Center for Interventional

PAIN & SPINE

ABINGTON SURGERY CENTER
2701 Blair Mill Road Ste. 35
Willow Grove, PA 19090
P: 215-957-1108
F: 215-443-9318

THE HELEN F. GRAHAM CANCER CENTER
4701 Ogletown Stanton Rd., Ste. 2131
Newark, DE 19713
P: 302-266-7800
F: 302-266-7851

BRANDYWINE TOWN CENTER
3401 Brandywine Pkwy Ste. 202
Wilmington, DE 19803
P: 302-477-1706
F: 302-477-1708

MAIN LINE HEALTH & FITNESS BLDG
931 E. Haverford Road Ste. 202
Bryn Mawr, PA 19010
P: 610-525-8200
F: 610-525-8201

NAME: _____
Last *First* *Middle initial*

Birthdate_____ **SSN** _____ **Sex**: ☐Male ☐Female

Address: _____

City: _____ **State**: _____ **Zip** _____

Home Phone (_____) _____**Cell** (_____) _____ **Work** (_____) _____

Emergency Contact: _____ **Phone number**: (_____) _____

Relationship: _____

Pharmacy: _____ **Phone** (_____) _____

Address _____ **City** _____ **State** _____ **Zip** _____

Email: _____

Marital Status: ☐Single ☐Married ☐ Widowed ☐Partnered ☐Divorced ☐Separated

Tobacco Use: ☐Former ☐Never ☐ Current _____pack(s)/day **How many years**? _____

Alcohol use: ☐No ☐Yes **Illicit drug use**: ☐No ☐Yes

Race: ☐Caucasian ☐African American ☐Asian ☐Hispanic ☐Mixed race
☐Indian ☐Other_____

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Caucasian ☐African American

Preferred Language: ☐English ☐ Spanish

PHYSICIAN INFORMATION

Primary Care Physician: _____ **Phone** (_____) _____

Address _____ **City** _____ **State** _____ **Zip** _____

Referring Physician: _____ **Phone** (_____) _____

Address _____ **City** _____ **State** _____ **Zip** _____

INSURANCE INFORMATION:

Primary Insurance Carrier: _____ **Secondary Insurance Carrier**: _____

Policy/ID #: _____ **Policy/ID #**:_____

Center for Interventional
PAIN & SPINE

ABINGTON
SURGERY CENTER
2701 Blair Mill Road Ste. 35
Willow Grove, PA 19090
P: 215-957-1108
F: 215-443-9318

THE HELEN F. GRAHAM
CANCER CENTER
4701 Ogletown Stanton Rd., Ste. 2131
Newark, DE 19713
P: 302-266-7800
F: 302-266-7851

BRANDYWINE
TOWN CENTER
3401 Brandywine Pkwy Ste. 202
Wilmington, DE 19803
P: 302-477-1706
F: 302-477-1708

MAIN LINE HEALTH &
FITNESS BLDG
931 E. Haverford Road Ste. 202
Bryn Mawr, PA 19010
P: 610-525-8200
F: 610-525-8201

Consent for Purposes of Treatment, Payment & Healthcare Operations (1/11)

I consent to the use or disclosure of my protected health information by The Center for Interventional Pain Spine, LLC for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills. I understand that analysis, diagnosis or treatment of me by The Center for Interventional Pain Spine, LLC may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Center for Interventional Pain & Spine, LLC is not required to agree to the restrictions that I may request. However, if Center for Interventional Pain & Spine, LLC agrees to a restriction that I request, the restriction is binding. I have a right to revoke this consent, in writing at any time except to the extent that Center for Interventional Pain & Spine, LLC has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, or my employer. This protected health information related to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have full access to view, and request a copy if needed, the Notice of Privacy Practices of Center for Interventional Pain & Spine, LLC. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of Center for Interventional Pain & Spine, LLC. The Notice of Privacy Practices for Center for Interventional Pain & Spine, LLC is posted in the waiting room. This Notice also describes my rights and duties of the practice with respect to my protected health information.

Center for Interventional Pain & Spine, LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by call the office of Center for Interventional Pain & Spine, LLC and requesting a revised copy be sent in the mail or asking for one at the time of my appointment.

Acknowledgement of Privacy Statement

I acknowledge receipt of the Notice of Privacy practice from Center for Interventional Pain & Spine. I understand that it is my responsibility to read the information provided therein.

Signature: _____ Date _____

Authorization and Assignment of Benefits

I authorize the release of any medical or other information necessary to process the insurance claim(s) for services rendered by Center for Interventional Pain & Spine LLC. I request payment of government benefits, if applicable, to the party who accepts assignment. I authorize payment of medical benefits to Center for Interventional Pain & Spine. I understand that even though I may have insurance coverage, I am ultimately responsible for payment of services rendered. I authorize Center for Interventional Pain & Spine to release any necessary information to the following surgery centers:

Bryn Mawr Hospital Surgery Center
Abington Surgical Center Orthoapedic Specialist Surgery Center
Christiana Hospital-Wilmington Hospital
Surgery Center of Main Line

Signature _____ Date_____

Center for Interventional
PAIN & SPINE

ABINGTON
SURGERY CENTER
2701 Blair Mill Road Ste. 35
Willow Grove, PA 19090
P: 215-957-1108
F: 215-443-9318

THE HELEN F. GRAHAM
CANCER CENTER
4701 Ogletown Stanton Rd., Ste. 2131
Newark, DE 19713
P: 302-266-7800
F: 302-266-7851

BRANDYWINE
TOWN CENTER
3401 Brandywine Pkwy Ste. 202
Wilmington, DE 19803
P: 302-477-1706
F: 302-477-1708

MAIN LINE HEALTH &
FITNESS BLDG
931 E. Haverford Road Ste. 202
Bryn Mawr, PA 19010
P: 610-525-8200
F: 610-525-8201

Appointments and Prescriptions

Should it become necessary, the following people have my permission to schedule, confirm, cancel or reschedule an appointment for me. They may also pick up prescriptions, refills, samples or anything that I have requested from Center for Interventional Pain & Spine LLC as long as they provide valid photo ID. *NO medical information will be given.* I understand that if I need to change this information, it is my responsibility to request this in writing.

1) **Name** _____ **Relationship**: _____

   Phone No. _____

2) **Name** _____ **Relationship**: _____

   Phone No. _____

Signature _____ **Date**: _____

Release of Medical Information

Should it become necessary, Center for Interventional Pain & Spine LLC and medical staff have my permission to discuss my health information, including test results, with the individuals listed below. The people that are listed below are also authorize for the above statement regarding appointments and prescriptions. I understand that if I need to change this information, it is my responsibility to request this in writing.

1) **Name** _____ **Relationship**: _____

   Phone No. _____

2) **Name** _____ **Relationship**:_____

   Phone No. _____

Signature _____ **Date**: _____

Center for Interventional
PAIN & SPINE

ABINGTON
SURGERY CENTER
2701 Blair Mill Road Ste. 35
Willow Grove, PA 19090
P: 215-957-1108
F: 215-443-9318

THE HELEN F. GRAHAM
CANCER CENTER
4701 Ogletown Stanton Rd., Ste. 2131
Newark, DE 19713
P: 302-266-7800
F: 302-266-7851

BRANDYWINE
TOWN CENTER
3401 Brandywine Pkwy Ste. 202
Wilmington, DE 19803
P: 302-477-1706
F: 302-477-1708

MAIN LINE HEALTH &
FITNESS BLDG
931 E. Haverford Road Ste. 202
Bryn Mawr, PA 19010
P: 610-525-8200
F: 610-525-8201

Consent for Chronic Opioid Therapy

In the chance that Center for Interventional Pain Spine will prescribe opioid medication/narcotic analgesics to me, the 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 breath rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction, and possibility that the medicine will not provide complete pain relief.

I understand that suddenly stopping some pain medicines can result in withdrawal symptoms, heart attack, stroke, seizures, permanent damage, disability or death.

I recognize my chronic pain represents a complex problem and chronic opioid therapy is only one part of my overall pain management plan. I understand my condition may also benefit from physical therapy, psychotherapy, behavioral medicine and other pain control strategies. I agree to cooperate and actively participate in all aspects of the pain management program to maximize functioning and improve coping with my condition.

I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug, and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine is very low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge.

Patient Printed Name: _____

Patient Signature: _____ Date: _____

Center for Interventional
PAIN & SPINE

ABINGTON
SURGERY CENTER
2701 Blair Mill Road Ste. 35
Willow Grove, PA 19090
P: 215-957-1108
F: 215-443-9318

THE HELEN F. GRAHAM
CANCER CENTER
4701 Ogletown Stanton Rd., Ste. 2131
Newark, DE 19713
P: 302-266-7800
F: 302-266-7851

BRANDYWINE
TOWN CENTER
3401 Brandywine Pkwy Ste. 202
Wilmington, DE 19803
P: 302-477-1706
F: 302-477-1708

MAIN LINE HEALTH &
FITNESS BLDG
931 E. Haverford Road Ste. 202
Bryn Mawr, PA 19010
P: 610-525-8200
F: 610-525-8201

CONTROLLED SUBSTANCES AGREEMENT

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you. Furthermore, this agreement is to prevent misunderstandings about certain medicines the patient will be taking for pain management.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the prescribing physician to consider the initial and/or continued use of controlled substances to treat your chronic pain:

1. **I am responsible for my controlled substance medications. If the prescription or medication is lost, misplaced, or stolen, or if I finish it before my refill date, it will not be replaced. I am responsible for taking the medication as prescribed and for keeping track of the remaining amount.**
2. I will not share, sell, trade or otherwise permit others to have access to my controlled substance medications. I will not alter/change any information on my prescriptions.
3. All controlled substances must be obtained at the same pharmacy, when possible. Should the need arise to change pharmacies; I will inform Center for Interventional Pain & Spine. The pharmacy I have selected is _____

   Phone # _____ Location _____
4. I give Center for Interventional Pain Spine the right to verify my prescription profile at any time by either contacting my pharmacy, other physician offices or prescription monitoring program.
5. **You must give 7 business days' notice to our office for any non-narcotic prescription refills. Prescription refills for all controlled substances can only be obtained during an office visit. There will be no exceptions made.** Refills will not be made if you "run out early", miss an appointment, nor as an "emergency" (such as on Friday afternoon because I suddenly realize I will "run out tomorrow"). Refills will not be made on nights, holidays, or weekends.
6. I agree I will not attempt to obtain any opioid medicines from another doctor or provider without informing Center for Interventional Pain & Spine. The prescribing provider has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of accountability.
7. I understand that I may not receive medications if I miss an appointment and prescriptions will not be mailed or filled without being seen on a regular basis at Center for Interventional Pain & Spine.
8. I understand that an unannounced urine, serum, and/or buccal toxicology screen may be requested, and my cooperation is required.

Center for Interventional
PAIN & SPINE

ABINGTON
SURGERY CENTER
2701 Blair Mill Road Ste. 35
Willow Grove, PA 19090
P: 215-957-1108
F: 215-443-9318

THE HELEN F. GRAHAM
CANCER CENTER
4701 Ogletown Stanton Rd., Ste. 2131
Newark, DE 19713
P: 302-266-7800
F: 302-266-7851

BRANDYWINE
TOWN CENTER
3401 Brandywine Pkwy Ste. 202
Wilmington, DE 19803
P: 302-477-1706
F: 302-477-1708

MAIN LINE HEALTH &
FITNESS BLDG
931 E. Haverford Road Ste. 202
Bryn Mawr, PA 19010
P: 610-525-8200
F: 610-525-8201

9. I understand that if I violate any of the above conditions, my controlled substance prescriptions and/or treatment with Center for Interventional Pain Spine may be terminated immediately. If the violation involves obtaining controlled substances from another individual, I may also be reported to my physician, medical facilities and other authorities.

10. 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: exercise, weight control, and the non-use of tobacco and alcohol. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treatment.
11. I will bring the containers of all medication prescribed by Center for Interventional Pain Spine each time I have an office visit; even if there is no medication remaining. These will be the original containers from the pharmacy for each medication.
12. I will not participate in any activities that would endanger others or myself while using opioids or while experiencing side effects such as sleepiness and drowsiness. This includes driving and operating heavy machinery. I will follow the guidelines set forth by my employer regarding the use of narcotic medication.
13. I agree I will not abuse alcohol or use any illegal controlled substances, including marijuana, cocaine, heroin, etc.
14. I understand that if I am verbally or physically abusive to any staff member or engage in any other illegal activity such as altering a prescription, that the incident may be reported to other physicians, local medical facilities, pharmacies, and other authorities such as the local police, drug enforcement agency etc.
15. If it appears to the physician that there are no demonstrable benefits to my daily function or quality of life from the controlled substance, I will agree to gradually taper my medication as directed by the prescribing physician
16. **I understand that if I violate ANY of the above conditions, my provider may choose to stop writing opioids for me.**

We understand that emergencies can occur and under some circumstances, exception to these guidelines may be made. Emergencies will be considered on an individual basis.

Patient Printed Name: _____

Patient Signature: _____ Date: _____

Center for Interventional
PAIN & SPINE

ABINGTON SURGERY CENTER
2701 Blair Mill Road Ste. 35
Willow Grove, PA 19090
P: 215-957-1108
F: 215-443-9318

THE HELEN F. GRAHAM CANCER CENTER
4701 Ogletown Stanton Rd., Ste. 2131
Newark, DE 19713
P: 302-266-7800
F: 302-266-7851

BRANDYWINE TOWN CENTER
3401 Brandywine Pkwy Ste. 202
Wilmington, DE 19803
P: 302-477-1706
F: 302-477-1708

MAIN LINE HEALTH & FITNESS BLDG
931 E. Haverford Road Ste. 202
Bryn Mawr, PA 19010
P: 610-525-8200
F: 610-525-8201

FINANCIAL POLICY

1) Insurance Referrals

Our office will not see a patient without the proper referrals from your insurance company, please check with your primary care physician to make sure all referrals have been completed and also keep track of the number of visits authorized as it is the *patient's responsibility*.

2) Attendance Policy/No Show Fees

Three consecutive or accumulated "No Show" appointments will result in being discharged from this practice. A patient who is more than 15 minutes late for an appointment may be considered a no show. If you fail to cancel your appointment within 24 hours and/or do not show to your office visit, you will be charged $25.00.If you cancel your procedure within less than 24 hour time frame or do not show, you will be charged a fee of $100.00.

.

3) Self-Pay Patients/ Non Covered Services:

Insurance companies do not pay for all medical services, even those that might be helpful to the patient. When a service is not covered by your insurance policy, you are responsible for paying the bill. Patients who do not have an insurance policy will be required to make a payment at the time services are rendered. Payment plan arrangements can be made for these situations.

4) Change of Information:

In order to bill your insurance carrier accurately and in a timely manner, we require you to provider our office with the following.

- ☐ Accurate Demographic Information (insurance coverage, address, phone number)
- ☐ A copy of your current insurance card (required to be presented at every visit)
- ☐ If your visit is related to an injury, you are required to provide ALL of the following information: *date of injury, body part injured, name of insurance carrier, name and phone number of insurance adjustor, insurance policy number, and applicable attorney information.*

It is the responsibility of the patient to notify us of any changes with information (insurance, phone number and/ or address), and any changes in primary care physicians or other treating physicians. **If insurance claims are denied and not paid due to incorrect, outdated or insufficient information provided by the patient, the outstanding balance will become the patient's responsibility.**

5) Other Fees:

Medical Records: Request for personal copies of medical records will take 3-5 business days to be completed. A processing fee up to $25.00 will be due at the time of request.
Medical forms will take 5-10 business days to complete; there is also a fee depending on the length and complication of the form ranging up to $25.00 and higher.
Bounced check fee is $40.00

I _____ understand all the above stated policies.
(PRINT NAME)

_____ _____
Signature **Date**