PATIENT REGISTRATION

Date/ Time of first appointment _____

Name: _____ **Date of birth** _____

Address: _____ **City** _____ **State** ___ **Zip** _____

Home #: _____ **Race:** _____ **Sex:** ____ **Marital Status:** _____ **Age:** ____

Employer: _____ **Work #:** _____ **Occupation:** _____

Work Address: _____ **City:** _____ **State** ___ **Zip** _____

Pt's SS # ____-___-_____ **Primary Physician:** _____

Address: _____ **Phone #:** _____

Emergency contact: _____ **Relation:**_____

Contacts phone #: _____ **Address:** _____

Who referred you to us? _____ **Phone #:** _____

Address: _____ **City:** _____ **State:** ___ **Zip** _____

INSURANCE INFORMATION:

********** Please give us a copy of your insurance cards **********

Primary Insurance: _____ **I.D. #** _____

Group # _____ **Policyholder's Name:** _____

Policyholder's SS# _____ **Date of birth:** _____

Name of Employer: _____

Secondary Insurance: _____ **I.D.#** _____

Group # _____ **Policyholder's Name:** _____

Policyholder's SS# _____ **Date of birth:** _____

CRYSTAL COAST
PAIN MANAGEMENT CENTER

KIRK E. HARUM, MD
ANGELO A. TELLIS, MD
ZACHARY J. KITCHEN, MD

2111 Neuse Blvd, Suite J
New Bern, NC 28560-4317
Phone: 252-636-0300 ext.106
Fax: 252-636-0335

FINANCIAL POLICY

Thank you for choosing our practice! We are committed to the success of your medical treatment and care.

Effective November 1, 2009 medical practices fell under the **Red Flag Rules**. The goal of the Rule is "to reduce the overall incidence and impact of identity theft, including medical identity theft along with credit information." Medical identity theft occurs when someone uses another person's name and sometimes other parts of their identity, such as insurance information, without the person's knowledge or consent. You will be asked to present a picture ID. If you refuse to comply with this rule we will not be able to treat you as a patient at Crystal Coast Pain Management.

For your convenience, we have answered a variety of commonly asked financial policy questions below. If you need further information about any of these policies, please ask to speak with our Billing Specialists or the Office Manager. Our staff has been instructed to make every effort available to you to clarify any misunderstanding you have concerning your financial obligations.

What about Missed Appointments?

We would appreciate your help and courtesy of a phone call if you are unable to keep an appointment. Please notify our office at least twenty-four (24) hours prior to the appointment time. Failure to do so will result in a missed appointment fee. The amount will depend on the type of appointment missed. If an office visit is missed without a 24 hour notice, the fee will be $30.00. If a procedure appointment is missed, there will be a $75.00 fee. Missed appointment fees will need to be paid prior to being seen again by your doctor. Multiple non-cancelled missed appointments will be considered grounds for being discharged from this practice.

How May I Pay?

All co-payments and co-insurance are due at time of service. This fee will be collected before you see the doctor. You must make arrangements in advance if you cannot pay at the time of service, or you may be asked to reschedule.

We accept payment by cash, Visa, MasterCard and American Express only.
We DO NOT accept checks. For your convenience, our billing office is staffed Monday through Thursday from 8:00 AM to 5:00 PM and of Friday 8:00 AM to 4:00 PM. The phone number is 252-636-0300 option 4 or 5.

Balance due	Terms
$100.00 or less	Payment in full within 30 days
$101-$500.00	3 Months
$501-1000.00	6 Months
$1001-$2500.00	12 Months

Other payment plans or options may be available upon request and proof of financial obligations that prevent you from the terms above.

When is my account delinquent?

An account is considered past due 30 days following billing unless other arrangements have been made. Unpaid accounts beyond 90 days are considered delinquent and may be sent to our collection agency and will have a service fee/billing fee added.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

I authorize my insurance benefits to be paid to Crystal Coast Pain Management.

I authorize Crystal Coast Pain Management to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

Signature _____ **Date**_____

Printed Name_____

Witness_____

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New Bern, NC 28560-5233
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Fax: 252-636-0335

Authorization of Benefits:

I request that payment of authorized benefits be made on my behalf to Crystal Coast Pain Management Center, PLLC, for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health care Financing Administration and its agent (or other insurance carrier) any information needed to determine those benefits or the benefits payable for related services.

We want to be helpful in every way possible. We are happy to assist you with pre-certification and filing of claims. Pre-Certification must be received prior to your office visit. However, your insurance policy remains a contract between you and your carrier, not Crystal Coast Pain Management and your carrier. **FINAL RESPONSIBILITY FOR PAYMENT FOR SERVICES RENDERED REMAINS THE PATIENTS.**

Patients who do not have insurance coverage are required to pay $496.00 before being seen by a physician. **PATIENTS WHO HAVE INSURANCE MUST PAY THEIR CO-PAY AND/OR DEDUCTIBLE AMOUNTS AT THE TIME OF THE OFFICE VISIT.**

I understand and agree to the above policies, including the policy regarding reimbursement.

Signature: _____ **Date:** _____

IN-NETWORK INSURANCE COMPANIES INCLUDE:

BCBS MEDICARE MEDICAID MEDCOST CIGNA

ATLANTIC INTEGRATED HEALTH

Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patients Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The practice reserves the right to change the Notice of Privacy Policies.
- The Patient has the right to restrict the used of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent.

This Consent was signed by: _____

Relationship to Patient (if other than patient):_____

Date:_____

Practice Representative Witness:_____

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Crystal Coast Pain Management

This form is for all Doctor Offices to use for obtaining medical records and health information. HIPPA laws require that all parties receiving copies of patient records must have the patient sign a release form.

Patient Name: _____
Patient Address: _____
Patient DOB: _____ Patient SSN: _____

I authorize release of my medical records from:
Physician/Facility:_____Fax:_____

Please forward my medical records to:
Crystal Coast Pain Management Center, PLLC
2111 Neuse Blvd. Suite J
New Bern, NC 28560
(252)636-0335 fax

Please release the following records all that applies:
__Clinic Notes
__Lab/Pathology Notes
__CT Scan/MRI Reports
__Radiology/Imaging
__X-Rays

This information is intended for use by the above name facility only. I am aware that the records release may contain information relating to my treatment. I understand that I may be charged for extra copies.

Patient Signature: _____ Date: _____

NAME:_____ DATE OF BIRTH:_____

Crystal Coast Pain Management

NEW BERN MOREHEAD CITY JACKSONVILLE

How did your Pain Begin?

_____
_____
_____

Was there an inciting event? (car accident, trauma, etc.)

_____
_____
_____
_____

Previous treating physicians or providers:

_____
_____
_____

Circle the treatments you have had:

Physical Therapy	Surgery	TENS
Medications	Injections	Massage
Acupuncture	Chiropractic	

Other:_____

List all Drug Allergies:

_____
_____

List all current medications, dosage, and frequency:

_____
_____
_____
_____
_____
_____
_____
_____

Circle the words that describe your pain:

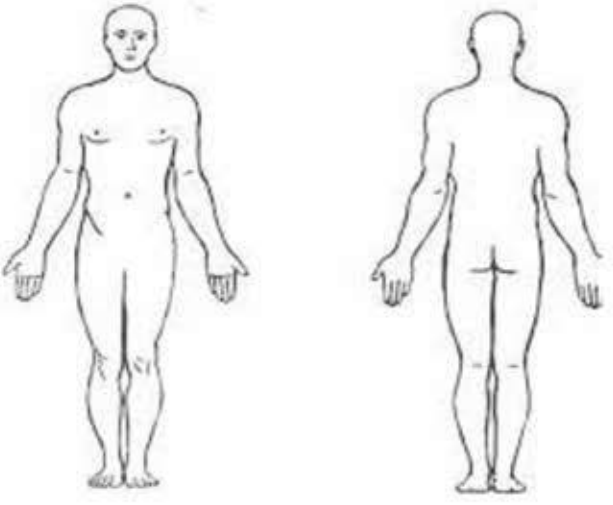
Burning	Aching	Sharp
Constant	Electric	Throbbing
Stabbing	Occasional	Prickling
Shooting	Frequent	Numbing
Cramping	Stinging	Dull

Other:_____

Circle your average pain:

None- 0 1 2 3 4 5 6 7 8 9 10-Worst

Shade your painful areas:



List all previous Pain Medications:

_____
_____
_____
_____
_____
_____
_____

NAME:_____ DATE OF BIRTH:_____

Review of Systems:

Do you have a history of any of the following?

___ **Neurologic Disease**
(seizures, strokes, etc)

___ **Cardiac Disease**
(heart attack, irregular heartbeat, etc)

___ **Vascular Disease**
(hypertension, poor circulation, etc)

___ **Pulmonary Disease**
(COPD, asthma, sleep apnea, etc)

___ **Kidney Disease**
(kidney stones, incontinence, etc)

___ **Liver Disease**
(hepatitis, jaundice, etc)

___ **Endocrine Disease**
(diabetes, thyroid problems, etc)

___ **Bleeding problems**
(anticoagulant use, hemophilia, etc)

___ **Gastrointestinal Disease**
(ulcers, irritable bowel, etc)

___ **Immune Disease**
(recent infection, HIV, etc)

___ **Skin Disease**
(psoriasis, rashes, etc)

___ **Rheumatologic Disease**
(arthritis, lupus, fibromyalgia, etc)

___ **Mental Illness**
(depression, bipolar, PTSD, etc)

___ **Cancer**

Past Medical History:

List all medical problems:

_____
_____
_____
_____
_____

List all surgeries:

_____
_____
_____
_____
_____

Social History:

Martial Status? _____
Children? _____
Are you currently working and at what occupation?_____
_____
What is the highest level of education you achieved? _____
_____
Do you smoke or use tobacco products?
_____
How often do you consume alcohol?
_____
Do you use any illicit or street drugs?
_____

Family History:

Do any relatives suffer from similar pain complaints?_____
_____
_____

Is there a family history of cancer, arthritis, substance abuse or bleeding disorders?

_____
_____
_____