Advanced Spine & Pain Interventions, LLC ● Woodley B. Mardy-Davis, M.D.
12389 Crabapple Road ● Alpharetta, GA 30004 ● Phone: (470) 299-1998 ● Fax: (470) 299-1898

PATIENT INFORMATION					
Last Name:		First Name:		MI:	
Street Address:					
City:	State:		Zip Code:		
Home Phone Number:			OK to Leave Voicemail?	☐ Yes ☐ No	
Cell Phone Number:			OK to Leave Voicemail?	☐ Yes ☐ No	
Work Phone Number:			OK to Leave Voicemail?	☐ Yes ☐ No	
Preferred/Primary Contact Number: ☐ Home Phone ☐ Cell Phone ☐ Work Phone					
Email Address:			OK to Send Email?	☐ Yes ☐ No	
Primary Care Physician:			Referring Physician:		
Referring Physician Phone Number:			Referring Physician Fax Number:		
Date of Birth:	Gender: ☐ Male ☐ Female		Social Security Number:		
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Unknown ☐ Partner					
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black or African American ☐ White or Caucasian ☐ Hispanic ☐ Other ☐ Decline to Answer					
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer			Primary Language:		

Pharmacy Preference & Rx Insurance			
Pharmacy Name:			
Street Address:			
City:	State:	Zip Code:	
Phone Number:		Fax Number:	
Rx Bin:	RxPCN:	RxGrp:	Issuer:

Employer Information		
Employer Name:		
Street Address:		
City:	State:	Zip Code:
Phone Number:		

Emergency Contact		
Emergency Contact Name:		
Street Address:		
City:	State:	Zip Code:
Phone Number:	Relationship to Patient:	

Please complete ALL sections. Mark N/A for any information that does not apply to you.

Primary Insurance	
Responsible Party: ☐ Self ☐ Guarantor ☐ Another Patient of Advanced Spine & Pain Interventions LLC	
Insurance Carrier:	Provider Services Phone Number:
Insurance Plan:	Subscriber Number/Member ID:
Policy Holder's Name:	Policy Holder's Date of Birth:
Patient's Relation to Policy Holder:	

Secondary Insurance	
Insurance Carrier:	Insurance Phone Number:
Insurance Plan:	Group Number/Member ID:
Policy Name:	Policy Number:

Workers' Compensation (employer refers to the company you were working for when injured; the phone and fax number should be that of your case manager)	
Employer:	Date of Accident:
Case Manager:	Case Number:
Phone Number:	Fax Number:
Workers' Comp Company:	Attorney:

I hereby authorize Advanced Spine & Pain Interventions, LLC to obtain and/or release all medical records for treatment pertaining to my work related injury. I authorize payment of medical benefits to Advanced Spine & Pain Interventions, LLC, and I understand I am responsible to pay for all medical service disputed or denied by my insurance company.

Patient Signature: _____ **Date:** ____/_____/_____

CONSENT TO TREATMENT

This is an established agreement between the patient and Advanced Spine & Pain Interventions, LLC (i.e. physicians, healthcare providers, and other medical staff) for the purpose of establishing written consent from the patient in order to receive pain management services and/or medications related to such treatment. This may include care from other areas including diagnostic and therapeutic interventions, behavioral medicine, weight management, alternative therapies, and prescription medication. This agreement and consent to treatment is an essential factor in maintaining the trust and confidence necessary for the provider-patient relationship at Advanced Spine & Pain Interventions, LLC

I consent to medical treatment for myself, or for the patient whom I am legally authorized to represent.

Patient Signature: _____ **Date:** ____/_____/_____

FINANCIAL POLICIES & DISCLOSURES

Payment Methods: We accept cash, MasterCard, Discover, VISA, and American Express.

Insurance & Billing: It is our policy to verify benefit coverage- patients are responsible for any services not covered by their insurance company. Patients authorize Advanced Spine & Pain Interventions, LLC to file claims on their behalf and payments may be rendered directly to Advanced Spine & Pain Interventions, LLC for benefits otherwise payable to them by any third party. We rely on accurate and updated information to process payments in a timely manner, so patients are advised to report any information changes to the office. **If the patient is considered a minor under state laws, their legal guardian will be held responsible for all patient payments.**

Copayments, Deductibles, & Co-insurance: A co-payment is a flat fee paid each time a medical service is accessed, and it must be paid before any policy benefit is payable by an insurance company. Co-payments are due at the time of service. Deductibles must be paid out-of-pocket by the patient before the benefits of the insurance policy can apply. If patients have not yet met their deductible for specialist visits, an estimation of that amount is calculated, payment will be due at the **time of service**. Co-insurance is a percentage of the allowed charge that patient's pay after their deductible has been satisfied, an estimation of that amount is calculated, payment will be due at the **time of service**. **Please note: All payments are due at the time of service.**

Self-Pay: If a patient is uninsured for our services, we will see them on a self-pay basis. We require self-pay patients to pay all account balance, in-full, at the time of service.

Outstanding Account Balance: Advanced Spine & Pain Interventions, LLC requires all patients to make a payment of one-half (i.e., fifty percent) towards their patient balance at each appointment, in which a patient balance exists, prior to receiving any services. We will assist in reminding patients of outstanding balances and upcoming payments prior to their next appointment; however, patients are ultimately responsible for keeping record of service fees, insurance payments, account balances, etc. – and they hold full responsibility towards making payments on-time, following all policies stated by Advanced Spine & Pain Interventions, LLC. If an outstanding balance remains unpaid 90 days past due, Advanced Spine & Pain Interventions, LLC reserves the right to send the patient's account information to an outside collection agency, which may include their listing information with the credit bureau. The above guidelines also apply in the event of patient/facility issues remaining unresolved in regards to unpaid account balances, and following a thorough account review, patients may be discharged from our facility.

Overpayment: Patients agree to allow Advanced Spine & Pain Interventions, LLC to apply account credits to any outstanding balance on their account. Advanced Spine & Pain Interventions, LLC can apply this credit to any outstanding balance on the patient's account, including balances related to professional or facility fees. Patients will be refunded any amounts paid in excess after all outstanding amounts have been credited.

Referrals: Referrals and authorizations may be required by insurance companies, which we will work to process in a timely manner. Advanced Spine & Pain Interventions, LLC reserves the right to cancel or reschedule patients who do not have proper documentation prior to receiving services.

Form Requests: Advanced Spine & Pain Interventions, LLC accepts written requests to complete forms in compliance with state laws and policies. This service requires an administrative fee to be paid in advance, and the patient information portion of each form must be completed prior to processing. Please note a **minimum** of five business days is required to complete any form, and processing may take anywhere from 5-7 business days once signed authorization and permission to release medical information has been provided. All completed forms are mailed or faxed to the disability carrier/employer as indicated by the patient, or available for pickup at our office.

Missed Appointments or Cancellations: Advanced Spine & Pain Interventions, LLC charges a $80 non-refundable fee to the patient's account for missed appointments and appointments not rescheduled 24 hours in advance, and $160 for missed procedures. Patients agree to pay any applicable fee at their next scheduled appointment, in addition to any copay, coinsurance, or account balance that is due. Patients are responsible for keeping track of their scheduled appointments and should contact our office to cancel or reschedule. Shall a patient fail to call, reschedule or appear for an appointment on three (3) separate occasions, Advanced Spine & Pain Interventions, LLC reserves the right to discharge the patient from the practice. In the event of an emergency, where proper and valid documentation is provided by the patient, Advanced Spine & Pain Interventions, LLC may review the issue and choose to waive the cancellation fee on the patient's account; however, this decision remains at the sole discretion of our company.

By signing below, I acknowledge that I have read, fully understand, and agree to the Financial Policies & Disclosures of Advanced Spine & Pain Interventions, LLC. I agree to follow all guidelines stated within, and I understand that fees charged to my account must be paid at my next scheduled visit before any medical service is rendered.

Patient Name (please print): _____

Patient Signature: _____ **Date:** ____/_____/_____

MEDICATION POLICY

I agree to follow and accept the following conditions:
(Please initial in the spaces provided)

_____Opioids and controlled substances may be prescribed through Advanced Spine & Pain Interventions, LLC for pain relief, if deemed appropriate by my physician. Shall I be prescribed medications of this nature, I understand that I cannot obtain those medications from any other provider, including those involved in emergency, hospital, and urgency care settings, as well as dentistry.

_____I understand that there are always potential risks and side effects involved with taking any medications, and overdose or misuse of particular medications may cause injury or death. Other complications may also occur, and it's important that I follow all provider guidelines to keep myself and others from harm.
_____Routine urine samples will be required if I receive opioid prescriptions from Advanced Spine & Pain Interventions, LLC. I understand that I must provide an adequate urine sample within a designated time. Shall I fail to do so, I am subject to receiving no prescriptions and must reschedule my appointment.

_____I understand that Advanced Spine & Pain Interventions, LLC is an interventional pain management facility that will provide therapy services to help treat my pain; however, the facility will not prescribe any narcotic medications in conjunction with a medical marijuana card.

_____Medication therapy can be discontinued for inaccurate urine-test results, including, but not limited to: testing positive for illegal substances or opioids not prescribed by Advanced Spine & Pain Interventions, LLC, or testing negative for medications I am prescribed by the facility.

_____I agree to use my medication at the rate discussed with my physician, and I am aware that Advanced Spine & Pain Interventions, LLC reserves the right to have me bring any or all of my prescribed medications to their office at any random time for a prescription compliance check.

_____Unless indicated and allowed otherwise, I must pick up all medications myself and handle them with care. I understand my medication will not be replaced if lost, stolen, or destroyed- even with documentation, such as a police report. I also agree that I will not give, lend, or sell my prescriptions.

_____I agree that refills are considered on a monthly basis and require a follow-up visit prior to having another prescription filled. I understand that refills cannot be called into the pharmacy, and medication requests will not be permitted before the prescribed date designated by my provider.

_____I am aware that altering dates, strengths, quantities, signatures, and other information on a prescription is against the law, and I understand that Advanced Spine & Pain Management, LLC cooperates fully with law enforcement agencies in all situations regarding prescription medication.

_____If I have any questions regarding my medication, I will call the office of Advanced Spine & Pain Interventions, LLC to report my concerns. If necessary, I agree to schedule an appointment for further evaluation by my physician.

_____In addition to complying with the terms stated in this Medication Policy by Advanced Spine & Pain Interventions, LLC, I agree to read and understand my prescribed medication and/or treatment guidelines, uses, benefits, risks, and other associated information. I will also cooperate with all law enforcement agencies, pharmacies, insurers, and physicians as required by state and federal regulations.

_____I understand that emergencies can occur, and under particular circumstances, exceptions can be made to these guidelines. Emergencies of such nature will be considered on an individual basis at the sole discretion of my provider. Lack of strict adherence to any provision of this agreement by the physician in no way invalidates other provisions of this agreement.

Patient Name (please print): _____

Patient Signature: _____ **Date:** ____/_____/_____

Please complete ALL sections. Mark N/A for any information that does not apply to you.

RELEASE OF INFORMATION

This is an established agreement between_____(the patient) and Advanced Spine & Pain interventions, LLC (the physician) for the purpose of establishing written consent from the patient in order to receive pain services and/or medication. This may include care from other areas, including diagnostic and therapeutic interventions, behavioral medicine, weight management, alternative therapies, and prescription medications. This agreement and consent to treatment is an essential factor in maintaining the trust and confidence necessary for the physician-patient relationship at Advanced Spine & Pain Interventions, LLC.

Patient Signature: _____ **Date:** ____/_____/_____

Signature of Legally Authorized Representative: _____

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPPA), healthcare providers are prohibited from releasing or discussing any personal health information without appropriate permission. In order to communicate with family members or other individuals regarding personal medical care, we must receive written consent from the patient.

Person(s) listed below must be 18+ years old with valid identification.

I authorize Advanced Spine & Pain Interventions, LLC to discuss/communicate my medical information to following person(s) listed below:

Name: _____ **Phone Number:** _____

Relationship to Patient: _____

Name: _____ **Phone Number:** _____

Relationship to Patient: _____

***Please provide your <u>initials and check</u> the appropriate check box.**

_____☐ Yes ☐ No I give the above person(s) permission to give consent for treatment.

_____ ☐ Yes ☐ No I give the above person(s) permission to pick-up my prescriptions.

_____ ☐ Yes ☐ No In my absence, I consent to messages/voicemails/documents (which may contain protected health care information) being shared with the above person(s).

Patient Signature: _____ **Date:** ____/_____/_____

HIPAA NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information will be used by Advanced Spine & Pain Interventions, LLC to provide health care (in some cases through multiple healthcare providers who are directly and indirectly involved with treatment), obtain payments from designated third-parties, and to conduct other health care operations- including quality assessments, evaluations, and physician certifications. In most cases, there will be no other use and disclosure of my information unless permitted. I understand under certain federal, state, and local laws that Advanced Spine & Pain Interventions, LLC is required to release information without my permission. I am aware that Advanced Spine & Pain Interventions, LLC has a more detailed document explaining their Notice of Privacy Practices, which contains more information regarding their policies and practices to protect patient's privacy, including other potential disclosures and uses of the patient's health information. I understand that I may receive a copy of this document at any time and reserve the right to view a detailed Notice of Privacy Practices from Advanced Spine & Pain Interventions, LLC before signing this Acknowledgement, and if updates are made to this document, I will be provided with the most recent version, upon my request. I understand Advanced Spine & Pain Interventions, LLC has established procedures to help them meet their obligations, which may include other written acknowledgements, authorizations, reasonable time frames for requesting information, charges for particular documentation needs, etc. I will assist Advanced Spine & Pain Interventions, LLC by following all procedures, and I understand that I may request in writing that this organization restrict how my private information can be used or disclosed; however, the organization is not required to agree to my requested restrictions, but if Advanced Spine & Pain Interventions, LLC does agree, it is bound to abide by such restrictions. I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent. If you believe your privacy rights have been violated, you may file a complaint with Advanced Spine & Pain Interventions, LLC by contacting the Privacy Officer or United States Department of Health and Human Services. **Privacy Officer:** (470) 299-1998 or info@davisanesthesia.com

Patient Name (please print): _____

Patient Signature: _____ **Date:** ____/_____/_____