Interventional Pain Institute

PATIENT REGISTRATION – *PLEASE PRINT CLEARLY*

PATIENT NAME (*Last, First, MI)*		DATE OF BIRTH	SEX ___M ___F
HOME ADDRESS *(Street, City, State, Zip)*			
PRIMARY PHONE #	ADDITIONAL PHONE #	OCCUPATION	
SOCIAL SECURITY NO	MARITAL STATUS: __ Single __ Married __Divorced __Widowed __ Separated	REFERRING PHYSICIAN	
EMERGENCY CONTACT AND RELATION		EMERGENCY NUMBER	
E-MAIL ADDRESS	PHARMACY NAME	PHARMACY PHONE	

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

POLICY CONCERNING PAYMENT OF MEDICAL BILLS & PATIENT AUTHORIZATION

We accept most major insurances and will file for insurance benefits as a COURTESY to our patients. I realize verification of insurance coverage is my responsibility. In the event any medical service is not covered by my insurance, I agree to be financially responsible for the charges for these services. I do hereby authorize INTERVENTIONAL PAIN INSTITUTE/OCCUPATIONAL & BEHAVIORAL THERAPIES/APEX DIAGNOSTICS to apply for benefits for services rendered. I request payments to be made directly to IPI/OBT/APEX. 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. 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.

____ _______________________
Signature of Patient or Guarantor* Date

____ _______________________
Printed name of Guarantor Date

*A patients Guarantor is the person with legal authority to act on behalf of a minor, incapacitated, or otherwise legally dependent patient, including the authority to consent to medical services. By signing this form as "Guarantor," you represent to Interventional Pain Institute and its partners that you have such authority and that you accept financial responsibility for services rendered.

Interventional Pain Institute

MEDICAL HISTORY QUESTIONNAIRE

Past Medical History (*please check ALL that apply*):

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

Past Surgical History (*please check ALL that apply*): ☐ No Significant Past Surgical History

Surgery	Year	Surgery	Year	Surgery	Year
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 (*please check ALL that apply*): ☐ Family History Unknown ☐ No Significant Family History

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

MEDICAL HISTORY QUESTIONNAIRE (continued)

Social History: (*please circle Yes or NO*):

Do you drink alcohol? YES // NO How many units per week?	History of Substance Abuse: YES // NO	Caffeine intake: YES // NO // Occasionally
Are you a smoker? YES // NO __Current __Former __Never	Are you currently using any illicit/illegal drugs? YES // NO	Do you exercise regularly? YES // NO
Pregnant? YES // NO Nursing? YES // NO	Are you currently in a substance treatment program? YES // NO	Are you in physical therapy? YES // NO

Is your pain/reason for visit due to a work related injury or automobile accident? (please circle one) YES // NO

Diagnostic Testing/Related Studies (*please tell us if you've had the following):*

X-Rays	Neck // Back // Other:	Date:
MRI or CT	Neck // Back // Other:	Date:
Nerve conduction study (NCV/EMG)	Upper (Arms) // Lower (Legs)	Date:
Balance & Vestibular (VNG)		Date:

Current Medications taken (*please list all medications you are currently prescribed as well as any over-the-counter medicines, herbal medications or supplements)* please use the back of this form if you need more space:

Medication name	Dosage (mg/mL/mcg)	Frequency (Time/Day)	Prescribing Physician

Allergies (*please list ALL that apply)*:

Allergen/Source	Reaction	Severity	Current treatment?

HIPPA 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 COPY OF THIS NOTICE CAN BE PROVIDED TO YOU UPON REQUEST.

I. The General Authorization for Release of Medical Records that you sign authorizes your medical care provider, INTERVENTIONAL PAIN INSTITUTE/OCCUPATIONAL & BEHAVIORAL THERAPIES/APEX DIAGNOSTICS ("Provider") to disclose the information in your medical record to the extent needed for the following purposes:
   a. 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.
   b. 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.
   c. 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.
   d. For the purpose of other health care providers' "health care operations" to the extent that they have a treatment relationship with you.

II. 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.

III. 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.

IV. 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.

V. 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.

VI. You have the following rights with respect to your medical records/information:
   a. 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.
   b. You have the right to receive confidential communications of your health information and to direct the place and manner of communication.
   c. 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.)
   d. 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.
   e. 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.
   f. You have a right to retain a paper copy of this notice.

VII. 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.

VIII. 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.

IX. 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.

X. 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.

XI. 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.

Please acknowledge receipt and understanding of this notice by initialing here _____________

DISCLOSURE OF MEDICAL INFORMATION TO FAMILY/FRIENDS

____I do not want IPI/OBT/APEX ("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:

NAME	RELATIONSHIP	PHONE
NAME	RELATIONSHIP	PHONE
NAME	RELATIONSHIP	PHONE

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

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PATIENT'S RIGHTS and TREATMENT AUTHORIZATION:

INTERVENTIONAL PAIN INSTITUTE/OCCUPATIONAL & BEHAVIORAL THERAPIES/APEX DIAGNOSTICS respects the unique differences of our patients and will ensure that health care ethics are maintained for all patients. I hereby authorize medical treatment of myself or my minor child by Providers at INTERVENTIONAL PAIN INSTITUTE. By signing below, I indicate that I am the patient or that I have legal authority to consent to medical treatment on the patient's behalf. I consent to, understand, and agree that:

- The patient has the right to considerate and respectful care
- The patient has the right to and is encouraged to obtain from the Provider(s) relevant, current, and understandable information concerning diagnosis, treatment, testing, and prognosis.
- The patient has the right to discuss the risk and benefits of all procedures and courses of treatment proposed by your Provider(s), together with available alternatives
- The patient has the right to know the identity of the providers, staff, and all involved in patient care.
- The patient has the right to make decisions about the plan of care prior to and during the course of treatment, and to stop or refuse a recommended treatment or plan of care at any time to the extent permitted by law, and to be informed of the consequences of this action.
- The patient has the right to every consideration of privacy.
- The patient has the right to expect that all communications and records pertaining to his/her care will be treated as confidential except in cases where reporting is permitted by law.
- The patient has the right to expect reasonable continuity of care when appropriate and to be informed by the Provider of available and realistic patient care options.
- Before prescribing any controlled substance to you, the Provider(s) may review information from the Maryland Prescription Drug Monitoring Program Regarding your prior receipt of controlled substances.
- During your visit, you may be asked to provide a fresh and unadulterated urine specimen for analytical testing. Failure to comply will result in a violation or subsequently withdrawal of treatment.
- I hereby request and consent to comprehensive evaluation/examinations (PT/OT/SLP/Mental health counseling), intervention (including but not limited to soft tissue mobilization, therapeutic exercises, stretching, posture and ergonomic training, home exercise program, activities of daily living training, counseling) from Providers who now or in the future treat me in this office or via telehealth.
- I understand that results of therapies, diagnostic testing, or procedures are not guaranteed and am informed that, as in the practice of medicine there are some risks to treatment including but not limited to fractures, disc injuries, strokes, dislocations, sprains, burns, bruising, local swelling, numbness or weakness.

____ ____________________

Signature of Patient or Guarantor Date

OFFICE POLICY & PROCEDURE

Thank you for choosing IPI/OBT/APEX for your health care services. This form describes our treatment and payment policies and covers important topics relevant to all patients.

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.

INSURANCE, BILLING & PAYMENT: Our policy is that the patient is ultimately responsible for all fees for services rendered. According to the terms of your insurance company, co-payments are required to be paid, in full, at the time of your appointment. 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. **You are responsible for ALL charges not covered through your insurance provider and are financially obligated to pay any remaining balance owed (including a pre-determined payment plan) to Interventional Pain Institute, in full, prior to your next visit.** You will not be permitted to see the physician unless your account status is current. If you are unable to pay your required co-payment, financial arrangements must be made with Interventional Pain Institute prior to your 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 as part of your treatment plan for which you may be responsible for. Furthermore, you understand that if care or treatment is suspended or terminated at any time, fees for products or professional services previously rendered will be immediately due and payable.

CONTROLLED SUBSTANCE PROGRAM AGREEMENT: INTERVENTIONAL PAIN INSTITUTE 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 regarding your treatment plan. You may "opt-out" and disable all access to your health information available through CRISP by calling 1-877-952-7477 or by 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.

- The purpose of this contract is to protect your ability to obtain controlled substances and to protect our ability to provide them to you while maintaining a safe, controlled treatment plan.
- You are required to have a primary care physician while in this program.
- Only this medical practice is permitted to prescribe you controlled substance medication, including other opioids/narcotics.
- We are unable to replace lost, misplaced, or prematurely used prescriptions and/or medications. You are not permitted to distribute any controlled substance to anyone.
- We will conduct toxicology testing on all program participants. You will be terminated from our program immediately if you refuse to take the test, are positive for non-prescribed controlled substances, illicit drugs, or for not taking prescribed medication.
- Your association with this practice will immediately be terminated, if you obtain controlled substances from another practice or alter a prescription. These actions will be reported accordingly to the proper authorities.
- Before consuming any medication, it is important to thoroughly review and act in accordance with all manufacturer warnings and recommendations. This includes consumption of alcohol or drugs that will further deter your ability to operate vehicles or machinery. Interventional Pain Institute cannot assume responsibility for your failure to do so.
- Treatment for chronic pain is a multimodal—just medication will never work long-term. As such, all patients on opioids agree to comply with our multidisciplinary program, inclusive of regular physical therapy and counseling.
- Pain must be treated at its source, not just as a symptom. As such, diagnostic testing upon admission and intermittently thereafter is required—all conditions change and must be objectively monitored with time.

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 Provider(s) an opportunity to review your case and determine adjustments, if necessary.

MISSED/RESCHEDULED APPOINTMENTS: IPI/OBT/APEX has the right to charge a fee of $25 for a missed therapy or testing appointment/$50 for a missed office visit/$100 for a missed procedure appointment not canceled and/or rescheduled at least 48 hours prior to your appointment. Therefore, if you have a Monday appointment, we require notification no later than the close of business on Thursday prior. 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 up to 30 days, 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 $0.73 per page.

COORDINATION of CARE: A $35 fee will be charged for any requested letter and/or medical statement issued from the Provider(s). 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(s).

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. **If you have been discharged from another pain practice, we require a discharge letter be faxed to our office prior to your initial visit.** These records can either be sent to our office by mail 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.**

By signing below, I agree to act in accordance with the aforementioned terms and conditions outlined in this policy and understand that my inability to comply will result in my immediate and permanent termination from the Interventional Pain Institute's comprehensive treatment program.

____ ________________________

Signature of Patient or Guarantor Date