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**Insurance Benefits**

Louisiana Pain Specialists requires that medical claims be paid by insurance carriers within 30 days. If your insurance carrier has not appropriately paid the submitted claim within 30 days, I understand that outstanding balances will become the responsibility of the policy holder.

**Insurance Co-Payments**

In accordance with my insurance contract, I understand that co-payments are due at time of service.

**Deductible**

If my insurance deductible has not been met, I understand that outstanding deductible amounts will be collected at time of service and at the time interventional procedures are scheduled.

**Co-Insurance**

I understand that co-insurance amounts may be collected at time of service, and the time interventional procedures are scheduled.

**Private Pay**

If I have no insurance coverage, or insurance with which Southern Pain Relief does not participate, or Louisiana Pain Specialists is unable to verify current insurance coverage, I understand full payment is expected at time of service and at the time interventional procedures/studies are scheduled. A full fee schedule will be provided upon request.

**Secondary Insurance**

I understand that Southern Pain Relief does not file claims with secondary insurance carriers and that I am fully responsible for secondary insurance amounts. **Notice to Medicare Patients:** If we are unable to verify from Medicare that there is automatic submission of claims to the secondary insurance carrier, you may be responsible for secondary insurance balances at the time of service and at the time interventional procedures are scheduled.

**Refund Policy**

I understand that amounts collected from me (including co-payments, co-insurance and deductibles) are based on information received by Southern Pain Relief from my insurance carrier. Refunds are made only after a written request is submitted, and there has been full insurance reimbursement for all medical services on the account, regardless of the date of service. Please allow 4-6 weeks for the requests to be processed.

**Verification of Benefits and Non-Covered Services**

Insurance policies are individualized per patient plan. Louisiana Pain Specialists may provide services that my insurance plan excludes. I understand that it is my responsibility to verify coverage, benefits, and exclusions. I understand that all non-covered services are my responsibility.

**Collections**

I understand that once an account is placed in a collection status, all future services must be paid in full at times of service (no checks accepted). If my account is placed into collections, I will be responsible for all collection and interest costs.

**No Show or Late Cancellations/Returned Checks**

Cancellations made less than 24 hours in advance or any "NO SHOW" appointments are subject to a \$48.00 charge for office visits and \$228.00 charge for procedures. These charges are my responsibility and will not be billed to my insurance carrier. Additionally, I acknowledge that if I have 3 or more "NO SHOW" or cancellations for any service, I may be referred for treatment to another clinic. Returned checks will be subject to a \$38.00 returned check fee. Detailed patient ledgers are available for \$12.00.

**Notice of Privacy Practices**

I understand that the Notice of Privacy Practices for Louisiana Pain Specialists is displayed for public inspection at the facility and on the website. This notice describes how medical information about you may be used and discloses how you can get access to this information. Please review it carefully. I acknowledge that I have had the opportunity to review the Notice Of Privacy Practices of Louisiana Pain Specialists.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**LOUISIANA PAIN SPECIALISTS**  
PAIN DIAGNOSIS & INTERVENTION EXPERTS

231 W. Esplanade Ave., Suite B  
Kenner, LA 70065  
4520 Wichers Dr. Suite 205  
Marrero, LA 70072

Phone: (504) 754-2334 Fax: (504) 324-2078

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT**

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Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge your receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

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Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Patient Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

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**FOR OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices, but was unable to do so as documented below:

- The patient refused to sign.
- Due to an emergency situation, it was not possible to obtain an acknowledgement.
- We were not able to communicate with the patient.
- Other (Please provide specific details)

Signature

Date

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Kenner, LA 70065

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Ph: (504) 754-2334 Fax: (504) 324-2078

4520 Wichers Dr. Suite 205  
Marrero, LA 70072

### Patient Information

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Telephone: \_\_\_\_\_

Gender: Male Female Ethnicity: Hispanic Non-Hispanic Refuse to Report

Race: American Indian Asian African American Pacific Islander White Refuse to Report

Preferred Language: English French German Japanese Mandarin Russian Spanish

### Policy Holder Information

Name of Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Employer: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Telephone: \_\_\_\_\_

### Primary Insurance Information

Primary Insurance: \_\_\_\_\_

Group Number: \_\_\_\_\_ Policy/I.D. No.: \_\_\_\_\_

### Secondary Insurance Information

Secondary Insurance: \_\_\_\_\_

Group Number: \_\_\_\_\_ Policy/I.D. No.: \_\_\_\_\_

**AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT:** I authorize treatment of the person named above and agree to pay all fees and charges for such treatment, promptly upon presentation of statement, unless prior credit arrangements have been agreed upon in writing. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing date. Although this office may assist me in filing an insurance claim, I understand that I am fully responsible for the balance and agree that payment will not be delayed because of any pending insurance claim. In the event legal action should become necessary to collect an unpaid balance, I agree to pay all reasonable attorney's fees or other costs the court may determine proper.

**ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION:** I authorize all insurance benefits, unless previously paid by myself, to be paid directly to this physician/facility and also authorize the physician/facility to release medical information to my referring physician, primary care physician, spouse, children, parents and any physician he/she may refer me to.

Signed: \_\_\_\_\_ (Patient) Date: \_\_\_\_\_

**ALL MEDICARE PATIENTS MUST SIGN THE FOLLOWING STATEMENT:** I request that payment under the medical insurance program be made on my behalf to Southern Pain Relief for any services furnished me by its physician(s) and /or practitioners. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Signed: \_\_\_\_\_ (Patient) Date: \_\_\_\_\_

### New Patient Form

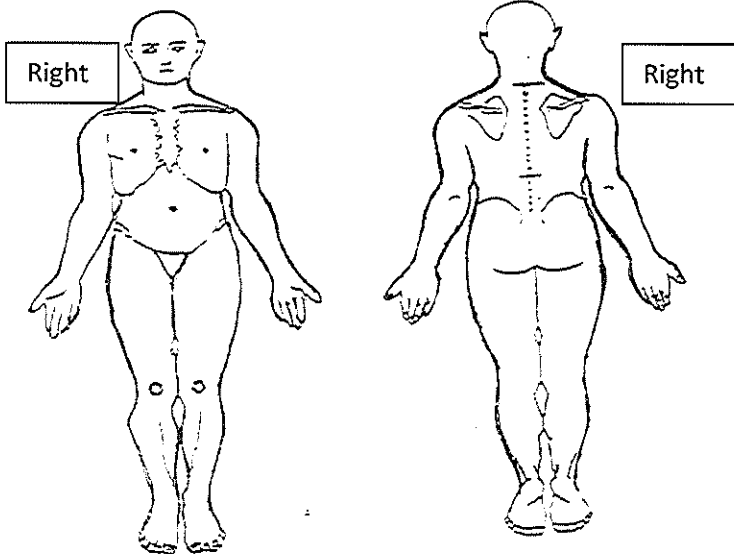
Name \_\_\_\_\_ SS# \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Email: \_\_\_\_\_ Emergency # \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Primary Care Physician \_\_\_\_\_ Surgeon \_\_\_\_\_

**How did you hear about us? (circle one)**

Friend/Family    Physician    Internet    Radio    TV    Paper    Insurance company

**Pain Diagram: (Shade specific areas of pain)**

**FOR OFFICE USE ONLY**



<b>Referring Physician:</b>	
<b>Height:</b>	
<b>Weight:</b>	
<b>Blood Pressure:</b>	/
<b>PO2:</b>	
<b>Heart Rate:</b>	
<b>Temp:</b>	
<b>LBP: Y N</b>	
<b>Allergies:</b>	
<b>Pharmacy:</b>	
<b>E-Mail Address:</b>	

**Pain Score Today: (Circle Numbers)**    No Pain = 0 - 10 = Worst Pain Ever Felt

Best Day:	0	1	2	3	4	5	6	7	8	9	10
Worst Day:	0	1	2	3	4	5	6	7	8	9	10
Usually:	0	1	2	3	4	5	6	7	8	9	10
Today:	0	1	2	3	4	5	6	7	8	9	10
Acceptable:	0	1	2	3	4	5	6	7	8	9	10

**Chief Complaint:** \_\_\_\_\_

**Pain History:**

- How long have you had this pain? \_\_\_\_\_ Days \_\_\_\_\_ Weeks \_\_\_\_\_ Months \_\_\_\_\_ Years
- Did the pain occur:    Gradually    Suddenly
- Is your pain the result of an illness or injury?    Yes    No

Work Related?    Date of injury \_\_\_\_\_    Please explain injury/accident: \_\_\_\_\_

4. Is the pain: Constant Intermittent Episodes Last: Minutes Hours Days Months

5. Describe your pain: (circle all that apply)

- Aching      Burning      Cold      Deep      Dull      Electric      Knife-Like
- Numbness      Pounding      Pulling      Shooting      Sore      Stabbing      Throbbing
- Tightness      Tingling      Hot      Sharp      Stretching

6. Does your pain shoot anywhere? YES NO

If yes, Starts from: Left Right Both Neck Shoulder Mid-back Low-back Hips Knees

Goes to: Left Right Both Head Arms Legs Hands Knees Hips Feet

7. What do the following do to your pain? (check one for each)

	Makes it better	Makes it worse
Activity	<input type="checkbox"/>	<input type="checkbox"/>
Bending Forward	<input type="checkbox"/>	<input type="checkbox"/>
Bending Backward	<input type="checkbox"/>	<input type="checkbox"/>
Cold	<input type="checkbox"/>	<input type="checkbox"/>
Heat	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>
Morning	<input type="checkbox"/>	<input type="checkbox"/>
Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Night Time	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>
Touching	<input type="checkbox"/>	<input type="checkbox"/>
Bad Weather	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>

8. Do you have any of the following associated factors with your pain? (circle any that apply)

- Bladder incontinence      Bowel incontinence      Nausea/Vomiting      Fever/Chills

Weakness? If so where? \_\_\_\_\_

**Interventional Pain History: (Please only answer for your CURRENT problem)**

**1. Studies done in the last year:**

MRI: Area \_\_\_\_\_ CT Scan: Area \_\_\_\_\_ X-Ray: Area \_\_\_\_\_ EMG: \_\_\_\_\_

**2. Therapies: (Check one for each)**

	HELPED PAIN	WORSENERD PAIN	HAVE NOT TRIED
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot/Cold Packs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TENS Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back Brace	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steroid Injection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal Cord Stimulator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**3. Previous Interventions: (check and complete all that apply)**

\_\_\_\_ Spine Surgery (fusion, laminectomy, etc.) Dates: \_\_\_\_\_ Levels: \_\_\_\_\_

Did the surgery help? YES NO

\_\_\_\_ Steroid Injections: Dates: \_\_\_\_\_ How many in the past year? \_\_\_\_\_

Did the injections help? YES NO

**4. Have you seen any of the following Specialists for your current pain? (circle all that apply)**

- |               |                  |                   |             |               |                 |
|---------------|------------------|-------------------|-------------|---------------|-----------------|
| Acupuncturist | Anesthesiologist | Chiropractor      | Dentist     | ENT Physician | Endocrinologist |
| Internist     | Hypnotist        | General Physician | Neurologist | Neurosurgeon  | Psychiatrist    |
| Orthopedics   | Pain Physician   | Ophthalmologists  | Podiatrist  | Psychologist  | Rheumatologist  |

**Medications:**

1. Medication Allergies: \_\_\_\_\_

2. List all PAIN medications you take:

Name	Dose	Amount Daily	% Pain Relief	Side Effects

**Past Medical History: (please circle all conditions you are diagnosed with now or have had in the past)**

Diabetes	High Cholesterol	Heart Disease	High Blood Pressure	Asthma	Tuberculosis
Sleep Apnea	Thyroid Deficiency	Stomach Ulcers	Gastric Reflux	Urinary Infections	Lupus
Cancer	Bleeding Disorder	Thyroid Excess	Hepatitis	Kidney Stones	HIV
Renal Failure	Epilepsy	Stroke	Anxiety	Neuropathy	Depression
Osteoarthritis	Fibromyalgia	Arthritis	Spinal Stenosis	Spina Bifida	CHF
Scoliosis	Herniated Disc	Sciatica	Other:	_____	

**Past Surgical History:**

\_\_\_\_\_  
Year: \_\_\_\_\_  
\_\_\_\_\_  
Year: \_\_\_\_\_  
\_\_\_\_\_  
Year: \_\_\_\_\_  
\_\_\_\_\_  
Year: \_\_\_\_\_

**Family History: (cancer, diabetes, heart disease, bleeding problems, painful conditions, ect. )**

\_\_\_\_\_  
Relative: \_\_\_\_\_  
\_\_\_\_\_  
Relative: \_\_\_\_\_

**Social History: (Circle all that apply)**

Marital Status: Single Married Divorced Widowed

Tobacco Use: Current Every Day Smoker Current Some Day Smoker Former Smoker Never Smoked

Years Smoking: \_\_\_\_\_ Cigarettes/Packs per day: \_\_\_\_\_

Alcohol Use: Currently Drinks Alcohol Denies Any Use of Alcohol Quit Drinking Alcohol

Illicit Substance Abuse: Currently Using Quit Using Never Used

Work Status: Employed Unemployed Disabled Retired Occupation: \_\_\_\_\_

Residence: City \_\_\_\_\_ State: \_\_\_\_\_

**Review of Symptoms: (Check all that apply)**

**General:** \_\_\_Fever \_\_\_Chills \_\_\_Fatigue \_\_\_Weight Loss/Gain

**Skin:** \_\_\_Rash \_\_\_Itching \_\_\_Color Change \_\_\_Texture Change

**HEENT:** \_\_\_Headaches \_\_\_Head Trauma \_\_\_Vision Change \_\_\_Eye Pain

\_\_\_Double Vision \_\_\_Ear Pain \_\_\_Runny Nose \_\_\_Hoarse Voice

**Nodes:** \_\_\_Swollen Glands

**Cardiovascular:** \_\_\_Chest Pains \_\_\_Short of Breath \_\_\_Heart Attach \_\_\_Hypertension

**Respiratory:** \_\_\_Short of Breath \_\_\_COPD \_\_\_Wheezing \_\_\_Cough

**GI:**           \_\_Appetite Change      \_\_Constipation      \_\_Diarrhea      \_\_Stomach Pain  
                  \_\_Nausea                    \_\_Vomiting            \_\_Blood in Stool      \_\_Ulcer Disease

**Hematology:**  \_\_Easy Bruising            \_\_Bleeding Problems

**Endocrine:**   \_\_Thyroidism            \_\_Diabetes            \_\_Hepatitis

**Urinary:**     \_\_Flank Pain            \_\_Urgency            \_\_Frequency            \_\_Kidney Stones  
                  \_\_Painful Urination      \_\_Blood in Urine

**Musculoskeletal:**            \_\_Joint Stiffness      \_\_Joint Swelling      \_\_Back Pain

**Neurologic:**   \_\_Seizures            \_\_Memory Loss        \_\_Dizziness            \_\_Difficulty Sleeping  
                  \_\_Anxiety            \_\_Depression            \_\_Suicidal Thoughts    \_\_Loss of Balance

**Other Information:**

1. Please tell us if you are on or are planning to apply for these programs?

	I am on this program	I am applying for this	I am planning on applying
Social Security	_____	_____	_____
State Disability	_____	_____	_____
Private Disability	_____	_____	_____
Workman's Comp	_____	_____	_____

Workman's Comp Adjuster Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Claim #: \_\_\_\_\_

2. Have you hired an attorney for your accident or pain condition?

\_\_\_ No, I have not hired a lawyer and do not intend to at this time

\_\_\_ No, but I plan to hire an attorney

\_\_\_ Yes, I have and the case is in litigation

\_\_\_ Yes, I have and the case is settled

3. If there is potential or ongoing litigation, please provide the following information:

Attorney's name: \_\_\_\_\_

Attorney's address: \_\_\_\_\_

Attorney's phone number: \_\_\_\_\_

Name of defendant: \_\_\_\_\_

Defendant's Attorney: \_\_\_\_\_