AMR PAIN & SPINE CLINIC
REGENERATIVE MEDICINE CENTER

NABIL AHMAD MD

PATIENT INFORMATION

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 Number: - -

Home Phone: ( )

City:

State:

Zip:

Cell Phone: ( )

Occupation:

Employer:

Employer Phone: ( )

Referring Doctor Name:

Address:

Phone / Fax:

Primary Doctor Name:

Address:

Phone / Fax:

Pharmacy 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 Number:

Group Number:

Policy Holder Name:

Policy Holder DOB: / /

Policy Holder SSN: - -

Relationship to Policy Holder: (Circle) Self Spouse Child Other

Secondary Insurance:

ID Number:

Group Number:

Policy Holder Name:

Policy Holder DOB: / /

Policy Holder SSN: - -

Relationship to Policy Holder: (Circle) Self Spouse Child Other

Other: (Circle) Self Pay Workers' Compensation Motor Vehicle Accident Personal Injury

Date of Injury: / /

Claim Number:

Case Worker / Attorney Name:

Case Worker / Attorney Phone:

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 that you understand the financial policies of AMR Pain & Spine Clinic, LLC. It is equally important that you understand the terms of your medical coverage. Although our staff is very knowledgeable about 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 of any changes in insurance prior to the date of service.

If you have an insurance plan that requires a **referral**, it is the patient's responsibility to contact their 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.

INSURANCE COMPANIES REQUIRE THE COLLECTION OF CO-PAYMENT ON THE 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.

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

Additionally, you may have coinsurance and/or deductible amounts required by your insurance carrier. Any outstanding balance on your account following insurance processing will be billed 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. The patient will be responsible for any and all costs associated with the collection agency, including legal costs.

Any patient balance delinquent after **120 days** may be discharged 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
- Cashier's Check
- Cash
- Credit Card

Per state regulations, checks, cashier's checks, or credit cards are the only accepted form of payment, with the exception of self-pay patients. Returned checks will be charged a $50.00 fee.

I, the undersigned, understand the financial policies of AMR Pain & 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

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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 & Spine, LLC to use and disclose my protected health information to carry out:

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

I have also been informed of and given the right to review and secure a copy of the 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 & 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 revocation date of this consent is not affected.

_____ _____

Print Patient Name | Signature

_____ _____

Relationship to Patient | Date

In addition, I authorize AMR Pain & Spine, LLC to disclose information regarding my billing, condition, treatment, and prognosis to the following individuals:

_____ _____ _____

Name | Relationship to Patient | Phone

_____ _____ _____

Name | Relationship to Patient | Phone

AMR PAIN & SPINE CLINIC
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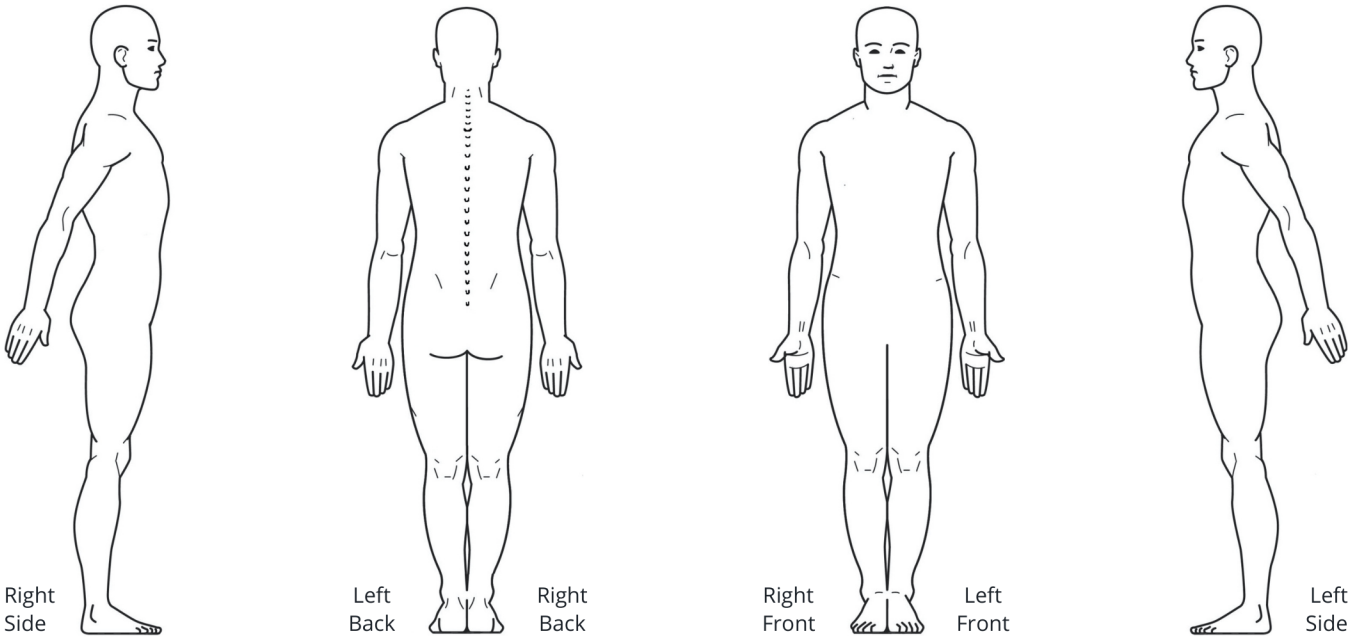
NABIL AHMAD MD

PLEASE SHADE IN AREAS ON THE DIAGRAM WHERE YOUR PAIN IS LOCATED:



Circle the number that best describes your pain within the last seven days:

0	1	2	3	4	5	6	7	8	9	10
No pain									Worst pain imaginable	

Please check all appropriate words that best describe your pain:

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

How long have you had this pain?

Years:	Months:	Days:

Are you now or could you become pregnant?

☐ Yes ☐ No

Are you diabetic?

☐ Yes ☐ No

Are you taking blood thinners?

☐ Yes ☐ No

If yes, please list medication and prescribing physician:

Do you have a pacemaker?

☐ Yes ☐ No

If yes, please list make, model, and cardiologist:

Previous Pain Treatments: (Check all that apply)

☐ Acupuncture	☐ Injections / Nerve Blocks	☐ Pain Clinic	☐ Physical Therapy	☐ TENS Unit
☐ Chiropractic Care	☐ Massage / Acupressure	☐ Pain Psychologist	☐ Surgery	☐ Traction

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

Current Medications: (please list all medications you are currently taking; prescriptions, over-the-counter, vitamins, and supplements)

Name of Medication / Strength	*Number of Doses per 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:

(Check all that apply)

☐ Latex ☐ IV Contrast / Dye ☐ Betadine / Iodine ☐ Adhesive Tape

Medications:

Food:

Have you taken / used any of the following in the last two months:	Yes	No
Prescription medication not prescribed to you		
Benzodiazepines		
Suboxone / Subutex		
Marijuana		
Cocaine		
Methamphetamine		
Heroin		
Fentanyl		

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Date of Birth:

2023 PAIN MANAGEMENT CONSENT AGREEMENT

The purpose of this consent agreement is to comply with the law regarding controlled pharmaceuticals and to prevent any misunderstandings about any controlled medication you may be given for pain. PLEASE NOTE: While the majority of our patients do not receive controlled pharmaceuticals, this agreement includes office policies that must be followed by ALL patients. Therefore, this agreement must be completed by every patient or patient representative.

Please check each box to indicate that you have read and/or have had the information explained to you.

- ☐ I understand that any follow-up appointment may be scheduled with a Licensed Nurse Practitioner or Physician Assistant. Additionally, I understand that refusing to see one of AMR Pain & Spine Clinic, LLC providers will likely result in my no longer being able to be treated by the practice.
- ☐ I understand that non-professional or inappropriate behavior toward any AMR Pain & Spine Clinic, LLC staff, affiliate, or provider will not be tolerated. I agree to be respectful to other patients I may encounter in the waiting room, lobby, hallways, etc. I understand that I may not loiter in the parking lot of any AMR Pain & Spine Clinic, LLC location.
- ☐ I understand that missing appointments, canceling, or rescheduling with less than 24-hour advance notice may result in the provider determining that I am unwilling or unable to comply with the treatment plan determined to be the best option for my care. A fee of $25.00 for missed appointments and $50.00 for missed procedures will be charged with no exceptions. Patients 10 minutes late to appointments will be rescheduled.
- ☐ I understand that non-compliance with my pain management treatment plan may result in providers' inability to properly treat my symptoms and could cause symptoms to worsen or become life-threatening.
- ☐ Due to the severity of the outcome of my non-compliance, I understand that I may be released from AMR Pain & Spine Clinic, LLC for missing appointments with less than 24-hour notice.
- ☐ I agree to submit to a blood, urine, or saliva test, if requested by my provider, to determine compliance with my program of pain medication.
- ☐ I understand that my first office visit may be a consultation only and no pain medication may be given at that time if further investigation and/or testing is deemed necessary.
- ☐ I understand that I may be called at any time to bring all prescribed medication for a mandatory pill count within a specified time frame (usually 24 hours).
- ☐ I understand if I choose to use marijuana (medical or recreational), I will NOT be prescribed medication.
- ☐ I understand if I am taking a Benzodiazepine, I will NOT be prescribed medication.
- ☐ I agree that I will use my medications ONLY as prescribed by my doctor. I understand that **any change to my prescriptions will require an office visit**. I understand that self-medicating is not tolerated. No refills will be made during evenings or weekends.
- ☐ I will not use any illegal substances.
- ☐ I understand that lost or stolen medication or unfilled prescriptions WILL NOT be replaced, and I will safeguard my medication from theft.

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Patient Name:

Date of Birth:

2023 PAIN MANAGEMENT CONSENT AGREEMENT CONT'D

- [ ] I will not share, sell or trade my medications with anyone.
- [ ] I will not alter the form of the medication nor will I take the medication in a route other than as prescribed by my provider.
- [ ] I will not attempt to obtain controlled medication from any other provider, nor will I borrow or buy medication from any other person.
- [ ] In the event of an emergency, if I do obtain controlled substances from another provider, I understand I am required to disclose this information to AMR Pain & Spine Clinic, LLC within 48 hours of discharge or emergency service. I understand it is my responsibility to make sure AMR Pain & Spine Clinic, LLC is notified of any such treatments and that I am to check with AMR Pain & Spine Clinic, LLC before combining any pain medication with the prescriptions AMR Pain & Spine Clinic, LLC provides me.
- [ ] I will notify AMR Pain & Spine Clinic, LLC of any change in insurance, name, address, or phone number. Failure to do so could result in delay or denial of medication.
- [ ] I authorize my provider to investigate fully any possible misuse of my pain medication using any city, state, or federal law enforcement agency, including this state's Board of Pharmacy.
- [ ] Once a prescription has been filled, direct all questions regarding that prescription to the pharmacy.
- [ ] I understand that AMR Pain & Spine Clinic, LLC does not mail prescriptions under any circumstances.
- [ ] I understand that with any controlled substance prescribed to me, there are inherent risks, namely: loss of efficacy over time, symptoms of withdrawal if abruptly stopped, addiction, respiratory suppression or failure, or death.
- [ ] I agree not to drive while under the influence of any prescribed controlled substance; sedation, loss of function, and impairment may occur.
- [ ] I understand that the combination of controlled substances and alcohol is contra-indicated; the combination may result in serious harm or even death.

I agree that the goals of pain management have been explained to me as to what is considered appropriate and reasonable and that alternative treatment plans, outside of the use of controlled pain medications, have been made available to me. I have agreed to proceed with pain management after a full explanation of the risks and benefits. I understand if I break this agreement, it will result in a change in my treatment plan, including safe discontinuation of my opioid medications when applicable or complete termination of the provider/patient relationship.

I understand that I am only to use the pharmacy listed below for all my medication needs with AMR Pain & Spine Clinic, LLC or any other provider and that information will be shared between AMR Pain & Spine Clinic, LLC and my pharmacy to process the prescription:

Pharmacy Name: _____ Address: _____ Phone / Fax: _____

I have read and/or this information has been explained to me and I understand the terms of this agreement:

Signature of Patient or Legal Representative: _____ Date: _____