SC PAIN & SPINE SPECIALISTS

PATIENT REGISTRATION FORM

843-839-PAIN (7246) | Fax: 843-839-7323

Patient First Name: _____ Middle Initial: _____ Last Name: _____

Permanent Address: _____

Local Address: _____

Phone: (H) _____ (W) _____ (Cell) _____

Social Security# _____ - _____ - _____ Sex: ☐ M ☐ F Date of Birth: _____

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widow (er)

Employment Status: ☐ Full time ☐ Part time ☐ Retired ☐ Unemployment ☐ Student

Employer / School: _____ Phone: _____

Address: _____

_____ May we contact you at work? ☐ Yes ☐ No

Emergency Contact / Release Medical Information: _____

Phone: _____ Relationship: _____

Allergies: _____

Referring Physician: _____

I authorize SC Pain & Spine Specialists to leave messages on my voice mail or answering machine ☐ Yes ☐ No

I have been given a HIPPA notification form from SC Pain and Spine Specialists _____

(Patient Signature)

INSURANCE INFORMATION:

Primary Insurance: _____

Address: _____ Phone: _____

Guarantor: _____ Relationship: _____

Group# _____ ID#: _____

Subscribers' DOB: _____ Co-Pay: _____ Effective Date: _____

Secondary Insurance: _____

Address: _____ Phone: _____

Guarantor: _____ Relationship: _____

Group# _____ ID#: _____

Subscribers' DOB: _____ Co-Pay: _____ Effective Date: _____

Authorization for release of information and to pay insurance benefits: SC Pain & Spine Specialists is hereby authorized to release information to healthcare providers that have referred me to this physician or who may benefit from this information as they care for me in the future. I authorize release of medical information to my insurance carrier, their utilization management agency, my employer, or any other agency that may be assisting in payment for my care. In the event of hospitalization, I hereby assign payment to SC Pain & Spine Specialists for surgical and/or medical benefits otherwise payable to me.

_____ _____

Signature / Parent or Guardian Date

_____ _____

SCPSS Representative Date

SC PAIN & SPINE SPECIALISTS

NEW PATIENT PAIN EVALUATION FORM

Patient Label

Name _____

Date of Birth _____ Age _____ Phone# _____ Work # _____

Soc. Sec. # _____

Residence _____

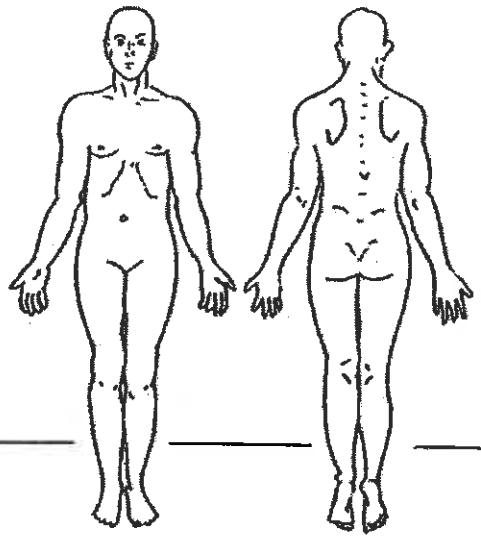
Height _____ Weight _____

Who referred you? _____

Who is your family doctor? _____

Where is your pain? _____

Please show the area of pain on the body diagram below.



R Handed L Handed

T _____ P _____

R _____ BP _____

O2 Sat. _____

CLINICAL SUMMARY:

Clinician Signature: _____

What is the intensity of the pain:

What is the pain at its worse?

No Pain 0 1 2 3 4 5 6 7 8 9 10 **worse**

What is the pain at its best?

No Pain 0 1 2 3 4 5 6 7 8 9 10 **worse**

What is your pain now?

No Pain 0 1 2 3 4 5 6 7 8 9 10 **worse**

When did the pain start? _____

Was there an injury or precipitation event? Yes / No *If so what happened and when?* _____

_____

What studies have been done? MRI CT XRAY MYELOGRAM _____

What therapy has been done to date?	**Help? Yes / No**		**Help? Yes / No**	
☐ Nonsteroid Anti-inflammatory Medication	☐	☐	☐ Brace/ Collar	☐ ☐
☐ Physical Therapy	☐	☐	☐ Epidural Steroid Injections	☐ ☐
☐ Oral Steroids	☐	☐	☐ Chiropractic therapy / OMT	☐ ☐
☐ Pain Medication	☐	☐	☐ Tens Unit	☐ ☐
☐ Muscle relaxants	☐	☐	☐ Surgery	☐ ☐
☐ Other _____	☐	☐		

Other doctors seen for this problem?.....Y / N Who?

Do you have any areas of numbness? .....Y / N Where?

When did numbness start?

Do you have weakness in any area of the body? .....Y / N Where?

When did weakness start?

Have you had any difficulty with bladder control? .....Y / N Bowel Control?.....Y / N

Which would describe your pain right now?

☐ No pain ☐ Mild ☐ Discomforting ☐ Moderate ☐ Severe ☐ Excruciating

☐ Other _____

Describe the pain you have all the time.

☐ aching ☐ burning ☐ sharp ☐ shooting ☐ stabbing ☐ dull ☐ cramping ☐ throbbing ☐ gnawing ☐ tearing

☐ sickening ☐ fearful ☐ cruel ☐ punishing ☐ tender ☐ other _____

Describe pain that comes and goes?

☐ aching ☐ burning ☐ sharp ☐ shooting ☐ stabbing ☐ dull ☐ cramping ☐ throbbing ☐ gnawing ☐ tearing

☐ sickening ☐ fearful ☐ cruel ☐ punishing ☐ tender ☐ other _____

Where Is pain most present? _____

Does pain radiate from main area of pain?.....Y / N Where? _____

What makes the pain worse? (eg: activities or positions)? _____

What makes the pain better? _____

What are you currently taking for pain control? _____ How much? _____

Family History of illness?.....Y / N What? _____

Families past medical history:

Mother: _____ Living? Y / N Age now or at death? _____

Father: _____ Living? Y / N Age now or at death? _____

Social History

☐ Married? ☐ Single? ☐ Divorced? ☐ Widowed?

Children? Y / N How many? _____

Occupation? _____ Are you currently working? Y / N

Do you smoke? Y / N How much a day? _____ How many years? _____

Did you previously smoke? Y / N How much & number of years? _____

Do you drink alcohol? Y / N How much? _____ How often? _____

Military? Y / N Prior or Current

Drug use? Y / N Prior or Current Name of drug(s) _____

Highest Level of Education: Grammar High College

Past Medical History

Universal Medical Condition sheet filled out? Y / N Taking **ASPIRIN**? Y / N

Allergies (medications, hay fever type, iodine/shellfish, latex) Y / N _____

Medical Conditions? Y / N _____

Previous Surgery / Implants / Prosthesis? Y / N _____

Review Of Systems

Birthplace: City_____ State_____ Country_____

Signature of Patient _____

NEUROLOGICAL (Brain and Spine)	Yes	No
Stroke	☐	☐
Seizure	☐	☐
Tumor	☐	☐
Fainting	☐	☐
RLS	☐	☐
Headache	☐	☐
Family history of neurological disease	☐	☐

CARDIOVASCULAR (Heart)		
Open Heart Surgery	☐	☐
Pacemaker / Defibrillator	☐	☐
Murmur	☐	☐
Chest Pain	☐	☐
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Congestive Heart Failure	☐	☐
Mitral Valve Prolapse	☐	☐
High Cholesterol	☐	☐
Atrial Fibrillation	☐	☐
Date of last EKG	☐	☐

RESPIRATORY(Lungs)		
Shortness of Breath	☐	☐
Tuberculosis	☐	☐
Lung Disease	☐	☐
COPD I Emphysema I Asthma	☐	☐
Sleep Apnea / CPAP	☐	☐
Cough	☐	☐
Pneumonia	☐	☐
Bronchitis	☐	☐

ENDOCRINE (Hormones)		
Thyroid	☐	☐
Diabetes	☐	☐

GASTROINTESTINAL (Stomach)		
Peptic Ulcers	☐	☐
Diverticulosis	☐	☐
Rectal Bleeding	☐	☐
Hemorrhoids	☐	☐
Reflux Disease	☐	☐
Irritable Bowel Syndrome	☐	☐
Abdominal pain	☐	☐
Nausea/vomiting	☐	☐
Loss of appetite	☐	☐

GENITOURINARY(Bladder)		
Kidney Dysfunction	☐	☐
Kidney Infections	☐	☐
Bladder Infections	☐	☐
Kidney Stones	☐	☐
Dialysis	☐	☐
Frequency /Urgency	☐	☐
Recent Burning with Urination	☐	☐

DERMATOLOGY(Skin)		
Rashes	☐	☐
Fungal Infections	☐	☐
Skin Cancer	☐	☐
Lumps/Bumps	☐	☐

OPHTHALMOLOGY (Eyes)	Yes	No
Glasses	☐	☐
Cataract Right Left (circle please)	☐	☐
Glaucoma	☐	☐
Acute vision loss	☐	☐
Blindness Right Left (circle please)	☐	☐

HEMATOLOGIC (Blood)		
Leukemia I Lymphoma	☐	☐
Bleeding Disorders	☐	☐
Anemia	☐	☐
Blood Thinners/ difficulty clotting	☐	☐
Easy bruising	☐	☐

OTOLARYNGOLOGY (Ears. Throat)		
Ear Infections	☐	☐
Sinus Problems	☐	☐
Vertigo	☐	☐
Hearing loss	☐	☐

MUSCULOSKELETAL (Arthritis)		
Gout	☐	☐
Fibromyalgia	☐	☐
Osteoarthritis	☐	☐
Rheumatoid Arthritis	☐	☐
Connective Tissue Disease	☐	☐
Lupus	☐	☐
Instability/falling	☐	☐
Muscle weakness	☐	☐

PSYCHIATRIC (Mental)		
Depression	☐	☐
Anxiety	☐	☐
Schizophrenia	☐	☐
Suicidal	☐	☐
Memory Loss	☐	☐

GYNECOLOGICAL (Reproductive)		
Possible Pregnancy	☐	☐
Menopause / Age at time	☐	☐
Periods	☐	☐
Previous Pregnancy / # of Preg(s)	☐	☐
Previous Delivery(s) / # of Del(s	☐	☐
Hysterectomy	☐	☐

MISCELLANEOUS (Other)		
HIV (AIDS) Exposure	☐	☐
Hepatitis Exposure/MRSA	☐	☐
Previous Blood Transfusion	☐	☐
Unexplained recent Weight Loss	☐	☐
Recent Cold / Infection	☐	☐
Other	☐	☐

CANCER		
Radiation	☐	☐
Chemo	☐	☐

VASCULAR		
Leg swelling	☐	☐
Leg blood clot	☐	☐
Lung blood clot	☐	☐

SC PAIN & SPINE SPECIALISTS

Universal Medication Form

Date form started:

Name:	Phone #:
Address:	
Birth Date:	
Emergency contact/phone#	

Immunization Record *(record the date/year of last dose taken, if known)*

Flu Vaccine(s)
Shingles Vaccine(s)
Allergic To / Describe Reaction:

List All Medications You Are Currently Taking.

Prescription and over-the-counter medications (examples: **aspirin**, antacids) and **herbals** (example: ginseng, ginko, vitamin E, garlic, fish oil.) Include medications taken as needed (example: nitroglycerin).

DATE	NAME OF MEDICATION/ DOSE	DIRECTIONS: Use patient friendly directions. (Do not use medical abbreviations.)	DATE STOPPED	NOTES: Reason for taking/Doctor Name

SC PAIN & SPINE SPECIALISTS

AUTHORIZATION FOR RELEASE MEDICAL INFORMATION

1 I hereby authorize _____ to release the following information from the health records of:

Patient Name _____ Medical Record# _____

Birthdate _____ Social Security # _____

Covering the periods of treatment from: _____ to: _____

2 ***Information Released:***

☐ History and Physical ☐ Discharge Summary ☐ Emergency Room ☐ Progress Notes ☐ Consultation Reports

☐ Cardiac Studies ☐ X-RayReports ☐ Laboratory Reports ☐ Nurse's Notes

☐ Other (please specify) _____

Type of access requested: ☐ Copies of the record ☐ Inspection of the records

_____ I understand that this information may include references to or treatments
Please Initial. of drug or alcohol abuse, psychological illness, or test results for HIV/AIDS.

3 ***Purpose of Disclosure:***

☐ Continued Health Care ☐ Personal Reasons ☐ Insurance ☐ Legal

☐ Other _____

4 This authorization expires 60 days from the date signed below and covers only treatment for the dates specified above.

5 I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I understand that redisclosure of this information to a party other than the one designated above is forbidden without additional authorization on my part. This facility is released and discharged of any liability and the undersigned will hold the facility harmless, for complying with this "Authorization for-Release of Medical Information."

6 A photostatic copy of the authorization is to be considered as valid as the original.

7 Fees/charges will comply with all laws and regulations applicable to release of information.

_____ _____

Patient Signature **Date**

_____

Relation to patient

Front 11/11/11

Information To Be Released To:

SC Pain & SPine Specialists | Phone: 843.839.PAIN (7246) | Fax:843.839.7323 | www.SCPainAndSpine.com

SC PAIN & SPINE SPECIALISTS, LLC

Patient Name_____

FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance what to expect and what our office policies are allows for a good flow of communication and enables us to achieve goal. Please read this carefully and do not hesitate to contact a member of our staff with any questions.

1- On arrival, please sign in at the front desk and present your current identification and insurance card at every visit. We will check these against our current records for accuracy and update as needed to ensure that all claims are filed on your behalf with the most current information you have provided us. IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL RECEIVE AN INVOICE AND WILL BE RESPONSIBLE FOR PAYMENT OF SERVICES RENDERRED. YOU WILL HAVE 30 DAYS FROM DATE OF SERVICE TO SUBMIT CORRECT INSURANCE INFORMATION FOR US TO REBILL ON YOUR BEHALF.
2- According to your insurance plan, you are responsible for any and all deductibles, co-pays, and co-insurance.
3- It is your responsibility to understand your benefit plan and to know if a written referral or authorization is required to see a specialist, if preauthorization is required prior to a procedure, and what services are covered.
4- If our providers do not participate in your insurance plan, payment in full will be required when service is rendered. Prior balances must be paid prior to visit or procedure or we reserve the right to reschedule until such time you can pay the balance due.
5- If you have no insurance, we require payment in advance for New Patient fee and all subsequent visits will be required to be paid upon checkin or we reserve the right to reschedule until such time you can pay the balance due.
6- Co-payments are due at time of service. No exceptions will be considered as this is a provider contractual obligation with insurance company and we are bound to Insurance Contractual obligations.
7- Patient balances are billed immediately on receipt of your insurance plan's (EOB) explanation of benefits and is due within 10 days of receipt of your bill.
8- If previous arrangements have not been made with our office, any account balance outstanding greater than 30 days will be considered past due and subject to collection activity. Any outstanding balance that is greater than 90 days will be forwarded to collection agency for further collection activity.
9- Our office offers a one-time installment plan for New Patient fee and/or procedure fees in excess of $200.00. You must sign installment agreement authorizing us to use a debit / credit card to process balance in (3) monthly installments not to exceed 60 days from original appointment / date of service. No more than one installment agreement will be authorized to be in effect per patient. If authorized draft is declined for any reason, the

patient is considered in breach of installment agreement and balance will be due immediately from patient. No further appointments will be honored until past due balances are paid.

10- We require a 24 hour notice of cancellation of appointments and a fee will be imposed should we not receive a 24 hour notice and/or if we receive no notice to cancel / reschedule. Our fees are as follows:

Established Patient No Show Fee	$25.00
New Patient No Show Fee	$50.00
Procedure No Show Fee	$100.00

11- A $30.00 fee will be charged for any checks returned for nonsufficient funds.

12- There will be a minimum of $25.00 Administrative fee for any Medical Record or forms request. All forms requested will require fee paid prior to request generated. All forms and records request will be available for pickup with 72 hours of fee paid.

13- Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Signature of Responsible Party for Patient

_____ Relationship_____Date_____

Signature of Patient

_____Date_____

SC PAIN & SPINE SPECIALISTS

Jason C. Rosenberg, MD
Board Certified
Interventional Pain Management
Board Certified
Neurology

C. Todd Beebe, PA-C
Physician Assistant-Certified

Each insurance carrier has their own rules, policies, and procedures in order to allow payment for services. These are most commonly used terms and definitions that patients need to know prior to receiving health services from a provider. If your plan has a deductible, you must meet this by paying the provider prior to insurance coverage paying for services. If deductible has been met then the carrier will pay a % of the allowed service amounts and a % will be due from the patient to the provider (this is called coinsurance). Patient is responsible for copay at every visit (this is separate from deductible and coinsurance).

Insurance Definitions

Benefit Plan-

A certificate of coverage, summary plan description or other document or agreement which specifies the health care services to be provided or reimbursed for the benefit of a Participant.

Coinsurance-

A payment that is the financial responsibility of the Participant to the Provider under a benefit plan for Covered Services that is calculated as a percentage of the contracted reimbursement rate for such services or, if reimbursement is on a basis other than fee-for-service amount, as a percentage of a Cigna determined fee schedule or as a Cigna determined percentage of actual charges.

Copayment-

A payment that is the financial responsibility of the Participant to the Provider under a benefit plan for covered services - a fixed dollar amount.

Deductible-

A payment for Covered Services calculated as a fixed dollar amount that is the financial responsibility of the Participant to the Provider under a Benefit Plan prior to qualifying for reimbursement for subsequent health care costs under the Terms of a Benefit Plan.

Medically Necessary / Medical Necessity

Means services and supplies that satisfy the Medical Necessity requirements under the applicable Benefit Plan. No service is a Covered Service unless it is Medically Necessary.