Welcome to our Practice!

Hello and welcome to Alliance Spine and Pain Centers where we provide life changing pain relief for our patients.

We currently have you scheduled on _____ at _____ a.m./p.m. If you need to change your appointment for any reason, please call our customer care center at **770-929-9033** at least 48 hours before your scheduled appointment. We appreciate the 48 hour notice because it allows us to provide someone else your previously scheduled appointment time.

For your convenience, we have included all of the usual check-in forms for you to fill out in advance, and want to call your attention to some of them:

- The demographic form includes a space for your insurance information. If you bring your current cards with you to your appointment you can skip this portion of the form.
- Everyone is different, and your unique health history is needed to determine the right plan for your treatment. Please complete the Health History form as completely as possible.
- The Notice of Privacy Practices (NPP) can easily be read on our webpage at: http://spinepains.com/wp-content/uploads/2017/02/Alliance-NPP-2016.pdf. Please let us know if you have any questions.
- Our financial form tells you about our policies and allows us to bill your insurance and collect directly from them.

We are honored that you have entrusted Alliance Spine and Pain Centers to treat your pain and we will work diligently to exceed your expectations and to provide to you the very best care possible.

Please take the time to review and fill out the forms. If you have any questions, please call our customer care center at 770-929-9033.

Your Alliance Care Team

Your New Patient Appointment is with Dr. _____

We currently have you scheduled on _____ at _____ a.m./p.m.

☐ **Augusta**: 1367 Interstate Parkway, Augusta, GA 30909

☐ **Austell**: 3870 Medical Park Drive, Austell, GA 30106

☐ **Brookhaven**: 3925 Peachtree Road Northeast, Suite 200, Atlanta, GA 30319

☐ **Camp Creek**: 3885 Princeton Lakes Way, Suite 400, Atlanta, GA 30331

☐ **Canton**: 134 Riverstone Terrace, Suite 101, Canton, GA 30114

☐ **Carrollton**: 812 South Park Street, Suite 5, Carrollton, GA 30117

☐ **Cartersville**: 15 Medical Drive, Suite 301, Cartersville, GA 30121

☐ **Conyers**: 1388 A Wellbrook Circle, Conyers, GA 30012

☐ **Covington**: 5303 Adams Street, Suite C, Covington, GA 30014

☐ **Dallas**: 110 Evans Mill Drive, Suite 803, Dallas, GA 30157

☐ **Douglasville**: 3400 Chapel Hill Road, Suite 101, Douglasville, GA 30135

☐ **Jasper**: 1020 J.L. White Drive, Suite 110A, Jasper, GA 30143

☐ **Johns Creek**: 6920 McGinnis Ferry Road, Suite 360B, Suwanee, GA 30024

☐ **Lawrenceville**: 4799 Sugarloaf Parkway, Building G-110, Lawrenceville, GA 30044

☐ **Marietta**: 400 Tower Road, Suite 350, Marietta, GA 30060

☐ **Piedmont**: 2061 Peachtree Road, Suite 225, Atlanta, GA

☐ **Roswell**: 1295 Hembree Road, Building A, Suite 101, Roswell, GA 30076

☐ **Woodstock**: 300 Parkbrooke Place, Suite 390, Woodstock, GA 30189

** If you have not filled out the forms, please arrive 30 minutes early. If you have filled out the forms, please arrive at least 15 minutes early. Be prepared with your current insurance cards, a valid state issued picture ID, and any imaging reports and/or discs that you have. **

If you have any questions or need to reschedule your appointment for any reason, please contact our customer care center at 770-929-9033.

Demographic Information	
Patient Name:	
Mailing Address:	
City:	State: Zip Code:
Home Phone:	Ok to Leave Message: ☐ Brief ☐ Extended ☐None
Cell Phone:	Ok to Leave Message: ☐ Brief ☐ Extended ☐None
Work Phone:	
Date of Birth:	
Marital Status:	
Patient Email:	
Employer Name:	
Employer Phone:	
Primary Care Provider:	
Referring Provider:	
Preferred Pharmacy Name:	
Pharmacy Phone Number:	
Pharmacy Address:	
Pharmacy City:	State: Zip Code:
Race: ☐ American Indian ☐ Asian ☐ Native Hawaiian ☐ Black ☐ White ☐ Hispanic ☐ Other	
Language Spoken:	
Sex: ☐ Male ☐ Female ☐ Transgender	
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino	
Emergency Contact Information	
Emergency Contact Name:	
Phone Number:	
Address:	
Relationship to Patient:	
Additional Information	
Do you have an Advanced Directive? ☐ Yes ☐ No	
Can you provide us with a copy? ☐ Yes ☐ No	
Power of Attorney for medical decisions: ☐ Yes ☐ No	

2019 HIPAA AUTHORIZATION FORM

I authorize the following individual to have full access to my health information:

_____	_____	_____
Print Name	Relationship	Date
_____	_____	_____
Print Name	Relationship	Date

I, _____ give my permission for you to leave any medical / lab information for me at the following phone numbers. I further consent to receiving medical reminders via text or email or will opt-out as noted below.

		Opt-Out
Home #		☐
Mobile #		☐
Work #		☐
Email		☐

_____	_____
Signature of Patient or Guardian	Date

Patient Name: _____ Patient Date of Birth: _____

I attest that the information provided is correct and I hereby authorize the release of information necessary for my insurance company to process my claim. The above information is correct to the best of my knowledge. I hereby allow the clinical staff of Alliance Spine and Pain Centers to view my medication history from external sources.

_____ _____

Patient, Please sign for permission to treat **Date**

_____ _____

Guardian, Please sign for permission to treat in your absence **Date**

HEALTH HISTORY

Patient Name:	Patient Date of Birth:
Height:	
Weight:	
Dominant Hand: ☐ Right ☐ Left	

Reason for Visit: _____

Past Medical History		Past Surgical History		
	YES		YES	YEAR
Do you have a history of cancer?		Appendectomy		
Do you have a history of diabetes?		Gall Bladder Removal		
Do you have a history of irregular heartbeat?		Tubal Litigation		
Do you have a history of chest pain?		Hysterectomy		
Do you have a history of a bleeding disorder?		Kidney Surgery		
Do you have a history of high blood pressure?		Heart Surgery		
Do you have a history of heart failure?		(Specify) _____		
Do you have a history of a heart attack(s)?		Neck Surgery		
Do you have a history of having a stroke?		(Specify) _____		
Do you have a history of asthma?		Back Surgery		
Do you have a history of COPD?		(Specify) _____		
Do you have a history of osteoporosis?		Knee Surgery		
Do you have a history of arthritis?		Hip Surgery		
Do you have a history of kidney disease?		Other_____		
Do you have a history of stomach ulcers?				
Do you have a history of reflux?				
Do you have a history of HIV/AIDS?				
Do you have a history of anxiety?				
Do you have a history of depression?				

Who were you referred by? _____

Are you taking any medications now? ☐ Yes ☐ No (This includes prescription, over the counter, vitamins or herbal medications.)

If yes, please list below including doses.

MEDICATIONS			
DRUG	DOSE	TIMES PER DAY	WHY
Example: Lortab	*5mg*	*3*	*Pain*

** PLEASE REMEMBER TO LIST ANY BLOOD THINNERS YOU ARE CURRENTLY TAKING INCLUDING ASPIRIN, COUMADIN, WARFARIN, PLAVIX, EFFIENT, PLETAL, AGGRENOX, GOODY'S POWDER, LOVENOX, AND PRADAXA **

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list them below.

ALLERGIES	
Name of Medication	Type of Reaction (Rash, Swelling, Etc.)

FAMILY HISTORY									
Is your Father Alive or Deceased?									
Alive ☐	Deceased ☐	Diabetes	Hypertension	Heart Attack	Stroke	Mental Illness	Cancer	Other	Unknown
Is your Mother Alive or Deceased?									
Alive ☐	Deceased ☐	Diabetes	Hypertension	Heart Attack	Stroke	Mental Illness	Cancer	Other	Unknown
Are your siblings (sisters, brothers) Alive or Deceased?									
Alive ☐	Deceased ☐	Diabetes	Hypertension	Heart Attack	Stroke	Mental Illness	Cancer	Other	Unknown

SOCIAL HISTORY
Occupation:
Marital Status: ☐ M ☐ S ☐ D ☐ W
Alcohol Use: ☐ Yes ☐ No
Tobacco Use: ☐ Yes ☐ No
Recreational Drug Use: ☐ Yes ☐ No
History of Alcohol Abuse: ☐ Yes ☐ No
History of Prescription or Illicit Drug Abuse: ☐ Yes ☐ No
Other Information?

ONSET OF PAIN AND DURATION
Briefly describe when and how your current pain started.

_____

_____

_____

Is this a Workers Comp accident? ☐ Yes ☐ No

If yes, what was the date of the injury? _____

Is this related to an auto accident? ☐ Yes ☐ No

If yes, what was the date of the injury? _____

PREVIOUS DIAGNOSTIC STUDIES – Please indicate approximate date and locations, if known.

Type	Date	Location
MRI		
CT		
X-RAYS		
EMG		

How would you describe your pain? (Choose as many as are applicable.)

☐ Aching ☐ Dull ☐ Shooting ☐ Weakness

☐ Burning ☐ Intermittent ☐ Spasm

☐ Constant ☐ Pins and Needles ☐ Sore

☐ Cramping ☐ Sharp ☐ Stabbing

Circle the pain intensity with a "0" representing no pain and "10" the most severe pain imaginable.

What is your current pain level?

0 1 2 3 4 5 6 7 8 9 10

What has been your average pain level for the last 7 days?

0 1 2 3 4 5 6 7 8 9 10

What has been your lowest pain level in the last 7 days?

0 1 2 3 4 5 6 7 8 9 10

What has been your worst pain in the last 7 days?

0 1 2 3 4 5 6 7 8 9 10

How long have you been in pain? ____ Hours ____Days ____ Months ____Years

How often do you have your pain? (Please check one.)

☐ Constantly (100% of the time) ☐ Waxes and wanes

☐ Intermittently (50% of the time)

What activities are you unable to do well because of your pain?

☐ Climb Stairs	☐ Walk long distances	☐ Sleep
☐ Sit for long periods	☐ Lift greater than 5 lbs.	☐ Meal preparation
☐ Stand for long periods	☐ Go shopping	☐ Housework
☐ Yard word	☐ Work	

What activities make your pain worse?

☐ Sitting	☐ Car rides	☐ Work
☐ Standing	☐ Exercise	
☐ Walking	☐ Weather	
☐ Position change	☐ Hot/Cold	

What activities make your pain better?

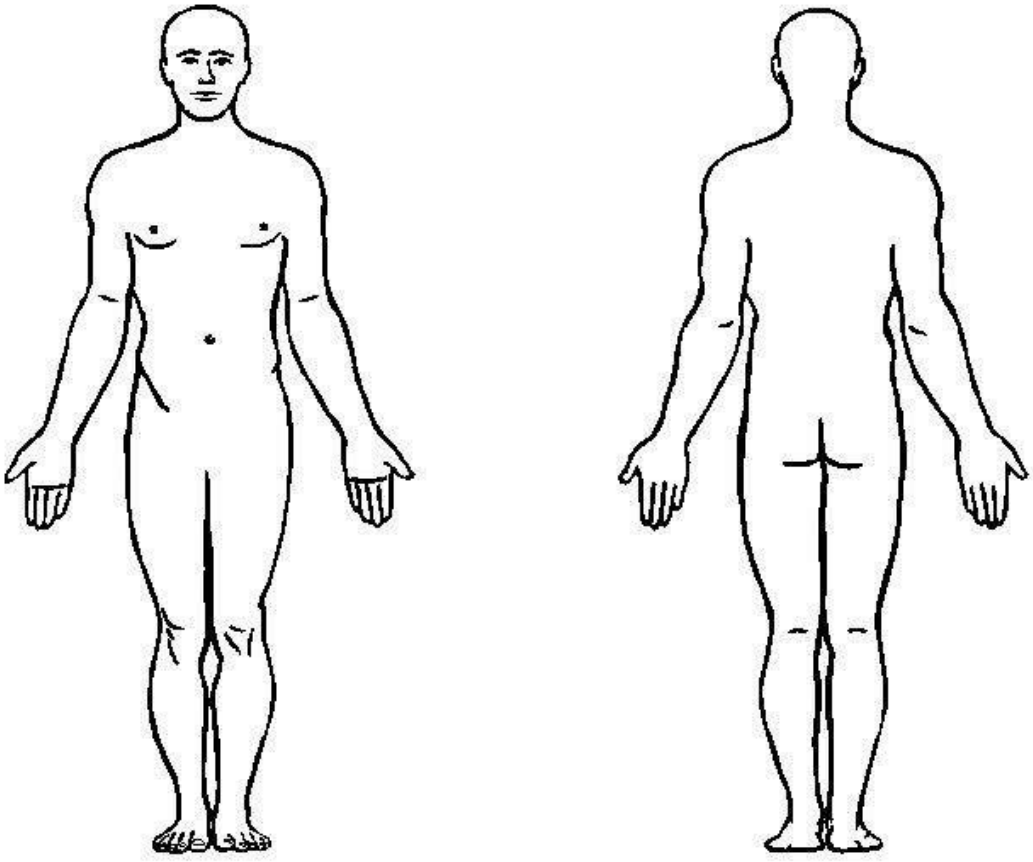
☐ Nothing	☐ Sitting	☐ Position change
☐ Medications	☐ Standing	☐ Rest
☐ Exercise	☐ Walking	☐ Massage
☐ Lying down	☐ Heat/Ice	☐ Chiropractic

What previous pain treatments have you tried?

Treatment	Date	How Long (1 month, 6 weeks)	Excellent Relief	Moderate Relief	No Relief
☐ Physical Therapy					
☐ Chiropractic					
☐ Medications					
☐ Injections					
☐ Surgery					
☐ Other					

PAIN LOCATION

Please mark the locations of your pain on the diagrams below with an "X." If whole areas are painful, please shade in the painful area.



Have you had any of the following symptoms within the last 30 days?

Constitutional Symptoms:

☐ chills	☐ difficulty sleeping	☐ fatigue	
☐ fever	☐ low sex drive	☐ night sweats	☐ unexplained weight change

Eyes:

☐ blurred vision	☐ changes in vision	☐ dry eyes	☐ eye pain

Ears, Nose, Mouth, Throat:

☐ changes in hearing	☐ congestion	☐ dental problems	☐ difficulty swallowing
☐ drainage	☐ dry mouth	☐ sore throat	

Cardiovascular:

☐ chest pain	☐ fainting	☐ palpitations	☐ swelling in legs/feet

Respiratory:

☐ cough	☐ shortness of breath	☐ wheezing

Gastrointestinal:

☐ abdominal pain	☐ acid reflux	☐ blood in stool	☐ constipation
☐ diarrhea	☐ nausea/vomiting	☐ incontinence of bowel	

Genitourinary:

☐ difficulty urinating	☐ impotence	☐ painful urination	☐ incontinence of urine

Musculoskeletal:

☐ back pain	☐ hip pain	☐ joint pain	☐ joint stiffness
☐ knee pain	☐ muscle spasm	☐ neck pain	☐ shoulder pain

Integumentary:

☐ dryness	☐ hives	☐ incisions	☐ lesions
☐ rash	☐ wounds		

Neurological:

☐ daytime sedation	☐ difficulty sleeping	☐ dizziness	☐ insomnia
☐ headache	☐ memory loss	☐ numbness/tingling	☐ seizures
☐ tremors	☐ Weakness		

Psychiatric:

☐ depressed mood	☐ feeling anxious	☐ hallucinations	☐ high stress level
☐ suicidal thoughts			

Endocrine:
☐ easy bruising ☐ excessive thirst

Hematologic/Lymphatic:
☐ bleeding disorder ☐ blood clot ☐ varicose veins

Allergic, Immunologic:
☐ difficulty breathing ☐ runny nose ☐ hives ☐ itching
☐ rash ☐ swollen gland

_____ _____
PATIENT SIGNATURE **DATE**

Alliance Spine and Pain Centers Notice of Privacy Practices Acknowledgment Form

Patient Acknowledgment of Understanding of Alliance Spine and Pain Centers Notice of Privacy Practices.

Patient's Name: _____ Date of Birth: _____

I understand that Alliance Spine and Pain Centers may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, to take care of other health care operations, and for other purposes described in the document called the "Notice of Privacy Practices." It contains more information about the policies and practices protecting the patient's privacy and is available online and in our offices. I have been given a copy of the Notice along with this acknowledgment and I understand that I have the right to read the "Notice" before signing this acknowledgment.

Alliance Spine and Pain Centers may update this acknowledgment and the "Notice of Privacy Practices." If I ask, Alliance Spine and Pain Centers will provide me with the most current "Notice of Privacy Practices."

Within this "Notice of Privacy Practices" is contained a complete description of my privacy/confidentiality rights. These rights include, but are not limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law, and requesting communication by specified methods of communication or alternative location.

Alliance Spine and Pain Centers has established procedures that help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist Alliance Spine and Pain Centers by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices."

My signature below indicates that I have been given the chance to review a current copy of Alliance Spine and Pain Centers' "Notice of Privacy Practices."

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.).

_____ _____ _____

Patient or legally authorized individual signature Date Time

* Alliance Spine and Pain Centers includes Interventional Spine and Pain Management, PC dba Alliance Spine & Pain Centers its affiliates and subsidiaries.

Patient's Name: _____ Date of Birth: _____

Financial Policy for Patient Care Services and Assignment of Benefits

We are happy that you have selected Alliance Spine & Pain Centers* for your healthcare needs and we look forward to working with you. At Alliance Spine & Pain Centers, we are committed to meeting your healthcare needs. Our goal is to make your insurance or other financial arrangements as simple as possible.

Patients are responsible for their co-payments, coinsurances and deductibles according to their plan at the time of service. We ask that you provide us with your current insurance information so we can file an insurance claim with your carrier. If you do not have active insurance you will be considered a "Self-Pay" patient. Our "Self-Pay" financial policy is based on very reasonable rates.

We have a dedicated team of Patient Advocates that will work with you on your financial responsibilities while ensuring your healthcare needs are being met. In the rare occasion your insurance does not make a payment to Alliance Spine & Pain Centers on your behalf, placing the financial responsibility on you for the services provided, a member from our Patient Advocate team will contact you prior to your scheduled procedure.

In the event you are not able to maintain your scheduled appointment we ask that you provide us with 24 hour notice. This will allow our practice to treat another patient. If we have not received 24 hour notice prior to your appointment you will be charged a "No Show" fee of $50.00.

By signing this form you are acknowledging you have read and understand you are assigning and transferring to Alliance Spine &d Pain Centers all of the benefits due to you under Medicare, Medicaid or any health insurance policy or health plan providing benefits for the services being rendered. You authorize Alliance Spine & Pain Centers to receive payment, file an appeal, and determine medical coverage from your health plan. You understand you are responsible for charges that are not covered by your health plan or that your health plan has assigned to you.

I have read and understood the above statements and certify that this form applies to all visits and procedures at any Alliance Spine & Pain Center.

_____ _____

Patient signature Date

* Alliance Spine and Pain Centers includes Interventional Spine and Pain Management, PC dba Alliance Spine & Pain Centers its affiliates and subsidiaries.

Patient Contract for Pain Management and Medication Agreement
(Not Required If Patient is being treated with Injection Procedures Only, No Pain Medications)

This agreement between _____ (the patient) and Alliance Spine and Pain Centers (ASPC) is for the purpose of establishing an agreement between the doctor and patient on clear conditions that the patient to in order to receive pain management and/or pain medications. This may include care from multiple disciplines, including diagnostic and/or therapeutic interventions, behavioral medicine (psychology, psychiatry, coping strategies, and biofeedback), alternative therapies, physical therapy, weight management and the prescription use of medications. The doctor and patient understand that this agreement is an essential factor in maintaining the trust and confidence necessary in a doctor/patient relationship. Pain medication may not completely eliminate your pain but is expected to reduce it enough that you may become more functional and improve your quality of life.

I agree to and accept the following conditions for my pain management:

**** Your initials are required next to each statement in the space provided.**

_____ 1. I understand that strong medications, which may include opioids and other controlled substances, may be prescribed for pain relief, if my physician determines it would be of benefit. I understand that there are potential risks and side effects involved with taking any medications, including the risk of addiction. Overdose of opioid medication may cause injury or death. Other possible complications include, but are not limited to, constipation which could be severe enough to require medical treatment, difficulty with urination, fatigue, drowsiness, nausea, itching, stomach cramps, loss of appetite, confusion, sweating, flushing, depressed respiration, and reduced sexual function. Men may have decreased testosterone from chronic opioids.

_____ 2. I realize that it is my responsibility to keep others and myself from harm. This includes the safety of my driving and the operation of machinery. If there is any question of impairment of my ability to safely perform any activity, I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have stopped the medication long enough for the side effects to resolve. This applies to all medications prescribed to me. Prescriptions and bottle of medications must be safeguarded from loss and out of reach of children.

_____3. I realize that all medications have potential side effects and interactions. I will inform the office of any adverse effects I am experiencing when they are of a nature to cause me concern. I understand and accept that there may be unknown risks associated with the long-term use of the substances prescribed.

_____4. I understand that if I am pregnant or become pregnant while taking medications, my child could be physically dependent on the opioids and withdrawal can be life threatening for a baby. If a female of child-bearing age, I certify that I am not pregnant, and I will use

appropriate contraceptive measures during the course of treatment with medications. Many medications could harm the fetus or cause birth defects.

____5. I understand I must contact my physician before taking newly prescribed tranquilizers or prescription sleeping medications. I understand that the combined use of various drugs, opioids, as well as alcohol, may produce confusion, profound sedation, respiratory depression, blood pressure decrease, and even death.

____6. I understand that opioid analgesics could cause physical dependence within a few weeks of starting opioid therapy. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (including nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24-28 hours of the last dose.

____7. Withdrawal from other medications can also have serious consequences, including the risks of injury or death. I will not discontinue any medication I take regularly without consulting my physician.

____8. I agree that continued treatment and/or refill of medications may be contingent upon compliance with other pain treatment modalities recommended by my doctor.

____9. I am for keeping my scheduled appointment. Prescription renewals are contingent upon keeping each scheduled appointment. Requests for refills of medications due to rescheduled or missed appointments are prohibited, except in emergency circumstances, as determined by and at the Physician's discretion and will only be bridged until the next available appointment.

A. Refill requests for medications requiring a written prescription must b called to the office 48 hours prior to pick up. Written prescriptions must be picked up at the office. Written prescriptions will not be mailed or delivered by any other manner.
B. Refills will not be made after hours, at night or on weekends. This policy will be strictly adhered to.
C. Refills will not be made if I "run out early" or "lose a prescription" or "spill or misplace my medication" or if someone else has taken some of my medication. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
D. Refills will not be made as an "emergency". I will call my pharmacy at least 4-5 days prior to needing my prescription(s) (**for medications that do not require a written prescription**).

____10. I agree that I will use my medication at a rate no greater than the prescribed rate unless it is discussed directly with my physician.

____11. I will not use any illegal substances (cocaine, heroin, marijuana, etc.) while being treated with controlled substances. Violation of this will result in the cessation of the prescribing of any controlled substances and termination of my care.

____12. I will not share, sell or trade my medication or exchange medication for money, goods or services.

____13. I will not alter my medication is any way (for example: crushing or chewing tablets) or use any other route of delivery (for example: injection or insufflation) other than as prescribed.

____14. I understand that changing dates, quantity or strength of medication or altering a prescription in any way is against the law. Forging prescriptions or physician's signature is also against the law. Our office cooperates fully with law enforcement agencies in regards to infractions involving prescription medications.

____15. I will discontinue all previously used pain medication, unless told to continue them by my physician. I will keep this office informed of all medications I may receive from other physicians.

____16. I agree that I will submit to random urine, blood, or saliva toxicology tests, if requested, to determine my compliance with this agreement and my regimen of pain control medication. Tests may include screens for illegal substances.

____ 17. I will not attempt to get pain medication from any other health care provider without telling them that I am already taking pain medication prescribed by this office.

____ 18. I understand that my medication regimen may be continued for a definitive time period as determined by my physician. My case will be reviewed periodically. If there is not significant evidence that I am improving or that progress is being made to improve my functioning or quality of life, the regimen might be tapered or possibly discontinued and my care referred back to my primary care physician.

____ 19. I will keep all scheduled follow up appointments as outlined in my treatment plan.

____ 20. I understand that the main treatment goal using pain medications is to improve my ability to function and/or work and/or to reduce pain. In consideration of that goal, and the fact that I may be given potent medication to help me reach that goal, I agree to help myself by following better health habits. This may include exercise, weight control, and avoiding the use of nicotine. I must also comply with the treatment plan as prescribed by my doctor.

____ 21. I understand with respect to the prescribing of my pain medications the doctors, my pharmacy, and insurers will cooperate fully with any city, state or federal agency in the investigation of any possible misuse, sale or other diversion of my pain medication as required by law, state and federal regulations.

____ 22. I authorize my physician to provide a copy of this agreement to my pharmacy, other healthcare providers, and any emergency department upon request. I give my permission to allow sharing of medical history in regards to medication use with other health care agencies.

____ 23. I agree that this agreement is important to my doctor's ability to treat my pain effectively, and that my failure to comply with the agreement may result in the discontinuation of prescribed medication by my doctor and termination of the doctor/patient relationship.

I have thoroughly read, understand and accept all of the above provisions. Any questions I had regarding this agreement have been answered to my satisfaction. I understand all the policies regarding the prescribing and use of opioids and other medications. I agree to comply with the pain management program. I also agree to testing physiological, toxicology and/or psychological and detoxification if indicated.

Your physician understands that emergencies can occur and under some circumstances exceptions to these guidelines may be made. Emergencies will be considered on an individual basis.

Lack of strict adherence to any provision of this agreement by your physician in no way invalidates any other provisions of this agreement.

If at any time you are concerned about your medication or side effects of of your medication, you may call our call center at 770-929-9033.

I agree to use _____ Pharmacy, located at _____,

telephone number _____, for all my pain medications. If I change my pharmacy for any reason, I agree to notify this office at the time I receive a prescription. I will also advise my new pharmacy of my prior pharmacy's address and telephone number.

This agreement is entered into on this _____ day of _____, 20____.

_____ _____

Patient Signature Witness

* Alliance Spine and Pain Centers includes Interventional Spine and Pain Management, PC dba Alliance Spine & Pain Centers its affiliates and subsidiaries.