Supreme Spine and Pain Physicians

335 Peachtree Industrial Blvd STE 2206 Suwanee GA 30024
Office phone: 770-810-5188 Office Fax: 678-528-1551

Patient Name:_____

Please provide the following information before your appointment. Please check the boxes if you have sent them. If you haven't done so already, kindly text it to 770-810-5188. Thank you!

☐ Photos of your **insurance card(s)** (front and back) If you have multiple insurances, include all cards and specify primary and secondary.

☐ A copy of your **driver's license** (If your address is out of state, please also provide your Georgia address)

☐ Your **email address**: _____

☐ **Primary Care Physician:** _____

☐ Your **pharmacy** name, phone number, and address:_____

☐ Optional: A copy of your **previous imaging results**

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PRACTICE POLICY

If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and understanding of our financial policy. If you do not currently have coverage or cannot provide our office with an active insurance card we will collect payment at the time of service.

CO-PAYMENTS / CO-INSURANCE / DEDUCTIBLES: These payments must be made either at time of service or at check-in. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, co-insurances and deductibles from patients is considered a violation of our contract. Please help us uphold the law by making your co-payments and co-insurance at each visit and paying deductibles owed at the beginning of the year (including Medicare deductibles and 20% co-insurance). We will estimate what your payment will be, apply it to your account and file your insurance. Any difference in payment will be invoiced to you after the Explanation of Benefits is received by us from your insurance company. If you are unable to pay your co-payment, co-insurance or deductible at the time of service then you may be asked to reschedule your appointment or pay a fee of $25.00 for nonpayment at the time of service.

CLAIM SUBMISSION: As a courtesy to you, we will process and file your insurance claims for services rendered by our Practice. Your insurance company may need additional information from you to process a claim, and it is your responsibility to comply with their request**. If your insurance company has not paid your claim within 60 days, the balance becomes your responsibility**. Your insurance is a contract between you, your employer and/or the insurance company. While we may provide services, we are not a party to that contract. We encourage you to contact your insurance carrier personally in order to remain informed of your benefits. Please note that we cannot hold claims waiting on your insurance information as the insurance company has a timely filing deadline. If you don't have the appropriate information at the time of service then payment in full will be collected.

NON-COVERED SERVICES:

Not all services are covered by insurance; they vary from contract to contract. Some insurance companies arbitrarily select certain services they will not cover or which they may consider not medically necessary. In these instances, you will be responsible for these services. We will make every effort to ascertain your coverage for our services before treatment and make you aware of our findings. However, this does not guarantee payment from your insurance carrier. For in-house diagnostic testing we will attempt to get an amount from your service company however if you are concerned about the amount of cost that will be put to patient balance, please call your insurance company with the CPT codes to confirm this amount. Please note that when we request the amount of patient balance the insurance company gives a disclaimer that this is an estimate and that they won't know the balance until the actual claim is filed.

For services that are not covered by insurance, the Practice requires payment of 100% of the total charges at time of service unless prior arrangements have been made.

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COVERAGE CHANGES: If your insurance changes, please notify us as soon as possible so that we can update our records and help you receive the maximum benefits allowed under your coverage. If you are insured by a plan that we accept, but you do not have a current insurance card, payment is expected in full at time of service until we can verify your coverage

MISSED APPOINTMENTS: We require 24-hour notice for appointment cancellations. Please be aware that there is a $50.00 fee for missing a scheduled procedure appointment. The fee for a missed regular appointment is $25.00. These charges are your responsibility and are not billed to your insurance company. Please help us in serving you better by keeping your scheduled appointments or by giving 24-hour notice before any cancellation.

NONPAYMENT: Balances are due upon receipt of our invoice. If your account is over 60 days past due, a late fee of $25.00 will be added and interest at the rate of 16% per annum, or 1.33% per month will accrue monthly. Our Billing department will work with you on monthly payment arrangements as long as you have a credit card to leave on file for the monthly amount of your payment. Please be aware that accounts that are 60 days past due are subject to being sent to a collection agency by our management company unless you have made arrangements for a payment plan with our office. Your account will become inactive until paid. If your account is turned over to an attorney or pursued legally for collection, you will be responsible for all reasonable attorney's fees, filing fees, and service fees.

PRIOR AUTHORIZATIONS FOR NON-COVERED MEDICATIONS

Our office will process up to 2 Insurance Prior-Authorizations per patient for medications at no charge to the patient annually. After 2 PA's have been processed there will be an administrative charge of $25.00 per P.A. If you wish to minimize your costs then please speak to your insurance company about which medications they prefer.

FORM FEES

There is a fee for form completion of $50-200 depending on the types of the form. This must be paid at the time that the form is sent in. Please note that some forms also require an office visit to be completed.

We are here to help!

PLEASE READ THE ABOVE FINANCIAL POLICY CAREFULLY BEFORE SIGNING.

I hereby authorize photocopies of this form to be as valid as the original.

PRINTED NAME:_____

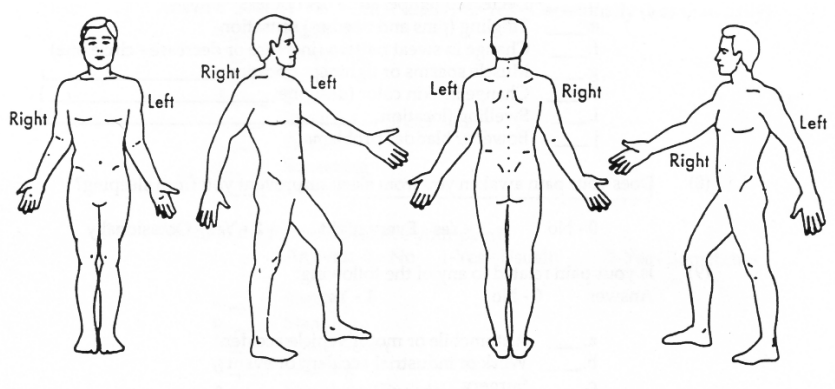
SIGNATURE:_____ DATE:_____

New Patient Form

Patient Name: _____Date of Birth: _____Referral Doctor: _____

What is the primary reason for your visit today? _____

Please shade in on the diagram below, the areas where you have pain and where it radiates to:



When did you first experience your symptoms? _____

If caused by injury, please describe: _____

Please describe your pain or discomfort.

☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Shock-like ☐ Other: _____

Pain Rating (1 = mild, 10 = severe): _____

What makes the pain worse?

☐ Sitting ☐ Standing ☐ Walking ☐ Bending Forward ☐ Bending Backward ☐ Other

What helps relieve the pain?

☐ Rest ☐ Ice/Heat ☐ Medications ☐ Stretching ☐ Lying down ☐ Other: _____

Do you have any of the following signs/symptoms?

☐ Numbness ☐ Tingling ☐ Weakness ☐ Bladder/bowel incontinence ☐ Fevers ☐None

Have you had any prior imaging for your pain?

☐ MRI ☐ CT ☐ X Ray ☐ EMG ☐None

Have you had any prior treatments for this condition (injection, meds, surgery)?

☐ Yes ☐ No If yes, please describe: _____

Are you taking any blood thinners? ☐ No ☐ Yes, what blood thinner(s): _____

Are you allergic to any medications? ☐ No ☐ Yes, medication(s): _____

Are you currently taking any antibiotics? ☐ No ☐ Yes, antibiotics: _____

Doctor to Complete:

Strength: ☐ Normal ☐ Decrease, location: _____

Sensation: ☐ Normal ☐ Decrease, location: _____

Joints: ☐ Normal ☐ Decrease ROM location: _____

Maneuvers: Positive on ☐ Spurling ☐ FABER ☐ Gaenslen ☐ Compression ☐ Thigh thrust ☐ Stinchfield ☐ Straight leg raise ☐ Facet loading ☐ Piriformis

Assessment:

☐ M54.12 ☐ M54.16 ☐ M47.812 ☐ M47.816 ☐ Primary Osteoarthritis of (Left, Right, Bilateral) (Knee shoulder hip) ☐ Myalgia M79.10 ☐ Other:_____

Procedure: ☐ Left ☐ Right ☐ Bilateral

Levels: ☐ C 1 2 3 4 5 6 7 T1 ☐ L1 2 3 4 5 S1 ☐ Other: _____

☐ 62321 ☐ 62323 ☐ 64483 ☐ 64484 ☐ 64490 ☐ 64491 ☐ 64493 ☐ 64494 ☐ 64633 ☐ 64634 ☐ 64635 ☐ 64636 ☐ 20611 ☐ 20610 ☐ 76942 ☐ 77002 ☐ 20553 ☐ 64450

Medication: ☐ Medro dose pack ☐ 4% lidocaine patch ☐ 1% diclofenac cream ☐ Meloxicam 7.5/10/15 QD/BID ☐ Tizanidine 2/4 TID/QID ☐ Methocarbamol 500/750 TID/QID ☐ Cyclobenzaprine 10/15/20 TID ☐ Gabapentin 300 mg TID ☐ Pregabalin 100 mg BID

☐ Hydro-Aceta 5/7.5/10 every 6/8/12/24 hr ☐ Oxy-Aceta 5/7.5/10 every 6/8/12/24 hr ☐ Hydromorphone 2/4 every 12 hours ☐ Tramadol 50/100 every 6/8/12 hours ☐ Other: _____

Diagnostic Imaging: ☐ MRI ☐ CT ☐ X Ray (☐ 3 Views ☐ 4 Views)

☐ Left ☐ Right ☐ Bilateral Contrast: ☐ With ☐ Without

☐ Cervical ☐ Lumbar ☐ Thoracic ☐ Shoulder ☐ Hip ☐ Knee ☐ Other: _____

PT: Strengthening: ☐ Neck and Shoulder ☐ Lumbar and Lower Extremity

Referral: _____ **Next Visit:** _____ **Reason:**_____