 3731 Rainbow Drive, Suite B

 Rainbow City, AL 35906

**Medication List**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- |
| **Medication** | **Strength** | **Frequency** | **Prescribing MD** |
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**HIPPA Disclosure Form**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

May we identify ourselves over the phone? \_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_ No

May we leave messages? \_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_ No

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize the physician to release my medical information (appointments, test results, diagnosis, treatment, medications) to the following family members:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I further release my medical information to the following physicians, or clinics

Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_

Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_

Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_

Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_

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**Financial Policy**

We are committed to providing you with the best possible medical care; if you have special needs, we are here to work with you. The following information is provided to avoid misunderstanding or disagreement concerning payment for professional services:

1. Our office participates with multiple insurance plans. It is your responsibility to:
* Bring your insurance card to every visit.
* Be prepared to pay your copay at each visit. Payment can be made by cash, or credit card.
* For medical care that your insurance does not cover, payment will be due at time of visit, unless payment arrangements have been made.
1. If you have insurance that we do not participate, we will be happy to file the claim; however if no payment is received total amount will be due at next office visit.
2. If your insurance requires a Physician referral ultimately it is the patients responsibility to have referral at time of appointment.
3. If you do not have insurance; first appointment will be $200.00, follow up appointments $100.00, which will be due at time of service.
4. If you have questions regarding your insurance, we are happy to help you. Specific coverage issues should be directed to your insurance company member services. (phone number is normally on back of card).

We firmly believe at Premier Pain & Spine that a good physician/patient relationship is based upon understanding and communication. Questions regarding a financial arrangement should be directed to our Office Manager and Billing Department.

Please Sign that you have read and agree to this Policy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient /Responsible Party Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Co-Responsible Party (if applicable) Date

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**Pain Treatment with Opioid Medications: Patient Agreement**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand and voluntarily agree that (initial each statement after reviewing):

\_\_\_\_\_ I will keep (and be on time for) all my scheduled appointments with the doctor or other members of the treatment team.

\_\_\_\_\_ I will not call between appointments, or at night or on the weekends looking for refills. I understand that prescriptions will be filled only during scheduled office visits with provider.

\_\_\_\_\_ I will keep medicine safe, secure and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment and may not be replaced at all.

\_\_\_\_\_ I will take my medication as instructed. I will not take more pills or take them more frequently than prescribed.

\_\_\_\_\_ I will not sell this medicine or share it with others. I understand that if I do my treatment will be stopped. I will not take anyone else medication.

\_\_\_\_\_ I will tell the doctor all other medicines that I take and let him/her know right away if I have a prescription of new medication.

\_\_\_\_\_ I will participate in all other types of treatment that I am asked to participate in.

\_\_\_\_\_ I will always treat the staff at the office respectfully. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

\_\_\_\_\_ I will sign a release form to let the doctor speak to all other doctors or providers that I see.

\_\_\_\_\_ I understand that my doctor or his/her staff will check the state prescription drug database to prevent against overlapping prescriptions.

\_\_\_\_\_ I will use only one (1) pharmacy to get all my medicines\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 Pharmacy name/phone #

\_\_\_\_\_ I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment will be stopped.

\_\_\_\_\_ I will come in for random drug testing and counting of my pills within the same day of being called. I understand that I must make sure the office has current contact information in order to reach me, and that any missed test will be considered noncompliant, and my treatment will be stopped.

\_\_\_\_ I will keep up to date with any bills from the office and tell the doctor or member of the treatment team immediately if I lose my insurance or can’t pay for treatment anymore.

\_\_\_\_\_ I understand that I may lose my right to treatment if I break any part of this agreement.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

**Patient signature Patient name printed Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

**Witness signature Witness name printed Date**



[**New PT Intake Symptoms Form**](http://premier.plexamedia.com/new-patient-forms/)

Do you have a history of or experience any of the following symptoms or problems

Please circle **YES** or **NO** for each problem

**YES NO** Blurry Vison

**YES NO** Glaucoma

**YES NO** Ringing in your ears

**YES NO** Clenching your teeth

**YES NO** Tightness in your chest or chest pain

**YES NO** Heart disease or irregular heart beats

**YES NO** Need to sleep sitting up in order to get your breath

**YES NO** Difficulty breathing

**YES NO** Emphysema or asthma

**YES NO** Abdominal pain

**YES NO** Stomach ulcer or gastritis

**YES NO** Irregular bowel

**YES NO** Irritable bowel disease

**YES NO** Blood in your stool

**YES NO** Pelvic pain

**YES NO** Frequent urination

**YES NO** Inability to urinate

**YES NO** Seizures

**YES NO** Frequent headache

**YES NO** Episodes of blacking out or passing out

**YES NO** Unexplained fevers

**YES NO** Excessive fatigue

**YES NO** Difficulty falling asleep or staying asleep

**YES NO** Rashes

**YES NO** Rheumatoid arthritis, lupus, sarcoid or scleroderma

**YES NO** Diabetes

**YES NO** Thyroid problems

**YES NO** Depression

**YES NO** Anxiety

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**Patient Information Sheet**

**OFFICE HOURS:**

* Monday through Thursday 8:00am – 5:30pm. We are closed all major holidays.

**APPOINTMENT EXPECTATIONS:**

* Please give 24-hour advance notice for cancellations. If you do not provide notice, are greater than 15 minutes late, or do not show for your appointment you may be charged a $25.00 fee.
* If you have tried and failed all other treatment modalities, the goal is to reduce the pain and improve quality of life.
* We attempt to run on schedule as much as possible, but there are multiple reasons why we could possibly run behind: Some patients have very complex pain pathology and could require more time. Every patient is given the time necessary for understanding his/her pathology, treatment methods and long- term goals.

**REMINDER OF SPECIFIC TERMS SIGNED IN YOUR CONTRACT:**

* Random pill counts and urine drug screening are done on every patient.
* Medication is not refilled between appointments even if stolen.
* Keep medication locked securely that only you (the patient) has access.
* Take medication as prescribed by the provider.
* Only use one (1) pharmacy
* Participate in all other treatment provider ask to participate in.

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**Demographics**

**Patient Information \_\_** Single **\_\_** Married **\_\_** Widowed **\_\_**Divorced

Sex: \_\_\_\_ M \_\_\_\_ F

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle Initial: \_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_Zip code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Drivers License # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Spouse Information:**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle Initial: \_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Insurance Information**

Insurance Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy Holder** \_\_\_\_ Self \_\_\_\_ Spouse \_\_\_\_ other

**Policy Holder Information** (only if different from patient)

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle Initial: \_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance Information** (if applicable)

Insurance Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy Holder:** \_\_\_\_Self \_\_\_\_ Spouse \_\_\_\_ other

**Policy Holder Information** (only if different from patient)

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle Initial: \_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_