CRYSTAL COAST PAIN MANAGEMENT
REGISTRATION FORM

Today's date:	Primary Care Doctor:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (check one) ☑ Single ☐ Mar ☐ Div ☐ Sep ☐ Wid

Is this your legal name? ❑ Yes ❑ No	Email Address for our patient portal:	Cell phone no:	Birth date:	Age:	Sex: ❑ M ☑ F

Street address:	Social Security Number:	Home phone:

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.:

Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Physician ❑ Other

Is this visit a result of a work related or auto accident? If yes, please explain:

INSURANCE INFORMATION (THIS IS IMPORTANT INFORMATION-PLEASE COMPLETE)

(Please give your insurance card and photo ID to the receptionist.)

Please indicate primary insurance ❑ BCBS ❑ Medicare ❑ Medcost ❑ Cigna ❑ Tricare ❑ United Healthcare ❑ AIH ❑ Other ❑ Self-Pay

Subscriber's name:	Subscriber's S.S. no.:	DOB:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Please indicate Secondary insurance ❑ BCBS ❑ Medicare ❑ Medcost ❑ Cigna ❑ Tricare ❑ United Healthcare ❑ AIH ❑ Other ❑ Self-Pay ❑ None

Subscriber's name:	Subscriber's S.S. no.:	DOB:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize CRYSTAL COAST PAIN MANAGEMENT or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

In-Network companies that we accept:

BCBS * Medicare * Medcost * Cigna *Tricare * AIH * Champ VA * United Healthcare * Heritage Summit * Sure Choice

***We do not accept Medicaid. If your insurance is not listed above, we may be considered an out of network provider.**

CRYSTAL COAST PAIN MANAGEMENT

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NEW BERN MOREHEAD CITY JACKSONVILLE

Name: _____ **DOB:**_____ **Date:** _____

How and when did your pain begin?

_____

_____

_____

Is the pain from an accident or injury? (car accident, trauma, other.) Describe:

_____

_____

Previous treating physicians or providers:

_____

_____

Circle the treatments you have had:

Injections	Surgery	TENS
Medications	Injections	Massage
Acupuncture	Other:_____	

Have you ever had Physical Therapy? (Yes/No) If yes, where? When? What body part?_____

Have you ever been to a Chiropractor? (Yes/No) If yes, where and when?

_____

Have you ever had an MRI? (Yes/No) If yes, where and when?

_____

List all tests or evaluations you have had:

_____

_____

List all medication allergies:

_____

_____

_____

List all previous pain medications:

_____

_____

What primary pharmacy do you use?

_____

Circle the words that describe your pain:

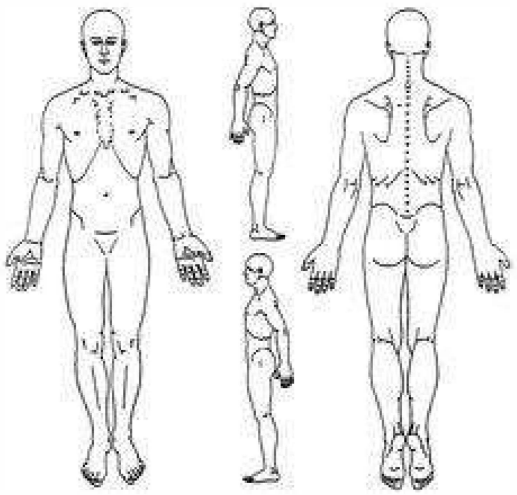
Burning	Aching	Sharp
Electric	Throbbing	Stabbing
Prickling	Shooting	Numbing
Cramping	Stinging	Dull
Constant	Frequent	Occasional

Other:_____

Circle your average pain:

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

Shade your painful areas:



What makes the pain worse:

_____

What makes the pain better:

_____

List all current medications, dosage, and frequency (prescription, over the counter & herbal):

_____

_____

_____

_____

_____

_____

Review of Systems:

Do you have a history of any of the following?

☐ **Neurologic Disease**
seizures, strokes, headaches, other:

☐ **Cardiac Disease**
heart attack, irregular heartbeat, other:

☐ **Vascular Disease**
high blood pressure, poor circulation, other:

☐ **Pulmonary Disease**
COPD, asthma, sleep apnea, other:

☐ **Kidney Disease**
kidney stones, incontinence, other:

☐ **Liver Disease**
hepatitis, jaundice, other:

☐ **Endocrine Disease**
diabetes, thyroid problems, other:

☐ **Bleeding problems**
take blood thinners, hemophilia, other:

☐ **Gastrointestinal Disease**
ulcers, irritable bowel, Crohn's, other:

☐ **Immune Disease**
recent infection, HIV, other:

☐ **Skin Disease**
psoriasis, rashes, other:

☐ **Rheumatologic Disease**
arthritis, lupus, fibromyalgia, RA, other:

☐ **Mental Illness**
depression, bipolar, PTSD, other:

☐ **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?
_____
_____
_____
_____

CRYSTAL COAST
PAIN MANAGEMENT CENTER

2024 Financial Policy

Thank you for choosing Crystal Coast Pain Management (CCPM) for your health care. We are pleased to participate in your health care and look forward to establishing a lasting relationship. Our goal is to provide you with any information you may need to make informed decisions regarding your financial responsibility.

We can often help with providing information about your health plan however; your medical insurance is a contract between *you* and *your* insurance company. Because of this, you are primarily responsible for any charge that you incurred as a patient with CCPM.

All patients with an outstanding balance with CCPM will be asked to make payment in full prior to being scheduled for an appointment or being seen by any of our providers.

1) **CO-PAYS, DEDUCTIBLES AND FEES- All co-payments, insurance deductibles and fees for services not covered by your insurance policy are due at the time service.** We accept cash or credit cards. You are able to pay your bill online through our patient portal. There is $40.00 return check fee for checks presented with non-sufficient funds.
2) **INSURANCE-** Patients or Responsible party must complete and sign information and insurance forms prior to services. **You will be asked to present a current insurance card at each visit. You will be considered uninsured if you do not provide a current insurance card or we are unable to verify your insurance. You are responsible for payment in full if your insurance carrier is not one with which we participate or we are unable to verify your insurance. Participation and Accepting insurance are different. Please ask for information if you require further explanation.** Some insurance plans and Medicare consider some services to be "non-covered," in which case you are responsible for payment in full. According to NC Statute 58-22253, most insurers are required to pay a properly submitted claim within 30 days. You have a responsibility to provide information to our office so a claim can be properly submitted. **If your insurance company has not paid a claim on your behalf within 60 days because of information that you have not provided, the balance will be transferred to your account and you will be responsible for payment.** If we receive payment at a later date, you will be reimbursed by CCPM.
3) **AUTHORIZATION/PRE-CERTIFICATION-** We are happy to assist you with pre-certification/authorization and filing of claims; however **you are responsible for ensuring this process is complete.** Pre-Certification/Authorization must be received prior to your office visit. In the event you are treated without authorization from your insurance company and they have not approved treatment, **financial responsibility of payment for services rendered will be your responsibility.**

4) **THIRD PARTY LIABILITY INJURIES**- If you receive treatment as a result of a third party liability injury (example: motor vehicle accidents, premises liability or other general liability claims against third parties), the balance for services rendered is considered due in full at the time of service. Crystal Coast Pain Management does not protect charges incurred relating to or arising out of third party liability, we will not accept a delay in payment due to settlement disputes and /or litigation. We will not accept a letter of protection from any attorney as a guarantee of payment or assignment of third party insurance payments. Crystal Coast Pain Management cannot act as an administrator to resolve these financial arrangements. **As a new or established patient, you are ultimately responsible for payment on all third party liabilities.**

5) **APPOINTMENTS**- ***Please notify our office at least twenty-four (24) hours prior to the appointment if you are unable to attend your appointment. Failure to do so will result in a missed appointment fee. If an office visit is missed without 24 hour notice the fee will be $50.00. If a procedure appointment is missed, there will be a $150.00 fee***. **Patient Initial: _____**

*Missed appointment fees will need to be paid prior to your next appointment with your provider. **Multiple non-cancelled missed appointments will be considered grounds for being discharged from the practice.**

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 provider. I authorize the release of my medical information by the holder to the Health Care Financing Administration and its agent (or other insurance carrier) along with any information needed to determine those benefits or the benefits payable for related services.

I have read the Financial Policy and agree to its terms.

Signature:_____ **Date:**_____

Printed Name:_____ **Witness:**_____

PLEASE NOTE: WE ACCEPT MEDICAID AS A SECONDARY INSURANCE ONLY

FORMS OF PAYMENT: CASH, CHECK, VISA, MASTERCARD, AND AMERICAN EXPRESS

For your convenience our billing office is staffed Monday through Thursday from 8:00 AM to 5:00 PM, Friday's 8:00 am to 12:00 pm. The phone number is 252-636-0300.

HIPAA 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information· is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment:

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:

We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician.We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose· your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization,** at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS:

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) - Under federal law, however you *may* not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality

You have the right to request a restriction of your protected health information - This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications - You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures - You have the right to receive an accounting of all disclosures except for disclosures pursuant to an authorization, for purposes of treatment, paymenthealthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS:

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will** not retaliate against you for filing a complaint

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgment "form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

CRYSTAL COAST
PAIN MANAGEMENT CENTER

Crystal Coast Pain Management

Notice of Privacy Practices Acknowledgment:

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ Date: _____

Patient Name or Legal Guardian

_____

Signature

I authorize CCPM to communicate appointment, treatment and financial information to me in the following ways:
Leave message via voicemail or person on my home phone
Leave message or speak to me on my mobile phone
Via text to my mobile phone or via email to _____

I give my permission for CCPM to share information about me with the persons specified below. This can include diagnosis, test results, treatment, prescription, appointment and financial information. This authorization will remain in effect until I notify CCPM in writing changing or deleting this authorization.
By signing this authorization, I authorize CRYSTAL COAST PAIN MANAGEMENT to receive, use and/or disclose certain protected health information (PHI) about me to the following person(s):

Name: _____ **Phone**: _____
Relation:_____

Name:_____**Phone:**_____
Relation:_____

Name:_____**Phone:**_____
Relation:_____

Office Use Only----------
We have made this following attempt to obtain the patient's signature acknowledge receipt of the Notice of Privacy Practices.
Date: _____

Attempt: _____ Staff Name: _____

Authorization to Disclose Protected Health Information

The undersigned authorizes

Crystal Coast Pain Management Center

Fx. 252-636-0335

to release my health information as noted below:

******All sections must be completed in order for request to be processed******

Patient Information

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Other Names? _____

City: _____ State: _____ Zip: _____ Phone #: _____

Release Information To (THIS SECTION MUST BE COMPLETED)

Email address for record delivery: *Please ensure email address is legible!*

You must provide a valid email address and name of your designated recipient if electronic delivery is chosen.

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax #: _____

Purpose of Request: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Transfer ☐ Other:_____

Information to be Released (THIS SECTION MUST BE COMPLETED)

If you fail to specify, 1 year of records will be provided.

☐ Office Notes ☐ Labs ☐ Operative Notes ☐ Diagnostic Reports ☐ Physical Therapy

Specify Date(s) of Service: _____

☐ **Other** (please specify):

_____

Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and delivering the copies.

At no time will the cost-based fees exceed NC law (Statute: §44-115-80)

I understand I will be responsible for the charges incurred in the release of my protected health information.

Rates are determined by Delivery Method Selected.
****** PAYMENT OPTIONS: Cash, Credit Card or Money Order***

DELIVERY METHOD	[ ] Send by Email*	[ ] Fax Records	[ ] Mail Records on Paper

A valid email must be provided above. If you do not select a delivery method, CCPM will determine the delivery method based on the information provided on this form.* **No charge for records being released to another healthcare provider.

Authorization to Release Protected Health Information

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.* _____ (*Please Initial)*

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will expire on the following date, event or condition:** _____. *If I do not specify expiration this authorization will expire in 1 year.*
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.

Please confirm that you have filled out this form in its entirety—if form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Signature*:_____ **Date:** _____

** For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.*