MD PAIN

## Patient Registration

**Please review the following information and make sure it is correct to your knowledge. If information needs to be updated please update and let us know. Please sign at the bottom consenting the information listed is correct:**

## PATIENT INFORMATION

| | | | |
|---|---|---|---|
| **Patient Name:** | | **Maiden Name:** | |
| **Current Address/PO Box:** | | | |
| **City:** | **State:** | **Zip:** | |
| **Primary Phone:** | **Cell Phone:** | **Work Phone:** | |
| **Email Address:** | | | |
| **Birth Date:** | **Age:** | **Sex:** | **SS#:** |
| **Emergency Contact:** | **Relationship to Emergency Contact:** | **Phone:** | |

**Race/Ethnicity:** ◯Asian ◯Black/African American ◯Hispanic/Latino ◯White ◯Other:_____

**Marital Status:** ◯Married ◯Single ◯Divorced ◯Widowed

| | |
|---|---|
| **Family Doctor:**<br>Phone: | **Referring Doctor:**<br>Phone: |

## RESPONSIBLE PARTY INFORMATION

Please complete if patient is under age 19

| | | |
|---|---|---|
| **Responsible Party:** | **Relationship to patient:** | |
| **Address/PO Box:** | | |
| **Home Phone:** | **Cell Phone:** | **Work Phone:** |
| **Employer:** | **Employer Address:** | |
| **If Minor, Other Parent's Name:** | | |

## PRIMARY HEALTH INSURANCE

| | |
|---|---|
| **Name of Insurance Company:** | **Policy Number:** |
| **Policy Holder's Name:** | **Date of Birth:** |
| **Relationship to Patient:** | **Policy Holder SS#:** |

## SECONDARY HEALTH INSURANCE

| | |
|---|---|
| **Name of Insurance Company:** | **Policy Number:** |
| **Policy Holder's Name:** | **Date of Birth:** |
| **Relationship to Patient:** | **Policy Holder SS#:** |

**Release of Information**

I hereby authorize MD Pain LLC and its staff to release to the above company (ies) or its representatives, to myself, to my primary care or referring physician(s), and to consulting physicians any information used for treatment or payment.

**Assignment of Benefits**

Authorization: I authorize payment of benefits directly to MD Pain LLC, I understand that I am financially responsible for all charges not covered by my authorization.

**HIPPA Privacy Notice**

The signature below acknowledges that MD Pain has provided access to our Notice of Privacy Practices.

**Consent to Medical Treatment**

I knowing that I have (or had) a condition requiring diagnosis and medical treatment, do hereby voluntarily consent to such diagnostic examination procedures and x-rays and to such medical treatment by DR MASSEY/DR DONOVAN, his/her assistants, or his/her designees as necessary in his/her judgment.

**Credit Card Payment Arrangement**

We will securely hold your credit card information until your health insurance processes your claim and mails you their Explanation of Benefits (EOB) which outlines the patient's financial obligation. Your credit card will only be charged when the exact patient responsibility charges are specified by your insurance company. If your financial responsibility is higher than $500.00, you will be charged this amount and will be expected to contact our office for payment of the balance. It is your responsibility to call if you would like to change credit card information or other payment arrangements. I understand that my credit card information will be saved to file for future transactions on my account.

**PHI RELEASE**

This authorizes MD Pain LLC to disclose your medical information to family members or friends designated by you, the patient. Please note this form does not alter our ability to communicate with family members involved in your care that are not designated below in the event of an emergency or other circumstance where you are unavailable and, in our professional judgment, we believe it is in your best interest to do so.

**I am permitting the following person(s) access to protected health information (PHI) from MD Pain LLC:**

**Name**: _____ **Relationship:**_____

**Name**:_____ **Relationship:**_____

SIGN HERE _____
Patient/Guardian Signature

_____/_____/_____
Date

MD PAIN

# MD PAIN LLC
# FINANCIAL POLICY

At MD Pain LLC we are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Our fees for services are based on the level of professional skill required; the severity and complexity of the injury or illness, as well as the time spent treating you. The **patient or responsible party** is responsible for seeing that the entire bill is paid in full. Your clear understanding of our Financial Policy is important to our professional relationship.

**Self-Pay Patients:** Payment in full is required for all self-pay/uninsured patients. If you don't have insurance, you will be asked to pay for services at the time of your visit. For many services, you will receive a 20% discount for payment in full on the day of your visit.

**Insurance:** Billing of insurance is a courtesy we provide our patients and is not required by law. Our professional services are rendered to a person, not an insurance company. The insurance company is responsible to the patient and the patient is responsible to us. Therefore, if your insurance does not respond within 30 days the bill will become your responsibility. Please notify us if your insurance carrier or policy has changed.

- **Co-Payments:** Your insurance contract REQUIRES that we collect your designated co-pay at the time of service. Please be prepared to pay your co-pay prior to each visit.

- **Deductibles:** We will verify your insurance benefits, and, at the time of your appointment, you will be expected to pay a deposit towards an estimated amount owed. Patients with high unmet deductible plans will be asked to remit a **minimum** deposit of $150 at the time of your visit. (We will collect your credit card information when you check in.) Following your appointment, as a courtesy we will bill your insurance company, and any patient responsibility portions are to be paid upon first receipt of your patient statement. If you have questions regarding any amount due after insurance has processed your claim, please contact them directly.

- **Referrals:** If your insurance plan requires a referral from your primary care physician, it is YOUR responsibility to obtain the referral prior to your appointment and have it with you at the time of the appointment. If you choose to seek the services of MD Pain LLC without the referral, YOU will be responsible for the payment of the charges.

**Medicare:** MD Pain LLC accepts Medicare assignment. By accepting assignment, we agree to accept Medicare's approved amount as payment for covered services. You, the patient, are responsible for any remaining balances. We will file a claim with your secondary insurance plan for you.

**Medicare ABN Form:** If you receive a service that may not be considered medically necessary by Medicare, you will be advised by the clinic staff and asked to sign and Advanced Beneficiary Notice (ABN). Medicare's determination that a service is not medically necessary does not mean that the service should not be provided to you. The Providers will recommend services based on your current health condition and their expert medical opinion. The ABN Form is your advance notification that the service(s) may not be covered, and you may be financially responsible. Testing or treatment will not proceed without your informed consent.

**Medicaid:** Clinic staff will verify Medicaid eligibility **at each visit**. Please have your current Medicaid card available. If a co-pay is required, your co-pay is due at the time of service.

**Workers Compensation/Accident Cases:** In order for us to file a claim with your work comp or other liability carrier you must provide complete billing information. Without this information we are unable to bill your insurance carrier and we will ask for payment in full at the time of service. Patients shall be financially responsible for medical services related to work com/accident if insurance fails to pay in full. We do not bill attorneys for medical services.

**Patient Statements:** You will be mailed your patient statement if a balance is due on your account. Payment is due upon receipt of your statement. Please contact our Billing Department for questions or concerns regarding your statement.

**Payment Arrangements:** If you are unable to pay for your patient statement balance in full, contact our Billing Department to discuss payment options. Payment plans may be available to payoff balances within 90 days.

**Outstanding Balances:** If you have any outstanding self-pay or insurance designated outstanding balances for co-pays, deductibles and other unpaid out-of-pocket expenses, you will be asked to remit payment at your next visit or you may be required to reschedule your appointment. Chronic non-payment of bills can constitute separation from the practice.

**Collections:** Unpaid balances will be forwarded to our collection agency. Once an account has been referred to a collection agency, you must work directly with them to satisfy your debt. If you return to our office for services, you will be required to pay in full **prior** to receiving any future services.

**Payment Methods:** We accept cash, checks, and most major credit cards

**Responsible parties** will be responsible for any expenses incurred in collecting the amounts owed, including attorney's fees, court costs and/or the collection agency fee. Any returned check from the bank for non-payment (insufficient funds) shall be result in the patient's account being assessed a $25 fee per check returned.

**NO SHOW POLICY AND LATE ARRIVALS:** Please note, our office charges for No Show/Missed Appointments, including late appointment check in. We understand that emergencies can and will happen, however this policy will stand. We will take a case-by-case review in waiving any true emergencies. You may be asked to provide details of the emergency. We will only allow one waiver per year per patient. Please note if you are late or miss more than 3 appointments, the office has the right to discharge you from the practice. All Fees will be due before next appointment will be scheduled. We appreciate your understanding in this matter.
The No-Show and Late Arrival Fee-

**Office and/or Procedure Appointment $50.00 FEE ***

***These fees are the responsibility of the patient, and we will not bill your insurance for this fee since these types of charges will not be covered by insurances, including Auto and Workers Comp.**

The fee will be charged in the following circumstances:

- Miss an Office Appointment or reschedule an Office Appointment with less than 24 hours business days' notice.
- Miss an Office appointment or Procedure Appointment because you have arrived later than 15 minutes after your scheduled appointment time
- Miss a Procedure Appointment or reschedule a Procedure Appointment with less than 48 hours business days' notice.

**Credit Card Payment Arrangement** We will securely hold your credit card information until your health insurance processes your claim and mails you their Explanation of Benefits (EOB) which outlines the patient's financial obligation. Your credit card will only be charged when the exact patient responsibility charges are specified by your insurance company. MD Pain will automatically run your credit card on file for any amount under $300.00. We will contact you for any amount due over $300.01. It is your responsibility to call if you would like to change credit card information or other payment arrangements. I understand that my credit card information will be saved to file for future transactions on my account.

I have read the Financial Polices of MD PAIN LLD and agree to comply with the Financial Policies. In addition, MD Pain LLC has my permission to provide medical documentation in order to obtain reimbursement.

Printed Patient Name: _____

Patient Signature: _____ Date: _____
(Patient or Parent of Minor)

MD PAIN

John R. Massey MD
Liane E. Donovan MD

Informed Consent/Treatment Agreement for Chronic Medication Therapy

Dr. is prescribing pain medicine to me for the diagnosis of _____.

This decision was made because my condition is serious or other treatments have not helped my pain.

I am aware that the use of such medicine has certain risks associated with it, including but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and possibility that medicine will not provide complete pain relief.

I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself.

I will tell my doctor about all other medicines and treatments that I am receiving.

I am aware that addiction during opioid therapy for pain can occur and includes impaired control, craving and compulsive use, and continued use despite negative physical, mental and/or social consequences. I am aware that the chance of becoming addicted to my pain medicine is very low. I am aware that development of addiction has rarely been reported in medical journals and is much more common in a person who has family or personal history of addiction. I agree to tell my complete and honest drug history and that of my family to the best of my knowledge.

I understand that physical dependence is a normal, expected result of using these medicines for a long time. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine use is markedly decreased, stopped, or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pian and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening.

(Males only) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my moods, stamina, sexual desire, and physical and sexual performance.

(Females Only) If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medicines; the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

I am responsible for requesting PRESCRIPTION REFILLS A MINIMUM OF 5 "BUSINESS" DAYS IN ADVANCE. I am aware that the telephone requests for refills must be made MONDAY-THURSDAY (8:30 am-3:00 pm). Refills will not be made at night, weekends, or holidays. Only my physician at MD Pain, LLC will prescribe any and all opioid pain medication.

I understand if in an emergency I have opioid medications prescribed by another source, the office must be notified in writing within 7 days. I am aware that I am only to fill my prescription at only ONE pharmacy of my choice. IF I FAIL TO COMPLY, I WILL BE DISCHARGED FROM MD Pain, LLC.

I must take my prescription as prescribed. Prescriptions will not be filled early and will be issued monthly when dose requirements are established.

Any opioid medication that I do NOT use because of side effects or dose adjustments should be brought to the office. I will NOT dispose of or throw away unused medication myself. I WILL NOT SHARE MY MEDICATION WITH ANYONE. IF I FAIL TO COMPLY, I WILL BE DISCHARGED FROM MD PAIN, LLC.

I am aware if I lose my medication, it will not be replaced and may result in being weaned from that medication. If medication is lost, I will write a note explaining what happened to the medication, date and sign it and send it to the office.

If my medication is stolen, a police report will be completed before any early refill, and this will be done at the discretion of my attending physician.

I understand I must comply with other recommendations, which may include psychological counseling, physical therapy, and nutrition changes as deemed necessary by my physician.

I am aware that at my physician's discretion; drug testing and serum toxicity screens may be performed. Failure to comply will result in dismissal from clinic. I understand that if my insurance does not cover urine drug screens, I will be responsible for the cost of the urine drug screen testing.

I must keep my scheduled appointments in the office if opioid medications are being maintained. Three cancellations and/or no shows can be grounds for weaning off the medications and/or may result in being discharged from MD Pain, LLC.

I have read this form and I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give my consent for treatment of my pain with pain medications.

A copy of this agreement will be given to me and may be sent to my designated pharmacy and to my other treating physicians.

Patient Name: _____

Patient Signature: _____ Date: _____

Physician Name: _____

Designated Pharmacy: _____ Telephone: _____