Patient Registration Information

4100 Duval Road Bldg III Ste 200
Austin, Texas 78759
Phone: 512.485.7200
Fax: 512.485.7225
painspecialistsofaustin.com

PSA Pain Specialists of Austin
RELIEF IS ON THE WAY

Is your condition a result of a work injury? ☐ Yes ☐ No -or- An auto accident? ☐ Yes ☐ No

Date of injury _____

PATIENT'S PERSONAL INFORMATION

Patient Name:_____ _____
Last Name First Name M.I.

Sex: ☐ Male ☐ Female Social Security # _____-_____-_____ Date of Birth: _____/_____/_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Mailing Address: _____

City: _____ State: _____ Zip: _____

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

Driver's License # / State: _____ / _____
Employer / Name of School: _____ ☐ Full-time ☐ Part-time

Spouse's Name (if applicable):_____ _____ _____
Last Name First Name M.I.

How do you wish to be addressed? _____

PATIENT'S / RESPONSIBLE PARTY INFORMATION

Responsible Party:_____ Date of Birth _____/_____/_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Other _____ Social Security # _____-_____-_____

PATIENT'S INSURANCE INFORMATION

PRIMARY Insurance Company's Name _____

Insurance address _____ City_____ State_____ Zip_____

Name of Insured_____ Date of Birth _____/_____/_____

Insurance ID#_____ Group #_____

SECONDARY Insurance Company's Name _____

Insurance address _____ City_____ State_____ Zip_____

Name of Insured_____ Date of Birth _____/_____/_____

Insurance ID#_____ Group #_____

PATIENT'S REFERRAL INFORMATION

Referred by_____ If referred by a friend, may we thank her or him? ☐ Yes ☐ No

Name(s) of the other physician(s) who care for you_____

EMERGENCY CONTACT

Name of person not living with you_____ Relationship_____

Address_____ City_____ State____ Zip_____

Home / Cell Phone_____ Work Phone_____

Patient Medical History

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PATIENT NAME _____ **DOB** _____/_____/_____

REFERRING PHYSICIAN_____

PRIMARY CARE PHYSICIAN_____

Age _____ Height _____ Weight _____

Location of pain _____

Onset of pain _____ (days, weeks, months or years)

Cause of pain _____ (accident, unknown)

Your occupation _____ Is this work related? _____

Other physicians/specialties you have seen for this pain, including other pain management clinics:

_____

Temporal Characteristics of your pain: ☐ Constant ☐ Intermittent Duration _____

Pain Intensity from 1 – 10, where 10 is the worst: _____ at it's worst, _____ at it's least

Your pain is: ☐ sharp ☐ shooting ☐ burning ☐ stabbing ☐ electrical shocks ☐ numbness ☐ aching

☐ Other _____

What makes your pain worse? _____

What makes your pain better? _____

Do you have: ☐ numbness ☐ weakness ☐ bowel incontinence ☐ bladder incontinence?

Which of the prior treatments or tests have you had? Include dates of service and results:

- ☐ MRI _____
- ☐ CT _____
- ☐ Physical Therapy _____
- ☐ Injections _____
- ☐ Chiropractic Treatment _____
- ☐ Acupuncture _____
- ☐ Massage Therapy _____
- ☐ EMG/Nerve Testing _____
- ☐ Other _____

How many hours per night do you sleep? _____

What medical conditions do you have (diabetes, high blood pressure, etc)? _____

_____

Prior surgeries, include dates and name of surgeon _____

_____

Do you have a family history of any kind of illnesses? _____

Are you allergic to: ☐ IV Iodine ☐ Latex ☐ Topical Iodine ☐ Shellfish Your reaction _____

Medication allergies and reactions _____

Current list of medications you are taking, including over the counter, include strength and daily dose _____

_____

_____

_____

Do you smoke or use tobacco products: ☐ No ☐ Yes, how much_____, how frequent _____
☐ Ex user, date quit _____

Do you drink Alcohol: ☐ No ☐ Yes, Type:_____ How much:_____ How often:_____
Do you have a history of or current drug use: ☐ No ☐ Yes, what type of drug_____
Do you have a history of:
Drug abuse: ☐ No ☐ Yes Alcohol abuse: ☐ No ☐ Yes Prescription drug abuse: ☐ No ☐ Yes

Female Patients Only

☐ I am NOT pregnant

☐ I am _____ weeks pregnant Name of OB/Gyn _____

Current Pharmacy: _____ Address _____

Phone number: _____ Fax number: _____

REVIEW OF SYSTEMS: check all that you have experienced in the last **month**

General: ☐ fever ☐ chills ☐ weight loss ☐ fatigue
Eyes: ☐ blurred vision ☐ photophobia ☐ eye pain ☐ double vision
Cardiovascular: ☐ chest pain ☐ palpitations ☐ peripheral edema
Respiratory: ☐ shortness of breath ☐ cough ☐ recent infections
GI: ☐ constipation ☐ abdominal pain ☐ bowel incontinence ☐ nausea ☐ vomiting
Genitourinary: ☐ dysuria ☐ bladder incontinence
Musc-skeletal: ☐ joint pain ☐ swelling ☐ warmth ☐ spasms ☐ cramps
Skin: ☐ lesions ☐ rash
Heme/lymph: ☐ bleeding ☐ bruising
Neurological: ☐ weakness ☐ numbness ☐ tingling ☐ syncope ☐ headache ☐ loss of balance
Psychiatric: ☐ depression ☐ anxiety ☐ hallucinations
ENT: ☐ decreased hearing ☐ ringing in ears ☐ difficulty swallowing ☐ hoarseness
Immunologic: ☐ hives ☐ hay fever ☐ persistent infection

Patient Acknowledgement Statement

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I, _____, understand that that services or items that I have requested be provided to me by Pain Specialists of Austin may not be covered under my insurance as being reasonable or medically necessary for my care. I understand the health-insuring agent determines the medical necessity of the services or items I request and receive. I also understand I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable or medically necessary for my care.

Advanced Practitioner Consent for Treatment

This facility has on staff a physician assistant and/or a nurse practitioner to assist in the delivery of medical care of pain management.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. A nurse practitioner is not a doctor. A nurse practitioner is a registered nurse who has received advanced education and training in the provision of health care. Under the supervision of a physician, a physician assistant and a nurse practitioner can diagnose, treat and monitor acute and chronic disease as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of the supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

A physician assistant and a nurse practitioner may provide such medical services that are within his/her education, training and experience.

I have read the above, and hereby consent to the services of an advanced practitioner for my health care needs. I understand that at any time I can refuse to see the advanced practitioner and request to see a physician.

Acknowledgement of Drug Screening Policy

I understand that Pain Specialists of Austin reserves the right to perform random drug screening on any patient. I have the right to refuse the drug screen, but may then not be prescribed any medications or given refills of medications.

Acknowledgement of Investigational Treatment

I am being informed that in certain circumstances the treatment being recommended maybe considered investigational, experimental, and not FDA approved. By signing this document I am giving consent to such treatments.

Acknowledgement of Late Arrival Policy

I understand that should I arrive more than 15 minutes late to my appointment I may be asked to reschedule.

Acknowledgement of Financial Interest

I have been informed that Dr. Vivek Mahendru has a financial interest in The Pain Relief SurgiCenter, Ambulatory Surgery Center of Killeen, and Pain Specialists of Austin Pharmacy. I am free to choose any facility for obtaining services that are ordered for me.

Permission to Leave Messages

I give permission for Pain Specialists of Austin to leave appointment information, test results, and/or pre-operative instructions on voice message for the following phone numbers or with the following individuals:

_____

_____

SIGNATURE OF PATIENT _____ **DATE** _____

Patient and Financial Policy

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Thank you for choosing Pain Specialists of Austin. In order to inform you of our current financial and office policy, please read the document, initial and sign the financial agreement. Our providers, clinical staff, and office staff are here to help you in any way possible and strive to make your experience with us pleasant and comforting. Keep a copy of this document for your records and should you have any questions please do not hesitate to ask one of our associates.

Please keep us informed of any address, telephone number, or name changes. If we are unable to contact you regarding your bill, we will refer the balance to our outside collection agency.

Please notify our office within 24 hours to reschedule or cancel an appointment. This will allow our staff to offer this time slot to another patient in need of an appointment.

We accept the following forms of payment: cash, credit cards, cashier's checks, money orders, and personal checks.

RETURNED CHECK POLICY

- Returned checks will accrue a $50.00 returned check fee as well as any applicable bank fees to your account.

INSURANCE POLICY

- It is your responsibility to know your level of benefits for services provided. Being that our providers are specialist, many services are required to have prior authorizations by the insurance company and/or Primary Care Physician.
- Please contact your insurance company before your appointment to ensure proper authorization estimate of payment due as we are not certain what the patient balance will be until the insurance company processes your claim.
- Payment of fees, co-pays, co-insurance and deductibles are due at the time of service.
- Co-pays are a requirement placed on you by your insurance company and therefore cannot be waived or reduced.
- Should you forget or cannot provide your co-pay at the time of visit, you will be asked to reschedule your appointment.
- You will be contacted prior to your appointment and notified of any balance due on your account and will be expected to bring payment to your appointment. You will be required to make arrangements with the financial counselor if you cannot pay the balance in full.

WORKER'S COMPENSATION

- Please keep in contact with your adjuster prior to and after your appointment to receive any pertinent information regarding your claim and injury.
- Authorizations are required for procedures and could take up to 1 week to obtain.
- Should your case become closed, undergo peer review, or determined that Maximum Medical Improvement has been met you must contact your referring physician and adjuster for written approval before scheduling any appointments or services.

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_____ I understand the insurance billing is a courtesy provided to me by Pain Specialists of Austin and I assume full financial responsibility of any balance I incur.
Please Initial

_____ I understand co-pays, co-insurance, and deductibles are due at the time of my visits as well as any prior balance I may owe.
Please Initial

_____ It has been explained to me that should I decide to have procedures performed at Pain Specialists of Austin my insurance company and I will receive two statements, one for the facility fees and one for the professional services rendered by the providers at Pain Specialists of Austin.
Please Initial

_____ I assign benefits to be paid by my insurance company directly to the provider of services rendered to me. Furthermore, should the insurance company issue a check in my name I will notify Pain Specialists of Austin immediately and arrange for payment of my balance. Should I cash any check issued by the Insurance company meant for reimbursement of services provided to me, I will assume full responsibility of the balance and will pay the balance within 30 days.
Please Initial

_____ I understand my balance will automatically be referred to an outside collection agency should my account surpass 90 days without payment activity.
Please Initial

_____ I agree to pay all reasonable attorneys, collection, or returned check fees in the event of default of payment of my charges or balance arrangements.
Please Initial

_____ I understand that a $50.00 no show fee may be assessed for any appointment that I do not keep.
Please Initial

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms at its discretion.

PRINTED NAME OF PATIENT _____

SIGNATURE OF
PATIENT OR GURANTOR _____ **DATE** _____

Notice of Privacy Practices

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN SET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used; "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA," we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

You have the following rights with respect to your protected health information, which you can exercise be presenting a written request to the Privacy Officer.

- The right to request restriction on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person indentified by you. We are, however not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to receive an accounting of disclosure of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of January 1, 2013 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you filing a complaint.

Please contact us for more information.

For more information about HIPPA or to file a complaint

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775