PENNSYLVANIA
PAIN & SPINE INSTITUTE
Center for Minimally Invasive Pain Management

PATIENT INTAKE FORM

Today's Date:			PCP:		
PATIENT INFORMATION					
Patient's Name last: First:		Middle: ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed		
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Former name:	Birth date: / /	Age:	Sex: ☐ M ☐ F
Street Address:					
City:	State:	Zip:			
Social Security no.:	Home phone #: ( )	Cell phone #: ( )			
Occupation:	Employer:	Employer phone #: ( )			
Chose clinic because/referred to clinic by: (Please choose one option)	☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other Other family member seen here? _____				
ACCIDENT INFORMATION- COMPLETE ONLY IF VISIT IS DUE TO AN ACCIDENT					
(Please give your insurance card to the receptionist.)					
Workers Comp/Auto Insurance:	Date of Accident: / /	Claim #:	Type of accident: ☐ Auto ☐ Work Related ☐ Other		
Street Address:					
City:	State:	Zip:			
IN CASE OF EMERGENCY					
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #: ( )	Work phone #: ( )		

The above information is true to the best of my knowledge. I request that payment of authorized Medicare/other insurance benefits be made on my behalf to the Pennsylvania Pain & Spine Institute for any services furnished me by physician or supplier. I authorize the release of my medical information to Center for Medicare & Medicade Services and/or my insurance company and its agents; any information needed to determine these benefit/benefits payable for related services I am responsible for all charges, regardless of insurance status, as well as copayments and deductibles.

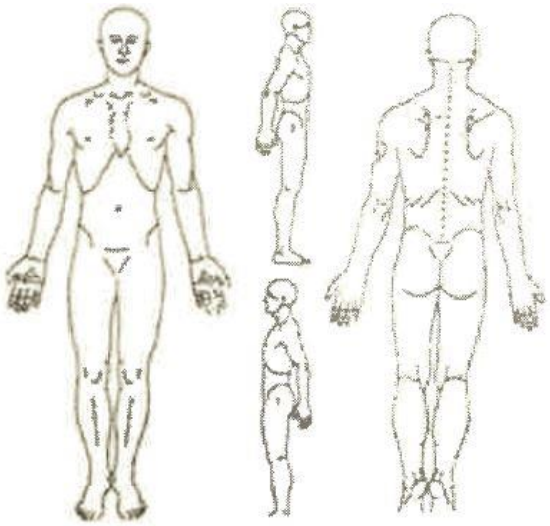
Patient/Guardian signature

Date

MORE INFORMATION		
Who referred you to us?	Date:	
History of your symptoms:		
When did it start?		☐ Gradual ☐ Sudden
Is your pain due to: ☐ Motor Vehicle Accident ☐ Work Injury		Cell phone #:

Please describe how your injury/pain occurred:

Where is your pain:



How would you characterize your pain: ☐ Dull ☐ Knife like ☐ Achy ☐ Cramping ☐ Burning ☐ Sharp ☐ Number ☐ Other:

How many hours do you sleep at night:	Have you felt depressed or frustrated due to your pain: ☐ Yes ☐ No

Previous Treatments: Have you had any of the following:

☐ Epidural/s Date(s): _____ Physician(s): _____

☐ Nerve block(s) Date(s): _____ Physician(s): _____

☐ Surgery/ies Date(s): _____ Physician(s): _____

☐ Physical Therapy Date(s): _____ Physician(s): _____

☐ Chiropractic Date(s): _____ Physician(s): _____

Social History:

What is your current work situation: ☐ Retired ☐ Working ☐ Disability ☐ On leave ☐ Other:

What is your home situation: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Tobacco Use: ☐ I do not smoke ☐ I do smoke _____ pack(s) per day

Alcohol Use: ☐ I do not drink ☐ I do drink _____drink(s) per day

Illegal Drug Use: ☐ I do not us any ☐ I currently use the following:

Family History:

Please list any conditions your parents or siblings may have:

Past Medical History:

Please list any medical issues you are being treated for or take prescription medication for:

Medications:

Please list all your prescription medications:

Allergies:

Other Symptoms:

Do you experience any of these other symptoms:

☐ Fevers ☐ Chills ☐ Unusual Bruises ☐ Weight Loss ☐ Night Sweats ☐ Rashes ☐ Recent Infections
☐ Bladder/Bowel Incontinence

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700 Horizon Circle, Suite 206
Chalfont, PA 18914

127 S. 5th St, Suite 180
Quakertown, PA 18951

215-395-8888

Consent to Treat and Administrative Authorizations

1. Authorization for Treatment and Diagnostic Procedures:
I voluntarily authorize, request and consent to outpatient care services, including procedures, examinations, and medical treatment as ordered by my physicians, his/her assistants, or other health care provides. I understand that, except in emergency situations, this consent does not include surgical procedures or other procedures or treatment that may require separate consent. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made as to the results of any procedures, treatments or examinations.

2. Release of Information (Including Medical Record Information):
I authorize the Pennsylvania Pain & Spine Institute to furnish health, demographic, and other information from my medical records to my insurance company, third party payers, case utilization, and managed care review organizations, which may be necessary in order for Pennsylvania Pain & Spine Institute to receive payment or obtain authorization for my care. I further authorize health, demographic, and other information from my medical record to be released to any health care provider or institution providing health care to me. Consent is also given for release of information to Pennsylvania Pain & Spine Institute by any insurer and all other agencies, institutions, or individuals from whom I have received medical services. This authorization does not apply to information specifically protected by state or federal laws or regulations.

3. Assignment of Insurance Benefits to Pennsylvania Pain & Spine Institute:
I authorize payment of health care benefits directly to Pennsylvania Pain & Spine Institute. In making this assignment, I understand and agree that I may be financially responsible to Pennsylvania Pain & Spine Institute for charges not paid under my insurance policy(ies). I permit a copy of this authorization to be used in place of the original.

I authorize payment of authorized Medicare or other payor benefits to be made to me or on my behalf, to the physician or supplier for any services provided to me by the authorized physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine th se benefits or the benefits payable for related services.

I hereby certify that I have read and fully understand the above consent. I have sufficient opportunity to ask whatever questions I might have and they have been answered to my satisfaction. I voluntarily and freely consent to the above and accept its term.

_____ _____
Signature Date

_____ _____
Witness Date

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A Word About Missed Appointments

Thank you for choosing Pennsylvania Pain & Spine Institute for your pain management care. To enable us to provide you with the best possible care please read the following carefully. It is important for you to follow these instructions to get the most from your upcoming appointment.

If you are unable to keep your appointment, please notify our office at least **24** hours prior to the appointment for rescheduling. This improves appointment availability for both you and our other patients. If you no-show for an appointment or cancel less than **24** hours before your appointment, you will be charged **$25.00**. If you miss two (2) appointments or are late (more than 10 minutes) two (2) times, we will take this as an indication that you are no longer interested in being a patient of Pennsylvania Pain & Spine Institute. We will then discharge you as a patient.

We recognize that emergencies occur, and you may be unable to cancel an appointment in rare circumstances. However, no shows and cancellations will force us to enforce this policy.

Thank you in advance for your cooperation.

Sincerely,

The Staff at Pennsylvania Pain & Spine Institute

_____ _____

Signature Date

Notice of HIPA Acknowledgement

I have acknowledged that I have received the attached copy of the Pennsylvania Pain & Spine Institute Notice of Privacy Practices.

_____ _____

Signature Date

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STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Patient Name:

DOB:

This is a statement of our financial policy. You understand that you are obligated to ensure that our fees are paid in full. We will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You agree that you will pay any deductible and co-payment or co-insurance as determined by your insurance plan. Those payments will be due at the time of service. Many insurance companies have additional requirements or stipulations that may affect your coverage. You are responsible for any amounts not covered or payable by your insurance. If your insurance denies any part of your claim, you agree to be responsible to pay the full balance.

ACKNOWLEDGEMENT:

I have read and understand the financial policy described above. I agree to pay, promptly and in full, any amounts due to the provider, including co-payments, deductibles, and amounts due for non-covered or services that are not payable by my insurance.

Patient Signature: _____

Date: _____

Authorized Representative Signature: _____
(Use if patient is a minor or otherwise has an authorized representative)

Date: _____

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Medical Information (HIPAA) Release Form

_____ _____
Signature Date

Release of Information

☐ I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

☐ Spouse
☐ Children
☐ Other

☐ Information is not to be release to anyone

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call: ☐ My home ☐ My work ☐ My cell

If unable to reach me:
☐ You may leave a detailed message
☐ Please leave a message asking me to return your call

The best time to reach me is (day) _____
Between (time): _____ _____

_____ _____
Signature Date

_____ _____
Signature Date