COMMONWEALTH SPINE & PAIN SPECIALISTS

VIRGINIA'S PROVEN INTERVENTIONAL PAIN EXPERTS

Demographic Information

****Please print legibly.****

Patient Name: _____ DOB: _____ SSN: _____

Marital Status (Circle One): S M W Sep. D Other Sex: F M

Current Address: _____

City: _____ State: _____ Zip: _____

Home Ph. #: _____ Cell Ph. #: _____ Email: _____

Emergency Contact Name & Relationship: _____ Phone #: _____

Referring Doctor: _____ Phone #: _____

PCP: _____ Phone #: _____

Reason For Referral: _____

Employer (REQUIRED FOR WORK COMP): _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work #: _____ Work Fax #: _____

Preferred Pharmacy Name: _____ Location: _____

Insurance Information

We need to make a copy of each insurance card. It is the Patient's responsibility to make sure CSPS has the most up to date information.

Primary Insurance Co.: _____ Effective Date: _____

INS. Address (on back of card): _____ Ph. #: _____

Policy Holder's Name: _____ Date of Birth: _____

Relation to Patient: _____ Member ID: _____ Group #: _____

Secondary Insurance Co.: _____ Effective Date: _____

INS. Address (on back of card): _____ Ph. #: _____

Policy Holder's Name: _____ Date of Birth: _____

Relation to Patient: _____ Member ID: _____ Group #: _____

_____ _____

Signature of Patient Date

_____ _____

Printed name of Patient Relationship to Patient

1501 Maple Avenue • Suite 301 • Richmond, VA 23226
Ph: (804) 288-7246 • Fax: (804) 288-7245
www.CommonwealthSpineandPain.com

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Financial/Appointment Policies

Please **initial** that you have read each section and sign at the bottom.

_____
Initial

Insurance

- I understand it is my responsibility to provide current, accurate billing information at the time of check in and to notify Commonwealth Spine & Pain Specialists (CSPS) of any change in this information.
- I understand that insurance companies have a limited time for filing claims, some as little as 90 days from time of service. In the event I do not provide accurate or current insurance information within my insurance plans timely filing, payment for these services will be my responsibility.
- I understand that it is my responsibility to obtain a referral (if required by my insurance). If a referral is not obtained, all charges will be the responsibility of the patient or guarantor.

_____
Initial

Payment for Services

- I understand that CSPS will estimate my responsibility for services. I understand that the patient responsibility amount for covered/non-covered services is a contractual agreement that I have with my insurance plan and an agreement between CSPS and my insurance. All estimated co-pays, co-insurance and deductibles not met are due at the time of service. If I am unable to pay the estimated amount, my appointment may be rescheduled. I understand that any additional patient responsibility, including fees for non-covered services, that are not paid at the time of services is payable in full within 30 days of the account statement.
- I understand that **any outstanding balance must be paid before I will be seen by the provider.**
- I understand that any charges billed to me and still outstanding after 90 days will be referred to a collection agency, attorney, or a subpoena for court will be issued. I agree to pay all cost of collections including, but not limited to attorney fees, collection agency fees, 1 ½ % judgments interest and court costs. I also agree that my employer may be contacted to verify my employment status. CSPS may resign as my provider of record if these collection efforts are necessary. Such notice will be provided in writing.
- I am aware that there is a **$35.00 service charge** for any returned checks and that CSPS may require future services be paid by cash or credit card.

_____
Initial

Appointments

- **I UNDERSTAND THAT I NEED TO HAVE A "RESPONSIBLE ADULT" (driver) DRIVE ME TO/FROM ANY PROCEDURE APPOINTMENT. This driver will need to stay in the waiting room while I'm receiving my procedure. I understand that if I do not bring a driver to my appointment, my procedure will be postponed and a $50.00 late cancellation fee will apply.**
- If I am unable to keep my appointment as scheduled, CSPS requires notification at a **minimum of 24 hours prior to my appointment**. In the event that the 24 hour minimum notice is not given, a fee **($50.00 for office visits; $100.00 for Surgery Center appointments)** will be charged (this fee is not covered by insurance) and must be paid prior to my next appointment. As a courtesy, CSPS provides an automated reminder call/text and email a day or two prior to most appointments. Please do not rely solely on this reminder.
- I understand that if I have (3) three appointments where the above proper notice is not given CSPS may resign as my provider of record. This notice of resignation will be provided in writing.
- It is important to arrive (15) fifteen minutes early for your appointment. Patients arriving on time without necessary information (insurance card, photo ID, paperwork, copay, etc.) or arriving late may be rescheduled.
- We recognize that everyone's time is valuable and make every effort to maintain an on time schedule; however, urgent situations sometimes alter the schedule. We ask for your understanding and patience during these delays. In these circumstances, patients have the option to reschedule their appointment, or wait for the provider to become available.

_____
Initial

Form Completion

- There is a fee **($50.00 for 1-2 pages; $100.00 for 3+ pages)** for the completion of forms such as: FMLA, Leave of Absence, etc. Pre-payment is required for any forms. Please allow five (5) business days for completion of these forms.

I have read the above policies regarding my responsibilities to CSPS for providing services to me or the patient listed below.

_____ _____
Signature of Patient Date

_____ _____
Printed name of Patient Relationship to Patient

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_____ Initial

CONSENT TO TREAT

I, the undersigned patient, consent to such treatment procedures as are deemed necessary by the provider, including those which are in addition to or different from those initially contemplated, and which are deemed necessary or advisable by the provider in the course of treatment.

_____ Initial

ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare or applicable private insurance benefits be paid directly to Commonwealth Spine & Pain Specialists for services provided under their care.

_____ Initial

RELEASE OF MEDICAL INFORMATION

I authorize Commonwealth Spine & Pain Specialists to release necessary medical information to my insurance company, its agents, or any third party payer in order for payable benefits for these services to be determined. I further authorize the release of medical information to my primary care physician (PCP) and/or referring physician. Further, I authorize Commonwealth Spine & Pain Specialists to forward my medical information to any provider deemed necessary for my medical care or to whom I may be referred.

_____ Initial

COLLECTION OF CO-PAYS AND DEDUCTIBLES

Per our agreement with your insurance carrier, you are required to pay any applicable copayments at the time of service (prior to being seen by our Providers). In addition, if you are insured with a high deductible insurance plan and have not met your deductible, we will collect the contracted rate for services prior to services being rendered. You agree, in order for us to service your account or to collect any amounts you may owe us, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I/we have read this disclosure and agree that our collection agency may contact me/us as described above.

_____ Initial

FINANCIAL RESPONSIBILITY

I understand that Commonwealth Spine & Pain Specialists will file my insurance claims as a courtesy; however, I understand that I am financially responsible for all charges whether or not paid by insurance. I agree to pay all balances due by me in a timely manner. All accounts are considered delinquent after 30 days and will be assessed a 1.5% per month, 18% per year finance charge. Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's responsible party, understands that Commonwealth Spine & Pain Specialists has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment of service rendered. The patient, or the patient's responsible party, understands and agrees to pay all collection including court cost and filing fees incurred by Commonwealth Spine & Pain Specialists. I understand and agree that should Commonwealth Spine & Pain Specialists be awarded judgment relating to this agreement or any debt incurred thereof, I will pay a service charge of one and one-half percent (1.5%) per month, beginning on the date of judgment.

_____ Initial

REFERRALS / AUTHORIZATIONS

I understand if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. If I do not have a referral I will be required to sign a waiver before being seen by the physician and payment in full for services rendered will be collected at the check-in desk.

_____ Initial

MISSED APPOINTMENTS

We require a minimum of twenty four (24) hour notice if you must cancel an appointment. In the event that the 24 hour minimum notice is not given, a fee **($50.00 for office visits; $100.00 for Surgery Center appointments)** will be charged (this fee is not covered by insurance) and must be paid prior to my next appointment. As a courtesy, CSPS provides an automated reminder call, text and/or email (correct demographics must be provided to the office) a day or two prior to most appointments. Please do not rely solely on this reminder

_____ Initial

RETURNED CHECKS

Our office will charge $35.00 for any check that is returned to us for insufficient funds.

I acknowledge that Commonwealth Spine & Pain Specialists will scan this document and may or may not destroy the original. I agree that the scanned document will have the same binding effect as the original. I have read the above policies regarding my responsibilities to CSPS for providing services to me or the patient listed below.

_____ Signature of Patient

_____ Date

_____

_____

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COMMONWEALTH SPINE & PAIN SPECIALISTS

VIRGINIA'S PROVEN INTERVENTIONAL PAIN EXPERTS

Printed name of Patient Relationship to Patient

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICIES

Our Notice of Privacy Practices (NPP) provides information about how Commonwealth Spine & Pain Specialists may use and disclose protected health information (PHI). As specified in the NNP, Commonwealth Spine & Pain Specialists *intends to use and disclose the minimum necessary PHI about you for treatment, payment or health care operation purposes. I understand that at any time I may ask questions to Commonwealth Spine & Pain Specialists if I do not understand any information contained in the NPP.*

I, _____, have had the opportunity to review the Notice of Privacy Practice for Commonwealth Spine & Pain Specialists and I was offered and;

**********ONLY INITIAL ONE**********

_____ *I have received a copy of the NOTICE OF PRIVACY PRACTICES (NPP)*
Initial

_____ *I declined a personal copy of the NOTICE OF PRIVACY PRACTICES (NPP)*
Initial

As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy. This notice is posted in our office and copies are available at any time.

HIPAA CONSENT

For medical results and/or messages:
You may leave a message at the phone number listed below (message may contain PHI) *[ ] Yes [ ] No*

*During daytime hours, you may contact **ME** at this phone number:* _____
Phone Number

For Financial Information:
You may leave a message at the phone number listed below (message may contain PHI) *[ ] Yes [ ] No*

*During daytime hours, you may contact **ME** at this phone number:* _____
Phone Number

I understand that disclosures of Personal Health Information (PHI) may be made to family and/or friends in accordance with my instructions below. As well as only information relevant to current treatment/billing will be disclosed. I understand that once my Provider discloses my PHI to the persons listed herein, my Provider/CSPS has no control as to whether those persons may re-disclose my PHI, which may no longer be protected by federal or state law. Accordingly, I authorize the disclosure of health care information to (list all that apply):

Name	Relationship	In Person	By Phone	Okay to Leave Message	Phone Number

I acknowledge that Commonwealth Spine & Pain Specialists will scan this document and may or may not destroy the original, and agree that the scanned document will have the same binding effect as the original.

_____ _____
Signature of Patient Date

_____ _____

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VIRGINIA'S PROVEN INTERVENTIONAL PAIN EXPERTS

Printed name of Patient Relationship to Patient

General Medical Records Release and

Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: _____
Address: _____
_____
Phone Number: _____
SSN: _____ Date of Birth_____/_____/_____

I, _____, authorize _____ (name of physician/practice and/or hospital) to disclose/release the following information. (Check all that apply.)

- ☐ All records
- ☐ Laboratory/pathology records
- ☐ X-ray/radiology records
- ☐ Abstract/Summary
- ☐ Pharmacy/prescription records
- ☐ Other (describe): _____
  _____

Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

These records are for services provided on the following date(s): _____

Please send the records listed above to:

Commonwealth Spine & Pain Specialists
1501 Maple Avenue, Suite 301
Richmond, VA 23226
PH: (804) 288-7246
FAX: (804) 288-7245

The information may be used/disclosed for each of the following purposes:

- ☐ At my request (only the patient can check this box)
- ☐ For my health care
- ☐ For payment/insurance
- ☐ For employment purposes
- ☐ Other: _____
  _____

This information shall expire no later than ____/____/____ or upon the following event _____ (whichever is sooner).

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information (PHI) and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this PHI.

_____ _____
Signature of Patient Date

_____ _____
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COMMONWEALTH SPINE & PAIN SPECIALISTS

VIRGINIA'S PROVEN INTERVENTIONAL PAIN EXPERTS

Health History

Name: _____ **Date of Birth**: _____/_____/_____

How were you referred to Commonwealth Spine & Pain Specialists?

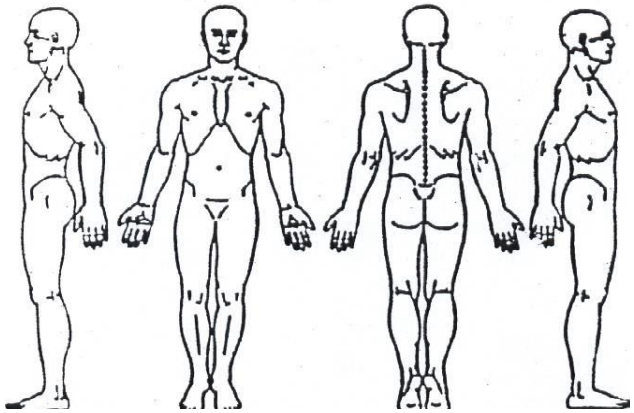
- ☐ PCP Physician: _____
- ☐ Other Physician: _____
- ☐ Work Comp - Claim Number: _____
- ☐ Other: _____

Tell us why you are here today:

- ☐ Lower Back Pain
- ☐ Mid Back pain
- ☐ Neck Pain
- ☐ Shoulder/Arm Pain
- ☐ Hip and Leg Pain
- ☐ Other: _____

How and when pain began (date/nature of injury): _____

Where is your pain?



Frequency of Pain:

- ☐ Intermittently
- ☐ Occasionally
- ☐ Frequently
- ☐ Constantly

Description of Pain:

- ☐ Stinging
- ☐ Achy
- ☐ Tingling
- ☐ Numb
- ☐ Stabbing
- ☐ Coolness
- ☐ Tender
- ☐ Shooting
- ☐ Burning
- ☐ Dull
- ☐ Spasms
- ☐ Throbbing

Severity of Pain:

Circle a number to indicate your usual level of pain.

0 1 2 3 4 5 6 7 8 9 10

No Pain **Moderate** **Severe Pain**

What activities increase and decrease your pain:

ACTIVITY	INCREASES PAIN	DECREASES PAIN
Sitting		
Standing		
Walking		
Bending		
Other		

Additional Symptoms (occur with current pain):

- ☐ Swelling
- ☐ Bowel Dysfunction
- ☐ Weakness in Legs
- ☐ Bladder Dysfunction
- ☐ Weakness in Arms/Hands
- ☐ Temperature Change
- ☐ Color Change

Prior Pain Treatment:

Treatment	Date	Physician
Injection Therapy		
Physical Therapy		
Chiropractor		
Acupuncture		
TENS		
Medication		
Other		

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Have you had any diagnostic imaging (MRI, CT, x-rays, bone scan) within the past 6 months? Yes ☐ No ☐

If yes, what facility? _____

Check the following conditions/problems that you have received treatment for at <u>any time during your life.</u>

❑ AIDS	❑ Emphysema	❑ Measles	❑ Stomach Ulcer
❑ Alcoholism	❑ Glaucoma	❑ Migraine Headaches	❑ Stroke
❑ Anorexia/Bulimia	❑ Heart Disease	❑ Mononucleosis	❑ Thyroid Condition
❑ Arthritis	❑ Hepatitis Type: _____	❑ Multiple Sclerosis	❑ Tuberculosis
❑ Asthma/COPD	❑ Hernia	❑ Mumps	❑ Typhoid Fever
❑ Bleeding Disorder	❑ High Cholestorol	❑ Pacemaker Implant	❑ Vascular Disease
❑ Cataracts	❑ HIV Positive	❑ Pneumonia	❑ Other (list)
❑ Cancer Type: _____	❑ Hypertension	❑ Polio	_____
❑ Chicken pox	❑ Kidney Disease	❑ Prostate Problems	_____
❑ Diabetes Type: _____	❑ Liver Disease	❑ Psychiatric Conditions	_____
❑ Drug Dependency		❑ Rheumatic Fever	_____

Are you allergic to any of the following? (Describe type of reaction)

a. Shellfish	☐ Yes	☐ No	_____
b. Contrast Dye	☐ Yes	☐ No	_____
c. Local Anesthetic	☐ Yes	☐ No	_____
d. Medications	☐ Yes	☐ No	_____

If 'Yes,' indicate which medications:_____

Are currently taking any Blood Thinners? (ie: Plavix, Coumadin, Asprin) Yes ☐ No ☐

What Medications are you <u>CURRENTLY</u> taking? (attach a separate piece of paper if needed)

Medication Name	Dose (#mg)	Times Taken Per Day

What Medications did you <u>PREVIOUSLY</u> take for your pain?

Medication Name	Dose (#mg)	Times Taken Per Day

Surgical History – Please list any previous surgeries and their respective dates

Date	Surgery

Please (√) any conditions experienced by your parents, grandparents, children, or siblings:

Condition	Mother or Father	Brother or Sister	Grandparent	Children
High Blood Pressure				
Diabetes				
Cancer				
Heart Disease				
Stroke				
Back/Neck Pain				
Rheumatoid Arthritis				

COMMONWEALTH SPINE & PAIN SPECIALISTS

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Social / Vocational / Work History:

Do you smoke cigarettes? ☐ Yes ☐ Never ☐ Former Smoker

Do you have a history of alcohol or drug abuse? ☐ Yes ☐ No

Employment Status: ☐ Unemployed ☐ Disabled ☐ Employed ☐ Full Time ☐ Part Time

Occupation: _____

If unemployed right now, indicate the last date worked: ____/____/____

If out of work, what was your reason for leaving? ☐ Due to pain problem ☐ Not due to pain

Review of Systems:

Please check (√) any of the following symptoms or problems that you have experienced during the last six (6) months

CONSTITUTIONAL	**CARDIOVASCULAR**	**GASTROINTESTINAL**
❑ Weight gain	❑ Heart Murmur	❑ Diverticulitis
❑ Weight loss	❑ Heart Attack	❑ Liver Disease
❑ Marked fatigue	❑ High Blood Pressure	❑ Diarrhea
❑ Fever	❑ Irregular Heart Beat	❑ Irritable Bowel Disease
❑ Depression/Anxiety	❑ Coronary Artery Disease	❑ Ulcers
❑ Change in sleep pattern due to pain	❑ High Cholesterol	❑ Colitis
		❑ Hiatal Hernia
		❑ GERD/Reflux
MUSCULOSKELETAL	**NEUROLOGICAL**	**RESPIRATORY**
❑ Arthritis	❑ Headaches	❑ Persistent cough
❑ Ambulation Aid:	❑ Blackouts/Fainting	❑ Coughing up blood
❑ Cane	❑ Seizures	❑ Wheezing
❑ Walker	❑ Memory loss	
❑ Crutches		
EARS, NOSE & THROAT	**SKIN**	**EYES**
❑ Loss of hearing	❑ Skin Cancer	❑ Blind
❑ Vertigo/Dizziness	❑ Psoriasis	❑ Blurred vision
❑ Ringing in ears	❑ Other:	❑ Double vision
❑ Sinus problems	_____	❑ Eye pain
GENITOURINARY	**PULMONARY:**	**HEMATOLOGICAL/LYMPHATIC**
❑ Bladder Problem: _____	❑ Emphysema	❑ Blood Thinner
❑ Kidney Problem: _____	❑ Shortness of Breath	❑ Anemia
	❑ Asthma	❑ Other: _____

Patient Signature: _____ **Date _____**

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Join Our Patient Portal!

What can I do with FollowMyHealth™ Universal Health Record?

- Review your medical records online in a safe, secure environment
- Communicate privately with physicians via secure messaging
- View test and lab results, read medical notes from your doctor
- Update your health information (allergies, medications, conditions, etc.)
- Request Rx refills
- Schedule or change appointments
- Fill out and submit forms prior to appointments

...and more!

And it's available online 24 hours a day, 7 days a week via any computer, tablet, or smart phone!

TO JOIN:

✓ Click on the link in the FollowMyHealth invitation you receive (see attached example)

✓ Follow the step by step instructions

If you have questions or concerns please contact Rebecca Trotier at rtrotier@commonwealthpain.com

---

Please fill out the below form and we will send you an email from FollowMyHealth to join our Patient Portal!

Patient Name: _____ Last four of SSN: _____

E-Mail Address: _____ Date of Birth: _____

By signing below, I authorize Commonwealth Spine & Pain Specialists to enroll me in their Patient Portal. I further understand that the Patient Portal is NOT for emergency situations, and I will contact the office by phone for those situations.

_____ _____

Patient Signature Date

By signing below, certify that I'm not interested in signing up for the Patient Portal at this time.

_____ _____

Patient Signature Date

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VIRGINIA'S PROVEN INTERVENTIONAL PAIN EXPERTS

Example Email

Trotier, Rebecca

From:	FollowMyHealth [noreply@followmyhealth.com]
Sent:	Friday, April 24, 2015 1:49 PM
To:	Trotier, Rebecca
Subject:	Commonwealth Pain Specialists Invites to join FollowMyHealth patient portal

Commonwealth Pain specialists

Dear Rebecca Trotier,

Congratulations on joining the new generation of patients who are taking a proactive role in managing their health care with FollowMyHealth.

Click Here to begin the registration process.

#1 Choose a login method on the registration screen. Use one of the IDs you already have for Google, Yahoo, Facebook or Windows Live. If you do not already have one of these accounts, you will be prompted to create a Google account for a login.

#2 Accept the agreement to share your email/username. This is solely for the purpose of authenticating your online health record account. Your email will never be shared or sold.

#3 Enter your Invitation Code. This is the last four digits of your social security number or number provided by clinic. Click "Agree" to the release of information.

You will then be ready to access and manage your personal health record in a secure online environment 24 hours a day / 7 days a week, from any computer, smartphone or tablet!

Don't forget – with FollowMyHealth you can review your medical information…update your demographic data…connect with physician offices for secure messaging…make new appointments…request prescription refills and so much more!
Thank you for signing up to use FollowMyHealth!

Sincerely,

Your FollowMyHealth team

- Bookmark FollowMyHealth Universal Health Record online at https://commonwealthpain.followmyhealth.com/bookmark
-