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!

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

☐ Your **email address**: _____

☐ **Referred Physician/Chiropractor:** _____

☐ **Attorney:** _____

☐ 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:_____

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Doctor's Lien
醫生的留置權

Claim#
理賠號碼:_____

Date of Accident
*意外發生日期:_____

Patient Name
病人姓名:_____

Insured Name
保險人姓名:_____

Attorney
*律師姓名:_____

I hereby authorize and direct my attorney, insurance company or liability insurance adjustor to promptly pay Dr. Hu any monies due and owing her for medical fees incurred either from this accident or by reason of any other bills that are due to her office and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect and fully compensate said doctor.
我特此批准和指導我的律師，保險公司或責任保險調節人，及時支付任何應付款項胡醫生和他因醫療產生之費用無論是從這次事故或因其它任何法案，為了必要充分保護和充分補償胡醫生。

I fully understand that I am directly and fully responsible to Dr. Hu for all fees incurred in her office. This agreement is made solely for the doctor's additional protection. I further understand that such payment is not contingent on any settlement, judgement, or verdict by which I may eventually recover said fees.
我完全明白我是要直接負責支付所有在胡醫生的診所的治療。此協議的目的僅僅是為了醫生的額外保護。

I authorize Dr. Hu to furnish to any attorney, insurance company or adjustor with any and all medical and/or financial information as requested.
我批准胡醫生提供任何律師，保險公司或調節人任何或所有的醫療和／或財務信息的要求。

I agree that Dr. Hu be given Power of Attorney to endorse/sign my name on any and all checks for payment of my medical bill.
我同意給胡醫生委託書在任何和所有支票支付我的醫療費用上認可／註冊我的名字。

I understand that this lien is effective for up to five years after my last office visit.
我明白這留置權的有效期是直致為最後一次治療的 5 年後才結束。

A photocopy of this agreement shall be considered as effective and valid as the original.
這協議的影印本能被視為和原版一樣有效。

Patient Signature
*病人簽名: _____

Date
日期:_____

The undersigned being either the attorney or insurance company representative of record for the above patient does hereby agree to observe all the terms of the above and agree to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect Dr. Danqing Hu, M.D., Ph.D.

Attorney's Signature: _____ Date: _____

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New Patient Form Personal Injury

Patient Name: _____Attorney: _____Referral Doctor: _____

Statement of Injury 车祸发生时的情况

Your vehicle: Sedan SUV Truck 你的车：轿车 SUV 皮卡

The other vehicle: Sedan SUV Truck Commercial truck

对方的车：轿车 SUV 皮卡 十八轮

Accident location: Highway Local Parking lot

车祸发生地点： 高速路 城市道路 停车场

Your speed: The other vehicle's speed:

你的车速： 对方的车速：

Impact on your car: Left Right | Front Rear Side

你的车受损部位：左 右 | 前 后 侧面

How did the accident happen:

车祸是怎样发生的：

Symptoms the day of accident: Lost consciousness Stomach issues Sleep disturbance

Pain in: Head Neck Low back Joints Arm Leg

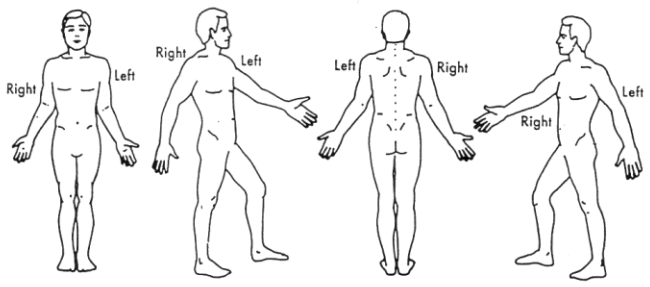
车祸当天你的症状：失去意识 胃部不适 恶心呕吐 睡眠不好

疼痛：头 脖子 腰 关节 上肢 下肢

Symptoms after the accident: Nausea/Vomiting Stomach pain Sleep disturbance

Pain in: Head Neck Low back Joints Arm Leg

车祸之后你的症状：疼痛：头 脖子 腰 关节 胃部不适 恶心呕吐 睡眠不好



Please mark the areas where you have pain and where it radiates to

请画出你的疼痛部位

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:**_____