Ashford
PAIN SOLUTIONS

Dear Sir or Madam,

We are pleased to have you as a patient at Ashford Pain Solutions. Our clinic is an interventional pain management clinic that utilizes many modalities in the treatment of chronic pain including medications, massage therapy, epidurals, a variety of nerve block procedures, as well as more advanced techniques such as implantable devices. We also have the means for referrals to neurosurgeons, orthopedic surgeons, neurologists, psychologists, and physical therapists.

On your visit, we will perform a thorough medical history and physical examination so that we may formulate an appropriate treatment plan for your specific pain problems. Some treatment plans require approval from your insurance company. Please note that this process can take several weeks to complete. We appreciate your patience and cooperation during this time.

The primary goal of our clinic is to help reduce or eliminate your pain so that you may comfortably perform routine daily activities and live a more normal life. An effective pain management strategy often requires several treatment modalities (nerve blocks, medications, massage therapy, physical therapy, etc.), but your help and motivation are essential in order for your treatment plan to be successful. Failure to comply with the advised treatment plan given to you by Dr. Ashford may result in discharge from our clinic.

Please note that we are not a walk-in clinic and you will not be seen without an appointment. If you must cancel or reschedule an appointment, please call our office 24 hours in advance of your scheduled appointment. Our time is valuable and other patients can be seen in your time slot if we have proper notice. You may be dismissed and no further appointments given if you fail to show for a scheduled appointment more than two times without reasonable cause. This decision will be made at the doctor's discretion.

We ask that you bring all of your prescribed medications or a list of all medications with you to your appointment. Please note that we will not call in medications to your pharmacy. All medications must be requested at your scheduled appointment. There will be a $10.00 charge for any prescriptions that are requested between your scheduled appointments.

Your pharmacy's name, address, and telephone number is required at your initial consultation. No prescriptions will be written until this information is provided. If you change pharmacies, doctors, or insurance, it is your responsibility to notify our office staff. Failure to comply may result in a delay of treatment.

Thank you,
Ashford Pain Solutions

Patient Signature: _____ Date: _____

Patient Name (please print): _____

# POLICIES & PROCEDURES

**Appointments**

- If you are greater than 15 minutes late to your scheduled appointment your appointment will be cancelled and rescheduled for a later date.
- Due to the nature of our practice, you may have an extended wait time for your appointment. We appreciate your patience and understanding.
- We require a 24-hour notice if you need to cancel or reschedule procedure appointments. If you fail to comply with this notice you will be charged a **$150.00 no show fee.**
- Please allow a reasonable amount of time for your prescribed treatment plan to take effect by keeping your scheduled appointments.
- If you have a patient balance your balance is expected to be paid in full at the time of your clinic visit. Failure to pay will result in cancellation of your scheduled appointment.
- **We are not a walk-in clinic and will not see patients without appointments.**

**Prescriptions**

- Please obtain all prescriptions during your scheduled appointment.
- There will be a $10.00 charge for any prescriptions requested between your scheduled appointments. You will be required to pick up your prescriptions at the front desk and payment will be required at the time you pick up.

**Office Etiquette**

- For the safety of our elderly patients, please refrain from bringing children under the age of 12 to your appointment. Failure to comply may result in cancellation of your scheduled appointment.
- Disruptive or disrespectful behavior will not be tolerated and may result in discharge from our clinic per your Doctor's discretion.

**Office Policies:**

- At times, you may be required to leave a message for the medical staff. Any messages left after 4:00 PM will be returned the following day. A $25.00 consult fee will be charged if a call from the physician is required.
- We ask that you limit your phone calls to urgent needs only. We see a large volume of patients in our office each day and it is difficult to provide one-on-one service and still attend to a large volume of patient phone calls.
- Patients should contact the office immediately if any of the following are new or present more than 48 hours after a procedure: (1) fever greater than 101 degrees, (2) neck stiffness, (3) drainage from a procedure site, (4) weakness, numbness or tingling in arm(s) or leg(s). Patients should also call if they are having an allergic reaction to new medication prescribed. Call 911 for all emergencies.

By Signing this document, you agree to follow and adhere to the Terms and Conditions stated above.

Patient Signature: _____ Patient Name (please print): _____

# AUTHORIZATIONS, RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS

Name of Patient: _____ Date of Birth: _____

I hereby authorize Ashford Pain Solutions, to release by electronic means or otherwise any medical and/or billing information concerning my care, including copies of my medical records to the following:

a. Any person or entity responsible for payment for the medical services rendered to me at the Facility, including third party payors, self-insurers, worker's compensation carriers and government agencies or any person or entity acting as the agent or contractor of such party responsible for payment, in connection with obtaining payment for the medical services rendered to me at the Hospital by employees of the Facility or any person providing services at the Facility.
b. Federal, State or other governmental or quasi-governmental agencies or such other parties required by law for reporting purposes or for purposes of determining eligibility in government sponsored benefit programs.
c. Any person or entity participating in quality studies, utilization review or similar studies of the care rendered by the Facility and /or its physicians.
d. Any health professionals involved in my care for the purpose of facilitating the continuity of my medical care.
e. To persons authorized by the Facility in connection with the performance of supervised research in compliance with the rules and procedures of the Facility. I also understand that an authorized researcher may contact me at some future date.
f. I acknowledge that the above authorization has no expiration date and is valid to authorize the release of medical records and billing information at any time a valid request is received. This includes information relative to alcohol abuse, drug abuse, psychological or psychiatric conditions and Acquired Immune Deficiency Syndrome (AIDS).

MEDICAL LIFETIME SIGNATURE ON FILE: (if applicable) I request that payment of authorized Medicare benefits be made to APS for any services furnished by a member of this group, I authorize the holder for medical information about me to release the finance administration and its agents any information needed to determine these benefits or benefits payable for related services.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize my Medicare and/or medical insurance benefits to be paid directly to Ashford Pain Solutions, separately from other Facility or professional bills. I understand that I am financially responsible for non-covered services as well as any deductibles, coinsurance or amounts in excess of insurance benefits. If coverage is denied, I give my express consent to appeal to the insurance on my behalf.

FINANCIAL RESPONSIBILITY: In consideration of services rendered or to be rendered to the patient designated herein at my request for this occasion of service, I guarantee and agree to pay charges for those services rendered including any amount not paid in my insurance plan, Medicare, health service plan or health maintenance organization. Members of health maintenance organizations (and preferred provider organizations) are generally required to comply with certain policies and procedures requiring use of participating providers and compliance with plan requirements for primary referral, emergency admission, pre-certification and utilization review. These are conditions to payment of benefits by the health maintenance organizations (and preferred provider organizations). OR Ashford Pain Solutions, may not participate with your health care coverage plan and their charges may not be covered.

By signing the financial responsibility statement, the patient and guarantor(s) acknowledge and agree they are responsible for payment of billed charges rendered in any case in which payment may be denied by the health maintenance organization (or preferred provider organization) because of a failure to comply with such coverage requirements or for any other reason.

I acknowledge that I have read and understand its contents fully. The undersigned is the patient, the patient's legal representative or is authorized by the patient to execute this form and accepts its terms. I authorize the use of email to contact me.

_____ _____

Signature of patient, parent or legal guardian of patient Date signed

**PLEASE READ AND SIGN THIS FORM**
**PATIENT HIPAA PRIVACY AUTHORIZATION FORM**
**ASHFORD PAIN SOLUTIONS**

Name of Patient: _____ Date of Birth: _____

I understand that my health information is private and confidential. I understand that Ashford Pain Solutions works very hard to protect my privacy and preserve my confidentiality of the personal health information. Some information can be relayed by telephone. In this instance, we will call your telephone we have on file that you have provided. For more pertinent information it is necessary to send a letter. In this case we will send a letter addressed only to you at the address you have provided.

I understand that Ashford Pain Solutions may use and disclose my personal health information (PHI) to help provide health care to me, to handle billing and payment, and to take care of the other health care operations. In general, there will be no other used and disclosures of this information unless I authorized it in writing. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual.

Ashford Pain Solutions has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting our patient's privacy. I understand that I have the right to read the "Notice" before signing this agreement. SCWH may update this "Notice of Privacy Practices" at any time. If I ask, Ashford Pain Solutions will provide me with the most current "Notice of Privacy Practices". I have been provided a copy of this at my first visit.

Our Notice of Privacy Practices states that we may disclose your PHI to others who may assist in your care, such as your spouse, children, parents, or caregiver. **Please list any family members and caregivers with whom we are authorized to discuss your medical care or to whom we may release medical records.**

☐ No Release to family/caregivers. If you wish to RESTRICT use/disclosure to TPO in other ways, please request a form.

Under the terms of this consent, I can ask Ashford Pain Solutions to limit how my personal health information is used or disclosed to carry our treatment, payment, or healthcare options. I understand that Ashford Pain Solutions does not have to agree to my request. If Ashford Pain Solutions does agree to my request, I understand that they would follow the agreed limits.

I may cancel this consent in writing at any time by writing, signing, and dating a letter to Ashford Pain Solutions. The letter must say that I want to revoke my consent to authorize the use and disclosure of my personal health information for treatment, payment, and health care operations. If I revoke this consent, Ashford Pain Solutions does not have to provide any further health care services to me.

My signature below indicates that I have been given the chance to review a current copy of Ashford Pain Solutions "Notice of Privacy Practices". My signature means that I agree to allow Ashford Pain Solutions to use and disclose my patient's personal health information to carry out treatment, payment, and healthcare operations.

_____ _____

Signature of patient, parent or legal guardian of patient Date signed

## ASHFORD PAIN SOLUTIONS
## AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize to release all medical records including history, finding, and prognosis to Ashford Pain Solutions. A copy shall be valid as the original document. I understand that when my PHI is disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and my no longer be protected by the federal HIPAA privacy rule. I have the right to revoke this authorization in writing, except (i) to the extent that the practice has acted in reliance upon this authorization; or (ii) to the extent that the authorization was obtained as a condition of obtaining insurance coverage claim under the policy. I understand that my revocation must be submitted in writing to the practice's privacy official/committee at 1000 Hawthorne Avenue Suite J, Athens, GA 30606, by sending a written request stating that I wish to revoke this authorization to the attention of the privacy official/committee. I understand that the practice may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. By signing this authorization, I authorize Ashford Pain Solutions (the "practice") to use and/or disclose certain protected health information (PHI) to or for the party or parties listed below.

**Records From: Facility Name(s):**

_____
_____
_____
_____
_____

Phone: _____ Fax: _____
Sent From: _____ Job Title: _____

***Ashford Pain Solutions***
***1000 HAWTHORNE AVE.***
***SUITE J***
***A THENS, GA 30606***
***(P): (706) 286-8344***
***(F): (706) 286-8346***

Patient Name: _____ DOB: _____Phone #: _____

_____ _____
Signature of Patient or Legal Representative Date Signed

If signed by legal representative, please check one:
_____ Relationship to this patient: _____
_____ Custodial Guardian
_____ Durable Power of Attorney for Healthcare

**ASHFORD PAIN SOLUTIONS**
**FINANCIAL POLICY**

Thank you for choosing us as your pain management provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this financial policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we are in network with, payment in full is expected at each visit. If you are insured by a plan we are in network with, but do not provide us with an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-covered services**. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

**7. Nonpayment.**
If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

**8. Missed procedure appointments.**
Our policy is to charge for $150.00 for missed procedure appointments not canceled within 24 hours of appointment time. These charges will be your responsibility and billed directly to you. These charges must be paid in full prior to your next clinic visit. Please help us to serve you better by keeping your scheduled appointment.

**9. Returned checks.**
We charge a $25 fee for any returned checks. If we received a returned check, you may no longer use checks as a method of payment.

**10. Patient responsibility for procedures.**
As a courtesy, we will call your insurance company ahead of time to determine eligibility and obtain approval for your procedure. This does not guarantee reimbursement. The patient or 'responsible party' remains fully responsible for eligibility and for the entire amount of the bill. In order to determine the cost for a procedure, contact your insurance company directly to determine the patient responsibility. Please contact our office if you need assistance.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

*I have read, understand, and agree to the above Ashford Pain Solutions Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility. I acknowledge that these policies do not obligate Ashford Pain Solutions to extend credit.*

*I authorize my insurance benefits to be paid directly to Ashford Pain Solutions.*

*I authorize Ashford Pain Solutions to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim in compliance with HIPAA regulations.*

Patient Name (please print): _____

Patient Signature: _____

Date Signed: _____

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## PATIENT DEMOGRAPHICS

First Name: _____ MI: _____ Last Name:_____

DOB: _____ Age: _____ SSN: _____ - ____ - _____ Email: _____

Sex: ☐ Female ☐ Male Ethnicity: ☐ White/Caucasian ☐ Black/African-American ☐ Asian ☐ Hispanic/Latino

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Physical Address: _____ City: _____ State: ____ Zip: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Employer Name: _____

Responsible Party (if other than patient):

Name: _____ Age: _____ Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

Emergency Contact Information:

Name: _____ DOB: _____ Relation: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

How did you hear about Ashford Pain Solutions?

☐ Google ☐ Healthgrades ☐ Family/Friend ☐ Facebook ☐ Mail ☐ Other: _____

Primary Care Physician: _____ Referring Physician: _____

Preferred Pharmacy Name: _____ Address: _____

Primary Insurance: _____ Subscriber: _____

Policy #: _____ Group #: _____

Secondary Insurance: _____ Subscriber: _____

Policy #: _____ Group #: _____

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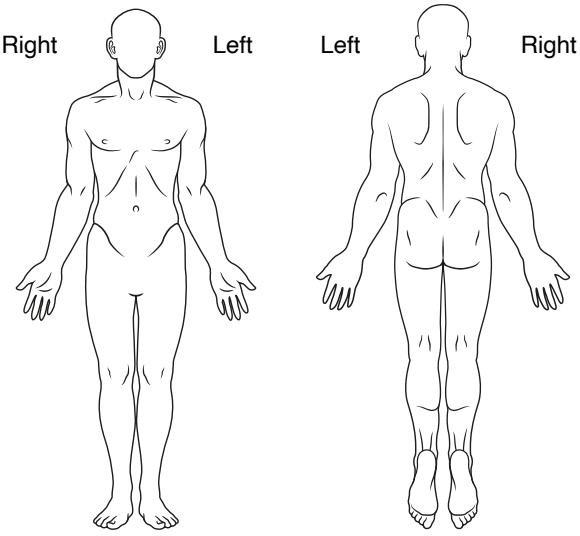
Name: _____ Phone Number: _____ Date of Birth: _____

Please shade in the chart below areas
where you feel pain.
Put an X on the area that hurts the most.

**FRONT** **BACK**

Right Left Left Right



What are your activity goals for your pain treatment?
1) _____
2) _____
3) _____

How long have you had chronic pain?
__ Month(s) __ Year(s) __ Week(s) __ Day(s)
Please describe events surrounding the onset of your pain. (Date of injury, activities that made it worse?)
_____
_____
_____
_____
_____

**PLEASE CIRCLE: In the last year, how many emergency room visits have you had for pain?**
0 1 2 3 4 5 6 7 8 9 10 other:_____

**Which words describe the QUALITY of your pain? (check)**
__ Throbbing __ Cramping __ Heavy/Pressure
__ Tingling/Pins & Needles __ Cold/Freezing __ Sharp/Shooting
__ Hot/Burning __ Stabbing __ Electric-Shock __ Itching

**Please circle all ACTIVITIES that <u>MAKE YOUR PAIN WORSE:</u>**
rest touch sitting standing bending lifting walking light exercise sex warm compresses cold compresses relaxation techniques other: _____

**Please circle all ACTIVITIES that <u>MAKE YOUR PAIN BETTER</u>:**
rest touch sitting standing bending lifting walking light exercise sex warm compresses cold compresses relaxation techniques other: _____

**Please circle <u>RELIEF(%)</u> YOU HAVE HAD <u>IN THE LAST 24 HOURS</u> from medications & treatments:**
No Relief 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% Complete Relief

**<u>WHEN YOU TAKE YOUR MEDICATION</u> how many <u>HOURS OF RELIEF</u> do you get?**
____Hours ____No help at all ____I do not take pain medications

Does your pain affect your sleep? _____ yes _____ no
Does your pain cause anxiety? _____ yes _____ no
Does your pain cause depression? _____ yes _____ no

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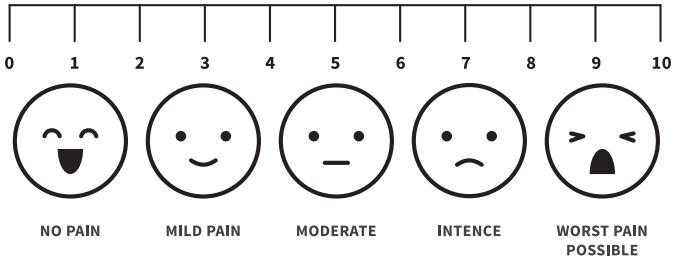
## PAIN MEASUREMENT SCALE




Please circle the number that indicates your **WORST PAIN LEVEL** over the last week:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain You Can Imagine

Please circle the number that indicates your **LEAST PAIN LEVEL** over the last week:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain You Can Imagine

Please circle the number that indicates your **AVERAGE PAIN LEVEL** over the last week:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain You Can Imagine

Please circle the number that indicates your **CURRENT PAIN LEVEL RIGHT NOW** over the last week:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain You Can Imagine

Please help us understand **HOW PAIN HAS INTERFERED WITH** your:

A. **General Activity**

Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

B. **Mood**

Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

C. **Ability To Walk**

Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

D. **Ability To Perform Tasks At Home Or Work**

Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

E. **Relations With Other People**

Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

F. **Sleep**

Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

A. **Enjoyment Of Life**

Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

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## PLEASE CHECK ALL OF THE PAIN MANAGEMENT PROCEDURES THAT YOU HAVE HAD.

| | How Many | Date(s) performed (approximate) |
|---|---|---|
| ___Trigger Point Injections | _____ | _____ |
| ___Medial Branch Nerve Blocks | _____ | _____ |
| ___Radiofrequency Nerve Ablation or Rhizotomy | _____ | _____ |
| ___Epidural Steriod Injection | _____ | _____ |
| ___Caudal Steroid Injection | _____ | _____ |
| ___Spinal Cord Stimulator | _____ | _____ |
| ___Facet Joint Injection | _____ | _____ |
| ___Sacroiliac Joint Injection | _____ | _____ |
| ___Stallate Ganglion Block | _____ | _____ |
| ___Lumbar Sympathetic Block | _____ | _____ |
| ___Intercostal Nerve Block | _____ | _____ |
| ___Knee Genicular Nerve Block | _____ | _____ |
| ___Occipital Nerve Block | _____ | _____ |
| ___Botox Injections | _____ | _____ |
| ___Kyphoplasty/Vertebroplasty | _____ | _____ |

**Have you ever had (currently or in the past):**

☐Yes ☐No Treatment for mood, anxiety, and/or sleep disorder?
☐Yes ☐No Nightmares or flashbacks from prior traumatic experiences?
☐Yes ☐No Alcohol, illicit drug, or prescription medication misuse/addiction?
☐Yes ☐No Problems with compulsive behaviors such as gambling, eating disorder, etc.?
☐Yes ☐No Hospitalization for anxiety or depression?

If yes, please explain: _____

**How many physicians have been involved in the treatment of your pain?** Please circle the number and then write who you have seen on the line: 1-3 4-5 6-10 11-15 16-20 _____

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**Please list <u>ALL CURRENT</u> medications:**

| Name of Medication & Strength | How to take (ex: 1 tablet by mouth 2x daily) | Why are you taking this medication? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Are you **<u>CURRENTLY</u>** taking any of the following blood thinners?

___Rivaroxaban/Xarelto
___Dabigatran/Pradaxa
___Apixaban/Eliquis
___Heparin
___Warfarin/Coumadin
___Enoxaparin/Lovenox
___Clopidogrel/Plavix
___Aspirin
___NSAIDs (Ibuprofen, Naproxen, etc.)
___Other:_____