Pain Specialists of Austin
relief is on the way
Phone: (512) 485-7200 www.painspecialistsofaustin.com Fax: (512) 485-7201

At Pain Specialists of Austin, we specialize in assisting individuals whose chronic pain has not responded to conventional treatments such as bed rest, medication, physical therapy and surgery. Pain that persists for more than three to six months is considered chronic.

Pain often presents itself as low back pain, neck pain, post-operative pain, abdominal pain, joint pain, headaches and pain from cancer. Over 40 million Americans are disabled by chronic pain.

Awareness of the problem of chronic pain has increased dramatically in recent years. Our goal at the Central Texas Pain Institute is to reduce or eliminate pain and to rehabilitate the patient to a productive lifestyle.

We request that all previous pertinent medical records be made available to us at the time of the initial evaluation. This includes any and all reports from studies such as x-rays, CAT scans, MRIs, nerve conduction studies and other physician evaluations. Our approach includes an evaluation by a physician, physician assistant or Nurse Practitioner specially trained in pain medicine.

Attached, you will find New Patient Information forms, please complete these forms to the best of your ability prior to your appointment. Upon arrival to our office, please bring your New Patient forms, your insurance card and all medications you are currently taking in the original container. It is your responsibility to bring a referral to our office if your insurance requires it and to keep that referral current for future visits.

Our office policy is that all co-pays and or co-insurance are due at time of service, as well as private pay.

PLEASE GIVE US AT LEAST 24 HOURS NOTICE IF YOU ARE UNABLE TO KEEP YOUR SCHEDULED APPOINTMENT. We have an office policy regarding no shows. Please be aware that all no shows will be assessed a charge of $50.00 for missed office appointments and a charge of $100.00 for missed procedure appointments.

If you have any questions regarding any of the forms or you do not understand our policies, please feel free to contact our office.

Please see attached HIPPA Privacy Practices and acknowledge and sign below.

_____ _____

Patient/Representative Signature Date

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Patient Registration Information

Please PRINT and complete ALL sections below:

Is your condition a result of a work injury? YES_____ NO_____ An auto accident? YES_____ NO_____ Date of injury_____

PATIENT'S PERSONAL INFORMATION Marital Status:_____Single:_____Married:_____Divorced:_____Widowed:_____

Sex:_____Female:_____Male:_____ Social Security# _____-_____-_____

Name: _____ _____ _____
Last Name First Name Initial

Street Address: _____(Apt#_____) City: _____ State: _____ Zip: _____

Home Phone: (_____) _____Work Phone: (_____)_____ Cell Phone: (_____)_____

Date of Birth:_____/_____/_____ Driver's License: (State & Number)_____

Employer/Name of School _____ Full Time:_____Part Time:_____

Spouse's Name: _____ _____ _____ Spouse's Work Phone: (_____)_____
Last First Initial

How do you wish to be addressed? _____

PATIENT'S/RESPONSIBLE PARTY INFORMATION

Responsible party: _____ Date of Birth: _____/_____/_____

Relationship to Patient: _____Self _____ Spouse _____ Other_____ Social Security # _____/_____/_____

PATIENT'S INSURANCE INFORMATION

PRIMARY Insurance company's name: _____

Insurance address: _____City: _____ State: _____ Zip:_____

Name of Insured: _____ Date of Birth: _____/_____/_____

Insurance ID number: _____ Group Number: _____

SECONDARY insurance company's name: _____

Insurance address: _____City: _____ State: _____ Zip:_____

Name of Insured: _____ Date of Birth: _____/_____/_____

Insurance ID number: _____ Group Number: _____

PATIENT'S REFERRAL INFORMATION

Referred by: _____ If referred by a friend, may we thank her or him? YES_____ NO_____

Name(s) of the other physician(s) who care for you: _____, _____

EMERGENCY CONTACT

Name of person not living with you: _____ Relationship:_____

Address: _____ City: _____ State: _____ Zip: _____

Phone number (home): (_____) _____ Phone number (work): (_____) _____

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Physician Assistant/or Nurse Practitioner Consent for Treatment

This facility has on staff a physician assistant and/or a nurse practitioner to assist in the delivery of medical care for pain management.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. A nurse practitioner is not a doctor. A nurse practitioner is a registered nurse who has received advanced education and training in the provision of health care. Under the supervision of a physician, a physician assistant and a nurse practitioner can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of the supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

A physician assistant and a nurse practitioner may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulating a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Offering counseling and education
- Making appropriate referrals

I have read the above, and hereby consent to the services of a physician assistant and/or nurse practitioner for my health care needs.

I understand that at any time I can refuse to see the physician assistant and/or nurse practitioner and request to see a physician.

Printed Name: _____

Signature: _____ Date: _____

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Office and Financial Policy

I _____, have read and understand the financial policy and agree to its terms. I understand that insurance billing is a courtesy provided to me by Pain Specialists of Austin and I assume full financial responsibility of the balance I incur. I understand co-pays, co-insurance, and deductibles are due at the time of my visit as well as any prior balance I may owe.

_____Initials

It has been explained to me that should I decide to have any procedures performed at Pain Specialists of Austin my insurance company and I will receive two statements, one for the facility fees and one for the professional services rendered by the providers at Pain Specialists of Austin.

_____Initials

I assign benefit to be paid by my insurance company directly to the provider of services rendered to me. Furthermore, should the insurance company issue a check in my name I will notify Pain Specialists of Austin immediately and arrange for payment of my balance. Should I cash any check issued by the insurance company meant for reimbursement of services provided to me, I will assume full responsibility of the balance and will pay the balance within 30 days.

_____Initials

I understand my balance will automatically be referred to an outside collection agency should my account surpass 90 days without payment activity. I agree to pay all reasonable attorneys, collection, or returned check fees in the event of default of payment of my charges or balance arrangements.

_____Initials

_____

Patients Printed Name Guarantor's Signature Date

_____

Witness Printed Name Signature Date

PSA Pain Specialists of Austin
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Office and Financial Policy

Thank you for choosing Pain Specialists of Austin. In order to inform you of our current financial and office policy, please read the document below and sign the financial agreement. Our providers, clinical, and office staff are here to help you in any way possible and strive to make your experience with us pleasant and comforting. Keep a copy of this document for your records and should you have any questions please do not hesitate to ask one of our associates.

Please keep us informed of any address, telephone number, or name changes. If we are unable to contact you regarding your bill, we will refer the balance to our outside collection agency.

Please notify our office within 24 hours to reschedule or cancel an appointment. This will allow our staff to offer this time slot to another patient in need of an appointment.

We accept the following forms of payment: cash, credit cards, cashier's checks, money orders, and personal checks.

Returned Checks

- Returned checks will accrue a $30.00 returned check fee, $10.00 administration fee, as well as any applicable bank fees to your account.

Insurance

- It is your responsibility to know your level of benefits for services provided. Being that our providers are specialist, many services are required to have prior authorizations by the insurance company and/or Primary Care Physician. Please contact your insurance company before your appointment to ensure proper authorization estimate of payment due as we are not certain what the patient balance will be until the insurance company processes your claim.
- Payment of fees, co-pays, co-insurance and deductibles are due at the time of service.
- Co-pays are a requirement placed on you by your insurance company and therefore cannot be waived or reduced. Should you forget or cannot provide your co-pay at the time of visit, you will be asked to reschedule your appointment.
- You are solely responsible for your balance in the form of co-insurance, deductible, or non-covered services as required by your insurance company.
- You will be contacted prior to your appointment and notified of any balance due on your account and will be expected to bring payment to your appointment. You will be required to make arrangements with the financial counselor if you cannot pay the balance in full.
- Should any balance remain unpaid more than 90 days past the processing date with the insurance company, a statement will be sent to the guarantor of the account and payment will be due upon receipt of the statement.

Worker's Compensation

- Please keep in contact with your adjuster prior to and after your appointment to receive any pertinent information regarding your claim and injury.
- Authorizations may be required for certain procedures and could take up to 1 week to obtain.
- Should your case become closed, undergo peer review, or determined that Maximum Medical improvement has been met you must contact your referring physician and adjuster for written approval before scheduling any appointment or services.

_____ _____

Signature Date

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HIPPA
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN SET ACCESS TO THIS INFORMATION.
PLEASE REVIEW CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used, "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restriction on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosure of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of _____, 20__ and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPPA
or to file a complaint

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775