Center for PAIN and REHAB Medicine

Manage your Pain.
Enjoy your Life!

D. Terrence ***Foster, M.D., M.A., FAAPMR, DABPM***
Board Certified in Pain Medicine, Physical Medicine & Rehabilitation

PATIENT INFORMATION

You must fill out this form in its entirety. Please print all information and use legal name printed on your insurance card

First Name:		**Last Name:**			**MI:**	**SSN:**	
Address:		**City:**			**State:**	**Zip:**	
Cell #:		**Home #:**			**Work #:**		
Email:		**Gender:**	☐ **M**	☐ **F**	**DOB:**		
Emergency Contact:		**Phone #:**			**Relation:**		
Referring Physician:				**Phone #**			
Primary Care Physician:				**Phone #**			
Last PCP Visit:							

Marital Status:	**Ethnicity:**	**Race:**
☐ Married	☐ Hispanic	☐ American Indian or Alaskan Native
☐ Single	☐ Non Hispanic	☐ Asian
☐ Divorced	☐ Refused to Report	☐ Black or African American
☐ Separated		☐ Native Hawaiian/Other Pacific Islander
☐ Widowed		☐ White
☐ Life Partner		☐ Other
		☐ Unreported/Refused to Report

Employment Status:	☐ **Employed**	☐ **Unemployed**	☐**Retired**	☐ **Disabled**

Employer Name:					**Occupation:**		
Employer Address:					**Phone #:**		
Responsible Party (Guarantor)					☐ **Same as Patient**		
Guarantor First Name:		**Last Name:**			**MI:**	**SSN:**	
Address:		**City:**			**State:**	**Zip:**	
Cell #:		**Home #:**			**Work #:**		
Relationship to Patient:		**DOB:**			**Email:**		
Employer Name & Address:					**Occupation:**		

INSURANCE INFORMATION							
POLICY HOLDER (If not Patient):							
First Name:		**Last Name:**			**MI:**	**SSN:**	
Address:		**City:**			**State:**	**Zip:**	
Cell #:		**Home #:**			**Work #:**		
Relationship to Patient		**DOB:**			**Email:**		
PRIMARY INSURANCE:		**SECONDARY INSURANCE:**					
Insurance Carrier:		Insurance Carrier:					
Group ID:		Group ID:					
Member ID:		Member ID:					
Effective Date:		**Effective Date:**					

ACCIDENT INFORMATION (If Applicable)	
Automobile Accident	**Work Related Accident**
Date of Accident:	Date of Accident:
Auto Insurance Company:	Auto Insurance Company:
Claim Adjuster's Name & Phone #:	Claim Adjuster's Name & Phone #:
Policy #:	Policy #:
Claim #:	Claim #:

ATTORNEY INFORMATION		
Attorney Name:	**Law Firm:**	
Address:	**Phone #:**	

WHO MAY WE THANK FOR REFERRING YOU TO THE PRACTICE?
Name & Contact Information:

*****It is your responsibility to notify our office of any changes in your address, telephone number and insurance plan. We will not be responsible for any returned or undeliverable mail.*****

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true, and accurate.

Signature of Patient/Responsible Party:	**Date:**
Name of Patient/Responsible Party (Please Print):	

PATIENT PHARMACY INFORMATION

PREFERRED PHARMACY	SECONDARY PHARMACY
Name :	Name :
Address:	Address:
Phone #:	Phone #:
Fax #:	Fax #:

Medications - List all medications you take, prescription and non prescription, and the do

☐ **I do not take any medications**

Medication Name	Strength	Frequency Taken	How Long have you been taking it?

Allergies to Medication - List all known allergies:

☐ **No Known Allergies**

Medication Name	Reaction You Had

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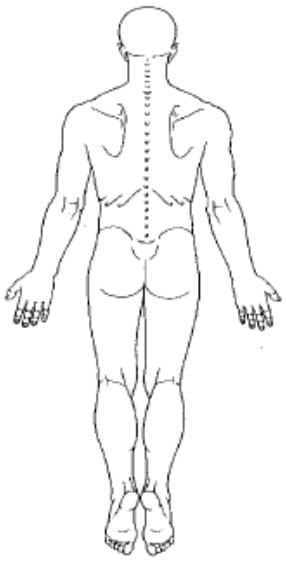
CHIEF COMPLAINT

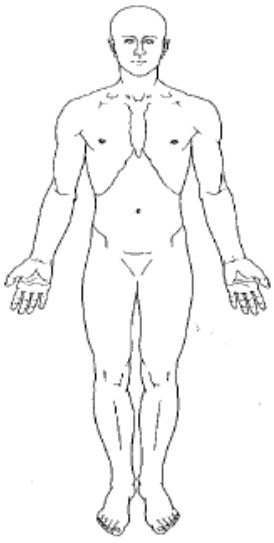
Please fill out the following form about you pain to the best of your ability.

Name			**Age**		**Date**						
How were you referred to our office?											
What is the main reason for you visit today?											
Progression of your current condition since it started	☐ **Same**		☐ **Improved**		☐ **Worse**		☐ **Other**				
How long have you been experiencing this problem (date if known)?											
How did the problem start?											
Have you seen any other doctor for this problem? If so, who and when?											
Is there anything that helps with the problem?											
Is there anything that makes the problem worse?											
Are your symptoms constant or do they come and go?											
Please rate your pain on a scale of 1-10 (1 being no pain and 10 being the worst pain you can think of).			**Right Now? _____/10**		**At its worse? _____/10**		**At its best? _____/10**				
Type of Pain: Check all that applies.	☐ **Sharp**	☐ **Tingling**	☐ **Throbbing**	☐ **Numb**	☐ **Aching**	☐ **Stabbing**					
	☐ **Dull**	☐ **Burning**	☐ **Cramping**	☐ **Stiffness**	☐ **Spasms**						

Please use the diagrams below to circle the location on your body where you experience pain.

Left Right Right Left





Please use this space to describe anything else you feel the doctor should know about this problem:

_____

_____

_____

HEALTH HISTORY

Name: _____**Age:** _____ **Date:** _____

Have you ever had? ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Polio ☐ Rheumatic Fever

Do you suffer from any of the following? Please check all that apply.

- ☐ Head/Neck pain
- ☐ Pain eyes in the eyes
- ☐ Chest/Heart pain
- ☐ Backache
- ☐ Pain in Joints Which?
- ☐ Swollen Joints Which?
- ☐ Stiffness Where?
- ☐ Spasms Where?
- ☐ Tightness Where?
- ☐ Pins and Needles Where?
- ☐ Weakness Where?
- ☐ Limb Pain Where?
- ☐ Cancer Where?
- ☐ Fainting
- ☐ Fatigue
- ☐ Lungs Problems What?
- ☐ Diabetes
- ☐ High/Low Blood Pressure
- ☐ Thyroid Problems
- ☐ Bladder Infection
- ☐ Poor Circulation
- ☐ Pregnant at this time
- ☐ Prostate Problems
- ☐ Other pain/discomfort:

Recent changes in:

- ☐ Weight
- ☐ Ability to sleep
- ☐ Appetite
- ☐ Stomach/Bowel
- ☐ Skin What?
- ☐ Breathing
- ☐ Memory
- ☐ Hearing
- ☐ Spinal Curvature
- ☐ Urination Frequency

Responses to the following are **completely optional** and will be **kept strictly confidential**. Do you deal with any of the following:

- ☐ Depression
- ☐ Drink Caffeine
- ☐ Drink Alcohol
- ☐ Tobacco
- ☐ Recreational Drugs What?
- ☐ Sexually Active
- ☐ Dieting
- ☐ Exercise How many Hrs/Wk?

Please list any Surgeries/Hospital stays you have had in the past:

Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No If so, when? _____

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240 Medical Blvd.
Stockbridge, GA 30281

Tel: (678) 284-4000
Fax: (678) 284-6500

P.O. Box 824
Morrow, GA 30260

RELEASE OF MEDICAL RECORDS

PLEASE PRINT

Name _____ Date of Birth _____

S-S-N _____

Practice / Doctor:_____

Address:_____

Phone #: _____Fax #_____

I authorize the release of information pertinent to my case to any insurance company, adjuster, attorney, or healthcare professional involved in this case. I do hereby authorize the release of my medical records to the Center for Pain and Rehab Medicine. Please send a copy of my medical history and records in your possession to:

Name of Recipient Dr. D. Terrence Foster

Practice/Facility Center for Pain and Rehab Medicine

Address 240 Medical Blvd., Stockbridge, GA 30281

Phone: 678-284-4000 Fax: 678-284-6500

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Witness Signature Date

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Agreement for Controlled Substance Prescriptions

Patient Name: _____ Date: _____

You are being evaluated for pain management which may involve the prescribing of controlled substance. Your evaluation will include a review of your medical records for possible diagnosis. You may be required to complete laboratory studies and /or diagnostic studies. Prescriptions for controlled substances are generally not ordered/written until the doctor/Rehab Medicine healthcare provider (the Provider) fully understands your condition.

Controlled substances (ex. Narcotics, opiates, tranquilizers, and barbiturates) can be useful in pain management treatment, but are commonly misused. Therefore, these substances are closely controlled by the local, state and federal governments. They are solely intended to help manage and relieve pain. **They are not intended for recreational or mind-altering purposes.** The following is a contract between, the provider and me.
With regards to the prescription given to me by the provider. I agree to:

___. I hereby forgo my rights to receive medications (controlled substance) from any other physician or individual while I am being treated by the Provider. I understand that doing so is, not only, illegal, but also could endanger my health. Exception will be made only for: medications that I have informed the Provider I am currently taking or medications that were given to me while I was admitted to the hospital.

___. I have been fully informed of the possibility of psychological and physical dependence to controlled substances. I understand that once a tolerance has formed, there may be a need to increase my dosage to better manage my pain. If for any reason I become dependent on my medication, I will inform the Provider so that provisions can be made to wean me off of this controlled substance.

___. I will maintain responsibility of the prescribed medications. If they are lost, misplaced, stolen, or I use them up sooner that the prescribed time. I understand they **WILL NOT BE REPLACED FOR ANY REASON.**

___. **I WILL NOT** give, sell, or make available my prescribed medication to anyone else. This could endanger the health of that person and it IS ILLEGAL.

___. **I WILL NOT** discard, flush down the toilet, give away or be neglectful with my prescribed medications. I will bring each original pharmacy pill bottle for which I have a prescription to each appointment to show whether I have any pills left or none at all.

___. **I WILL TAKE** my medication as prescribed by the doctor as stated on the bottle. In doing so, I should not have pills left over at the end of the month or run out early. This way I can let the doctor know of the effectiveness of the treatment.

___. Refills of these controlled substance:

- Will **Only** be provided at time of monthly appointment. None will be given outside of regular business hours.
- **Will not be made if** "I ran out early." You are responsible for making appointments for refills one or two days before you run out.
- **WILL NOT** be made on an "emergency" basis.

___ . I understand that the Provider has the right to administer random drug screening and random pill count to monitor my compliance with proper medication use.

___. Any drug test/screening indicating the presence of illegal substances will lead to immediate termination of treatment by this office/healthcare provider. **REFUSAL TO SUBMIT A SAMPLE FOR TESTING** will also result in termination of treatment.

___. Violating any of the above conditions could lead to termination of prescription and/or termination of treatment by the Provider/office. If illegal use or distribution of the controlled substances (such as obtaining controlled substances from another individual or office, or providing another individual with your prescribed controlled substance) occurs, this may be reported to other healthcare providers and law enforcement.

___. Our Office has always demonstrated professionalism and courtesy to all our patients and will continue to do so. We will not tolerate any inappropriate behavior or verbal abuse to our staff.

___. **I understand that by initialing on this line,** I am stating that I **do not want any controlled substances prescribed to me at this time.** However, if in the future I change my mind, I have these conditions and agree to them.

DO NOT SIGN THIS AGREEMENT UNLESS YOU UNDERSTAND CLEARLY ALL THE TERMS AND CONDITIONS.

I HAVE READ AND UNDERSTAND THE ABOVE CONDITIONS AND THE CONSEQUENCES OF VIOLATING THIS CONTRACT.

Patient Name _____ Signature_____

Witness Name_____ Date_____

USE AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

Notice of Privacy Practices

Please Review Carefully.

Center for Pain and Rehabilitation Medicine is committed to protect the privacy of patient's health information, and to comply with applicable federal and state laws that protect the privacy and security of patient's health information.

Generally, your PHI may be used and disclosed by us only with your written authorization. However, there are some exceptions to this rule. During the course of serving your interests, it may be necessary to share information with other healthcare providers or business associates. The following are examples of instances where information may be shared:

Treatment Purposes: We may use or disclose your PHI to provide, coordinate, or manage your medical treatment or services.

Payment Purposes: We may use or disclose your PHI for payment purposes. It is necessary for us to use or disclose PHI so that treatment and services provided by us may be billed and collected from you, your insurance company, or other third party payers.

Health Care Operations: We may use and disclose your PHI in order for us to conduct our healthcare business and to perform functions that support our business activities.

If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided by law.

If you have any questions or comment regarding your Protected Health Information, feel free to contact our Practice Administrator at 678-284-4000.

I have read and fully understand the above Notice of Privacy Practices.

Patient Name: _____

Signature: _____ Date: _____
(Patient or Legal Guardian)

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FINANCIAL POLICY

In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your or minors name to which charges are made and payments credited. The words "we," "us," and "our" refer to Center for Pain and Rehab Medicine.

COPAYS/DEDUCTIBLES

All copays, deductibles and coinsurance are collected in full at time of service. If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-payment or deductible, you must pay that at the time of service. It is the insurance that makes the final determination of your eligibility and benefits.

REFERRAL/PREAUTHORIZATION

You, as the patient, is responsible to make sure that all authorizations and referrals are obtained prior to your office visit and/or procedure. **As a courtesy** to you, our office staff may assist you in obtaining referral and/or pre authorization for additional office visits and Physical Therapy sessions, Procedure, Durable Medical Equipment (i.e. Braces, TENS units, etc)**.** Failure to obtain a referral and/or prior authorization may result in claim denial making you responsible for the payment of the services rendered.

NON-COVERED SERVICES

There are various services and treatments, although medically necessary, may not be covered by your health insurance, therefore you will be responsible for payment(s) at the time service(s) are rendered.

NON-CONTRACTED INSURANCE

It is your responsibility to make sure that our Provider is in network with your health insurance plan. If you have an insurance plan that we are not contracted with, we will collect up front the estimated patient responsibility according to the service(s) rendered. If the patient responsibility is higher than what was collected at time of service, we will bill you for the remaining balance(s).

PATIENT STATEMENTS and COLLECTION

We expect that you will make every effort to pay all your balance(s) in a timely manner. If you fail to pay your account balance in a timely manner and do not set up a payment plan with our office, any fees that are incurred by the Practice for any and all collection efforts will be added to your account. CPARM will attempt to collect any balances, coinsurances, deductibles or any additional fee(s) charged to your account at a maximum of four (4) statements. **Delinquent accounts will be turned over to a collection agency after the fourth (4th) statement and a 40% fee calculated from your total balance will be added to your account for the administrative and collection agency fees.**

MEDICAL RECORDS and MEDICAL FORMS FEES

We will gladly send your medical records to another physician free of charge. If the patient requests a copy of his/her medical records for his/her file, an insurance company or lawyer's office, there will be a charge. There is a minimum charge of $35.00 for completing medical forms and minimum charge of $150.00 for Disability Form. These charges are **not** covered by your insurance plan and are your responsibility and payable at time of service(s). Please allow 24-48 hours for these forms to be completed.

Patients with a balance in their account must pay the balance in FULL or make payment arrangements prior to making any future appointments.

Self Pay patients must pay their account balance to zero ($0) prior to receiving further services by our Practice.

We accept Cash, Checks, Debit/Credit Cards (Visa, MasterCard & Discover). There is a **$50.00** charge for returned checks.

Please remember that the responsibility for the payment of medical bills rests with you, the patient. Medical insurance is a method for reimbursing the patient for medical expenses. As such, the agreement for insurance payment is between the patient and his insurance company. Insurance companies are under no obligation to send payment to the physician. **You are responsible for any portion of the bill not covered by insurance**.

I have read and fully understand this Financial Policy.

Patient's Name: _____ Date: _____

Patient's Signature: _____ Date _____

Responsible Party's Name: (if not Patient): _____ Date: _____

Responsible Party's Signature: _____ Date: _____

BILLING POLICY

Thank you for choosing us as your physical medicine and pain care provider. We are committed to providing quality care and service to all our patients. We are entering into an agreement with you, with obligations on both sides. Please read this Billing Policy, ask us any questions you may have, and sign in the space provided.

Insurance Billing:

• We will submit your claims and assist you in any way we reasonably can to help get your claims paid. **Billing your insurance is a courtesy service we provide for you**. In order to do this, we must receive all the information necessary to bill. If the information is not supplied, **you will be billed, and payment in full will be your responsibility.**

• **Co-payments, co-insurance and charges that apply to your deductible are due at time of service**. Insurance companies require that we collect your co-pay at time of service. **We do not bill for co-pays**. If you are unable to pay your co-pay, we may reschedule your appointment. **Three missed co-pays may result in dismissal from our practice**.

• Your **insurance coverage is a contract between you and the insurance company**. It is your responsibility to know your insurance benefits.

• We participate in many health insurance plans. If we participate in your health insurance plan, our fees are subject to a contracted fee schedule. It is your responsibility to verify participation prior to service.

• If your insurance company has **not paid within 60 days of service**, **the payment will become your responsibility**. It is your responsibility to contact your insurance company regarding a disputed insurance claim.

• It is your responsibility to **notify us of any changes in insurance coverage**, and to give us a copy of your current insurance card. Failure to provide us with your correct insurance information will result in you being billed and payment in full will be your responsibility.

Billing Statements:

• You will receive a statement listing all services, payments and adjustments, and noting the date(s) your insurance was billed. The statement may specify an amount due from you, and payment is due upon receipt.

• A late fee of 15% APR, with a minimum monthly charge of $5, will be added to patient due balances that are outstanding over 60 days.

• If you are unable to pay and have a good credit history with our office, we may allow you to pay for services on a financial agreement. Reasonable and timely monthly payments are expected. Missing a payment means that you have broken the contract with us and may result in referral to a collection agency and/or dismissal from the Practice. We allow one financial agreement at a time per family. The original agreement must be paid in full before another agreement may begin. Additional services will not be added to an existing financial agreement. **New patient charges may not be paid on a financial agreement.**

• If you are on a payment plan or have had payment issues in the past, we may place your account on "**Cash Pay**" terms. This means, we will require payment before you can see the doctor.

• We accept payment by cash, checks, debit cards and certain credit cards. **We do not hold checks or accept post-dated checks**.

I have received this Billing Policy, and understand that regardless of any insurance coverage I may have, **I am responsible for payment of my account**. I understand that delinquent accounts will be referred to a collection service. If it becomes necessary to send my account to a collection service, I agree to pay for all costs and expenses, including reasonable attorney fees. I also acknowledge that I have received a copy of this billing policy for my records.

Print Name **Signature** **Date**

PATIENT NO SHOW POLICY

We expect that you would make every effort to make your scheduled appointment. In the event that you cannot, please alert our office at least **24 hours in advance of your scheduled appointment.** A "**no show"** is termed as an appointment that was missed with no call to reschedule or cancel at least 24 hours in advance of the scheduled appointment time.

Our Practice charges a NO SHOW fee for failure to give us 24 hours notice of cancellation or reschedule. This No Show fee is **NOT covered** by your insurance plan, and is therefore, your responsibility. **All no show fees must be paid prior to services being rendered.**

Below are our NO SHOW charges:

$35.00 – No Show Fee for missed Office Visit or Physical Therapy visit.

$60.00 - No Show Fee for missed Procedure including EMG/NCS.

All patients who miss their appointments will be charged accordingly.

- **1st Offense** - A charge of No Show Fee ($35.00 or $60.00), whichever is applicable. This fee must be paid in full before a service is rendered.

- **2nd Offense** - A charge of No Show Fee ($35.00 or $60.00), whichever is applicable. A written warning will be given stating that a 3rd occurrence will result in dismissal from the Practice. **This fee and all account balances must be paid in full before a service is rendered**.

- **3rd Offense** - A charge of No Show Fee ($35.00 or $60.00), whichever is applicable. A dismissal letter notifying the patient to seek another provider will be given. **This fee and all account balances must be paid in full**.

Payment for NO SHOW Fees:

We accept Cash, Checks, Debit Cards, MasterCard and Visa**. There is a $50.00 charged for all returned checks.**

Patient Signature_____ Date_____

Witness Signature_____ Date_____

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PATIENT AUTHORIZATION

PLEASE READ THOROUGHLY. IF YOU HAVE ANY QUESTIONS, PLEASE ASK BEFORE SIGNING.

I hereby authorize medical/surgical treatment care and/or services by Dr. D. Terrence Foster of Rehabilitation Medicine & EMG (REMEG) Center, PC to the below named patient.

I, the undersigned, fully understand that I am primarily and financially responsible for the fees incurred by the below named patient. I also understand that the payment to said doctor is not contingent on any settlement, judgment or verdict by which the above patient may eventually recover for said medical/surgical fees. The undersigned individually obligates him/her to pay the account of the medical services in accordance with the regular rates and terms of the physician practice. **IT IS THE POLICY OF THIS OFFICE THAT PAYMENT IS DUE AT THE TIME OF SERVICE.**

I hereby, assign, transfer, and convey payment and authorize said payment to be made directly to Rehabilitation Medicine & EMG (REMEG) Center, P.C. for any hospital benefits, sick benefits, injury benefits, due because of liability of a third party, or proceeds of all claims resulting from the liability of a third party, payable by any party, organization, et cetera, to or for discharge or completion of all outstanding obligations related to these medical services. I further agree that this assignment **WILL NOT BE WITHDRAWN OR VOIDED** at any time until this account for this medical service is paid in full.

I hereby authorize photocopies of this form to be valid as the original. I authorize the release of information pertinent to my case to any insurance company, adjuster, attorney, or healthcare professional involved in this case. I understand that a charge of $35.00 will be incurred for copies of medical record/documentation requested by me or a third party. I authorize Rehabilitation Medicine & EMG (REMEG) Center, P.C. to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I acknowledge that I have received a copy of Rehabilitation Medicine & EMG (REMEG) Center, PC's Notice of Privacy Practices. This Notice describes how Rehabilitation Medicine & EMG (REMEG) Center, P.C may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information. This is in accordance with HIPAA regulations, effective April 14, 2003.

I certify that I have read and fully understand the above.

Signature: _____ Print Name: _____
(Patient or parent/guardian*)

Witness: _____ Date: _____

***NOTE: IF A PATIENT IS A MINOR (LESS THAN 18 YEARS OF AGE), A PARENT OR GUARDIAN MUST SIGN.**

NOTICE TO OUR PATIENTS

Center for Pain and Rehabilitation Medicine (CPARM) believes in providing our patients a family-oriented medical setting. However, we established policies that we feel are to the best interest of both parties – you, as our patient, and we, as your medical provider, and ask that you to adhere to these policies.

PATIENT ACCOMPANIED BY CHILDREN

Due to our Providers' type of specialty and procedure they perform, the type of medication they prescribe, and our Practice's insurance liability limitations, **CHILDREN ARE NOT ALLOWED IN OUR FACILITY**. Our staff will strive to make your appointments convenient for you so that you may arrange for childcare. ***In the event that you arrive at our office with child(ren), your appointment will be rescheduled to another day and time***.

PATIENT ACCOMPANIED BY SEVERAL FAMILY MEMBERS/FRIENDS

Although some patients prefer to be accompanied by several family members or friends during their office visit and/or procedure, CPARM require our patients to limit their companion to one (1) adult during office visit and/or procedure. This will allow our office to optimize our waiting room areas and at the same time protect your privacy and the privacy of other patients.

By signing below, I understand and agree to abide by this Policy.

Patient Name: _____

Patient Signature: _____ Date: _____