To help us help you, it is important for us to know:

1. Is there any chance your pain/condition is due to a work-related injury or injury on the job?

   ☐ Yes ☐ No

2. If yes, do you have an attorney helping you with work-related injury? (**Your own** attorney not one given to you by work/job/HR)

   ☐ Yes ☐ No

3. If yes, who? (so we can best support you and coordinate care):

   _____

4. What pharmacy do you use? (Name of pharmacy and town):

   _____

Information to start your path to relief.

PATIENT INFORMATION

Date: _____

Patient name: _____

Date of birth: _____

Address (no PO boxes): _____

_____

Email: _____

(for inclement weather, emergencies, etc)

Sex: Male: ☐ Female: ☐

Patient social security #: _____

Primary care physician: _____

Previous pain management provider: _____

Whom may we thank for referring you? _____

CONTACT NUMBERS

Home: _____

Cell: _____

Work: _____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Home phone/cell phone: _____

RELEASE

I, the undersigned, certify that I (or my dependent) have insurance with: _____ and assigns directly to Greater Maryland Pain Management all insurance 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 insurance. I hereby authorize Greater Maryland Pain Management to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible party signature Date

PRIMARY INSURANCE

Primary insurance company: _____

Policy #: _____ Group #: _____

If you're not the subscriber or policy holder, please fill out the remaining information in this section:

Subscriber's/Policy holder's name: _____

Relation to patient: _____

Subscriber's DOB: _____

Home ph: _____ Cell ph: _____

Address (no PO boxes): _____

_____

SECONDARY INSURANCE

Secondary insurance company: _____

Policy #: _____ Group #: _____

If you're not the subscriber or policy holder, please fill out the remaining information in this section:

Subscriber's/Policy holder's name: _____

Relation to patient: _____

Subscriber's DOB: _____

Home ph: _____ Cell ph: _____

Address (no PO boxes): _____

_____

** If this is related to
an AUTO ACCIDENT or WORKERS' COMPENSATION,
please fill out the below section completely
or you may be personally responsible for the bill!

AUTO INFORMATION / WORKERS' COMP

Date of accident/injury: _____

Has a claim been filed with
auto insurance or workers' comp? Y: ☐ N: ☐

Auto insurance/Work comp name: _____

Auto insurance/Work comp mailing address: _____

_____

State of accident: _____ Claim #: _____

Adjustor's name: _____ ph: _____

Do you have an attorney? Y: ☐ N: ☐

Type of accident: Auto: ☐ Work: ☐ Home: ☐

First name: _____ Last name: _____ Date of birth: _____

Please fill in the information below as **concisely** and **accurately** as possible. This form may seem lengthy, but it is very important to help us understand your pain complaints. This will help us provide you with the highest level of care.

List the worst area of pain follow by the second and third worse

1. _____
2. _____
3. _____

My pain started: _____ number of weeks / months / years ago *(circle the appropriate period)*

How did your pain start? _____

Does your pain radiate anywhere? *(example: into your arm, leg)* _____

Is the pain ☐ intermittent or ☐ constant? *(check one)*

Circle the words which best describe your pain:

aching	sharp	cramping
throbbing	shooting	burning
tightness	stabbing	numbness
deep	searing	tingling
gnawing	tearing	other _____

Circle the number that represents your pain **on average** with 0 being no pain and 10 being the worse you can ever imagine:

0 • 1 • 2 • 3 • 4 • 5 • 6 • 7 • 8 • 9 • 10

Circle the number that represents your pain **at its worse** with 0 being no pain and 10 being the worse you can ever imagine:

0 • 1 • 2 • 3 • 4 • 5 • 6 • 7 • 8 • 9 • 10

What makes the pain better? _____

What makes the pain worse? *(example: bending, lifting, twisting)* _____

Pain diagram:

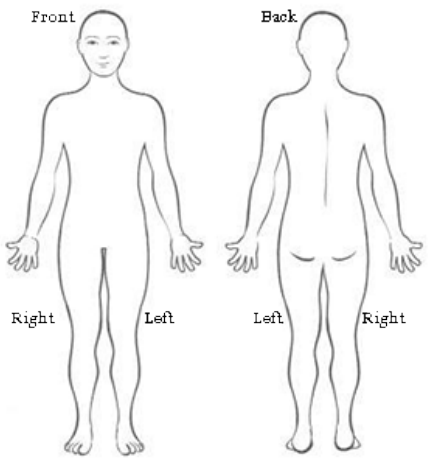
stabbing: //////

burning: XXXXXX

pins and needles: OOOOOO

aching/throbbing: ^^^^^^

numbness: ------



What pain medications have you tried?

Medications tried (stopped because)	Medications tried (stopped because)	Medications tried (stopped because)
☐ tylenol _____	☐ neurontin/Gabapentin _____	☐ Methadone _____
☐ aspirin _____	☐ Lyrica _____	☐ Morphine _____
☐ ibuprofen _____	☐ duloxetine/Cymbalta _____	☐ Kadian _____
☐ naprosyn/Naproxen/Aleve _____	☐ Savella _____	☐ Avinza _____
☐ Celebrex _____	☐ Lexapro _____	☐ Opana IR/Opana ER _____
☐ diclofenac/Arthrotec/Flector _____	☐ amitriptyline/Elavil _____	☐ Fentanyl patch _____
☐ meloxicam/Mobic _____	☐ nortriptyline/Pamelor _____	☐ Actiq lollipops _____
☐ torodol/Ketorolac _____	☐ Lidoderm patches _____	☐ Fentora _____
☐ Amrix/Flexeril _____	☐ Tylenol #2, #3, #4 (w/ codeine) _____	☐ oxycodone/Oxycontin _____
☐ Soma _____	☐ hydrocodone/Lortab/Norco/Vicodin _____	☐ hydromorphone/Dilaudid _____
☐ Zanaflex _____	☐ Percocet _____	☐ tramadol/Ultram/Ultracet _____

List any other pain medications tried:

1. _____
2. _____
3. _____
4. _____

Have you tried:	How long ago?	Effective? *(Y/N)*
physical therapy		
aquatherapy		
acupuncture		
TENS unit		
chiropractor		
trigger point injections		
epidural injections		
nerve blocks		
facet injections		
sacroiliac joint injection		
spinal cord stimulator		
other		

List **ALL** medical problems: *e.g.* hypertension, heart attack, diabetes, depression, *etc.*

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

List **ALL** surgeries:

1. _____ date: _____ 3. _____ date: _____ 5. _____ date: _____
2. _____ date: _____ 4. _____ date: _____ 6. _____ date: _____

List **ALL** medications you are taking:

1. _____ 3. _____ 5. _____ 7. _____
2. _____ 4. _____ 6. _____ 8. _____

List **ALL** medication allergies:

1. _____ 2. _____ 3. _____

Are you allergic to x-ray contrast or IV dye? ☐ Yes ☐ No

First name: _____ Last name: _____ Date of birth: _____

Is your mother ☐ alive List major illnesses _____
☐ dead Age and cause of death _____
Is your father ☐ alive List major illnesses _____
☐ dead Age and cause of death _____

Are you employed? ☐ Yes ☐ No
If yes, what is your job? _____
If no, are you: ☐ disabled ☐ retired ☐ other
For how long? _____

Are you? ☐ single ☐ married ☐ divorced ☐ widowed
Do you have any children? If so:
_____ sons # _____ daughters
List your hobbies and interests:
1. _____ 3. _____
2. _____ 4. _____
Does your pain stop you from doing the things you enjoy?
☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If yes, how much? _____
Do you drink alcohol? ☐ Yes ☐ No If yes, how much? _____
Do you use any illegal drugs? ☐ Yes ☐ No If yes, what? _____
Have you ever used any illegal drugs? ☐ Yes ☐ No If yes, what? _____

Do you have any of the symptoms?

Constitutional:
- fevers ☐ No ☐ Yes
- chills ☐ No ☐ Yes
- fatigue ☐ No ☐ Yes

Skin/Allergy:
- rash ☐ No ☐ Yes
- itching ☐ No ☐ Yes
- sweating ☐ No ☐ Yes

Musculoskeletal:
- joint stiffness ☐ No ☐ Yes
- joint swelling ☐ No ☐ Yes
- muscle cramps ☐ No ☐ Yes

Head:
- headaches ☐ No ☐ Yes
- dizziness ☐ No ☐ Yes
- fainting ☐ No ☐ Yes
- sensitivity to light ☐ No ☐ Yes
- sinus congestion ☐ No ☐ Yes
- nose bleeds ☐ No ☐ Yes
- bleeding gums ☐ No ☐ Yes

Endocrine:
- neck swelling ☐ No ☐ Yes
- heat/cold intolerance ☐ No ☐ Yes
- weight loss ☐ No ☐ Yes
- weight gain ☐ No ☐ Yes
- appetite change ☐ No ☐ Yes
- male erectile problem ☐ No ☐ Yes

Female:
- abnormal discharge ☐ No ☐ Yes
- discharge pain ☐ No ☐ Yes

Respiratory:
- wheezing ☐ No ☐ Yes
- cough ☐ No ☐ Yes
- short of breath ☐ No ☐ Yes

Cardiovascular:
- chest pain ☐ No ☐ Yes
- palpitations ☐ No ☐ Yes
- leg swelling ☐ No ☐ Yes

Lymph nodes:
- enlargement ☐ No ☐ Yes
- tenderness ☐ No ☐ Yes

Gastrointestinal:
- painful urinating ☐ No ☐ Yes
- difficulty urinating ☐ No ☐ Yes
- urgency/frequency ☐ No ☐ Yes
- incontinence ☐ No ☐ Yes
- blood in urine ☐ No ☐ Yes

Neurologic:
- fainting ☐ No ☐ Yes
- weakness/paralysis ☐ No ☐ Yes
- tremors ☐ No ☐ Yes
- headaches ☐ No ☐ Yes
- migraines ☐ No ☐ Yes

Psychiatric:
- depression ☐ No ☐ Yes
- suicidal thoughts ☐ No ☐ Yes
- anxiety ☐ No ☐ Yes
- sleep disturbances ☐ No ☐ Yes

Patient signature: _____ Name of person filling out form: _____ Date: _____

Policies

Release of Information (for release to/from healthcare practitioners, agents, insurance companies, and legal counsel): I authorize Greater Maryland Pain Management to release any and all findings and information in connection with my examinations, care, treatment, and billing.

I authorize Greater Maryland Pain Management to obtain my medical information from other healthcare agents or public databases as necessary for my continuing care and treatment.

I authorize Greater Maryland Pain Management to obtain my prescription history from other healthcare agents or third-party for treatment purposes.

Photo ID / insurance card: To help combat medical identity fraud with the Federal Trade Commission, patients must provide a valid photo ID and insurance card at every visit. You will be asked to reschedule if you do not have the appropriate documentation.

Insurance assignment: If I have an insurance with which Greater Maryland Pain Management participates, a claim for reimbursement for services will be submitted based on the information I provide. If due to incomplete or incorrect information, payment has not been received by the practice within 45 days from the date of services or originally filed, all charges become my responsibility and are immediately payable by me.

Balance: All balances, including due to Greater Maryland Pain Management or Checkerspot Surgery Centers must be paid in full before future care is rendered.

Patient responsibility for non-contracted plans: My signature below acknowledges that the office of Greater Maryland Pain Management has informed me that if they are not contracted with my insurance plan, they will provide me with a form listing the services (procedures) and the reasons for the services (diagnosis) for me to submit for possible reimbursement by my insurance company, as a courtesy.

Referrals/authorizations: If required, I understand that without a referral/authorization from my insurance carrier, I am financially responsible for all charges I incur.

Self-pay: If, on the day of services are rendered, I 1) do not have health insurance or am uncertain as to which insurance I have, 2) do not want my insurance to be billed, or 3) do not comply with the terms of the insurance policy (including, but not limited to, failing to supply adequate insurance information or bring authorization/referral forms), I agree to be financially responsible for all charges incurred, will pay in full for services rendered at the time of the visit when charged and will pursue reimbursement from third parties myself.

Workers' compensation: I understand that if my workers' compensation insurance carrier of the Workers' Compensation Commission denies my claim and I failed to supply adequate health insurance information, I will be financially responsible for any unpaid balances. PLEASE NOTE: If your health insurance requires a referral/authorization to be seen, your health insurance company still requires you to obtain it, even though your workers' compensation insurance carrier is being billed as the primary insurance. I understand that failure to obtain the referral/authorization can result in my health insurance denying payment once Workers' Compensation denies the claim. In such a situation, I agree that I am financially responsible for the unpaid balance.

MVA/personal injury: We will file claims with your PIP carrier with the necessary documentation from your physician. In the event your PIP becomes exhausted, your health insurance will be billed and you will become responsible for any coinsurance, copayment or deductible. PLEASE NOTE: If your health insurance requires a referral/authorization to be seen, your health insurance company still requires you to obtain it, even though the PIP carrier is being billed as the primary insurance. I understand that failure to obtain the referral/authorization can result in my health insurance denying payment once PIP has been exhausted. In such a situation, I agree that I am financially responsible for the unpaid balance.

Greater Maryland Pain Management and/or Checkerspot Surgery Centers may factor or sell your accounts receivable to a third party.

Missed appointments: If you fail to provide at least 24 hours' notice to cancel or fail to show up for an appointment on time, we reserve the right to charge $25.00. Greater Maryland Pain Management reserves the right to discharge a patient in the event of 3 missed appointments or late cancellations. All missed appointment fees must be paid in full before future care is rendered.

Returned checks: There will be a returned check fee of $35.00 assessed for any check returned.

Completing forms: There is an office charge for completing forms. Forms include paperwork and/or completing application for MVA, handicap license, Family Medical Leave Act (FMLA), disability, jury duty, etc. This fee is subject to change.

Medical records: Any information from the medical record must have the patient's signed consent to release. Please allow 2 weeks for the copying of medical records. I understand that I must pre-pay the copying fee based upon allowed charges under current Maryland law for copying medical records. Patients or other parties authorized by the patient to request medical records for legal issues, insurance, disability (not workers' compensation), physician change or relocation from the area are subject to a processing charge in addition to the copying charge. There will be no charge for copying records for a referral to another physician made by a Practice physician, or workers' compensation issue or any other solutions covered under Maryland law. Records can only be faxed or picked up and not emailed or mailed at this time.

I permit a copy of this authorization and agreement to be used in place of the original. By signing below, the patient, parent, legal guardian or responsible party agrees to make all required payments as provided above.

Signature and agreement: THE UNDERSIGNED, AND EACH OF THEM, CERTIFY THAT THEY HAVE READ AND UNDERSTAND EACH OF THE ABOVE.

Signature of patient or parent/legal guardian: _____

Relation to patient if parent or legal guardian: _____

Witness: _____

HIPAA Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

A. The General Authorization for Release of Medical Records that you sign authorizes your medical care provider, Greater Maryland Pain Management ("Provider"), to disclose the information in your medical records to the extent needed for the following purposes:

1. For the purpose of providing treatment to you. This would include, for example, sharing information with employees and contractors of Provider, or with other healthcare providers who are treating you or consulting in your care.
2. For the purpose of arranging payment for your care. This could include, for example, your insurer, or other third-party payor who is responsible for paying all or part of the cost of your care.
3. For the purpose of Provider's "healthcare operations." This would include such things as internal quality assessment activities, contacting other healthcare providers regarding treatment alternatives, evaluating provider performance, training providers of care, legal and medical review of care provided, business planning and management, customer service, resolutions of internal grievances and the provision of legal and auditing services.
4. For the purpose of other healthcare providers; "healthcare operations", to the extent that they have a treatment relationship with you.

B. A specific Authorization for Release of Medical Records that you may sign authorizes Provider to make a specific disclosure that is not covered under section A, above. A Specific Authorization will name the party to whom you are authorizing discourse, and will contain any limitations on the authority to disclose your records.

C. You may revoke an authorization by giving Provider a written notice of revocation. Provider may refuse to treat you if you revoke the General Authorization.

D. Provider may be required by law, in some cases, to make disclosures of your record that you have not authorized. Examples are subpoenas in criminal or civil litigation, or requests/surveys by licensure agencies or the U.S. Department of Health and Human Services.

E. Provider may contact you to provide appointments reminders or information about treatment alternative or other health-related benefits and services that may be of interest to you.

F. You have the following rights with respect to your medical records/information:

1. You have the right to request restrictions on the use and disclosure of your medical records/information, however, Provider is not required to agree to restrictions not guaranteed by law. You will be informed if Provider will not agree to a requested restriction.
2. You have the right to receive confidential communications of your health information and to direct the place and manner of communication.
3. You have the right to inspect and copy your medical records. (Provider is entitled to charge you a reasonable fee related to the cost of copying your records).
4. You have the right to seek to amend your medical records, and if Provider does not agree with your request, to note your objection in the medical records.
5. You have the right to receive an accounting (list) of disclosures of your medical records/information made by Provider. (Except for close disclosures that are made to your or with your specific authorization, that fall with the scope of Provider's "healthcare operations", or disclosures made. You have the right to seek to amend your medical records, and if Provider does not agree with your request, to note your objection in the medical records.
6. You have the right to receive a paper copy of this notice.

G. Provider is required by law to maintain the privacy of protected health information, and to provide patients with this notice of its duties and practices, as well as changes to those practices. Patients will be provided with revised notices, as appropriate.

H. If a patient believes that his or her privacy rights have been violated, then patient may complain to Provider, or the Secretary of the U.S. Department of Health and Human Services. To complain to Provider, please write or call us with the details. Provider will not retaliate in any way against a patient for making a complaint.

I. If you as a patient or guardian believe that your privacy rights have been violated, and wish to notify our practice, please call our office and ask to speak with our designated Privacy Complaints Contact Person: Practice Administrator.

J. Provider reserves the right to change its privacy practices, and to make its new policies effective for all protected health information that Provider maintains. If such changes are made, Provider will issue an updated "Notice to Patients" to all Provider's patients.

Signature of patient or parent/legal guardian: _____

Relation to patient if parent or legal guardian: _____

Witness: _____

Authorization for Release of Information to Family Members

Patient name: _____ DOB: _____

Many of our patients allow family members such as their spouse, parents, or others to call and request medical or billing information. If you wish to have your medical or billing information released to a family members, you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Greater Maryland Pain Management to release my medical and/or billing information to the following individual(s):

1. _____ Relationship to patient: _____
2. _____ Relationship to patient: _____
3. _____ Relationship to patient: _____

I understand I have the right to revoke this authorization at any time and I also have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing.

Signature: _____ Date: _____