INTERVENTIONAL PAIN INSTITUTE

PATIENT REGISTRATION – *PLEASE PRINT CLEARLY*

PATIENT NAME *First* *Last* *Middle Initial*			DATE OF BIRTH	SEX ___M ___F
HOME ADDRESS	CITY	STATE	ZIP CODE	
PRIMARY PHONE #	DAYTIME PHONE #		ADDITIONAL PHONE #	
OCCUPATION	SOCIAL SECURITY NO.		MARITAL STATUS: __ Single __ Married __Divorced __Widowed __ Separated	
EMERGENCY CONTACT	EMERGENCY NUMBER		REFERRING PHYSICIAN	
E-MAIL ADRESS	PHARMACY			

POLICY CONCERNING PAYMENT OF MEDICAL BILLS

Our policy is that the patient is ultimately responsible for all fees for services rendered. Whether or not your insurance company pays in full, a portion, or no portion, your medical bill is a matter between you and your insurance carrier.

I realize verification of insurance coverage is my responsibility. In the event that the listed medical service is not covered by my insurance. I agree to be financially responsible for the charges for these services.

I do hereby authorize the INTERVENTIONAL PAIN INSTITUTE to apply for benefits for services rendered. I request payments to be made directly to the INTERVENTIONAL PAIN INSTITUTE. I verify that the information reported regarding my coverage is correct and further authorize the release of any necessary information for any claim to my insurance company.

Sign Here X _____

BILLING AND INSURANCE INFORMATION

Primary Insurance

INSURANCE COMPANY NAME	ID NUMBER	GROUP NUMBER
SUBSCRIBER'S NAME	SUBSCRIBER'S DATE OF BRITH	RELATIONSHIP TO PATIENT

Secondary Insurance

INSURANCE COMPANY NAME	ID NUMBER	GROUP NUMBER
SUBSCRIBER'S NAME	SUBSCRIBER'S DATE OF BRITH	RELATIONSHIP TO PATIENT

PATIENT AUTHORIZATION

I, _____, hereby authorize the INTERVENTIONAL PAIN INSTITUTE to apply for benefits on my behalf for services rendered. I request payment be made directly to the INTERVENTIONAL PAIN INSTITUTE. I certify that the information I have reported with regard to my insurance is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above-named insurance company. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked at any time in writing.

_____ _____

DATE PATIENT SIGNATURE

HIPPA FORM 1

INTERVENTIONAL PAIN INSITUTE

NOTICE TO PATIENTS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET THIS INFORMATION. PLEASE REVIEW CAREFULLY.

A. The General Authorization for Release of Medical Records that you sign authorizes your medical care provider, INTERVENTIONAL PAIN INSTITUTE ("Provider") to disclose the information in your medical record to the extent needed for the following purposes:

1. For the purpose of providing treatment to you. This would include sharing information with employees and contractors of Provider, or with other health care providers who are treating you or consulting in your case.
2. For the purpose of arranging payment for your care. This would include your insurer or other third party payer who is responsible for paying all or part of the cost of your case.
3. For the purpose of Provider's "health care operations". This would include such things as internal quality assessment activities, contacting other health care providers regarding medical review of your care, evaluating provider performance, legal and medical review of care provided, business planning and management, resolutions of internal grievances and provision of legal and auditing services.
4. For the purpose of other health care providers' "health care operations" to the extent that they have a treatment relationship with you.

B) A Specific Authorization for Release of Medical Records that you may sign authorizes Provider to make a specific disclosure that is not covered under section A, above. A Specific Authorization will name the party to whom you are authorizing disclosure., and will contain any limitations on the authority to disclose your records.

C) You may revoke any authorization provided to Provider by giving Provider a written notice of revocation. Provider may refuse to treat you if you revoke the General Authorization.

D) Provider may be required by law, in some cases, to make disclosures of your record that you have not authorized. Examples are subpoenas in criminal or civil litigation, or requests/surveys by licensure agencies or the U.S. Department of Health and Human Services.

E) Provider 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.

F) You have the following rights with respect to your medical records/information:

1. You have the right to request restrictions on the use and disclosure of your medical records/information, however Provider is not required to agree to restrictions not guaranteed by law. You will be informed if provider will not agree to a requested restriction.
2. You have the right to receive confidential communications of your health information and to direct the place and manner of communication.
3. You have the right to inspect and copy your medical records. (Provider is entitled to charge you a reasonable fee related to the cost of copying your records.)
4. You have the right to seek to amend your medical records, and if Provider does not agree with your request, to note your objection in the medical record.
5. You have the right to receive an accounting of disclosures that are made to you or with your specific authorization, that fall within the scope of the Provider's "health care operation", or disclosure made for payment or treatment purposes.
6. You have a right to retain a paper copy of this notice.

G) Provider is required by law to maintain the privacy of protected health information, and to provide patients with this notice of its duties and practices, as well as changes to those practices. Patients will be provided with revised notices, as appropriate.

H) If a patient believes that his or her privacy rights have been violated, the patient may complain to Provider, or to the Secretary of the U.S. Department of Health and Human Services. To complain to Provider, please write or call us with the details. Provider will not retaliate in any way against a patient for making a complaint.

I) If you as a patient believe that your privacy rights have been violated and wish to notify our practice, please call our office and ask to speak with the designated Privacy Complaints Contact Person.

J) Provider reserves the right to change privacy practices, and to make its new policies effective for all protected health information that Provider maintains. If such changes are made, Provider will issue an updated "Notice to Patients" to all of Provider's patients.

K) CRISP: NAME has chosen to participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a regional health information exchange. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt- out" and disable all access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through the website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers. Please contact our staff for more information about CRISP or to request an opt-out form.

Please acknowledge receipt and review of this notice by signing below. For further information, please call our office.

_____ _____

Name of Patient *(please print)* Date

_____

Signature

HIPAA FORM 2 INTERVENTIONAL PAIN INSTITUTE

GENERAL AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, patient of NAME. "Provider"), understand that my signature below gives Provider permission to the extent necessary, to use my medical record and to provide access to my medical record, while and after I am treated by Provider, for the reasons that follow:

1. For the purpose of providing medical treatment to me, including release of information to other health care providers with whom I am already in treatment.
2. For the purpose of arranging for payment for my care.
3. For the purpose of Provider's "health care operations", including such thing as alternative, evaluating provider performance, legal and medical review of care provided, business planning and management, customer service, resolution of internal grievances and the provision of legal and auditing services.
4. For the purposes of other health care providers' "health care operations", to the extent that they have a treatment relationship with you.

I understand that my permission allows Provider to transmit permissible information through any means that is reasonably secure, including via e-mail, assuming that reasonable protective measures are taken to preserve the confidentiality of the information.

I understand that I may revoke this authorization at any time, but that Provider may refuse to give me further treatment if I do.

I understand that I have the right to request that Provider restricts how my medical information is used. If I wish to request a restriction I will initial here:_____
(In this case, Provider will give me a separate form to fill out, which will also be used for provider to indicate whether or not Provider agrees to the requested restriction)

I understand that I have a number of rights identified below *(These rights are listed more fully on the Patient Notice provided to me by Provider)*:

- the right to review and copy my medical record
- the right to request an amendment of my medical record
- the right to grant or deny access to my record to others
- the right to decide how information from my record will be conveyed to others
- the right to complain about how my medical record is handled to the Secretary of the U.S. Department of Health and Human Services and to Provider
- the right to revoke, in writing, any consent that I provided for access to my records
- the right to authorize Provider to give information about my care to relatives or friends, to the extent of their involvement with my care or payment
- the right to review a record of access to my medical record

I understand that I have the right to either grant or deny access to my medical record, and that my specific written permission will be sought if access is requested for any reason not set forth above, or in most cases, for the release of psychotherapy notes.

The provider may decide to change some of the above-stated polices, and I understand that I will given a revised Notice if this occurs.

_____ _____

Name of Patient *(please print)* Date

_____

Signature

HIPAA FORM 3 INTERVENTIONAL PAIN INSTITUTE

DISCLOSURE TO FAMILY/FRIENDS
TREATMENT AUTHORIZATION

_____ I do not want INTERVENTIONAL PAIN INSTITUTE ("Provider") to disclose any information concerning my care or treatment by Provider to individuals without my express written consent or legal authorization.

_____ I authorize Provider to disclose information related to my care and treatment to the following individuals:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

The authorization provided for above are subject to the following limitations and restrictions:

_____

_____

TREATMENT AUTHORIZATION:

I _____ authorize medical treatment of myself or my minor child by physicians at INTERVENTIONAL PAIN INSTITUTE.

NOTIFICATION AUTHORIZATION:

I authorize INTERVENTIONAL PAIN INSTITUTE physicians and staff to contact me at the following number(s) for scheduling or to inform me of medical or laboratory test results:

_____ # _____ # _____

_____ I authorize the Providers' staff and physicians to leave messages regarding test results.

_____ I do not authorize Providers' staff and physicians to leave messages regarding test results.

_____ _____

Name of Patient *(please print)* Date

_____

Signature

INTERVENTIONAL PAIN INSTITUTE

OFFICE POLICY & PROCEDURE

EMERGENCIES: If you have a life threatening emergency, DO NOT contact our office; call 911 immediately. For all NON-life threatening emergencies, you may contact Interventional Pain Institute at (443) 599-4000 and we will attempt to handle your case in-office, to the best of our ability. If we are unable to assist you, we will make a recommendation as to which medical location would best suit your needs.

REPEAT PRESCRIPTIONS: If you are on long-term, non-narcotic medication, you may request a refill from our office staff. We require a minimum of forty-eight (48) hours' notice to process and prepare your prescription, although five (5) business days is preferred and would be greatly appreciated. After multiple repeat prescription refills, you may be asked to schedule an office visit to give the Doctor an opportunity to review your case and determine adjustments, if necessary.

MISSED/RESCHEDULED APPOINTMENTS: There is a $50 missed office visit appointment fee for ALL missed appointments not canceled and/or rescheduled at least 48 hours prior to your office visit. If you have a Monday appointment, we require notification no later than the close of business on Thursday prior. In addition, there is an $100.00 missed procedure appointment fee not canceled and/or rescheduled at least 48 hours prior to your procedure. INSURANCE DOES NOT COVER THIS CHARGE. **This fee must be paid in-full prior to your next appointment.**

ARRIVING LATE: If you are going to be late for your appointment, please call and inform the office. As a reminder, you are to present for check in 15 min prior to your appointment. Arriving late for appointments causes the office to run behind schedule with other patients. When you do arrive, please understand that you may have to wait to be seen, or possibly even rescheduled.

RETURNED CHECK: If you make a payment to Interventional Pain Institute via check and it is returned for any reason, we charge a $50 returned check fee, in addition to any fees assessed through your banking institution. INSURANCE DOES NOT COVER THIS CHARGE.

MEDICAL RECORDS: There will be a charge assessed for all requested medical records. This charge is regulated by the state and is determined by the total number of pages included. Processing a medical record request may take 1-2 weeks, variably. INSURANCE DOES NOT COVER THIS CHARGE. This fee must be paid in-full prior to your next appointment. There is a flat fee of $22.50, and then $0.73 per page.

COORDINATION of CARE: A $35 fee will be charged for any requested letter and/or medical statement issued from the Doctor. This fee may be greater, dependent on the extent of the request and/or. subsequent preparation time. Therefore, an additional charge of $5 per page may be added at the discretion of the provider. Doctor-patient phone consultations are billed per minute with a five (5) minute minimum; Fees based on $600 per hour.

PREVIOUS MEDICAL RECORDS: Before you are seen at Interventional Pain Institute, you MUST provide copies of all medical records pertaining to the condition for which you are being treated; including medication history, radiology/lab reports, and referrals. Although we will assist in obtaining these records, it is your responsibility to contact ALL physician(s) you have seen for this condition, sign the required release forms and have all documents sent to Interventional Pain Institute. These records can either be sent to our Boston St. office location via mail at 2700 Lighthouse Point East Suite 402 Baltimore, MD 21224 or via fax at (443) 599-4012. **Please Note: If you fail to provide the necessary medical records at least two (2) days prior to your initial appointment, we will reschedule the appointment until all reports are received.**

PHYSICIANS REFERAL: Interventional Pain Institute is a Specialty Medical Practice that REQUIRES a physicians' referral in order to be seen. We understand some insurance carriers do not require a referral for a specialist visit, however, this is a requirement enforced by Interventional Pain Institute. **Please Note: If we have not received a valid physicians' referral prior to your initial appointment, we will be forced to reschedule until one is obtained.**

TOXICOLOGY SCREEN: A toxicology screen is administered during the check-in of EVERY appointment and requires each patient provide a urine sample. Failure to comply will result in a violation or subsequently withdrawal of treatment. **Please Note: You may receive notice for charges not covered by your insurance from a third-party organization that handles all toxicology related testing and may be responsible for payment.**

INSURANCE: We accept most major insurances and will file for insurance benefits as a COURTESY to our patients. According to the terms of your insurance company, co-payments are required to be paid, in full, at the time of your appointment. If you are unable to pay your required co-payment, financial arrangements must be made with Interventional Pain Institute prior to your visit. Failure to comply will result in rescheduling until a payment is received. **Please Note: You are responsible for ALL charges not covered through your insurance provider and are financially obligated to pay any remaining balance owed to Interventional Pain Institute, in full, prior to your next visit. You may also receive notice for charges not covered by your insurance from a third-party organization that handles billing for other services rendered at IPI that may be services as part of your treatment plan for which you may be responsible for.**

BILLING/PAYMENT: Payment of your outstanding financial account balance (including a pre-determined payment plan) is due prior to your next scheduled appointment. You will not be permitted to see the physician unless your account status is current.

By signing below, I agree to act in accordance with the above policy and understand anything less than complete compliance will result in my immediate and permanent termination from the Interventional Pain Institute Pain Management Program.

_____ _____/_____/_____

Patient Signature Date

INTERVENTIONAL PAIN INSTITUTE

Medical History Questionnaire

Past Medical History (check ALL that apply:

☐Alzheimer's Disease	☐Cerebral Palsy	☐Heart Failure	☐ Neck Disorder	☐ Seizure Disorder
☐Anemia	☐Cervicalgia (Neck Pain)	☐Hepatitis	☐ Osteoporosis	☐ Sleep Apnea
☐Aneurysm	☐COPD (Emphysema)	☐Hernia	☐ Pain in Knee Joint	☐ Spinal Cord Injury
☐Anxiety	☐Dementia	☐High Cholesterol	☐ Pain in Shoulder Joint	☐ Stroke (CVA)
☐Arthritis	☐Depression	☐ Hip Injury/Pain	☐ Paraplegia	☐ Thyroid Abnormality
☐Asthma	☐Developmental Delay	☐HIV/AIDS	☐ Parkinson's Disease	☐ TMJ Pain
☐Atrial Fibrillation	☐Diabetes	☐Hypertension (High BP)	☐ Peripheral Neuropathy	☐ Tremors
☐Back Disorder	☐ DVT (Blood Clot)	☐ Intestinal Disorder	☐ Peripheral Vasc. Disease	☐ Other: _____
☐Bladder Incontinence	☐Gallbladder Disorder	☐ Irritable Bowel Synd.	☐ Psoriasis	☐ Other: _____
☐ BPH/Prostate Enlarge	☐Gastric Ulcer	☐ Kidney Stones	☐ Quadriplegia	☐ Other: _____
☐ Bursitis (Hip Region)	☐Gout	☐ Lupus	☐ Rheumatoid Arthritis	☐ Other: _____
☐ Cancer, Type: _____	☐ Head Inj./Concussion	☐ Migraine	☐ RSD	☐ Other: _____
☐Cardiac Pacemaker	☐Headache	☐ Multiple Sclerosis	☐ Sacroilitis	☐ Other: _____
☐Carpal Tunnel Syndrome	☐Heart Disease	☐ Muscle Spasm	☐ Scoliosis (Idiopathic)	☐Other: _____

Past Surgical History (check ALL that apply):

☐ No Significant Past Surgical History

Surgery	Date	Surgery	Date	Surgery	Date
☐ Amputation		☐ Elbow Surgery		☐ ORIF/Surgical Fixation of Fracture	
☐ Aneurysm Repair		☐ Eye Surgery		☐ Prostate Surgery	
☐ Angioplasty		☐ Foot/Ankle Surgery		☐ Shoulder Surgery	
☐ Appendix Removal		☐ Gallbladder Removal		☐ Spine Surgery: Cervical	
☐ Bilateral Tubal Ligation		☐ Gastric Bypass		☐ Spine Surgery: Lumbar	
☐ Bladder Surgery		☐ Heart Valve Replacement		☐ Spine Surgery: Thoracic	
☐ Bowel Surgery		☐ Hip Replacement		☐ Stent: Artery in Leg/Torso/Pelvis	
☐ Breast Biopsy		☐ Hysterectomy		☐ Stent: Heart (Cardiac)	
☐ Breast Augmentation		☐ Implanted Pacemaker		☐ Thyroid Surgery	
☐ CABG (Cardiac Bypass)		☐ Kidney Surgery		☐ TMJ Repair	
☐ Carpal Tunnel Release		☐ Knee Replacement		☐ Trigger Finger Release	
☐ D & C		☐ Knee Surgery		☐ Other:	

Family Medical History (check ALL that apply):

☐ No Significant Family History ☐ Family History Unknown

Condition	Relative	Condition	Relative	Condition	Relative
☐ Arthritis		☐ Heart Disease		☐ Spine Disorders	
☐ Cancer		☐ High Blood Pressure		☐ Stroke	
☐ Diabetes		☐ Migraine		☐ Other:	

Social History:

Alcohol: ____Yes____No

Smoking: __Current __Former __Never

☐ Recent Substance Abuse: ≤ 1 yr.

☐ Past Substance Abuse: ≥ 1 yr

Marital Status: _____

Have Children? _____(# of children if any)

Work Status:_____ Occupation: _____

Are you currently in a substance treatment program? _____

Pregnant?___Yes ___No___N/A

Currently Nursing?:

____Yes ____No ____ N/A

Regular Exercise?

____ Yes ____ No

Allergies (w/ Reaction):

_____

_____

Medications (PLEASE CONTINUE ON THE BACK OF THIS FORM IS YOU NEED MORE SPACE):

Medication	Dosage	Frequency (Time/Day)	Prescribing Physician	Current/Past	If Past: Why discontinued?