Patient Registration Form

Patient Information: (Please Print)

Patient Name:

(First)_____ (Middle Initial)_____(Last)_____

Address:_____City_____State_____Zip_____

Home tel:(___)_____ Work tel: (___)_____ Cell: (___)_____

Date of Birth:_____Age:_____ Sex : M F Email: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone:_____

Referred By: Friend _____Doctor (Name)_____Other_____

Is this a work injury? Yes ___No___ Is this an auto accident? Yes___No___ Date of Injury:_____

Responsible Party (person responsible for insurance/bill):

(First)_____ (Middle Initial)_____(Last)_____

Address:_____City_____State_____Zip_____

Phone:_____ Birth Date:_____Age:_____ Sex: M F

Employer:_____

Relationship to Patient:_____

Primary Insurance Co:_____Address:_____

Policy #:_____ Group #:_____

Name of Insured:_____Relationship:_____

Secondary Insurance:_____ Address:_____

Policy #:_____Group #:_____

Name of Insured:_____Relationship:_____

International Pain Solutions, Inc. is committed to ensuring the privacy and confidentiality of your medical records. We comply with the Health Insurance Portability and Accountability Act of 1996, (HIPAA). In order to assist us in protecting your privacy, please complete the following:
If we may speak with anyone other than yourself regarding your medical care, please list name, relationship, and telephone:_____.
May we leave a message on your voice mail at the following: Home ____ Work_____ Cell_____?

I have been made aware of the privacy policy of Pain Solutions, Inc., and have received (or made available to me) a copy of the Notice of Privacy Practices of Pain Solutions, Inc.

_____ _____

Signature Date

7120 E. Orchard Rd, Suite 110 Centennial, CO 80111 T: (303)243-5180 F: (303)243-5181

International Pain Solutions, Inc.
7120 E. Orchard Rd, Suite 110
Centennial, CO 80111
Tel: (303)243-5180 Fax: (303)243-5181

CONSENT TO TREAT

I, _____ understand that by signing this "Consent To Treat" form, I authorize the comprehensive Evaluation and any therapeutic intervention considered medically necessary by H. Lee Carman, P.T., or a representative of International Pain Solutions, Inc.

_____ _____

Signature Date

MEDICAL SERVICES FINANCIAL AGREEMENT

Insurance is a method of receiving reimbursement for services rendered by a provider. If you have medical insurance, we are happy to help you receive your allowable benefits. It is your responsibility to verify benefits with your insurance carrier. If you require a referral or prescription from your primary care physician (PCP), you are responsible for obtaining that referral/prescription and renewing it when it is necessary.

Having insurance is not a substitute for payment. Many insurance companies have fixed allowances or percentage rates set by your contract with them, not our office. Payment for services, including co-payment, coinsurance and deductible amounts, is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, Visa and MasterCard. Our failure to collect these amounts may be a violation of our contract with your insurance company and may result in civil and criminal penalties and/or expulsion from your insurance plan. In addition, your failure to pay the required co-amounts is a violation of your financial responsibility for coverage and we may report your refusal to pay these amounts to your employer and/or insurance company representative.

If you are being seen for a work or auto related injury, it is your responsibility to provide our office with any and all information necessary to receive payment or it will become your financial responsibility to pay for services rendered.

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. While the filing of insurance claims is a courtesy that we extend to patients, all charges are your responsibility from the date the services are rendered.

International Pain Solutions, Inc. is a specialty clinic focusing upon the needs of people suffering from pain, injuries and various related symptoms. Appropriate treatment of these conditions takes a significant amount of time and energy. International Pain Solutions, Inc. is different from the majority of medical/rehabilitation facilities in that we emphasize quality....not quantity. Your sessions will always be one-on-one with a focus upon your specific needs. Secondary to this, appointment availability is limited and **there is typically a "wait list" to receive an evaluation or treatment.**

Forty-eight (48) hours' notice must be given in case of cancellation so that others in pain may be given the opportunity to receive treatment.

Failure to keep an appointment without appropriate notice of cancellation will result in a $50.00 charge to cover time and costs. This charge will not be covered by your insurance provider and must be paid prior to rescheduling further appointments.

****Initial to confirm you have read the yellow section above _____**

Return checks will result in a $25 fee that will be posted to your account. Returned checks, balances older than 60 days and failure to pay account balances as promised may be subject to external collection and additional collection fees, including attorney and other court fees. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, please contact us promptly.

I have read and understand the above statements.

_____ _____

Signature of Patient/Responsible Party Date

Assignment of Benefits

I authorize release of all medical information necessary to process my insurance claims that are for my medical care. I assign all medical benefits for which I am entitled to International Pain Solutions, Inc., if payment is not rendered at the time of service. A photocopy of this assignment is to be considered as valid as the original.

I understand that I am financially responsible for all charges unless other arrangements have been made with this office.

_____ _____

Signature of Patient/Responsible Party Date

Please sign only if you have Anthem Blue Cross Blue Shield Insurance

Pain Solutions, Inc.
7120 E. Orchard Rd, Suite 110
Centennial, CO 80111

Anthem Cross Blue Shield
Patient Billing Acknowledgement
Non-Authorized/Non-Covered Services

On October 1, 2015, Anthem Blue Cross Blue Shield implemented a new authorization process for physical therapy services, managed by OrthoNet. Per this new plan, ***your physical therapy visits may or may not be authorized/covered. If the authorization request is denied, Anthem Blue Cross and Blue Shield will not pay for the visits. Per the policy, Pain Solutions will submit an authorization request after your initial visit and we will notify you as to whether or not future treatment has been authorized. In the event your treatment is not authorized you will be financially responsible for the uncovered visits.***

Your signature below affirms that you are financially responsible for any/all visits not authorized or covered by your insurer,
Anthem Cross Blue Shield.

Patient Acknowledgement:
I understand that I am financially responsible for all visits not authorized or covered by Anthem Blue Cross Blue Shield beginning October 1, 2015.

Patient Name _____

Patient Signature_____

Date _____

INTERNATIONAL pain Solutions, inc.

7120 E. Orchard Rd, Ste. 110
Centennial, CO 80111
Tel: (303)243-5180 Fax: (243)243-5181

Patient Name: _____ **Date:** _____

Referred by: _____

Reason for Visit: _____
_____
_____

Date of Injury: _____

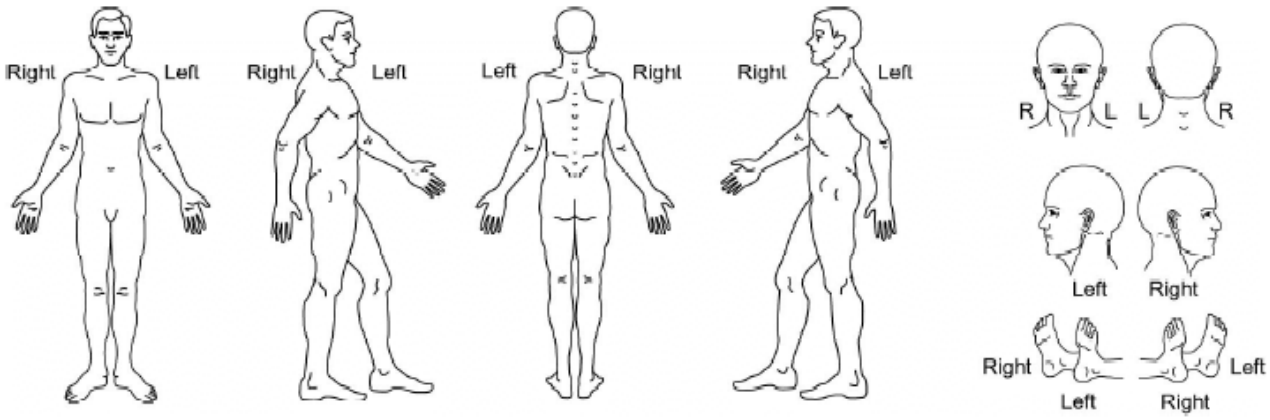
Is your pain the result of:

___ Motor Vehicle Accident ____ Sports Injury ___ Congenital
___ Work Injury ____ Illness ___ Other

Please describe the nature of your accident/illness:
_____
_____
_____

Please indicate the location of your pain on the diagram below. Please use the following indicators to describe your pain:

////// = Sharp/Stabbing OOOOOO = Numbness XXXXXXX = Aching T T T T T = Tingling



Please rate your pain by circling the number that best describes your pain, with 0 being no pain and 10 being the worst pain imaginable:

Today's pain:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Your average pain:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Pain on your best day:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Pain on your worst day:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
	No pain										**Worst pain**

What treatments have you tried to alleviate your pain?

- □ Chiropractor
- □ Physical therapy
- □ Massage therapy
- □ Acupuncture
- □ Medications (please list) _____
- □ Surgery
- □ Injections / Nerve blocks
- □ Exercise
- □ Other _____

What makes your pain better? _____

What makes your pain worse? _____

Does your pain limit you from:

- □ Walking
- □ Standing
- □ Working
- □ Enjoying life
- □ Sitting
- □ Exercising
- □ Sleeping
- □ Other _____

What would be an acceptable level of pain for you (please circle)?

0 1 2 3 4 5 6 7 8 9 10

No pain **Worst pain**

What is your goal in seeking treatment at Pain Solutions, Inc? _____
_____

How did you hear about Pain Solutions, Inc? _____

Patient's Social History

Age: _____ **Gender: M / F**

Occupation: _____ **Marital Status: _____**

Highest level of education achieved: _____

Do you smoke or use tobacco products?

□ No □ Yes (How many packs a day?) _____

Do you use alcoholic beverages?

□ No □ Yes (How often?) _____

Do you use illegal substances/street drugs?

□ No □ Yes (How often?) _____

Please rate how much your pain interferes with the following:

(0 ="Does Not Interfere" and 10 = "Completely Interferes")

Ability to work:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Completion of household chores:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Relationships with other people:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Ability to sleep:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Enjoyment of life:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
	Does not interfere										**Completely interferes**

Patient's Medical History

Place a "√" in the boxes below to indicate whether you or any members of your immediate family have ever had the following:

	You	**Family Member**
Anxiety		
Asthma		
Arthritis		
Allergies		
Cancer		
Depression		
Diabetes		
Eating Disorders		
Epilepsy/ Seizures		
High Blood Pressure		
Kidney Problems		
Headaches		
Hepatitis		
Mental Illness		
Osteoporosis		
Thyroid Problems		
Tuberculosis		
Ulcers/Gastritis		

Please list the dates and reasons for any hospitalizations / surgeries:

Date	**Reason**
_____	_____
_____	_____
_____	_____

What medications are you currently taking? Please include dosages.

_____

_____

Are there any other medical concerns we should know about?

_____

_____