Today's Date: _____

Annapolis Pain Management
45 Old Solomons Island Rd. Ste 205
Annapolis, MD 21401
P: 410-224-4348 F: 410-224-4732

# PATIENT INFORMATION

Name: _____ Age: _____ Gender: M F Birth Date: ___/___/_____

Home Address: _____ City, State, Zip: _____

Home Phone: (_____) _____ - _____ Cell : (_____) _____ - _____ Work: (_____) _____-_____

Email Address: _____

May we include you on our email list? Y N (You will be included unless you opt out.)

Occupation: _____ Marital Status: S M D W

Spouse's Name: _____ Phone #: (_____) _____-_____

Names of Children: _____ Ages: _____

Primary Care Physician: _____ Phone #: (_____) _____-_____ Office Name: _____

How were you referred to our office? ☐ Family/Friend: _____

☐ Google ☐ Social Media ☐ Promo Offer ☐ Event ☐ Insurance Website ☐Other: _____

# REASON FOR TREATMENT

**-Complaint #1 :** _____ **Location: L / R / Bilateral**

**- When it started:** ☐ **days** ☐ **weeks** ☐ **months** ☐ **years** **Date**_____

- **Severity of Discomfort:** on a pain scale (0-10) with 0 being no pain and 10 being highest.

**Current** ____/10 At it's **Best** ____/10 At it's **Worst** ____/10 **Average** ____/10

**- Mechanism of injury (How it happened):** _____

**- Frequency:** ☐ Constant ☐ Frequent ☐ Intermittent ☐ Off and On ☐ Random ☐ Recurring

**- Quality:** ☐ Aching ☐ Burning ☐ Tingling ☐ Numbing ☐ Sharp ☐ Other_____

**- Radiating Pain:** ☐ None To:_____

**- Provoking factors:**_____

**- Modifying factors:** Relieved by: _____

**- Medications Tried:** ☐ NSAID ☐ Steroid ☐ Muscle Relaxer ☐ Rx. Pain Med

**- Previous Episodes:** ☐ Yes ☐ No Details:_____

**- Previous Care:** ☐ Medical ☐ Physical Therapy ☐ Chiropractic ☐ Other:_____

**- Recent Diagnostic Tests:** ☐ YES ☐ NO Details:_____

**- ADL/Functional Deficits most affected:** ☐ Work ☐ Lifting ☐ Personal Care ☐ Sitting

☐ Standing ☐ Bending ☐ Sleeping ☐ Traveling ☐ Driving ☐ Walking

**- Patient Short Term Goals:**

_____

**- Patient Long Term Goals:**

_____

# INSURANCE INFORMATION

I clearly understand that all insurance coverage, whether accident, work related, or general health coverage is an arrangement between my insurance carrier and myself. I understand that if this office chooses to bill any services to my insurance carrier they are performing these services strictly as a convenience to me. Annapolis Pain Management will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid claims or balances.

I understand that there may be some services that my insurance company will not cover. If my insurance company notifies me that they are refusing payment for any services I have received, I will contact Annapolis Pain Management immediately to notify them of the nonpayment/rejection notice.

Patient's Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

Who should receive charges on your account?

□ Health Insurance □ Medicare □ Auto Insurance □ Worker's Compensation
□ Patient □ Spouse □ Parent/Guardian

Name of Insurance Company _____ Policy # _____ Group # _____

Policy Holder's Information (if different from patient)

Insured's Name_____ Insured's DOB _____/_____/_____

Relationship to Patient _____ Insured's SSN _____-_____-_____

Do you have a secondary or supplemental insurance policy? Y N

Secondary Insurance Company _____ Policy # _____ Group # _____

**If auto accident or work injury:**

Accident Location (City & State) _____ Date of injury _____

Which auto insurance should be billed for medical claims?
If you have a **Maryland** policy, we must bill the vehicle owner's insurance or your auto insurance, NOT the at-fault party's.
If you have a **Virginia** policy, we must bill your auto insurance or the vehicle owner's insurance, NOT the at-fault party's.
If you have a **DC** policy, we must bill your health insurance first; then your auto insurance if the accident happened outside DC.
***Please note: We cannot bill the at-fault party's auto insurance; we are required to bill your auto insurance or health insurance.***

Insurance Carrier _____ □ Patient's insurance □ Vehicle owner

Claim # _____ Policy State _____

Adjuster _____ Adjuster Phone # (_____) _____-_____

Mailing Address _____ Fax # (_____) _____-_____

Do you have an attorney on your case? Y N Attorney _____ Phone # (_____) _____-_____

Mailing Address _____ Fax # (_____) _____-_____

# MEDICAL HISTORY

***REVIEW OF SYSTEMS*** *****Check any and all of the following that have significantly affected you:

**MUSCULOSKELETAL**: (Other than presenting complaints for this visit)

☐ None ☐ Joint pain ☐ Swelling ☐ Stiffness ☐ Muscle Pain ☐ Instability Other:_____

**NEUROLOGICAL**: (Other than presenting complaints for this visit)

☐ None ☐ Numbness ☐ Tingling ☐ Dizziness ☐ Tremors ☐ Nervousness ☐ Anxiety

☐ Balance Disturbances ☐ Seizures Other:_____

**HEAD, EAR, NOSE, AND THROAT**

☐ None ☐ Corrective Lenses ☐ Blurred/Double Vision ☐ Eye Pain ☐ Earaches ☐ Difficulty Swallowing

☐ Nose Bleeds ☐ Sinus ☐ Allergy Other:_____

**CARDIOVASCULAR**

☐ None ☐ Chest Pain ☐ Palpitations ☐ Fainting Other:_____

**RESPIRATORY**

☐ None ☐ Shortness of Breath ☐ Wheezing ☐ Cough ☐ Asthma Other:_____

**GASTROINTESTINAL**

☐ None ☐ Heartburn ☐ Nausea ☐ Vomiting ☐ Constipation ☐ Diarrhea Other:_____

**RENAL**

☐ None ☐ Difficult/Painful Urination ☐ Frequency ☐ Urgency ☐ Incontinence Other:_____

**SKIN**

☐ None ☐ Skin Changes ☐ Poor Healing ☐ Rash / Itching ☐ Lesions Other:_____

**HEMATOLOGIC**

☐ None ☐ Easy Bleeding ☐ Easy Bruising Other:_____

**ENDOCRINE**

☐ None ☐ Excessive Thirst ☐ Excessive Urination ☐ Heat / Cold Intolerance Other:_____

**GENERAL**

☐ None ☐ Unexpected Weight Loss ☐ Unexpected Weight Gain ☐ Fever ☐ Chills ☐ Fatigue

***SOCIAL HISTORY***

Are you a smoker? Y N Current: _____ pk/day Previous: _____ years

Do you drink? Y N Current: _____ drinks/week Social settings/on occasion

Any other substance use? Y N Frequency: _____ Other: _____

Today's Date: _____

# CARE AUTHORIZATION & X-RAY CONSENT

I authorize and agree to allow the Provider to evaluate, diagnose, and treat my areas of complaint as they see fit. I understand that a thorough history and evaluation will be performed and a plan for care will be discussed. I also understand that treatment is not a guarantee of resolution of my conditions and if I have any exacerbations of my condition or concerns at any point during care, it is requested I immediately bring this to the attention of the treating provider or clinic manager.

My health care providers will not be held responsible for any health conditions or diagnosis, which are pre-existing, given by another health care practitioner, or are not related to conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctor's specific recommendations at this clinic that I will not receive the full benefits from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits to be directed to the doctor for services rendered.

I give my consent to allow Annapolis Pain Management, as deemed appropriate by the examining physician, to take radiographs (x-rays) of my spine and/or extremities. I affirm that to my knowledge I am not pregnant. **_____ (Initial)**

Patient's Signature _____ Date_____

I hereby authorize Annapolis Pain Management to administer care as deemed necessary to my child or dependent, a minor under the age of 18 years old.

I wish to be physically present for all treatment rendered to my minor child (circle): YES NO

I understand I must be present for all examination days and if there is any financial issue my minor child's care will be paused until I can be reached to discuss the issue.

**Parent/Guardian's Signature _____ Date _____**

# NOTICE OF PRIVACY PRACTICES

We care about our patients' privacy and are committed to protecting the confidentially of your personal and medical information. We are required by law to maintain the privacy of protected health information and to inform you of our privacy practices.

Treatment at Annapolis Pain Management is provided in an open room where other patients are also being treated. Other persons in the office may overhear some of your health information during the course of your treatment. Should you need to speak with your health care provider in private, the doctor or therapist will provide a private room for these conversations. You may also request a private room should you need to discuss financial matters with a billing professional.

Your personal information and clinical records may be used for the following purpose:

- To provide you with the best care and service possible, including for quality control and training purposes.
- To contact you with appointment reminders, health-related email messages, and birthday or holiday cards.
- To coordinate treatment with other health care professionals, including referring practitioners and primary care providers.
- To obtain payment, billing information and medical records may be provided to your insurance and to our billing service.

You have the following rights with regard to your health information:

- The right to review the above notice prior to signing this consent.
- The right to receive a copy of this notice of privacy practices for your records.
- The right to request restrictions as to how your personal or contact information may be used. Requests must be in writing.
- The right to request copies of your medical records. There may be a reasonable fee for photocopying and postage.
- The right to ask us, in writing, to amend your medical records if you feel the information is incomplete or innacurate.
- The right to file a written complaint with our office or with the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be penalized or discriminated against for filing a complaint.

***I have reviewed the notice of privacy practices provided to me by Annapolis Pain Management and grant permission for APM to use and disclose my protected health information in accordance with the conditions listed above.**

**Patient or Parent/Guardian Signature _____ Date _____**

***I authorize the following people to pick up my prescriptions/records: (name & relationship)**

**_____(Initial/Date)_____/_____**

# MEDICAL HISTORY CONT.

***ALLERGIES*:** (list all including: medications, food, solutions & metals)

| Allergen Name | Type of Reaction |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |

***SURGERIES***: Please list **all** you have had: **if you are providing your own list, circle: SEE SURGERY LIST

| Type | Date | Reason |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

***CURRENT MEDICATIONS*** *** if you are providing your own list, circle here: SEE MED LIST

| Medication Name | Dose | What is the medication for? |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

***FAMILY HISTORY*** *write relationship (i.e. father) of any blood relative who has had any of the following:

| | | |
|---|---|---|
| Cancer | Diabetes | Epilepsy |
| Heart Disease | High BP | Psoriasis |
| Congenital Prob. | Obesity | Asthma |
| Alcoholism | TB | Thyroid Prob. |
| Rheumatic Fever | Rheumatoid Arthritis | Stroke |
| Other: | | |

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***Clinic Use Only***

Provider Notes:

_____

_____

_____

_____

Reviewed by:_____ Date:_____

Reviewed by:_____ Date:_____

Reviewed by:_____ Date:_____

# ANNAPOLIS PAIN MANAGEMENT FINANCIAL POLICY

We are committed to providing you the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our relationship. Our office participates in several insurance plans. Each plan has its own set of rules and regulations. Our office participates in these programs to allow you, the patient, to reduce your health care cost in this office.

**Initial _____DEDUCTIBLES & CO-PAYMENTS:**
By law we MUST collect your carriers designated co-payment at the time of service. Please be prepared to provide co-payment or deductible fees each visit.

**Initial _____MEDICARE:**
We will submit to Medicare for the Medicare allowed amount. Medicare ONLY covers 80% of the adjustment cost. The patient will be responsible for the exam, therapeutic modalities, deductible, and 20% co-insurance (of the adjustment cost). We are happy to bill to your secondary insurance if you have one.

**Initial _____NON-COVERED MODALITIES, XRAYS, & EXAM FEES:**
In the event your policy does not cover the cost for therapeutic modalities, x-rays, and/or exam codes, you will be responsible for the cost. We cannot guarantee payment, as we are not the insurance carrier. HOWEVER, as a courtesy to you, we will confirm your coverage. It is our suggestion that you also confirm your chiropractic & physical therapy coverage to eliminate any chance for misinformation. If payment(s) from insurance are delayed more than three months, we require you to reimburse our office in full for services rendered.
**The patient is liable for any and all expenses incurred in our office.*

**Initial _____PATIENTS WITHOUT INSURANCE COVERAGE:**
Payment is required at the time of service unless other financial arrangements have been made prior to your visit.

**Initial _____THIS APPLIES TO TODAY'S VISIT AND ALL FUTURE VISITS:**
*Our office accepts cash, checks, and all major credit card carriers. There is a $25 service charge for all returned checks.*
I understand that failure to pay outstanding balances or make payment arrangements within 90 days, will be considered delinquent and subject to legal action. I agree to pay for reasonable collection and attorney fees.

**Initial _____MISSED APPOINTMENT (WITHOUT CALL) FEE:**
*Our office asks that you give us a 24-hour notice if you need to cancel or reschedule an appointment. If you miss three or more appointments without calling to let us know that you won't be able to make it, we charge a $50 "no-show" fee.*
I understand that if I miss a scheduled appointment and did not call to cancel/reschedule within 24 hours prior to that appointment, on 3 or more occasions, I will be responsible for the office fee of $50 per visit thereafter that I miss without calling the office.

**Initial _____CREDIT CARD ON FILE CONSENT:**
As a convenience to you, we have the ability to save your credit card, debit card or health savings account card in our secure network. The card number is securely stored with only the credit card type, and last 4 digits available to us to help identify with you what card we have on file. If you permit us to store your card, we can use it for any future authorized payments to your account. You will receive a receipt to your email on file at the time of payment.
**So we can individualize care and alter treatment according to your progress it is agreed that we may need to settle a balance on a subsequent visit when new modalities are introduced.*
By signing below, you are agreeing to keep a credit card on file for future payments.

**SIGNATURE** _____ **DATE** _____
**PRINTED NAME** _____