NEW PATIENT INFORMATION

DR. AUST INTERVENTIONAL PAIN

What to bring with you at your 1st appointment with Dr. Aust

1. Current Insurance Card(s)
2. Current Picture ID
3. List of current Medications (dosage, times per day)
4. Medical records pertinent to visit
   (INCLUDING any related disc imaging; MRI's, X-Rays or other relevant tests.)**
5. New Patient Forms completely filled out if you haven't mailed in
6. Co-pay (if applicable)

**Please mail back New patient forms to make your first visit with us a little easier

Thank you,

Debbie Moser

Office Manager

NEW PATIENT INFORMATION

DR. AUST INTERVENTIONAL PAIN

PLEASE COMPLETE THE FOLLOWING INFORMATION:

Name: DOB:

SEX: MARITAL STATUS: MARRIED WIDOWED SEPARATED DIVORCED SINGLE

SSN: DL State: Driver License #: eMail:

Address: City: State: Zip Code:

Home Phone: Cell phone: Preferred: Home: Cell: eMail:

Ethnicity/Race: Primary Language:

Emergency Contact Name: Number: Relation:

INSURANCE INFORMATION

Primary Insurance Name: Subscriber/Member/Policy ID:

Subscriber Name: Subscriber DOB: Realtion to Subscriber:

Secondary Insurance Name: Subscriber/Member/Policy ID:

Subscriber Name: Subscriber DOB: Realtion to Subscriber:

AUST
INTERVENTIONAL PAIN

NEW PATIENT INFORMATION

DR. AUST INTERVENTIONAL PAIN

Do you have a pain pump?

☐ YES ☐ NO If yes, What kind? ☐ Flowonix ☐ Medtronic ☐ St. Jude ☐ Other

What year was it put in?

Name of Doctor that implanted Pain pump:

Medication (if known)

Do you have a Spinal Cord Stimulator?

☐ YES ☐ NO If yes, What kind? ☐ Boston Scientific ☐ St Jude ☐ Other (name)_____

What year was it put in?

Name of Doctor that implanted Stimulator?

Is this visit related to a motor vehicle accident (MVA) or workplace injury?

☐ MVA ☐ Workplace Injury ☐ Not Applicable

Do you have an attorney representation related to the MVA or workplace injury? If yes, please provide name and contact information.

Attorney Name: Phone: Email:

If this is related to a workplace injury, please provide a brief description of incident, the name of your worker's compensation adjuster and contact information.

Adjuster Name: Phone: Email:

Brief Description:

Claim number: Date of injury:

AUST
INTERVENTIONAL PAIN

NEW PATIENT INFORMATION

DR. AUST INTERVENTIONAL PAIN

Patient Name: DOB: Age:

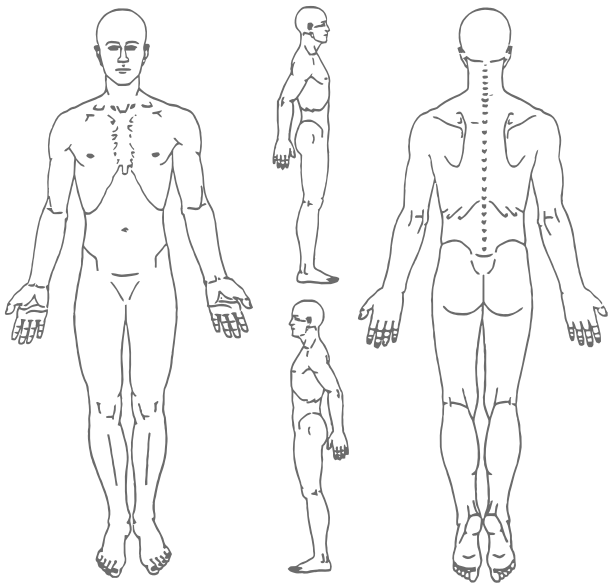
Height Weight

Which is your dominant hand?

☐ Right ☐ Left

Chief Complaint: In your own words why are you here today:

Please shade In areas of pain:



Mark a number below to Indicate your usual pain Intensity daily:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Pain Score: Referring Physician:

How did you hear about us:

When did the pain start:

Where is it located?

Does it radiate into your arms?

☐ Right ☐ Left ☐ Both

Does it radiate into your legs?

☐ Right ☐ Left ☐ Both

Was this due to a MVA or Work Injury:

AUST
INTERVENTIONAL PAIN

NEW PATIENT INFORMATION

DR. AUST INTERVENTIONAL PAIN

Quality of Pain: (please circle all that apply to your pain)

- Tenderness
- Aching
- Burning
- Cramping
- Muscle weakness
- Pins/needles
- Pressure
- Shocking
- Shooting
- Spasms
- Stabbing
- Stinging
- Throbbing
- Tightness
- Tingling
- Other:

What makes the pain WORSE?

What makes the pain BETTER?

Do you have any bladder or bowel incontinence:

YES NO

PAST TREATMENTS

- Nerve Blocks
- Epidural Steriod Injection
- Chiropractor
- Physical Therapy
- Other:

With Who/How long ago

RADIOLOGY TESTING

- Xrays
- MRI
- CT Scan

Date:

Where:

SOCIAL HISTORY

Smoker:

- Yes
- No
- Quit

Packs per day:

Number of years:

Alcohol:

- None
- Occasional
- Daily

How much per week:.

Recreational Drugs:

- Yes
- No

Do you have any history of prescription medication Abuse/Overuse

YES NO

Do you have any history of addiction:

YES NO If yes what was the treatment?

WORK STATUS

- Currently working
- Retired
- Unemployed
- Disabled

Occupation:

AUST INTERVENTIONAL PAIN

NEW PATIENT INFORMATION

DR. AUST INTERVENTIONAL PAIN

MARITAL STATUS/CHILDREN

☐ Married ☐ Single ☐ Divorced ☐ Widowed

How many children do you have you?

Have you ever been treated by another Pain Management Physician:

Who: When:

Who is your Primary Care Physician:

Who is your Cardiologist:

Who is your Psychiatrist/Psychologist:

MEDICAL HISTORY

Please list any medical conditions you have been diagnosed with

☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Heart Disease

☐ COPD ☐ Anemia ☐ HIV ☐ Hepatitis

☐ Other:

PSYCHIATRIC

Please circle if you have any of the following:

☐ Anxiety ☐ Depression ☐ Memory Loss ☐ Suicidal Ideation ☐ ADHD/ ADD

☐ Other:

SURGICAL HISTORY

Please list any surgical procedures you have had

Year	Describe	Doctor

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INTERVENTIONAL PAIN

NEW PATIENT INFORMATION

DR. AUST INTERVENTIONAL PAIN

ALLERGIES

☐ No known Allergies

Medication	Reaction

CURRENT MEDICATIONS

List all medications you are currently taking including over the counter medication, herbs, and vitamins. Please use additional sheet of paper if more room is needed.

Medication Name	Strength	Dose	Prescriber

FAMILY HISTORY

Please list any outstanding medical conditions:

Mother:

Father:

Siblings:

Maternal Grandfather:

Maternal Grandmother:

Paternal Grandfather:

Paternal Grandmother:

Other:

RELEASE OF MEDICAL FORM

DR. AUST INTERVENTIONAL PAIN

Name: DOB:

RELEASE OF INFORMATION

I authorize the release of information including the diagnosis, records, examination results, medication dose changes and claims information. This information may be released to:

Spouse (Name)

Child(ren) (Name)

Other (Name)

MESSAGES

Please call

☐ My home phone at

☐ My cell phone at

If unable to reach me:

☐ You may leave a detailed message

☐ You may leave a message asking me to return your call

☐ DO NOT LEAVE ANY MESSAGES ON MY PHONE/VOICEMAIL

**Best time to reach me is (day of week):

Between (times):

E-MAIL MESSAGES

☐ Use my e-mail address to send messages for me to contact the nurse for information

☐ Use my e-mail address to leave detailed messages and information.

My E-mail address is:

This Release of Information will remain in effect until terminated by me in writing. This release **specifically excludes** any psychiatry and psychology evaluation/records which are further restricted by HIPAA regulations.

Patient Signature: Date:

Witness Signature: Date:

PAIN MANAGEMENT AGREEMENT

DR. AUST INTERVENTIONAL PAIN

I _____ DOB _____ agree to use controlled substances (narcotics/pain killers, sleeping pills) in the treatment of my pain only as prescribed for me by Aust Interventional Pain physician(s). I understand that the goal of treatment can include physical therapy, minimally invasive procedures, psychological services, and may or may not include prescription strength medication. The overall GOAL will be to DECREASE the amount of narcotics used concurrently with other treatments. (*If your intention is to be treated solely with narcotic medications, then you may not be a qualified patient for this practice.)

PLEASE INITIAL EACH ITEM AND SIGN BELOW:

_____ I understand that if I violate any of the terms of this agreement, my treating physician(s) may discharge me from the practice.

_____ I will take my medication as instructed and not change the way I take it without first speaking to the doctor or other member of my treatment team with Aust Interventional Pain. I understand stopping controlled substances suddenly may result in withdrawal symptoms that can lead to possible heart attack and seizures.

_____I understand that the physicians of Aust Interventional Pain do not write prescriptions for Soma, Xanax, Valium, Ativan or Klonopin.

_____ I will keep all prescribed medications in a safe and secure location and out of the reach of children. If my prescribed medication is misplaced, lost or stolen I understand that IT WILL NOT be replaced until my appointment and may not be replaced at all. I take full responsibility for safe guarding my medication and storing them properly.

_____ I have not been involved in the sale of, illegal possession of, diversion of or transport of prescribed controlled substances nor am I currently abusing illicit drugs or prescription medication. I am not currently undergoing treatment for substance dependence or abuse.

_____ I will not misuse or abuse prescribed controlled substances, which means that I agree to take my medication as it is written for me and it will last for the period of time it was written for. My medications are NOT to be shared, given away or sold. I am NOT to take anyone else's medication. I will NOT go to the Emergency room for pain management of my chronic condition for which my doctor is currently treating me.

_____ I consent for my doctor, his associates and medical staff o communicate directly with my pharmacy to obtain information regarding my prescription history. I agree to waive any applicable privilege or right of confidentiality with respect to the prescribing of my pain medication. I authorize my pain management physician and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the Louisiana Board of Pharmacy in the investigation of my possible misuse, sale, or diversion of my pain medication: I authorize a copy of this agreement to be provided to my pharmacy and my consulting physician.

_____ I agree to refrain from all mind/mood altering drugs including alcohol and I consent to random urine, blood and saliva screens as well as random pill counts. My failure to comply will result in immediate dismissal from the practice. I understand that the screen results can be given to my other healthcare providers, insurance company or other reimbursing agencies. I also authorize any healthcare provider, pharmacy and law enforcement or judiciary body to release any pertinent information regarding my prescription or specimen results.

_____ I will make sure I have an appointment for medication refills and will notify a member of my treatment team immediately if I am having trouble making an appointment. I will not call in between appointments, at night or on weekends requesting refills. I understand that prescriptions for opioids will ONLY be filled during scheduled office visits with my treatment team.

_____ I understand that I must arrive in a timely manner for my scheduled appointments and if I am late I can/will be rescheduled. I also understand that an appointment does NOT guarantee a prescription.

_____ I will keep all scheduled appointments. In the event an office visit has to be cancelled, I will do so with at least 24 hours notice. In the event a procedure appointment has to be cancelled, I will do so with at least 72 hours notice. I understand that Aust Interventional Pain reserves the right to charge a cancellation fee for any cancelled appointments.

_____ I understand that in order to have narcotic medication refilled, in accordance with LA State Law (Act 488), I will need to be seen in an office visit a minimum of every 60 days. A fill may be written for the medication to last a period of no longer than 30 days without a refill.

_____ I will be COURTEOUS and RESPECTFUL to ALL office staff. This includes any family members or representatives speaking on my behalf and I understand that if I or my representatives are not courteous and respectful at all times that it is grounds for immediate dismissal from Aust Interventional Pain.

_____ I understand that failure to comply with my treatment plan may result in dismissal from Aust Interventional Pain. This includes failure to attend physical therapy, failure to undergo imaging such as X-Rays and MRI's and failure to attend procedure appointments. *Multiple re-schedules, no-shows and more than TWO cancellations for procedures or regular appointments may result in dismissal from the practice.

_____I understand that I cannot take and will not take Benzodiazepines and Opioids concurrently. I also understand that if I choose to do so, that Dr. Aust will no longer be able to prescribe me ANY Opioid medication.

PAIN MANAGEMENT AGREEMENT

DR. AUST INTERVENTIONAL PAIN

_____ FEMALES ONLY: I certify that I am not pregnant, and do not plan to become pregnant. I also certify that I am taking all precautions, which may include use of contraceptives to prevent my becoming pregnant while undergoing treatment. In the event I become pregnant or decide I would like to try to become pregnant, I will notify Dr. Aust and/or Aust Interventional Pain physician(s).

_____ I agree to keep up to date with any bills due from Aust Interventional Pain and tell the doctor(s) or member of the treatment team immediately if I lose my insurance or can't pay for treatment anymore.

_____ I assume full responsibility for operating any type of vehicle, machinery, or any potentially hazardous task while taking controlled substances that are prescribed by my physician as well as I assume full responsibility in making any important decisions legal or otherwise while taking controlled substances as controlled substances can decrease mental functions.

_____ I am NOT allowed to flush, throw away, give away or otherwise dispose of controlled pain medication(s). I MUST bring in any remaining medication to the office to be disposed of and documented properly by an Aust Interventional Pain provider or team member. Medication changes WILL NOT be made unless I comply with this policy.

_____ I agree to adhere to all conditions from my doctor and pharmacy for safe use of my prescribed medication(s).

_____ I am responsible to make certain I do not run out of my medication on weekends, holiday and vacations. I will not ask for my medication to be phoned in to my pharmacy. If I require a refill I will call the office FIVE days in advance for my request. Most medications WILL NOT be dispensed without an office visit. Medications are NOT phoned in after hours or on weekends. I also take full responsibility for knowing when my refills are and making sure my follow up appointments correspond with my refill date.

_____ I understand that if I test positive for any illicit drugs forbidden by law Aust Interventional Pain can dismiss me from the practice.

_____ I understand that I cannot take Kraton while on prescribed opioids and that it can/will be tested in my urine screening tests. I also understand that if I do test positive for Kraton, Aust Interventional Pain reserves the right to dismiss me from the practice.

_____ I understand that Aust Interventional Pain utilizes a Nurse Practitioner to see patients in follow up office visits when needed.

_____ I agree to use ONLY one pharmacy _____ (Name)

_____ (Location) _____ (Phone)

_____ I understand that I am responsible for personally picking up my own prescriptions. If I am physically unable to pick up my prescriptions, I authorize the following person to do so on my behalf; _____

**** This person will be required to show a picture ID as well as sign for the prescription.***

_____ **I understand that if I refuse to initial or sign ANY of the items in this agreement I will NOT be prescribed ANY narcotic medications by Dr. Aust and Aust Interventional Pain.**

Patient/Guardian (Please PRINT):

Patient/Guardian Signature:

Staff Signature:

Date:

NEW PATIENT INFORMATION

DR. AUST INTERVENTIONAL PAIN

I _____ authorize _____ (healthcare provider) to release my complete health record (including X-Rays, MRI's, medical history, office visits and procedures as well as records relating to mental healthcare, communicable diseases, HIV or AIDS and treatment of alcohol or drug abuse) to Dr. Aust Interventional Pain.

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation.

I understand that I have the right to revoke this authorization, in writing at any time.

I understand that this authorization if for use or disclosure of Protected Health Information (Required by the Health Insurance Portabili-ty and Accountability Act, 45 C.F.R. Parts 160 and 164)

***Please be advised if you are a Workers Compensation Patient, we work with "Work Comp Solutions" to process needed documents to submit to adjusters and various entities for you claim. Signing below is you acknowledging you understand that your medical records will be visible to this entity. State regulations and guidelines are followed and strictly adhered to by all parties involved when processing such documentation.*

Signature of Patient or legal representative

Printed name of Patient or legal representative

Date of Birth

Date

HIPAA PRIVACY PRACTICES ACKNOWLEDGEMENT

DR. AUST INTERVENTIONAL PAIN

I understand it is the policy of Dr. Aust Interventional Pain to comply with the privacy rules and regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I have received a copy of Aust Interventional Pain HIPAA Privacy Policies and have read it carefully.

I hereby acknowledge that I have reviewed and understand the above referenced policies and procedures.

Print Name:

Patient Signature:

Date:

MEDICATION REFILL PROCESS & APPOINTMENT POLICY

DR. AUST INTERVENTIONAL PAIN

Dear Patient,

Current practice and regulatory requirements require frequent office visits for medication management. Therefore most medication refills will be provided at office visits only.

An office visit is required for any new prescriptions OR changes to prescriptions (NO exceptions)

Controlled substances cannot be phoned in to your pharmacy; therefore you MUST make an appointment to receive your prescription.

Please understand that it is your (the patient) responsibility to keep up with your medication refills.

As a courtesy to other patients, we reserve the right to reschedule your appointment if you are more than 15 minutes late.

Thank you for your understanding and cooperation.

Sincerely,
Dr. Tod Aust MD
Dr. Aust Interventional Pain

My signature below acknowledges I understand, medication refills and medication changes both require and can ONLY be done at an appointment.

Signature _____ Date _____

Patient Name: _____ Date: _____

Please see and read the attached article outlining the dangers of certain medication interactions with chronic opioid use. It is **Dr. AUST INTERVENTIONAL PAIN** practice policy to NOT prescribe Benzodiazepines (Xanax, Ativan, Valium, Klonopin) and Soma. Once you have read this article, please sign below to ***acknowledge that you understand*** and are aware that extreme sleepiness, respiratory depression, coma and death can occur with the use of these medications at the same time and ***you also agree NOT to take Benzodiazepines from another provider while using opioids from out practice.***

Thank you

Patient Signature _____ Date: _____

Staff Member Signa ure _____ Date _____

FDA News Release

FDA requires strong warnings for opioid analgesics, prescription opioid cough products, and benzodiazepine labeling related to serious risks and death from combined use

Action to better inform prescribers and protect patients as part of Agency's Opioids Action Plan

For Immediate Release

August 31, 2016

Release

En español (/NewsEvents/Newsroom/ComunicadosdePrensa/ucm518790.htm)

After an extensive review of the latest scientific evidence, the U.S. Food and Drug Administration announced today that it is requiring class-wide changes to drug labeling, including patient information, to help inform health care providers and patients of the serious risks associated with the combined use of certain opioid medications and a class of central nervous system (CNS) depressant drugs called benzodiazepines.

Among the changes, the FDA is requiring boxed warnings – the FDA's strongest warning – and patient-focused Medication Guides for prescription opioid analgesics, opioid-containing cough products, and benzodiazepines – nearly 400 products in total – with information about the serious risks associated with using these medications at the same time. Risks include extreme sleepiness, respiratory depression, coma and death. Today's actions are one of a number of steps the FDA is taking as part of the agency's Opioids Action Plan, which focuses on policies aimed at reversing the prescription opioid abuse epidemic, while still providing patients in pain access to effective and appropriate pain management.

"It is nothing short of a public health crisis when you see a substantial increase of avoidable overdose and death related to two widely used drug classes being taken together," said FDA Commissioner Robert Califf, M.D. "We implore health care professionals to heed these new warnings and more carefully and thoroughly evaluate, on a patient-by-patient basis, whether the benefits of using opioids and benzodiazepines – or CNS depressants more generally – together outweigh these serious risks."

Given the importance of reaching health care professionals and the public with information about the risks of using these products together, today the FDA also issued a Drug Safety Communication. Through the Drug Safety Communication and by requiring patient Medication Guides, the agency also provides information for anyone who is taking, or who knows someone taking, either of these types of medications and encourages them to better understand the risks of taking them together; and, when it is medically necessary, for health care providers to be careful to prescribe them as directed, without increasing the dose or dosing frequency for either drug.

Opioid analgesics are powerful pain-reducing medications that include prescription oxycodone, hydrocodone, and morphine, among other drugs, under both brand and generic names. Certain other opioid medications are also approved to treat cough. Opioid analgesic misuse and abuse have increased significantly in the United States over the past two decades, and represent major public health concerns due to the risk of coma and fatal respiratory depression associated with opioid analgesic overdose. Benzodiazepines are drugs typically prescribed for the treatment of neurological and/or psychological conditions, including anxiety, insomnia and seizure disorders. Both classes of drugs depress the central nervous system ("CNS depressants"); however, each has unique pharmacology, safety risks, and labeling information related to its use. Therefore, the FDA is requiring opioid analgesics, prescription opioid cough products, and benzodiazepines to have slightly different labeling. Additionally, due to the unique medical needs and benefit/risk considerations for patients undergoing medication-assisted therapy treatment (MAT) to treat opioid addiction and dependence, the FDA is continuing to examine available evidence regarding the use of benzodiazepines and opioids used as part of MAT.

The FDA's data review showed that physicians have been increasingly prescribing them together, and this has been associated with adverse outcomes. Among the data reviewed by the FDA, the agency concluded that from 2004 to 2011, the rate of emergency department visits involving non-medical use of both drug classes increased significantly, with overdose deaths (from taking prescribed or greater than prescribed doses) involving both drug classes nearly tripling during that period. Additionally, the number of patients who were prescribed both an opioid analgesic and benzodiazepine increased by 41 percent between 2002 and 2014, which translates to an increase of more than 2.5 million opioid analgesic patients receiving benzodiazepines.

Clinical guidelines from the U.S. Centers for Disease Control and Prevention (CDC) and existing labeling warnings regarding combined use caution prescribers about co-prescribing opioids and benzodiazepines to avoid potential serious health outcomes. The actions of the FDA today are consistent with the CDC.

In February 2016, the FDA received a citizen petition from numerous local and state public health officials and other stakeholders asking the agency to make certain changes to the existing labeling for benzodiazepines and opioid analgesics. The FDA had already initiated a review of the scientific information on concomitant use of these two drug classes when the agency received the petition, and was encouraged that these public health officials shared the agency's concerns. Today, the FDA also responded to the citizen petition.

Working with the health care community and federal and state partners to help reduce opioid misuse and abuse and improve appropriate opioid prescribing, while ensuring that patients in pain continue to have appropriate access to opioid analgesics, is a top priority for the FDA and part of HHS' targeted approach focused on prevention, treatment, and intervention. The agency is committed to continuing to monitor these products and take further actions as needed.

The FDA, an Agency within the U.S. Department of Health and Human Services, protects the public health by assuring the safety, effectiveness, and security of human and veterinary drugs, vaccines and other biological products for human use, and medical devices. The Agency also is responsible for the safety and security of our nation's food supply, cosmetics, dietary supplements, products that give off electronic radiation, and for regulating tobacco products.

###

Please answer each question as honestly as possible. Keep in mind that we are only asking about the past 30 days. There are no right or wrong answers. If you are unsure about how to answer the question, please give the best answer you can.

Please answer the questions using the following scale:	**Never**	**Seldom**	**Sometimes**	**Often**	**Very Often**
	0	**1**	**2**	**3**	**4**
1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?	☐	☐	☐	☐	☐
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments)	☐	☐	☐	☐	☐
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient ain relief from medications? (i.e., another doctor, the Emergency Room, friends, street sources)	☐	☐	☐	☐	☐
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?	☐	☐	☐	☐	☐
5. In the past 30 days, how often have you seriously thought about hurting yourself?	☐	☐	☐	☐	☐
6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?	☐	☐	☐	☐	☐
7. In the past 30 days, how often have you been in an argument?	☐	☐	☐	☐	☐
8. In the past 30 days, how often have you had trouble controlling your anger (e.g., road rage, screaming, etc.)?	☐	☐	☐	☐	☐
9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?	☐	☐	☐	☐	☐
10. In the past 30 days, how often have you been worried about how you're handling your medications?	☐	☐	☐	☐	☐
11. In the past 30 days, how often have others been worried about how you're handling your medications?	☐	☐	☐	☐	☐
12. In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?	☐	☐	☐	☐	☐
13. In the past 30 days, how often have you gotten angry with people?	☐	☐	☐	☐	☐
14. In the past 30 days, how often have you had to take more of your medication than prescribed?	☐	☐	☐	☐	☐
15. In the past 30 days, how often have you borrowed pain medication from someone else?	☐	☐	☐	☐	☐
16. In the past 30 days, how often have you used your pain medicine for symptoms other than for pain (e.g., to help you sleep, improve your mood, or relieve stress)?	☐	☐	☐	☐	☐
17. In the past 30 days, how often have you had to visit the Emergency Room?	☐	☐	☐	☐	☐

PAYMENT POLICY

DR. AUST INTERVENTIONAL PAIN

Thank you for choosing Dr. Aust Interventional Pain. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. Non-covered services. Please be aware that some - and perhaps all - of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.\
4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
8. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Patient Signature

Date:

Patient Name: Date:

Employer: Insurance:

I hereby instruct and direct Insurance Company to pay my doctor for his professional or medical services rendered, otherwise payable to me, by check, mailed to the above address, OR, if my current policy prohibits direct payments to my doctor, I hereby also instruct and direct my insurance company to make out the check to me and mail it to the address above for my doctor.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. I have agreed to pay, in a current manner, any balance of said professional service charges over and above the insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my care to any insurance company, adjuster, or attorney involved in this case.

I authorize my doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated this day of ,

Signature of Policyholder Date:

Signature of Claimant, if other than Policyholder Date