



Date of visit: ___ / ___ / _____

New Patient Packet

Demographics:

Patient Name: _____

DOB: ___ / ___ / _____ Gender: M F Social Security Number: ___ - ___ - _____

Address: _____ City: _____ State: ___ Zip: _____

Mobile #: _____ Secondary contact #: _____ (Home Work Other: _____)

Primary Insurance: _____ Insurance ID #: _____

Secondary Insurance: _____ Insurance ID #: _____

Emergency contact name (relation): _____ Contact #: _____

Primary care physician's name: _____ Office #: _____

Were you referred for this visit? YES NO If yes, please write his/her name: _____

How did you hear about Centurion Spine & Pain Centers?

Google Facebook Friend Family TV Radio Print ad Other: _____

Reason for visit/Pain history:

What is the reason for your visit? _____

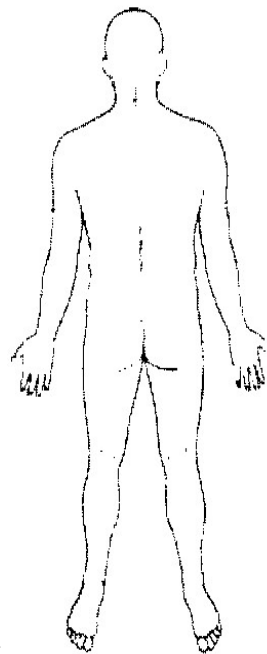
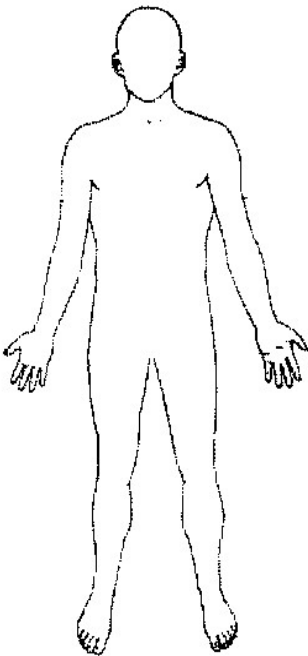
Was there an accident, fall, work injury or motor vehicle accident? YES NO

If yes, please specify: _____

Have you retained an attorney for this accident or work injury? YES NO

If yes, please give the name of your attorney: _____

Please mark on the diagram where you experience your symptoms (X = pain; // = numbness)



Right

Left

Left

Right

When did your pain begin? _____ Has your pain gotten worse, better or the same? _____

Do you recall being treated for this pain before? YES NO

Do you recall seeing a pain management physician before? YES NO

If yes, please give the name of your physician: _____

How did your pain start? _____

On a scale of 0-10 (10 being the worst pain imaginable), what is the:

AVERAGE daily pain: ____ WORST daily pain: ____ BEST daily pain: ____ Is the pain constant? YES NO

How would you describe the pain (choose all that apply):

Achy Burning Sharp Stabbing Dull Pins/Needles Other: _____

Do you experience any numbness? YES NO If YES, where? _____

Do you experience any weakness? YES NO If YES, where? _____

Does the pain spread? YES NO If Yes, where? _____

What makes your pain better? _____

What makes your pain worse? _____

Have you had any of the following therapies/treatments?

Therapy/treatment	Helpful?		Therapy/treatment	Helpful?	
	YES	NO		YES	NO
Physical therapy	YES	NO	Trigger point injections	YES	NO
Chiropractic therapy	YES	NO	Joint injections	YES	NO
Psychological counseling	YES	NO	Nerve blocks	YES	NO
Biofeedback	YES	NO	Epidural steroid injections	YES	NO
Acupuncture	YES	NO	Facet blocks	YES	NO
Brace support	YES	NO	Radiofrequency ablation	YES	NO
TENS unit	YES	NO	Spinal cord stimulation	YES	NO
Massage	YES	NO	Peripheral nerve stimulation	YES	NO
Other:					

Have you had any imaging or diagnostic tests performed?

Study	Month	Year	Hospital, Imaging Center or location
X-ray of the:			
CT scan of the:			
MRI of the:			
EMG/NCV of the:			
Other:			

Do you currently have or in the past 12 months experienced any of the following?

Decreased level of activity	Chronic/frequent cough	Urinary retention
Fatigue	Shortness of breath	Painful urination
Depression	Chest pain	Blood in urine
Anxiety	Heart palpitations	Dark urine
Memory loss	Swelling in hands/feet	Swollen glands
Persistent fever	Enlarged veins	Muscular weakness
Difficulty with sleep	Nausea	Swollen joints
Chills	Vomiting	Joint stiffness
Weight gain	Difficulty swallowing	Muscle aches
Weight loss	Abdominal cramping	Leg cramps
Lightheadedness	Coughing blood	Poor coordination
Dizzy/fainting spells	Heartburn	Dry skin
Hallucinations	Bowel incontinence	Yellow skin
Night sweats	Chronic constipation	Skin rash
Headaches	Chronic diarrhea	Hair changes
Easy bruising/bleeding	Change in bowel habits	Erectile dysfunction
Vision problems	Rectal bleeding	Heavy menstruation
Ringling in ears	Black tarry stools	Irregular menstruation
Hearing loss	Frequent urination	Hives
Seizures	Urinary incontinence	Scarring/keloids

Other symptoms you would like us to know about:

Past Medical History:

Please list your medical problems (high blood pressure, heart disease, cancer, COPD, asthma, diabetes, kidney disease, liver disease, hepatitis, HIV, depression, anxiety, seizures, osteoporosis, etc.):

Past Surgical History:

Please list your previous surgeries/procedures (please include month and year if known):

Allergies (please include type of reaction if known):

Medications (please include dosage and frequency if known):

Are you on any blood thinners? YES NO If yes, please list: _____

What pharmacy do you use?

Name: _____ Phone: _____

Address: _____

Do you recall taking any of the following pain medications in the past?

Medication	Helpful?		Medication	Helpful?	
	YES	NO		YES	NO
Neurontin (Gabapentin)	YES	NO	Robaxin (Methocarbamol)	YES	NO
Lyrica (Pregabalin)	YES	NO	Skelaxin (Metaxalone)	YES	NO
Topamax (Topiramate)	YES	NO	Voltaren (Diclofenac)	YES	NO
Cymbalta (Duloxetine)	YES	NO	Mobic (Meloxicam)	YES	NO
Milnacipran (Savella)	YES	NO	Toradol (Ketorolac)	YES	NO
Effexor (Venlafaxine)	YES	NO	Advil (Ibuprofen)	YES	NO
Elavil (Amitriptyline)	YES	NO	Aleve (Naproxen)	YES	NO
Pamelor (Nortriptyline)	YES	NO	Morphine	YES	NO
Ultram (Tramadol)	YES	NO	Percocet (Oxycodone)	YES	NO
Zanaflex (Tizanidine)	YES	NO	Norco (Hydrocodone)	YES	NO
Flexeril (Cyclobenzaprine)	YES	NO	Other:	YES	NO

Social History:

Relationship status: Married Single Divorced Widowed

Occupation: _____ Unemployed Retired Disabled Student

Do you smoke or use tobacco? YES NO If yes, how often? 1-2x/day 3-6x/day >7x/day

Do you consume alcohol? YES NO

If yes, how often do you drink? Monthly or less 2-4x/month 2-3x/week >3x/week

Do you currently use any illegal and/or non-prescribed drugs? If yes, which? _____

Have you ever used any illegal and/or non-prescribed drugs? If yes, which? _____

Are you in recovery from alcohol or drug abuse? YES NO If YES, when did you quit? _____

Family History (Please list any medical history of your first-degree relatives):

Father: _____

Mother: _____ Siblings: _____

Patient/Doctor Treatment & Medication Agreement

Centurion Spine & Pain Centers is primarily an *interventional* practice as opposed to a *pain medication* management practice.

The purpose of this Agreement is to prevent misunderstandings about certain medicines that might be prescribed for a pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

This Agreement is essential to the trust and confidence necessary in a physician/patient relationship and the trust that the physician undertakes to treat the patient based on this Agreement.

By signing this agreement you will have read, understood, and agreed to these rules:

- If I break this Agreement, my doctor may stop prescribing my medications and I may be DISCHARGED from the practice.
- I will keep Centurion Spine & Pain notified OF MY CURRENT PHARMACY AND THEIR PHONE NUMBER.
- 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 will not use ANY medications that were not prescribed to me or ILLEGAL substances (narcotics) (e.g., heroine, cocaine, methamphetamines, LSD).
- If recommended by the physician, I will submit to an evaluation by an addiction specialist, which may include a psychiatric evaluation and subsequent treatment.
- I will not SHARE, SELL, or TRADE, my medication with anyone.
- I will not attempt to obtain any controlled pain medication from any other doctor or practice.
- I will SAFEGUARD my pain medication from loss or theft. Lost or stolen medicines WILL NOT be replaced.
- Refills of my prescriptions for pain medication will be made only during regular office hours. ALL refill requests must be made THREE business days in advance. NO REFILLS WILL BE AVAILABLE DURING EVENINGS, WEEKENDS, OR HOLIDAYS.
- I understand that I must be seen at a minimum of every NINETY DAYS to request a Schedule II controlled medication (opioid) refill or my refill will be denied until I am seen.
- I authorize my doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation or any possible misuse, sale, or other diversion of my pain medicine. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
- I authorize my doctor to provide a copy of this Agreement to my pharmacy.
- I will submit to a blood or urine test if requested by my doctor to determine compliance with my program of pain control medication.
- I will use my medicine at a rate no greater than the prescribed rate and that use of my medication at a greater rate will result in my being without medication for a period of time.
- If at any time I break my medication contract, I am aware that the local Sheriff's Office may be notified and my records could be released to them.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment and medications have been adequately answered. If requested, a copy of the Agreement has been given to me.

This Agreement has been reviewed and signed on this _____ day of _____ in the year of _____.

Patient Name: _____ Patient Signature: _____

ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF INFORMATION

Assignment of Medicare Benefits:

I hereby authorize and assign all payments and/or authorized Medicare benefits due to me for medical services rendered to me, directly to **Centurion Spine & Pain Centers**. I authorize **Centurion Spine & Pain Centers** to release medical records and other information related to medical services provided by **Centurion Spine & Pain Centers** to Medicare, which is necessary to process claims for services rendered, for the payment of a bill, determination of benefits, appeal of claims, utilization and quality review purposes or health care operations. I direct my insurance company to send payments directly to **Centurion Spine & Pain Centers** to be payable to **Centurion Spine & Pain Centers**. In the event that I receive a check directly from my insurance company payable to me for services rendered by **Centurion Spine & Pain Centers**, I understand that this payment belongs to **Centurion Spine & Pain Centers**. I agree to endorse the back of the check payable to **Centurion Spine & Pain Centers** and promptly deliver the check to **Centurion Spine & Pain Centers**. I understand that I am financially responsible for all charges not covered by Medicare for which I have signed an Advance Beneficiary Notice (ABN) of Non-Coverage. I permit a copy of this assignment to be used in place of the original.

Assignment of Benefits:

I hereby authorize and assign all payments and/or insurance benefits due to me under my insurance plan for medical services rendered to me, directly to **Centurion Spine & Pain Centers**. I authorize **Centurion Spine & Pain Centers** to furnish medical records and other information related to medical services provided by **Centurion Spine & Pain Centers** to my insurance company or health maintenance organizations, other payers, payor network organizations, and the contractors or third-party administrators of any of these parties which is necessary to process claims for services rendered, for the payment of a bill, determination of benefits, appeal of claims, utilization and quality review purposes or health care operations. I direct my insurance company to send payments directly to **Centurion Spine & Pain Centers** to be payable to **Centurion Spine & Pain Centers**. In the event that I receive a check directly from my insurance company payable to me for services rendered by **Centurion Spine & Pain Centers**, I understand that this payment belongs to **Centurion Spine & Pain Centers**. I agree to endorse the back of the check payable to **Centurion Spine & Pain Centers** and promptly deliver the check to **Centurion Spine & Pain Centers**. I permit a copy of this assignment to be used in place of the original.

Caution: Please read carefully before signing. Please ask to view a copy of our charges. If you do not completely understand this document, please ask us to explain it to you. If you sign below, we will assume you understand and agree to the above.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving medical services at **Centurion Spine & Pain Centers**. I have not received any promises or guarantees from anyone at **Centurion Spine & Pain Centers** as to the results that may be obtained by any treatment or service; and I agree **Centurion Spine & Pain Centers** prices for medical services, treatment and supplies are reasonable, usual and customary.

Patient Signature: _____ **Date:** _____

Patient Name: _____

Legal Representative Signature: _____ **Date:** _____

Name of Legal Representative: _____

Legal Representative Authority to Act for Patient (Parent, Guardian, Power of Attorney, Healthcare Surrogate, etc.):

FINANCIAL POLICY

- Payment is due at the time of service unless other arrangements have been made in advance. For your convenience, we accept cash, check, MasterCard, Visa, Discover, and American Express credit cards.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be “not covered”; you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. It is your responsibility to know your insurance benefits.
- You are responsible for promptly responding to your insurance company to provide any additional information they may request regarding your treatment, pre-existing conditions, accidents or other insurance coverage. Failure to respond in a timely manner may result in your account becoming due and payable, in full immediately.
- Be prepared to present your insurance card and proof of identity (e.g. driver’s license) at each visit. You are responsible for providing a change of address, phone number and/or insurance information anytime a change occurs.
- A prepayment of your deductible and coinsurance is required for your portion of our fees, based on our contract with your insurance plan. Any balance remaining, after your health plan pays, is your responsibility. Payment is due upon receipt of a statement from our office. Such payment is not contingent on any insurance, settlement or judgment payment.
- There is a \$35.00 service fee on all returned checks in addition to the amount of the check. NSF (non-sufficient funds) checks must be redeemed with certified funds (cashier’s check, credit card, money order, certified check or cash) at or before the next office visit.
- You must provide our office with at least a 24-hour notice to cancel or reschedule your appointment or you will be charged a \$25.00 cancellation or “no show” fee for an office visit and a \$50.00 cancellation or “no-show” fee for a procedure, including an injection. This appointment cancellation or “no show” fee is not covered by insurance and therefore becomes your responsibility. All “no show” fees must be paid before a new appointment can be scheduled. Patients that repeatedly fail to provide the requisite notice prior to appointment cancellation may be discharged from **Centurion Spine & Pain Centers**.
- We will look to the adult accompanying a minor for payment of all services rendered to minor patients.
- **Centurion Spine & Pain Centers** may add one and one-half percent (1.5%) per month to any balance owed, and in the event of default, you agree to pay reasonable collection charges, not to exceed 30% of the unpaid balance at the time the account is assigned to a collection agency, and/or attorney fees, court costs and post judgment and interest as allowed by state law.

Certification: I certify that: I have read and agree to the above terms and conditions of the Financial Policy.

Patient Signature: _____ **Date:** _____

Patient Name: _____

Legal Representative Signature: _____ **Date:** _____

Name of Legal Representative: _____

Legal Representative Authority to Act for Patient (Parent, Guardian, Power of Attorney, Healthcare Surrogate, etc.):
