Interventional Spine Medicine

Leaders in Innovative Pain Management

944 Calef Highway Barrington, ,NH 03825
Telephone: 603-664-0100 Fax: 603-664-0101
Email: ismscheduled@nhpain.com www.ism@nhpain.com

Patient Name:____

Address:____

City:_____________________________________State:______________Zip:_____________

Home Telephone :(______)___________________________ Cell: (______)_____________________

SSN:______________DOB:____________ Sex:_________Marital Status:____________

Email address: ____

EMERGENCY CONTACT:____

Telephone :(________)_________________________Relationship:____________________________

May we leave a message on your answering machine? ☐ **Yes** ☐ **No**

Personal Health Information (PHI) can be discussed with ______________**Relationship:**______________

As a new patient, we are very interested in learning how you came to know about our practice.

___ Internet ___ Friend/Relative ___ An Interventional Spine Patient ___ Employer ___ Chiropractor

___ Primary Care Physician ___ Physical Therapist ___ Surgeon ___ Another Physician

A source not listed above (please specify): ____

Current Employer: ____

Address: ____

Telephone: (________)____

Primary Health Insurance: _________________________________Copay:______________

Policy Holder/Subscriber:_____________________DOB:_______SSN:______- _____ -______

Relationship to Patient: _____________Policy/ID #:______________Group #: ______________

Employer's Name & Address:____

Secondary Insurance:___________________________ _Copay:_________________________

Policy Holder/Subscriber:________________DOB _________SSN: ______-_____-_

Relationship to Patient:_________________Policy/ID #:_____________Group #: _____________

Employer's Name & Address:____

Additional Insurance:______________________________________Copay:__________

Policy Holder/Subscriber:_________________DOB:____________SSN: ____-____-____

Relationship to Patient:__________________Policy/ID #:______________Group #:_____

Employer's Name & Address:____

Primary Care Physician:_____________________________Telephone:(______) __________

Address:____

Referring Physician:___________________________________Telephone:(_______)__________

Address: ____

Revised 3/22/2018 ; 7/30/2018

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If Worker's Compensation Case (only open claims are accepted):

Carrier Name:____

Address:____

Case Manager:_______________________Telephone: (_______)___________________

Date of Injury:______________________Claim #:_________________________

Specifically What Part of Your Body was injured?______________________________

Employer at Time of Injury:____

Employer Address:____

Employer Telephone #: (____)_______________Contact Person:_________________

The following information is optional. Please circle one.

Race: American Indian or Alaska Native / Asian / White / Black or African American/Other or Pacific Islander / More than one race / Native Hawaiian / I prefer not to reply

Preferred Language: ____I

I authorize the release of any information required to act on any insurance claim. I have by assign to Northeast Medical Consultants, PC d/b/a Interventional Spine Medicine all present and future medical and/or surgical benefits I am entitled from my insurance company(s) and/or Medicare and Medicaid, until I choose to revoke it in writing. A copy of this authorization shall be considered as valid as the original. I understand it is ultimately **my responsibility** to obtain all required authorizations and/or precertification for medical services that are required by my health insurance plan and/or third party payers. I acknowledge that this is **not** the responsibility of Northeast Medical Consultants, PC d/b/a Interventional Spine Medicine (further known as ISM). **A. I also acknowledge no guarantees have been made by any employee of ISM or any other party about: (1) my treatment; (2) whether it will be paid for by any third party payer(s) or health insurance plans; or (3) whether any care rendered by ISM including but not limited to physician services, radiology services, and surgical center fees are in or out of network with my insurance plans. I agree to fully cooperate** with ISM to assist in their efforts to get claims paid on my behalf but understand that ultimately I am financially responsible for, and agree to pay, and unconditionally guarantee payment, of all charges not paid by my health insurance plan or third party payers.

______________________________________ ______________

Patient/Responsible Party Signature **Date**

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Billing Policies

INSURANCE INFORMATION AND BILLING POLICY:

Interventional Spine Medicine participates with Aetna, Anthem-BCBS of NH, Cigna of NH, Harvard Pilgrim, Medicare, Tufts, Martins Point, and Tricare. . For these participating carriers, Interventional Spine Medicine will submit all claims and necessary supporting documentation on your behalf. **Any co-payment required by your plan will be collected up-front at the time of your office visit a $20 service fee will be charged for non-payment at time of service for all scheduled office visits or consults.** After final payment has been received from your insurance company, you will be billed for any remaining patient due balance, as specified by your carrier. If deductibles have not been met, you are responsible for payments.

If your insurance company is not listed here Interventional Spine Medicine will consider you a self-pay patient. If you are new to ISM you will be required to pay in full up-front at time of service by either cash or credit card. Established patient will be required to pay fifty (50%) of the balance up-front at time of service. ISM will, as a courtesy to you, submit your claim to your insurance carrier. However, you will immediately become responsible for payment of the balance of your account. Please note: For those insurance carriers that ISM does not participate with the claim check may be mailed directly to you. In these cases please sign and forward the check to our billing office.

You will be responsible for ensuring we have all necessary referrals or pre-certifications prior to your scheduled appointment. If you do not have a referral or pre-certification in place when you arrive for your visit you will be held responsible for payment of your office visit or procedure or your appointment may need to be rescheduled.

A picture ID is scanned into your record for security purposes, failure to comply may result in refusal of treatment.

WORKERS COMPENSATION:
Interventional Spine Medicine will submit “open” claims only, on your behalf, unless we are aware in advance that the claim will be denied. It is your responsibility to provide the office staff with complete insurance information, as well as your current case management contact and phone number. ISM will bill your primary health insurance in cases where worker’s compensation denies the claim for whatever reason. Any balance not paid by the worker’s compensation carrier or primary health plan will be your responsibility.

MOTOR VEHICLE ACCIDENT (MVA) AND LITIGATION CASES:
Interventional Spine Medicine does not recognize MVA or Litigation claims. As such, you will be classified as a self-pay patient unless you have active health insurance coverage as specified above, in which case we will submit all claims to your health insurance carrier.

SELF-PAY POLICY:
All self-pay patients (no insurance, non-participating insurance carrier, motor vehicle accident (MVA) or litigation claimants) will receive a 40% “quick-pay” discount off our current rates for paying up-front at the time of service. Otherwise, you will be required to pay at least 50% of the office visit or procedure up-front at the time of service and will be billed for the remaining balance. New patients who are self-pay must pay for their initial visit up-front at the time of visit in cash, by credit card (Discover, Visa and MasterCard) or money order (personal checks will not be accepted).

CANCELLATION POLICY:
A 24-hour notice is required for cancelled appointments. A $50 cancellation fee will be imposed for any appointment not cancelled with a 24-hour notice. Repeatedly not showing for your scheduled appointment may result in discharge from the practice.

A 48-hour notice is required for cancelled procedures. A professional fee of $100 will be imposed for any procedure not cancelled with a 48-hour notice.

RETURNED CHECKS:
A fee of $25.00 will be charged to your account for any/all returned check(s). All future payments must be made in cash, charge, money order or bank check.

PAST DUE BALANCES:
To avoid interruption in provided care, all past due balances are expected to be paid in full prior to future treatment, unless you have made payment arrangements prior to your appointment.

We are pleased to service you and welcome your feedback at all times. Our front office staff would be glad to answer any questions you may have in regards to these policies.
I have read and understand the above:

Patient Signature:______________________________________ Date: _____________________

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Northeast Medical Consultants P.C. d/b/a/ Interventional Spine Medicine
NOTICE OF PRIVACY PRACTICES

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.**

Effective Date: April 14, 2003.

Uses and Disclosures of Your Health Information

Interventional Spine Medicine will use and disclosure your health information as follows:

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, we may send relevant portions of your medical record to specialists to whom you are being referred or to whom your provider here may want to consult regarding your medical diagnosis or treatment.

***Payment*:** We will use your health information for payment. For example, your protected health information (PHI) may be disclosed to your insurance company(s) or case manager to obtain approval for a treatment or procedure.

Health Care Operations: We will use your health information to support day-to-day activities and management of Interventional Spine Medicine. For example, providers, clinical, and/or administrative staff members may assess the information in your medical record in an effort to continually improve the quality and effectiveness of the healthcare services we provide.

Business Associates: We provide some services with business associates, who are independent professionals that use patient health information provided by us in order to perform these services. Examples include quality assurance consultants, transcript services, a copy service or a billing service. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do. We require our business associates to appropriately safeguard your information.

Uses and Disclosures that we may make unless you object: Unless you object, health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Other Uses and Disclosures that we may make without your authorization: Uses and disclosure required by law, public health activities, victims of abuse, neglect or domestic violence, health oversight activities, judicial or administrative proceedings, law enforcement purposes, coroners, funeral directors medical examiners about descendants, organ donations, research purposes, health and safety, specialized government functions, workers compensation.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send or leave messages for appointment reminders.

Information about treatments: Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Other uses and disclosures require your written authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. You may revoke an authorization. However, your revocation will not affect or undo any use or disclosure of information that has occurred before you notified us of your decision to revoke.

Individual Rights

You have certain rights under the federal privacy standards. These include:

Right to inspect and copy your protected health information by providing a written request to the Privacy Officer specifying your name, date of birth, what information you are requesting access to and in what format. If you request a copy of information, we may charge a fee for the costs of copying, mailing or other supplies needed to fulfill your request.

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Right to request restrictions on the use and disclosure of your protected health information for treatment, payment or healthcare operations by submitting a written request to the Privacy Officer specifying your name, date of birth, the exact restriction you are requesting, the date the restriction would be in effect, if approved, the purpose of the restriction and contact information. While we will accept requests for restrictions, we are not required to agree to the restriction.

Right to request confidential communications by asking us to communicate with you concerning your health information only in certain ways or at certain locations. For example, you may request that we only contact you at work or by mail. Any such request must be made in writing to the Privacy Officer and include your name, date of birth, current address and phone number, the specific alternative means of communication or location to communicate with you. Where possible, we will accommodate all reasonable requests.

Right to request amendment to your protected health information. If you feel your information maintained by Interventional Spine Medicine is incorrect or incomplete, you may ask us to amend the information by contacting the Privacy Officer in writing. Your request must include your name, date of birth, what amendment is being requested and the reason for the requested amendment. While we will accept requests for amendment we are not required to agree to the amendment.

Right to an accounting of disclosures for disclosures made for reasons other than for treatment, payment or health care operations. Requests for accounting may be made in writing or verbally and must include your name, date of birth, the request for accounting, and the period to be accounted for. Requests can be for periods up to six years prior to the request but may not include dates prior to April 14, 2003. We may charge a fee for the costs of copying, mailing or other supplies needed to fulfill your request.

Right to obtain a paper copy of this notice upon oral or written request.

Interventional Spine Medicine's Duties

Interventional Spine Medicine is required by the Federal Privacy Rules to do the following:

- Make sure your protected health information is kept private.
- Provide you this notice of our legal duties and privacy practices related to the use and disclosure of your PHI.
- Follow the terms of the notice currently in effect.
- Communicate any changes in the notice to you.

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal or state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised copy on your next office visit.

Complaints

If you believe these privacy rights have been violated you may file a written complaint within 180 days to our Privacy Officer or the Department of Health and Human Services. No retaliation will occur against you for filing a complaint.

For More Information or to Report a Problem

Privacy Officer
Interventional Spine Medicine
944 Calef Highway
Barrington, NH 03825
privacyofficer@nhpain.com
603-664-0100

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I, (Print Name) ____, DOB __________________ have received Northeast Medical Consultants P.C. d/b/a Interventional Spine Medicine's NOTICE OF PRIVACY PRACTICES.

If I have received the NOTICE OF PRIVACY PRACTICES by mail I will return this acknowledgement to Interventional Spine Medicine at my earliest convenience. Until such time the fact that the NOTICE was mailed will serve as a good faith attempt by Interventional Spine Medicine to receive such Acknowledgement.

Signed: ____ Date: __________________

For Interventional Spine Medicine Use Only

Patient Declined to Acknowledge Receipt of Notice on:

Date: ____

By: ____

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DATE: _______________

NAME: ____________________________ AGE:_____________

DATE OF BIRTH:____________________ SEX: _____________

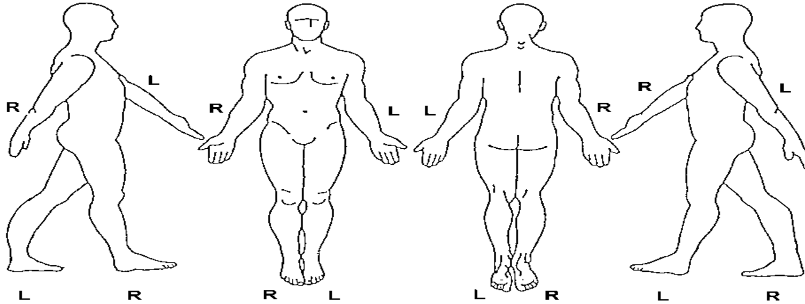
REFERRED BY: ____________________ FAMILY DOCTOR:_______________

ATTORNEY (if applicable):___________________

LIST SPECIFIC PROBLEM you would like us to help you with: ____

PAIN HISTORY

When did your pain start – specific date started	
How did the pain start (suddenly, gradually, injury, at work, etc.	
How does the pain **feel** (constant, burning, ache, sharp, dull, electric-like, shooting, nagging, etc.)	
What makes your pain **better**	
What makes your pain **worse**	
Where is your pain (paint the chart)	
Associated problems (numbness, tingling, bladder, bowel, weakness, swelling, etc.)	
Pain level now (0=no pain, 10=worst imaginable pain)	0 1 2 3 4 5 6 7 8 9 10
Lowest it has been during the last month or two	0 1 2 3 4 5 6 7 8 9 10
Highest it has been during the last month or two	0 1 2 3 4 5 6 7 8 9 10



PAIN TREATMENT HISTORY

Medication for pain [name]	**Dosage and frequency**	**Started [date]**	**Stopped [date]**	**Why stopped**	**How much helped [%]**	**Adverse reaction**

Pain treatment	**When [date]**	**Where**	**How much helped [%]**	**Treatment**
Pain Clinic				
Psychological help				
Other (injections, etc.):				

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Date:________________ Name:____ DOB:________________

CONSERVATIVE TREATMENT

HAVE YOU HAD ANY CONSERVATIVE TREATMENT WITHIN THE PAST SIX (6) MONTHS? IF SO, PLEASE COMPLETE THE FOLLOWING:

Type of Conservative Treatment	When [date]	Where [location]	YES	NO	% of Relief
Physical Therapy					
TENS					
Chiropractic					
Supervised Home Exercise Program					
Aquatic/Pool Therapy					
Other					
If unable to do PT Why?					

ILLNESSES You Have Had

☐ Heart Murmur	☐ Stroke	☐ Tuberculosis	☐ Other Psych. Disease
☐ Rheumatic Fever	☐ Parkinson's Disease	☐ Muscle/Joint Disease	☐ Serious Injuries
☐ Heart Attack	☐ Dementia	☐ Diabetes ◇Diet ◇Pills ◇ Insulin	☐ Cancer
☐ High Blood Pressure	☐ Emphysema	☐ Hepatitis	☐ Sexual Transmitted Diseases
☐ Blood Transfusions	☐ Asthma	☐ Urinary Infection	☐ HIV- Aids
☐ Bleeding Disorder	☐ Chronic Bronchitis	☐ Depression	☐ MRSA
☐ Anemia	☐ Pneumonia	☐ Anxiety/Panic Disorder	☐ Other:

OPERATIONS

LIST OPERATIONS	YEAR	LIST OPERATIONS	YEAR

ALLERGIES

Allergic to (Medications, Latex, Tape, Food, Environmental, etc.)	Type of Response (hives, difficulties breathing. etc.) Please explain	Last reaction dated

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Date____________ Name:____ DOB:____________

SYSTEMS

Do you now have or have you ever had…	Yes	No	Do You Now Have Or Have You Ever Had…	Yes	No
☐ Eye disease ☐ eye injury ☐ impaired sight			Kidney ☐ disease ☐ stones		
☐ Ear disease ☐ ear injury ☐ impaired hearing			☐ bladder disease ☐ difficulty in urination		
Any trouble with ☐ nose ☐ sinuses ☐ mouth ☐ throat ☐ teeth			☐ blood ☐ albumin ☐sugar ☐ pus in urine		
☐ Fainting spells ☐ dizziness			Weak urinary stream		
Convulsions/seizures			Prostate trouble		
☐ Paralysis ☐ numbness ☐ tingling			Abnormal thirst		
Tremors			☐ Stomach Pain ☐ Black Tarry Stools		
Headaches: ☐ frequent ☐ severe			☐ stomach ulcer		
Enlarged glands			Indigestion☐gas ☐ belching ☐ heartburn ☐ bloating		
Thyroid: ☐ overactive ☐ underactive			☐ nausea ☐ vomiting		
Skin disease/rashes			☐ liver disease ☐ gall bladder disease		
Cough: ☐ acute ☐ chronic			☐ colitis ☐ other bowel disease		
☐ Chest pain ☐ angina pectoris			☐ hemorrhoids ☐ blood in stool		
Coughing up blood			☐ constipation ☐ diarrhea		
☐ Night sweats ☐ recent fever			Other:		
Shortness of breath ☐ exertion ☐ at night			**Have you noticed any change in your:**		
☐ Palpitation ☐ fluttering heart			Appetite ☐ increased ☐ decreased		
Swelling of ☐ hands ☐ feet ☐ ankles			Energy levels ☐ increased ☐ decreased		
Varicose veins/phlebitis			Body weight ☐ gain ☐ loss____lbs./___months/yrs		

WOMEN ONLY

Menstrual history				Yes	No
Age at onset			Are you regular: ☐ heavy ☐ medium ☐ light		
Usual duration of period days			Do you have ☐ tension ☐ depression before period		
Cycle (start to start) days			Do you have ☐ cramps ☐ pain with period		
Date of last period			Do you have hot flashes		
Pregnancies…	Yes	No			
Children born alive (how many)_______			Still born (how many)_______		
Caesarean section (how many)_______			Miscarriages (how many)_______		
Premature (how many)_______			Any complications		

HABITS

Do you …	Yes	No	Do you use …	Never	Rare	Often	Daily
Exercise adequately			Laxatives				
how			Vitamins				
Awaken rested			Sedatives/tranquilizers				
Sleep well (if not why)			Sleeping pills				
average 6-8 hours sleep (per night)			Aspirin				
Have regular bowel movements			Cortisone				
Have satisfactory sex			Alcoholic beverages (circle) Wine-beer-spirits how much?_____/per day				
Have a vacation (___weeks per year)			Coffee (____cups per day)				
Watch TV (______hours per day) Read (________hours per day)			Tobacco: ☐ cigarettes __________pks/day				
Have you ever been treated for alcoholism			__________how many years __________if quit, when				
Have you ever been treated for drug abuse			☐ cigars ☐ pipe				
Recreation/hobbies (which give you relaxation at least 3 hours a week)			"street" drugs you use or used in the past (name)				
			Appetite depressants				
			Other				

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Date:________________ Name:__________________________________ DOB:________________

Current Occupation ________ Since Hours Per Week ______________

Employer's Name ________ Working Now If not, Why? _____

Previous Occupations From (Year) To (Year) ____________________

Current Volunteer Work Where/How Hours Per Week ______

Highest Grade Of Education Completed ____________

Are You Disabled? Yes No Since Why (Diagnosis) _____

Marital status S M D W Number of years ____

Height [ft/in]: __________ **Weight** [lbs.]: __________ **Handedness** Left_____ Right_____

Check Any TESTS You Have Had

	X-Ray	CT scan	MRI scan	EMG	Other:
When					
Where					

FAMILY HISTORY ("blood" relatives)

	FATHER	MOTHER	BROTHER				SISTER				SPOUSE	CHILDREN					
			1	2	3	4	1	2	3	4		1	2	3	4	5	6
Age (if living)																	
Health (G) good (B) bad																	
Cancer																	
Diabetes																	
Heart trouble																	
High blood pressure																	
Stroke																	
Epilepsy																	
Nervous breakdown																	
Asthma, hives, hay fever																	
Tuberculosis																	
Blood disease																	
Chronic pain																	
Alcoholism, drug use																	
Other																	
Age (at death)																	
Cause of death																	

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Record Release

I, ___________________________________, DOB ________________, request that you release to Interventional Spine Medicine, copies of my medical records, including x-rays, laboratory reports, and any other pertinent medical data. I am aware that this agreement will be updated on an annual basis and will be considered valid one year from the date of signing.

Date:____________________

________________________ ________________________

Patient Signature Witness