am <u>***solely***</u> responsible for the safekeeping of my medications. I will treat my medications as I would any valuable possession. I know that <u>**Advance Pain Management does not replace LOST OR STOLEN prescriptions or controlled medications.**</u>
- 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 <u>**Advance Pain Management LLC**</u> if I experience any adverse effects or dosage problems with my prescribed medications. I may be asked to bring any unused medication to <u>**Advance Pain Management, LLC**</u> for disposal.
- I agree that if I receive a controlled substance prescription from **Advance Pain Management, LLC** I am <u>***NOT***</u> allowed to accept controlled substance prescriptions from any other physician without my doctor's consent.
- I agree to use only <u>***ONE***</u> 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 <u>**scheduled appointment**</u> 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 <u>***15 MINUTES LATE***</u> 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 MAY 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____

Advance Pain Management, LLC

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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
Building A, Suite B
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: ______________________