



**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



## Financial/Appointment Policies

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

### Insurance

Initial

- 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.

### Payment for Services

Initial

- 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.

### Appointments

Initial

- **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.

### Form Completion

Initial

- 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

**CONSENT TO TREAT**

Initial

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.

**ASSIGNMENT OF BENEFITS**

Initial

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.

**RELEASE OF MEDICAL INFORMATION**

Initial

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.

**COLLECTION OF CO-PAYS AND DEDUCTIBLES**

Initial

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.

**FINANCIAL RESPONSIBILITY**

Initial

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.

**REFERRALS / AUTHORIZATIONS**

Initial

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.

**\*\*MISSED/LATE CANCELLATION APPOINTMENTS\*\***

Initial

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.

**RETURNED CHECKS**

Initial

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

\_\_\_\_\_  
Printed name of Patient

\_\_\_\_\_  
Relationship to Patient



**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES**

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 NPP, 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

\_\_\_\_\_  
 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

\_\_\_\_\_  
Printed name of Patient

\_\_\_\_\_  
Relationship to Patient

**Health History**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**How were you referred to Commonwealth Spine & Pain Specialists?**

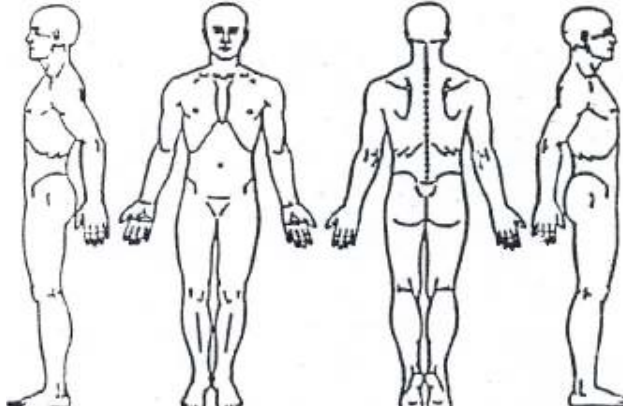
PCP Physician: \_\_\_\_\_  Work Comp - Claim Number: \_\_\_\_\_  
 Other Physician: \_\_\_\_\_  Other: \_\_\_\_\_

**Tell us why you are here today:**

Lower Back Pain  Neck Pain  Hip and Leg Pain  
 Mid Back pain  Shoulder/Arm 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  Tingling  Stabbing  Tender  Burning  Spasms  
 Achy  Numb  Coolness  Shooting  Dull  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 (occurs with current pain):**

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

**Prior Pain Treatment:**

Treatment	Date	Physician
Injection Therapy		
Physical Therapy		
Chiropractor, Acupuncture		
Home Exercises		
NSAIDs(Ibuprofen, Advil, Aleve, Motrin)		
Oral Steroids		
Other		

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

If yes, what facility? \_\_\_\_\_

**Medical History-Check the following conditions/problems that you have received treatment for at any time during your life.**

NONE

<input type="checkbox"/> AIDS	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Stroke
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Thyroid Condition
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Asthma/COPD	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Typhoid Fever
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Liver Disease/Cirrhosis	<input type="checkbox"/> Vascular Disease
<input type="checkbox"/> Cancer Type: _____	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Other (list)
<input type="checkbox"/> Diabetes Type: _____	<input type="checkbox"/> Multiple Sclerosis	_____
<input type="checkbox"/> Drug Dependency	<input type="checkbox"/> Pacemaker Implant	_____
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Prostate Problems	_____
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Psychiatric Conditions	_____
<input type="checkbox"/> Hepatitis Type: _____	<input type="checkbox"/> Rheumatic Fever	_____
<input type="checkbox"/> Hernia	<input type="checkbox"/> Stomach Ulcer	_____

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

a. Shellfish	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
b. Contrast Dye	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
c. Steroids	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
d. Local Anesthetic	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
e. Latex	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
f. Medications	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

If 'Yes,' indicate which medications: \_\_\_\_\_

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

Have you ever been told you need to take antibiotics prior to any dental or surgical procedures?  Yes  No

List all **CURRENT** medications you are taking for your pain and health conditions, including supplements (attach a separate piece of paper if needed)

Medication Name	Dose (#mg)	Times Taken Per Day

What medications did you **PREVIOUSLY** take for your pain?  NONE

Medication Name	Dose (#mg)	Times Taken Per Day

Surgical History - Please list any previous surgeries and their respective dates.  NONE

Date	Surgery

Identify any conditions experienced by your parents, siblings or children.  UNKNOWN

Condition	Mother (M) or Father (F)	Brother(B)or Sister(S)	Children (D or S)
High Blood Pressure			
Diabetes			
Cancer			
Heart Disease			
Stroke			
Kidney Disease			
Rheumatoid Arthritis			
Neck/Back Pain			

**Social / Vocational / Work History:**

Do you smoke cigarettes?  Yes  Never  Former Smoker

Do you drink alcoholic beverages?  Yes  No Amount & Frequency? \_\_\_\_\_

Do you use recreational drugs?  Yes  No Type & Frequency? \_\_\_\_\_

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

**Employment Status:**  Unemployed  Disabled  Employed? (Circle one) Full Time/ Part Time  Retired

Current or most recent 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.

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

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## 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 Newman at [rnewman@commonwealthpain.com](mailto:rnewman@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

**Example Email**

**Trotier, Rebecca**

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**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>
-