

BLUE RIDGE PAIN MANAGEMENT
172 Asheland Avenue, Suite C
Asheville, NC 28801

Registration Information

(Please Print)

Date: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Patient _____
Last Name First Name Middle Initial

Street Address: _____

City _____ State _____ Zip Code _____

Single Married Widowed Separated Divorced

Social Security # _____ Sex: M F Age _____ Birthdate _____

Employed Disabled Full-Time Student Part-Time Student

Patient Employed by/Occupation: _____

Business Address & Phone: _____

Spouse's Name: _____ Birthdate: _____

Spouse's Phone Number: _____ Spouse's SSN: _____

Do you have Medical Insurance? Yes No

If yes, Name of Primary Insurance: _____

ID #: _____ Group #: _____ Insured's Name: _____

Name of Secondary Insurance (if any): _____

ID #: _____ Group #: _____ Insured's Name: _____

Are you covered under Worker's Compensation? Yes No

If yes, Adjuster's Name: _____ Claim #: _____

Address to send claims to: _____

Adj's Phone #: _____ Adj's Fax # _____ Date of Injury: _____

Is your condition related to an auto accident? Yes No Which state? _____

Date of Injury: _____

Other reason for injury? Please describe: _____

IN CASE OF EMERGENCY, who should be notified? _____

Emergency contact's number: _____ Relationship to patient: _____

(see other side)

General Practitioner: _____ City/State: _____

Please list other doctors you have seen in the past 5 years:

How did you learn of our practice? _____

Whom may we thank for referring you? _____

Assignment and Release

I, the undersigned, have insurance coverage with _____
Name of Insurance Company
and assign directly to Dr. Buzzanell all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

(SEAL) _____
Signature of Insured/Guardian Date

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Buzzanell for any services furnished by my physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

(SEAL) _____
Beneficiary Signature Date

Medication History Consent

I give my permission for Blue Ridge Pain Management to access my pharmacy history electronically.

Signed: _____ (SEAL) Date: _____

**Blue Ridge Pain Management & Palliative Care
New Patient Form**

Patient Name: _____ DOB: _____ Date: _____
Referring Physician: _____ Primary Care Physician: _____

Pain Assessment:

Cause of pain: _____

How long have you had the pain: _____

Location of Pain: _____

Description of pain: **(check the ones that apply to you)**

Sharp Stabbing Burning Stinging
 Dull, aching Numbness Pressure Electrical/Shooting
 Throbbing Pins & Needles Cramping

Is the pain Rarely Occasionally Frequently Always Present

Is the pain always the same? **Yes or No**

What makes your pain worse? _____

What makes your pain better? _____

What pain treatments have you had? **(Check what applies to you)**

Nerve Blocks/Injection Physical therapy Psychiatrist/Psychologist
 Epidural Steroids TENS unit Hypnosis
 Chiropractor Acupuncture Narcotic pain medication
 Other

Past Medical History/ Problems: **(Check what applies to you)**

Heart Attack Angina Heart Surgery Asthma/bronchitis
 Emphysema Kidney disease Stroke Infection-TB_AIDS
 Hepatitis/liver disease High blood pressure Bleeding tendency
 Seizures Cancer Depression Diabetes Anxiety Arthritis
 Other

Past Surgical History: (Please include dates) _____

Special studies to diagnose the cause of your pain. (X-Ray, MRI, CT Scan, Myelogram, EMG): _____

Family History: **(Check what applies to your family)**

Migraine Seizures Stroke Heart Attack Cancer
 Back Problems Depression Anxiety DM HTN

Social History:

Smoking habits: _____ packs per day _____ years

Alcohol intake: _____ Amount & Frequency _____

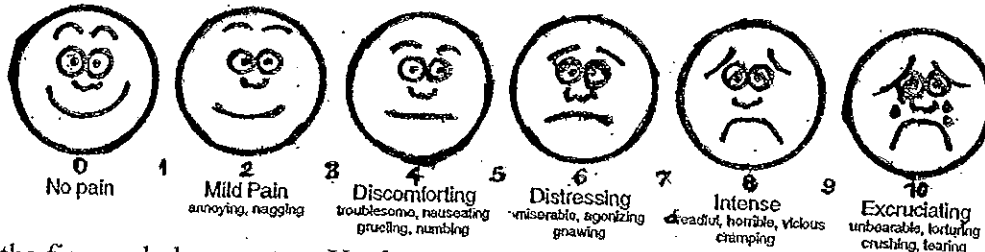
Have you been treated by another pain management center? Yes No

If yes, where? _____

BLUE RIDGE PAIN MANAGEMENT & PALLIATIVE CARE, P.A.
 172 Asheland Avenue, Suite C
 Asheville, NC 28801
 Phone (828) 350-9310 Fax (828) 350-9311

Patient: _____ DOB: _____ Date: _____

1. Circle, on a scale of 0 to 10, your pain score.

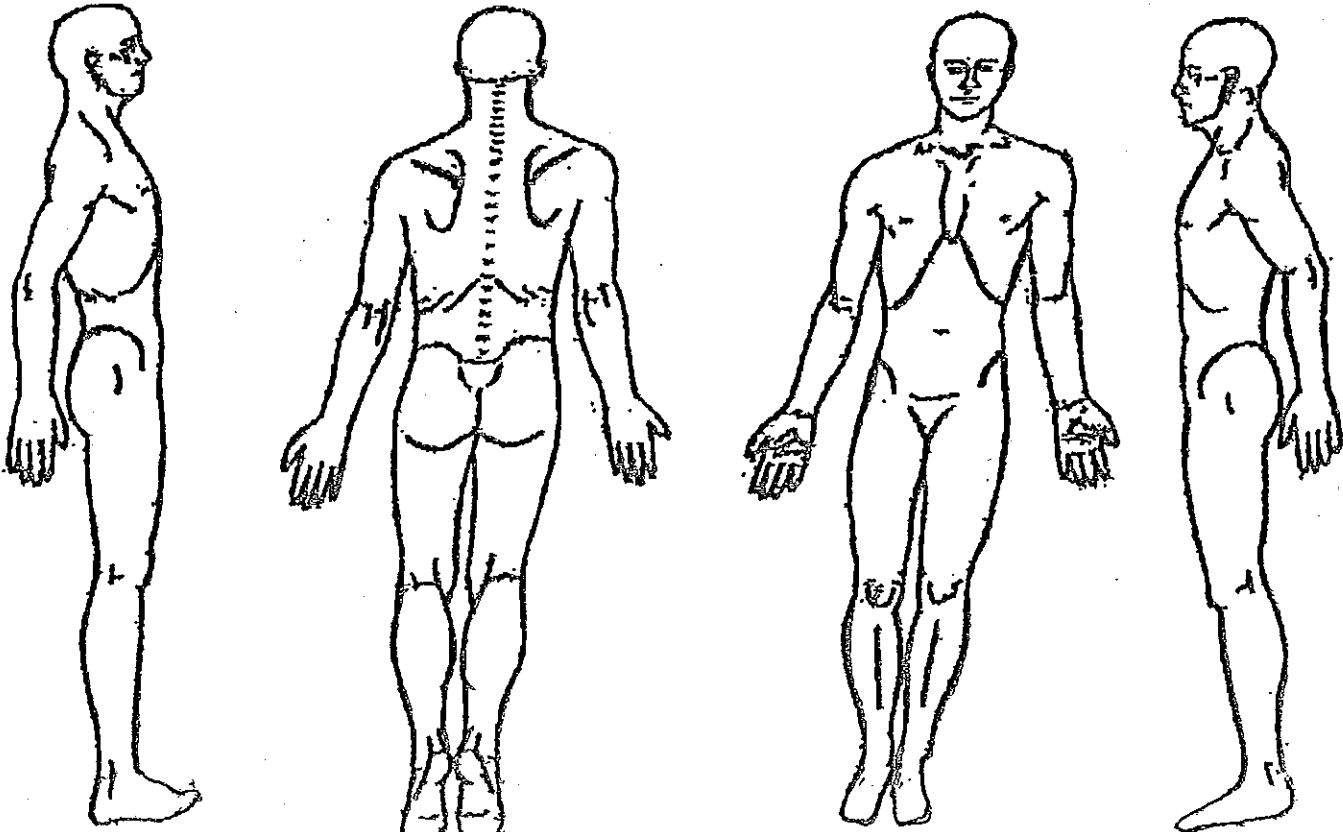
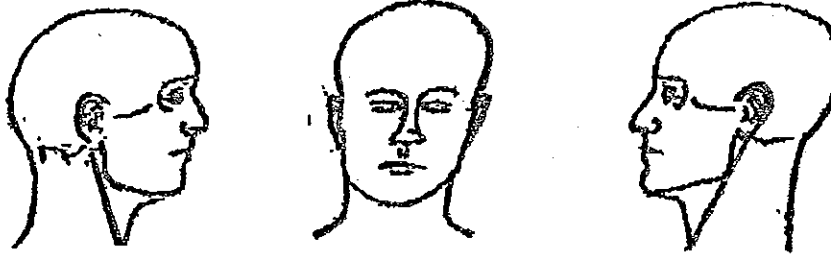


2. On the figures below, put an X where your pain starts and an arrow from there to where the pain radiates. Then, using the number scale above, indicate the pain score in those areas where you put an X.

Right

Front

Left



Right Side

Back

Front

Left Side

BLUE RIDGE PAIN MANAGEMENT & PALLIATIVE CARE, P.A.
1025 Brevard Road, Ste 3
Asheville, N.C 28806
(828) 667-4043 Fax: (828)665-8340

CONTRACT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications (e.g., narcotics, tranquilizers, and barbiturates) are very useful but have a high potential for misuse and are closely controlled by the local, state and federal government. They are intended to relieve pain to improve function and/or ability to work, not simply to help you "feel good". I agree to the following conditions because my physician is prescribing such medication for me to help manage my pain.

1. **I am responsible for my controlled substance medication!** If the prescription of medication is lost, stolen, or misplaced or if I use my medication sooner than prescribed, I understand that **it will NOT be replaced.**

If the violations involves obtaining controlled substance medications from another individual, or the concomitant use of non-prescribed illicit (illegal) drugs example: marijuana, cocaine, etc. I may also be reported to all my other physicians, medical facilities and appropriate authorities.

2. I will not request nor accept controlled substance medications from any other physician or individual while I am receiving such medication from this office. Besides being illegal to do so, it may endanger my health. The only exception is if it is prescribed while I am admitted to a hospital.
3. For my own protection against potential misuse of these medications, I hereby appoint _____ as the designated medico legal custodian of my controlled prescription drugs. I will obtain my prescribed medication from _____ Pharmacy only. My medico legal custodian will give only the current day's worth of medications while securing the rest.
4. I agree to give a copy of this contract to the aforementioned pharmacy, my primary care physician, and all other health care providers currently participating in my care, as well as the designated emergency facility, _____ from which I agree to seek acute/emergency care.
5. Refills of controlled substance medication:
 - a) will be made only during regular office hours or once each month during a scheduled office visit.
 - b) **will not** be made if I "Run out early". I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.

- c) Will not be made as an “emergency” such as on a Friday afternoon because I suddenly realize I will “run out tomorrow”. I will call at least forty-eight (48) hours ahead if I need assistance with a controlled substance medication prescription.
6. I agree to comply with random: pill count, and/or urine, blood, or breath testing, documenting the proper use of my medications as well as confirming compliance. I understand that driving a motor vehicle or operating heavy machinery may not be allowed while taking controlled substance medications, and that it is my responsibility to comply with the laws of the state while taking the prescribed medications.
7. I understand that if I violate any of the above conditions, my controlled substance prescriptions and/or treatment at BLUE RIDGE PAIN MANAGEMENT & PALLIATIVE CARE, P.A. may be ended immediately!
8. I understand that the main treatment goal is to improve my ability to function and/ or work. In consideration of that goal and the fact that I am being given potent medication to help me reach that goal, I agree to help myself by following better health habits such as: exercise, weight control, and the cessation of tobacco and alcohol use. I understand that only through following a healthier lifestyle can hope to have the most successful outcome in my treatment.

I have been fully informed by Dr. Charles A. Buzzanell and/ or his staff about psychological dependence (addiction) of a controlled substance. I know that some persons may develop a tolerance, that is, a need to increase the dose of the medication to achieve the same effect of pain control and I know that I may become physically dependent on the medication if I continue on it for several weeks. When I stop the medication, I must do so slowly and under medical supervision or I may experience withdrawal symptoms.

I have read this contract and it has been explained to me by Dr. Buzzanell and/or staff. In addition, I fully understand the consequences of violating this contract.

Patient's Name (Print)

Date

Patient's Signature (SEAL)

Date

Witness Signature

Date

FINANCIAL POLICY

- A. **MEDICAL AND SURGICAL CONSENT.** I, the undersigned, consent to the treatment and procedures which may be performed during this and any further service, and which may include but are not limited to any medical/surgical treatment or procedures. I have the right to refuse any treatment and to be informed of the possible medical consequences of refusal. My signature on this document indicates my general consent to be treated. My physician may request that I sign a more specific form relative to any procedure that may be performed.
- B. **RELEASE OF INFORMATION.** The physician(s) may disclose any or all parts of these medical records to my insurance carrier(s) and any organization(s) contractually responsible for purposes of satisfying all charges billed by the physician(s). This includes but is not limited to all claim filings, appeals, and correspondence in regard to the charges billed.
- C. **FINANCIAL RESPONSIBILITY.** I, the undersigned, hereby understand and acknowledge that it is the policy of this office that payment is made at each visit and I am responsible for payment of all services rendered in my behalf. I agree to pay interest at one and one-half percent (1 1/2%) per month (eighteen percent (18%) APR) upon any outstanding balance due over sixty (60) days. I understand that if my account is unpaid after ninety (90) days, and no payment arrangements have been made with this office, my account will be subject to the following collection process: My account will be turned over to an attorney for collection. This process may include reporting to the credit bureaus and obtaining a judgment for the balance due plus interest, court costs, and a thirty-three and one-third (33 1/3) attorney fee. I am aware that if a judgment is obtained, I will be responsible for the balance due plus interest, court costs and said attorney fee. If the treating physician(s) is a participant in an HMO, PPO or IPA, of which I am a member, I agree to pay any co-payment required and any fees for uncovered services that any medical insurance, HMO, PPO, or other payer does not pay.
- D. **CANCELED VISIT.** I, the undersigned, hereby and understand and acknowledge that I will be responsible for charges incurred due to failure to cancel any appointment within twenty-four (24) hours. This failure will result in a \$35.00 fee charged to your account, which is due immediately upon receipt.
- E. **AUTHORIZATION FOR MEDICAL PAYMENTS.** I hereby authorize payment of medical benefits to any physician or supplier for services rendered.
- F. **INSURANCE MATTERS.** I understand the following concerning insurance:
- ❖ We will file your insurance claim, however we **MUST** have a copy of your insurance card in order to file. At the time of service, you will be responsible for any and all copays, deductibles and co-insurance amounts.
 - ❖ All insurance changes must be given to us at the time of service. If your insurance changes and we are not notified in writing, you will be responsible for all charges and we will be unable to bill your insurance for any services before the change notification.

FINANCIAL POLICY

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- ❖ IN Network Insurance Office Policy: If we are contracted with your insurance company, you will only be responsible for your co-pays and co-insurance as outlined on your EOB (Explanation of Benefits). See the front desk for a current list of payers.
- ❖ OUT of Network Insurance Office Policy: If we are not in contract with your insurance company, we will file the insurance on your behalf and accept assignment of the payments. Any balance will be patient responsibility. We are not obligated to write off amounts your insurance company recommends to us. We will give a remaining insurance balance discount of 20% as a courtesy to our patients.
- ❖ Self Pay Policy: Patients with no insurance are given a 20% discount on Office Visits and a 50% discount on Procedures. Payment is mandatory at time of visit. You will not be permitted to carry a balance and if a balance remains you will not be able to come back for another visit until the balance is paid in full.
- ❖ As a courtesy, we will file your secondary insurance provided that all information is given at the time of service. If no payment is received from the secondary carrier within forty-five (45) days of filing, the unpaid balance becomes your responsibility. In the event of duplicate payment by the insurance and/or patient, refunds will be sent to the appropriate party as soon as possible.
- ❖ All patient balances become due and payable immediately upon your benefits determination or our receipt of the payment or denial notice from your insurance carrier.
- ❖ For those patients who are members of an insurance plan that requires a referral, please verify with our front desk staff that current authorization has been received prior to your visit. If we do not have a completed authorization, you will be responsible for your visit.
- ❖ The patient, not our office or the insurance company, is responsible for all charges incurred in regarding to all medical/surgical care. We advise you to know your insurance plan and your covered benefits. You will be billed directly for all non-covered services and supplies.

G. MEDICARE AND/OR MEDIGAP PATIENTS. I hereby request that payment of authorized Medicare and/or Medigap Benefits be made on my behalf to Sandhills Orthopaedic and Spine Clinic for any services rendered to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits payable for related services.

H. RETURNED CHECKS. A service charge at the current statutory rate will be applied to your account for all returned checks. Once a returned check has been received, all future payments must be made with cash, money order or cashier's check.

FINANCIAL POLICY

Page Three of Three

I. **RESPONSIBILITY FOR SERVICES PROVIDED TO MINORS.** The responsibility for payment of services rendered to any dependent children rests with both parents. The responsibility for payment of services rendered to any dependent children of divorced parents rests with both parents as well. Any court ordered responsibility judgment must be determined between the individuals and/or the court system without the inclusion of our office.

J. **DISABILITY FORMS.** If a disability form is needed, there will be a thirty-five dollar (\$35.00) fee for the initial completion of your form and a twenty-five dollar (\$25.00) fee for any subsequent form. Our office requires five to seven (5-7) business days to complete all forms.

I, the undersigned, further state that the foregoing Financial Policy has been carefully read, and that I understand the contents thereof, and have signed of my own free and voluntary act, and have not been influenced in executing this Financial Policy by any representative of BLUE RIDGE PAIN MANAGEMENT or its agents. I hereby acknowledge the continuing nature of this agreement unless or until withdrawn by me in writing.

_____ [SEAL] Dated: ____ / ____ / ____
Patient Signature (or Parent if Patient is a Minor)

Witness

Copy Provided to Patient

BLUE RIDGE PAIN MANAGEMENT & PALLIATIVE CARE

Blue Ridge Pain Management & Palliative Care's Notice of Privacy Practices has been provided to me for review.

I understand that the purpose of this notice is to inform me of my rights in regard to my Protected Health Information and also the ways in which the Practice may use my Protected Health information.

I acknowledge that I have been given a copy of the HIPAA Compliance Policies and Procedures. I understand that any updated amendments to this document will be posted at Blue Ridge Pain Management's office and I may ask for and receive a copy of it.

Patient's Name: _____

Patient's Signature: _____ (SEAL)

Date: _____

Witness: _____

To be filed in patient's chart

BLUE RIDGE PAIN MANAGEMENT & PALLIATIVE CARE

AUTHORIZATION FOR THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive, may be re-disclosed and no longer protected by federal privacy regulations.

1. Please list the family members or other person with names and phone numbers, if any, who we may release information to about your appointments, lab and x-ray results and/or other healthcare information. I authorize this information to be released verbally or in writing to the following:

_____	_____
_____	_____
_____	_____

2. Can confidential messages including appointment reminders, lab and x-ray results and/or other health care information be left on your home answering machine or voicemail? YES _____ NO _____

If NO, please print the telephone number, if any, where you want to receive this information: _____

3. If you do not have voicemail, can a confidential message be left at your place of employment? YES _____ NO _____

4. I understand that I may revoke or change this authorization at any time by notifying Blue Ridge Pain Management in writing.

Patient's Name: _____

_____(SEAL) _____
Signature of Patient or Patient Representative Date

Signature of Witness Date