Advanced Pain Management

Be Advised:

Please Arrive 15 minutes prior to your appointment time with this paperwork completed.

If it is not completed when you arrive, we need to reschedule your appointment.

We are sorry to inform you that we do not accept Worker's Comp or Auto Accident Claims. Please call office if you have one of these claims to discuss your scheduled appointment.

Thank you in advance for your cooperation.

Advanced Pain Management Staff

Advanced Pain Management

325 Clyde Morris Blvd, Suite 400 Ormond Beach, FL 32174 386-671-0600	780 Dunlawton Ave, Suite 103 Port Orange, FL 32127 386-756-2223	9 Pine Cone Drive, Suite 101 Palm Coast, FL 32137 386-597-7753

Our Fax number is 386-677-9710

WELCOME!

Welcome to our practice. We are pleased that you have chosen us to care for your medical needs. We are committed to providing you with the highest quality of healthcare.

On your first visit you can expect:

- A physical examination and review of your health history by Dr. Bhalani or his ARNP Dawn Tucker.
- A careful evaluation of your medical status
- A discussion of the most satisfactory treatment plan to meet your health needs

Forms:

Enclosed you will find the forms, including a Current Medications List, that needs to be completed and brought with you to your appointment.

Records:

Please be sure your referring doctor has sent any needed medical records to us prior to your scheduled visit. If not, please make arrangements to bring a paper copy of your X-rays, MRIs, CTs, Lab work or other test results related to the problem or reason for your visit with us.

Identification:

We will ask you for some form of identification such as a driver's license or State ID card so be sure to bring that to your visit.

Insurance/Payments:

If you have insurance, we require that you present your insurance cards to us when you arrive for your appointment. If there are known out of pocket costs, such as deductibles or co-payments, we will ask for payment of those costs when you check in for your appointment.

If you do not have insurance, you will need to pay in full when you check in for your appointment unless prior arrangements have been made.

WE CAN NOT ACCEPT CHECKS FOR A NEW PATIENT

We are sorry to inform you that we do not accept Worker's Comp or Auto Accident Claims.

Thank you for helping us to make your appointment with our doctors as smooth and efficient as we can for you. We appreciate the opportunity to help with your health care needs.

Advanced Pain Management Staff

Advanced Pain Management	Welcome To Our Office

PATIENT INFORMATION

Patient Name	Social Security Number:
Street	Date of Birth: Gender M__ F__
City & State Zip Code	Occupation:
Telephone-Home	Full time____ Part- Time ___ Retired ____
Telephone- Other	Unemployed____ Disabled_____ Student fulltime or part time
Telephone -Work	Employer Name and Address:
Marital Status: Single__ Married__ Significant Other___ Widowed__	Emergency Contact:
Email Address:	Relationship: Phone:
Primary Care Physician:	Referred by

Financial Responsibility (Please give insurance cards to front desk with this form)

Primary Insurance	Secondary Insurance
Primary Insurance Name:	Secondary Insurance Name:
Name of Insured:	Name of Insured:
Relationship to Insured:	Relationship to Insured:
Insured Social Security #:	Insured Social Security #:
Insured Date of Birth:	Insured Date of Birth:
Insurance Policy ID#:	Insurance Policy ID#:
Group#:	Group#:
Claims Address:	Claims Address:
Telephone:	Telephone:

- All co-payments and/or deductible payments are due at the time of your visit today.
- If you do not have insurance, payment in full is expected at the time of your visit today.

Payment for Professional Services Rendered

I understand that many procedure performed by Advanced Pain Management (APM) are highly specialized and demand extensive education and training. I also understand that the fees for services provided by APM may exceed the amount paid by my insurance company. I agree upon co-insurance, deductible, or eligible charge as determined by the contract APM currently has with my insurance carrier. In those situations wherein APM is not contracting provider with my insurance company, I understand that I must pay that portion if any, of my bill that is not covered by in insurance. I understand that by signing this agreement as patient or as agent, I obligate myself to pay my account in full.

Patient Signature: _____ Date: _____

Advanced Pain Management

Urine Screen Policy

I certify that I have voluntarily provided a fresh and unadulterated urine specimen for analytical testing. The specimen will be sent to a laboratory for complete results. This specimen is to assist the physician in my care and treatment. I also understand that a specimen is required on my first visit to the practice and subject to random request from the physician as he deems necessary.

The specimen may or will include testing for THC, Cocaine, Opiates, Amphetamines, Methamphetamine, phencyclidine, MDMA, Barbiturates, Methadone, Tricyclic Antidepressants and Oxycodone.

Please be advised that you may receive a separate billing statement from the Laboratory.

_____ _____

Patient Signature Date

CONTRACT FOR CONTROLED SUBASTANCE PRESCRIPTIONS

Controlled substance medications (narcotics, tranquilizers and barbiturates) are very useful, but have a high potential for misuse and abuse and we are therefore closely controlled by local, state and federal government. They are intended to relieve pain to improve function and/or ability to work. If I am given a prescription for any controlled substance to aid in managing my pain,
I agree to the following conditions.

1. I am responsible for my controlled substance medication. If a prescribed medication is lost, misplaced, stolen, or if it used sooner than prescribed, I understand that it will not be replaced.

2. I will no request no accept controlled substance medication from any other physician or individual while I am receiving such medications from Advanced Pain Management. Besides being illegal to do so, it may endanger my health. The only exception is if it is prescribed while admitted to the hospital.

3. Refills on controlled substance medication will be made during regular office hours only or during your scheduled office visit. Refills will not be made at night, weekends or on holidays. Refills will not be made if I "run out early" and I understand that I am responsible for taking the medications in the dose prescribed and for keeping track of my remaining amounts. I further understand that refills will not be made on an emergency basis, such as a Friday afternoon because I may run out over the weekend. I must keep track of my medications and agree to call at least 48 hours in advance for a refill on my medications.

4. I understand that if I violate any of the above conditions my controlled substance prescriptions and/or treatment at Advanced Pain Management may be ended immediately and I understand that I may be fired from the practice. If this violation involves obtaining controlled substances from another physician as described above, I understand that I will be reported to my primary physician, local medical facilities and other authorities, including law enforcement.

I have been fully informed by Advanced Pain Management and the staff about the psychological dependence (addiction) of controlled substance. I know that some persons may develop a tolerance, which is the need to increase the dose of the medication to achieve the same effect of pain control and I do know that I can become physically dependent on the medication. I have been informed that I will need a physician's assistance when I am instructed to stop any narcotic therapy to prevent withdrawal symptoms.

_____ _____

Patient Date

Advanced Pain Management

FINANCIAL POLICY

IF YOU HAVE QUESTIONS ON THE FOLLOWING FINAICAL POLICY PLEASE LET OFFICE STAFF KNOW BEFORE SIGNING.

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. Be advised that if there is any procedure not covered by your insurance company, you will be responsible for payment.

PAYMENT ID DUE AT THE TIME OF SERVICE

You are financially responsible for the services we provide you. As courtesy we will file insurance claims on your behalf, when supplied with current insurance information. If you present without this information, please be prepared to pay cash or rescheduled your visit. It is your sole responsibility to know the individual coverage and benefits of your plan and to ensure your provider is a contracted provider with your plan.

METHOD OF PAYMENT

We accept Cash, Checks, Visa, Mastercard, Discover, and American Express.

PRIOR BALANCES

Patients with an account showing a prior balance will be asked to pay balance in full before being seen. If the balance cannot be paid in full, you may be asked to meet without billing department to arrange for payment.
We accept assignment for major insurances. You will be required to pay an applicable co-pays, coinsurance, deductibles and/or any non-covered services rendered at the time of service. Please understand that your insurance plan is a contract between yourself and your insurance company. If a claim has been filed correctly on your behalf and not paid within 45 days by your insurance carrier, you will be responsible to pay the balance.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY

Patient Name: _____ Patient Signature _____Date: _____

ASSIGNMENT OF BENEFITS
Private Insurance Authorization for Assignment of Benefits and Information Release

I, the undersigned, authorize payment of medical benefits to Advanced Pain Management (APM) for any services furnished to me by the physician. I understand I am financially responsible for any amount not covered by my insurance policy. I also authorize Advanced Pain Management (APM) to release to my insurance company, referring physician and other consultants on my case information concerning health care, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims benefits.

Patient Signature: _____ Date: _____

MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized Medicare benefits made on my behalf to Advance Pain Management (APM) for services furnished to me by the physician. I authorize any holder or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Patient Signature: _____ Date: _____

CERTIFICATION

Advanced Pain Management (APM) is pleased to offer you treatment for your injury or suffering. However, you are advised that according to most commercial insurance policies and generally accepted practice, treatment for work related chronic injuries must first be filed under Worker's Compensation. We will be happy to assist you in this process. Also, if this is a litigation case, our office needs to be informed before services are rendered, I_____ hereby certify that I **am/ am not** seeking treatment for an illness that resulted from an incident/accident at my place of work or from a motor vehicle accident.
If applicable: MVA/ Date of incident: _____

If applicable: Attorney's Name: _____ Phone number: _____

_____	_____	_____
Patient Name	Patient Signature	Date

Advanced Pain Management

RESTRICTED PHI AUTHORIZATIONS

Release of PHI (Personal Health Information)

I authorize Advanced Pain Management to speak to the following people on my behalf if needed and at any time regarding my health care conditions. I understand that this authorization shall become effective immediately and shall be valid until expressly revoked by me in writing. Request to change needs to be in writing to the Compliance Officer for Advanced Pain Management.

PLEASE READ CAREFULLY: Initial each box for your approval. If you **do not initial** a box, then this information will be considered Restricted and your information will not be disclosed. (Only a person(s) who will be able to receive such information has been disclosed to you in the HIPAA regulation, in which you have signed.)

Please initial boxes to give approval:

☐ PHYSICAN NOTES

☐ LAB RESULTS

☐ DIAGNOSTIC TESTS

☐ MEDICATIONS

☐ PHYSCOLOGIC NOTES

☐ DRUG TESTING RESULTS

☐ **I DO NOT AUTHORIZE ANYONE TO MY INFORMATION AT THIS TIME**

☐ I AUTHORIZE APM to leave a detailed message on my voicemail regarding necessary information. The number I authorize for messages is: _____ _____ _____.

I release the above information, which I have initialed to the following people on my behalf

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

_____ _____

Patient Signature Date

_____ _____

APM Witness Date

Advanced Pain Management

Kirit Bhalani MD

Patient Authorization for Medical Records

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

Phone Number: _____

To be released to:

Advanced Pain Management 325 Clyde Morris Blvd. Suite 400 Ormond Beach, FL 32174 (386) 671-0600 Phone (386) 677-9710 Fax	Advanced Pain Management 780 Dunlawton Ave. Suite 103 Port Orange, FL 32127 (386) 756-2223 (386) 677-9710	Advanced Pain Management 9 Pine Cone Drive Suite 101 Palm Coast, FL 32137 (386) 597-7753 (386) 677-9710

I _____ authorize Advanced Pain Management to obtain any medical records pertaining to my pervious treatment for Pain Management, to include any pertinent imaging reports, laboratory reports, and previous office notes. This authorization shall become effective immediately and shall be valid until expressly revoked by me in writing.

_____ _____

Signature if Patient or Authorized Person Date

_____ _____

Relationship to Patient if other than Patient Date

_____ _____

Witness Date

Advanced Pain Management

Name_____ Date of Birth_____ Today's Date_____

ARE YOU ALLERGIC TO ANY MEDICATIONS?

(If Yes, List Here)

MEDICATION LIST

Medication Name (ex. Flexril)	Strength (ex. 10mg)	Directions (ex 3 times a day)

_____ _____

Patient Signature Date

Advanced Pain Management

- Must be completed prior to examination

Date of Exam_____ Patients Name_____ DOB: _____ Age: _____

Referring Physician: _____ Primary Care Provider_____

Pain History:

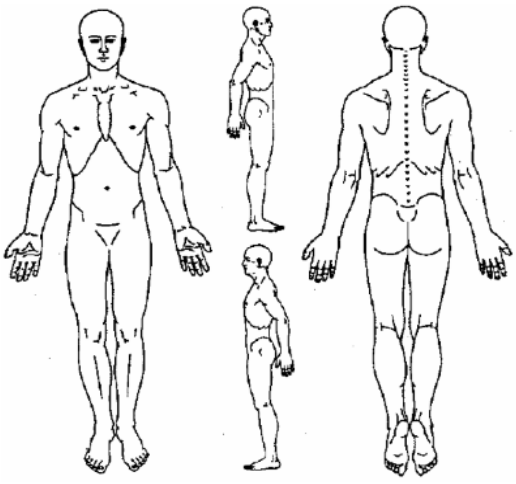
When did the pain begin? Month: _____ Year: _____

The pain is related to a motor vehicle injury____ Work related injury_____ Surgery_____ Other____

- Are you on Disability/Worker's Compensation? Yes___ No ____
- Are you suing anyone because of your pain or injury? Yes___ No___

Where is your pain? _____

_____



Mark you pain site(s) on the diagrams to the left.

Please rate your pain by circling the number that best describes your pain at its worst in the past 24 hours:

_____

0 1 2 3 4 5 6 7 8 9 10

Please rate your pain by circling the number that best describes your pain at its least in the past 24 hours:

_____

0 1 2 3 4 5 6 7 8 9 10

Which statement best describes your pain?

_____ Constant ____ Intermittent ____ Occasional ____ Rare

Does your pain interrupt your sleep? _____ How often does it wake you up? _____

How would you describe the pain (please circle):

Throbbing Shooting Stabbing Sharp Cramping Gnawing
Burning Aching Heavy Tender Exhausting Boring

Are your symptoms worse during (please circle):

Bending Sitting Rising Walking Standing Lying Down Heat Cold
Particular Position or Movement (Please Explain) _____

Are your symptoms better during (please circle):
Bending Sitting Rising Walking Standing Lying Down Heat Cold
Particular Position or Movement (Please Explain) _____

Do you have numbness or weakness? __No __ Yes If yes where? _____

Do you have any Bowel/Bladder problems related to your pain? ___ No ___Yes

Previous Treatments:

Treatment			Helpful/ Complications Comments
Traction	___ Yes	___ No	
TENS Unit	___ Yes	___ No	
Physical Therapy	___ Yes	___ No	
Couseling/ BioFeedback	___ Yes	___ No	
Chiropractor/Acupuncture	___ Yes	___ No	
Heat/Ice	___ Yes	___ No	
Injections	___ Yes	___ No	

Are you on any "blood thinners" such as Coumadin (Warfarin), Plavix (Clopidogrel), Lovenox(Enoxaprin), Ticlid(Ticiopidine), Aspirin/Ecotrin, Excedrin?
____ No ____ Yes If yes, Which Drug? _____

Are current under a narcotic agreement with or receiving narcotics from any other physicians?
_____ No _____Yes

Have you been in treatment for misuse of alcohol? Illicit Drugs, or prescribed medications? ___ No ___Yes

List the pain medications that you have previously tried: _____

_____

Notes