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 (Circle One): 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: _____

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

Relation to Patient: _____

Secondary Insurance Co.: _____ Effective Date: _____

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

Relation to Patient: _____

_____ _____

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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CSPS Office Procedures and 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 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.
- 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/Financial Responsibility

- 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.
- 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.

_____ Initial

Consent to Treat/Release of Information

- 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. 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.

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

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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**********

_____ ***Initial*** *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)*

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

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COMMONWEALTH SPINE & PAIN SPECIALISTS
VIRGINIA'S PROVEN INTERVENTIONAL PAIN EXPERTS

General Medical Records Release

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

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General Medical Records Release

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 **COMMONWEALTH SPINE & PAIN SPECIALISTS** 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:

THE PATIENT LISTED ABOVE

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 Representative's authority to sign for Patient *(parent, guardian, POA for healthcare, or executor)*.

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Health History

Name: _____ **Date of Birth**: ____/____/____ Today's Date: ____/____/____

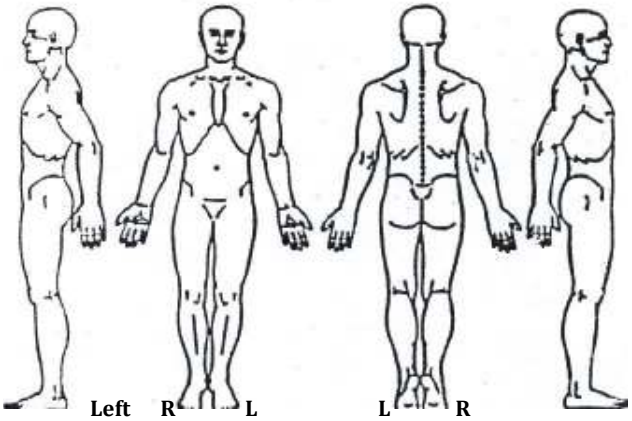
How were you referred to Commonwealth Spine & Pain Specialists?

- ☐ PCP Physician: _____
- ☐ Other Physician: _____
- ☐ Self-Referred or Source_____
- ☐ Work Comp(Date of Injury): _____
- ☐ Motor Vehicle Accident (Date of Incident_____)

Are you in litigation? Y/N Attorney's Name_____

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

Shade in the areas where you feel pain?



Frequency of Pain:

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

Are you right-handed or left-handed?

Description of Pain:

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

Severity of Pain: (0= no pain, 10= unbearable)

Pain level today:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Most Severe Pain Level:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Average Pain Level:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Circle all that apply:

What activities increases your pain?
nothing sitting standing walking
driving lifting bending coughing
sneezing changing body positions

What activities decreases your pain?
nothing sitting standing walking resting
driving lifting bending sleeping ice heat
stretching massage changing body positions

Has your pain affected any of the following?
Activities of Daily Living (basic daily tasks)
Work/Home Duties
Recreational Activities
Sleep

Additional Symptoms (occurs with current pain):

- ☐ Swelling
- ☐ Bowel/Bladder Dysfunction
- ☐ Weakness in Legs
- ☐ Numbness
- ☐ Weakness in Arms/Hands
- ☐ Tingling
- ☐ Other_____

Prior Pain Treatment:

Treatment	When? How Long?	Any Relief? Yes/No
Injection Therapy		
Physical Therapy		
Chiropractor or Acupuncture		
Home Exercises		
NSAIDs (Ibuprofen, Advil, Aleve, Motrin)		
Oral Steroids		
Nerve Pain Medication (Gabapentin, Lyrica)		
Muscle Relaxers		
Other prior treatments		

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Have you had any diagnostic imaging (MRI, CT, x-rays, bone scan) within the past 12 months? ☐ **Yes** ☐ **No**

If yes, what facility? _____

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

☐ NONE

❑ Alcoholism	❑ Drug Dependency	❑ Migraine Headaches
❑ Anxiety	❑ Emphysema	❑ Pacemaker Implant
❑ Arthritis	❑ Heart Disease	❑ Prostate Problems
❑ Asthma	❑ Hepatitis Type: _____	❑ Stomach Ulcer
❑ Bleeding Disorder	❑ High Cholesterol	❑ Stroke
❑ Cancer Type: _____	❑ HIV Positive	❑ Thyroid Condition
❑ COPD	❑ Hypertension	❑ Vascular Disease
❑ Diabetes Type: _____	❑ Kidney Disease	❑ Other (list)
❑ Depression	❑ Liver Disease/Cirrhosis	_____
		_____
		_____
		_____

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

a. Shellfish	☐ Yes	☐ No	_____
b. Contrast Dye	☐ Yes	☐ No	_____
c. Steroids	☐ Yes	☐ No	_____
d. Local Anesthetic	☐ Yes	☐ No	_____
e. Latex	☐ Yes	☐ No	_____
f. Medications	☐ Yes	☐ No	_____

If 'Yes,' indicate which medications: _____

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

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

List all <u>CURRENT</u> medications you are taking for your health conditions as well as your pain, including supplements ☐ **NONE**

Medication Name	Dose (#mg)	Times Taken Per Day

What medications have you <u>PREVIOUSLY</u> taken for your pain? ☐ **NONE**

Medication Name	Dose (#mg)	Times Taken Per Day

Surgical History – Please list any previous surgeries and their respective dates. ☐ **NONE**

Month/Year	Surgery

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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			

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 out of work, what was your reason for leaving? ☐ Due to pain problem ☐ Not due to pain Last date worked: ____/____/____

Review of Systems: (Check all that apply)

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

CONSTITUTIONAL	CARDIOVASCULAR	GASTROINTESTINAL
❑ Weight gain ❑ Weight loss ❑ Marked fatigue ❑ Fever ❑ Depression/Anxiety ❑ Change in sleep pattern due to pain	❑ Heart Murmur ❑ Heart Attack ❑ High Blood Pressure ❑ Irregular Heartbeat ❑ Coronary Artery Disease ❑ High Cholesterol	❑ Diverticulitis ❑ Liver Disease ❑ Diarrhea ❑ Irritable Bowel Disease ❑ Ulcers ❑ Colitis ❑ Hiatal Hernia ❑ GERD/Reflux
MUSCULOSKELETAL	**NEUROLOGICAL**	**RESPIRATORY**

❑ Arthritis
❑ Ambulation Aid:
  ❑ Cane
  ❑ Walker
  ❑ Crutches
	❑ Headaches
	❑ Blackouts/Fainting
	❑ Seizures
	❑ Memory loss
		❑ Persistent cough
		❑ Coughing up blood
		❑ Wheezing

EARS, NOSE & THROAT	**SKIN**	**EYES**
❑ Loss of hearing ❑ Vertigo/Dizziness ❑ Ringing in ears ❑ Sinus problems	❑ Skin Cancer ❑ Psoriasis ❑ Other: _____	❑ Blind ❑ Blurred vision ❑ Double vision ❑ Eye pain
GENITOURINARY	**PULMONARY:**	**HEMATOLOGICAL/LYMPHATIC**
❑ Bladder Problem: _____ ❑ Kidney Problem: _____	❑ Emphysema ❑ Shortness of Breath ❑ Asthma	❑ Blood Thinner ❑ Anemia ❑ Other: _____

Patient Signature: _____ **Date:** _____

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Join Our Patient Portal!

What can I do with FollowMyHealth™ Universal Health Record?

- Communicate privately with physicians via secure messaging
- Update your health information (allergies, medications, conditions, etc.)
- Request Rx refills...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 the office directly.

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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Example Email

From: FollowMyHealth <noreply@followmyhealth.com>
Sent: Friday, April 1, 2022 2:08 PM
To: Office Manager
Subject: Commonwealth Pain Specialists Invites to join FollowMyHealth patient portal

Dear Office Manager,

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
-