AMR PAIN AND SPINE CLINIC, LLC
NABIL AHMAD, MD

Today's Date:	Email:			
Patient Last Name: First: Middle:		Date of Birth: / /	Sex: (circle) Male Female	Marital Status: (circle) M S D W
Street Address:	Social Security #: - -	Home Phone #: ( )		
City:	State:	Zip Code:	Cell Phone #: ( )	
Occupation:	Employer:	Employer Phone #: ( )		
Referring Doctor Name: Address: Phone#/ Fax#:				
Primary Doctor Name: Address: Phone#/ Fax#:				
Chiropractor Name: Address: Phone#/ Fax#:				
INSURANCE INFORMATION				
PHOTO ID AND INSURANCE CARDS MUST BE PROVIDED. ALL COPAYS DUE ON DATE OF SERVICE NO EXCEPTIONS				
Primary Insurance:	ID #: Group #:			
Policy Holder Name:	Policy Holder DOB: / /	Policy Holder SS#: - -		
Relationship to Policy Holder: (circle) Self Spouse Child Other				
Secondary Insurance:	ID #: Group #:			
Policy Holder Name:	Policy Holder DOB: / /	Policy Holder SS#: - -		
Relationship to Policy Holder: (circle) Self Spouse Child Other				
OTHER: (CIRCLE) Self Pay Workers Compensation Motor Vehicle Accident Personal Injury				
Case Worker/ Attorney Name:	Case Worker/ Attorney Phone #:			
Date of Injury:	Claim #:			

AUTHORIZATION & ASSIGNMENT OF BENEFITS: I the undersigned hereby authorize the performance of such services deemed medically necessary to diagnose and treat my condition(s). Further, I authorize my insurance benefits to be paid directly to AMR Pain and Spine Clinic, LLC. I understand that I am financially responsible for any co-payments, deductibles or uncovered amounts. I authorize AMR Pain and Spine Clinic LLC to release any information necessary for the purpose of processing claims with my insurance company. I hereby order all parties to accept a copy of this authorization in lieu of the original.

Signature of Patient

Date

FINANCIAL POLICY

PLEASE READ CAREFULLY

We are pleased you have chosen our practice for your pain management needs. It is important you understand the financial policies of AMR Pain and Spine Clinic, LLC. It is equally important that you understand the terms of Your medical coverage. Although our staff is very knowledgeable of most insurance plans, it is important that you understand the details and terms of your personal plan. We strongly encourage all patients to contact the insurance company directly with specific questions regarding coverage. Ultimately, it is the patient's responsibility to know his/ her insurance benefits plan. In addition, the office must be notified prior to date of service of any changes in insurance.

If you have an insurance plan that requires a referral, it is the patient's responsibility to contact the Primary Care Physician PRIOR to the appointment. Regretfully, many insurers will not cover specialty services without a referral and you will be held responsible for the costs. If we do not have a referral on file, we will not be able to render services.

We participate with most major health plans and will submit claims for services rendered. It is the patient;s responsibility to provide all necessary information to file the claims prior to services being rendered. We will file your primary and secondary insurance claims and work diligently with the carrier to resolve any conflicts that may arise. However, your insurance carrier may need you to supply certain information directly. It is your responsibility to comply with this request.

Please bring a valid photo ID and insurance cards to every visit.

INSURANCE COMPANIES REQUIRE COLLECTION OF CO-PAYMENT ON DAY SERVICES ARE RENDERED. If you do not have your co-payment, we are not required to see you. Failure to collect or waiver of co-payment may constitute fraud under state and federal law.

Additionally, you may have coinsurance and/ or deductible amounts required by your insurance carrier. Ant outstanding balance on your account following insurance processing will be be to you.

It is the policy of the practice to treat all patients in an equitable fashion related to account balances. The practice will NOT waive or fail to collect any co-payments, co-insurance, deductibles, or other patient financial responsibility in accordance with state and federal law as well as participating agreements with payers.

Patient Balances

Any patient balance delinquent after 90 days may be referred to a collection agency. Patient will be responsible for any and all costs associated with the collection agency up to and including legal costs.

Any patient balance delinquent after 120 days may be discharge from the practice. If this occurs, the patient will have 30 days to seek alternative medical care. During the 30 day period, the physician will only be able to treat you on an emergency basis. After this 30 day period, the patient will be discharged from the practice.

For your convenience, the practice accepts the following payment methods: Money Order -Check-Cashiers Check-Cash- Credit Card

With the exception of self-pay patients, Check, Cashiers Check, or credit card only can be accepted for payment per state regulations.

Returned Checks will be charged a $50.00 fee.

I, the undersigned, understand the financial policies of AMR Pain and Spine, LLC and agree to abide by the plan I have signed. In addition, I understand I am fully responsible for any and all charges for all professional treatments and services I have received.

_____ _____

Signature of Patient **Date**

HIPAA CONSENT FORM

I understand I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996. I understand by signing this consent, I authorize AMR Pain and Spine, LLC to use and disclose my protected health information to carry out:

- **Treatment, including direct and indirect treatment by other health care providers involved in my treatment**
- **Obtaining payment from third party payers (e.g. patient insurance companies)**
- **The day-to -day health care operations of AMR Pain and Spine, LLC**

I have also been informed of and given the right to review and secure a copy of Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand you reserve the right to change the terms of this notice from time to time and that I may contact AMR Pain and Spine, LLC at any time to obtain the most current copy of this notice.

I understand I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

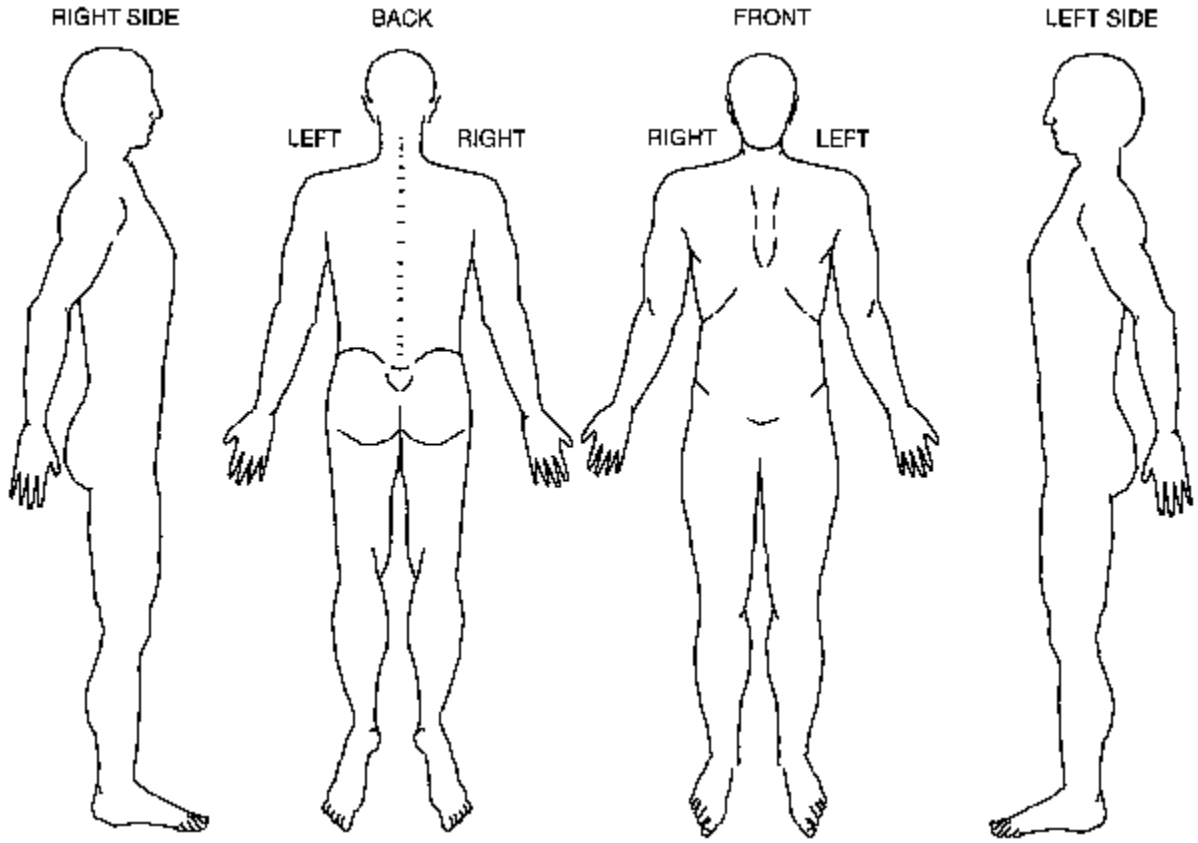
Print Patient Name _____

Signature _____

Relationship to Patient _____

Date _____

Please shade in areas on the diagram where your pain is located:



Circle the number that best describes your pain within the past 7 days. 0 represents no pain. 10 represents worst pain imaginable.

0 1 2 3 4 5 6 7 8 9 10

Please circle all appropriate words that best describe your pain:

Aching	Cramping	Hot	Mild	Throbbing	Sharp	Cold	Moderate
Dull	Stinging	Heavy	Severe	Deep	Stabbing	Constant	Annoying
Sore	Shooting	Intermittent	Unbearable	Tight	Burning	Excruciating	

How long have you had this pain? _____Years _____Months _____Days

Women Only:

Are you now or could you become pregnant? YES NO

Date of last period_____

Date of last Pap Smear_____

Date of last Mammogram_____

Previous Pain Treatments: (Circle all that apply)

Injections/ Nerve Blocks Chiropractic Care Massage/Acupressure Pain Psychologist
Pain Clinic TENS Unit Acupuncture Hypnosis Physical Therapy Traction
Deep Muscle Stimulation Surgery

Previous Imaging/ Testing	**Date**	**Location Performed**
X-Rays		
Myelogram		
CT/ MRI		
Ultrasound		
EMG/ NCS		

Current Medications: (Please list ALL medications you are currently taking, Prescription and over the counter)

Name of medication/ Strength	# of doses/ day

Medical Conditions: (Please list all illnesses/ conditions you have been diagnosed with)

Surgeries:	**Date Performed:**

Family History: (Please specify grandparents, parents, siblings, children)

Heart Disease_____ Epilepsy_____
Hypertension_____ Glaucoma_____
Stroke_____ Bleeding Disorders_____
Cancer_____ Kidney Disease_____
Diabetes_____ Thyroid Disease_____

Allergies:
Medications: _____
Food: _____
Circle All that Apply:

Latex IV Contrast/ Dye Betadine/ Iodine Adhesive Tape

Have you taken/ used any of the following in the last two months:

	YES	NO
Cocaine		
Marijuana		
Methamphetamine		
Suboxone/ Subutex		
Opana		
Sleeping Medication		
Anxiety Medication		
Morphine		
Hydrocodone		
Oxycodone		
Heroin		
Prescription Medication not prescribed		

MEDICATION RISK ASSESSMENT SURVEY

Name:_____ **DOB:**____/____/_____ **Sex: M F**

This information is designed to assess your risks with the use of common medications to treat pain.

	Personal History	**Family History**
Please mark box that applies	Please mark the appropriate box if you have a personal history of abuse or addiction in the following categories	Please mark the appropriate box if there is anyone in your family (Grandparents, Parents, Siblings, Children) who has or has had a history of abuse or addiction the following categories
Alcohol	□	□
Illegal Drugs	□	□
Prescription Drugs	□	□
Check this box if you are between 16-45 years old:		□
Check this box if you have a history of sexual abuse as a child:		□
Please mark the appropriate box if you have been diagnosed with any of the following disorders: □ Depression □ ADD, OCD, Bipolar Disorder, Schizophrenia		

Total Score: **Risk Level: Low Med High**

_____ ____/____/____

Patient Signature Date

_____ ____/____/____

Scored By Title Date

Adapted from questionnaire developed by Lynn R. Webster, M., et,al *Pain Medicine*. 2005