



CAPITAL
INTERVENTIONAL
PAIN & SPINE CENTER



Phone (301) 841-6600



Fax (301) 841-6500



Web capitalpaincenter.com

PATIENT DEMOGRAPHICS

FULL NAME: _____ SEX: _____ DOB ___/___/___

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ EMAIL _____

EMERGENCY CONTACT _____ PHONE _____ RELATIONSHIP _____

RACE: _____ PRIMARY LANGUAGE: _____ MARITAL STATUS: _____

SOCIAL SECURITY NUMBER: _____

EMPLOYMENT STATUS

EMPLOYED: FT / PT / NO _____

EMPLOYER

EMPLOYER PHONE #

IS YOUR CONDITION THE RESULT OF AN AUTO ACCIDENT? YES / NO

IS YOUR CONDITION THE RESULT OF AN INJURY WHILE AT WORK? YES / NO

IS YOUR CONDITION PART OF A WORKERS COMPENSATION CASE? YES / NO

IF THIS IS AN INJURY CASE, DO YOU HAVE AN ATTORNEY FOR THIS INJURY? YES / NO

ATTORNEY NAME

ATTORNEY PHONE #

By providing my email address or cell phone number, I hereby consent and state my preference to have my physician and other staff at Capital Interventional Pain & Spine Center, LLC communicate with me by email or standard SMS messaging regarding various aspects of my medical care, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing. I understand that email and standard SMS may be insecure and could potentially be intercepted by a third-party.

Signature

Date



NEW PATIENT QUESTIONNAIRE

Referring Physician: _____
(first & last name)

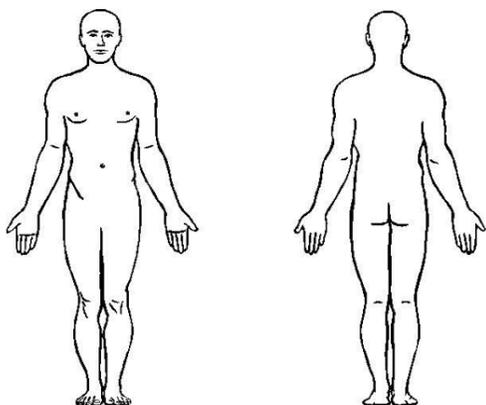
Primary Care Physician: _____
(first & last name)

Where do you feel your pain? _____

What makes your pain better? (i.e. sitting, lying down, heat, cold, standing, etc)

Circle the locations you have pain:

What makes your pain worse? (i.e. movement, walking, bending over, weather, etc)



How would you rate your pain?

0 1 2 3 4 5 6 7 8 9 10
No Pain Worst pain imaginable

Other Symptoms or Concerns:

Previously Tried Pain Medications:

When did your pain begin? _____

PREVIOUSLY TRIED THERAPIES:

Was there an event that caused your pain?

Physical Therapy: YES / NO

If yes where: _____

For how long?: _____

Describe your pain (circle all that apply):

Sharp Dull Achy
Burning Numbness Tingling
Electric Stabbing Throbbing

Chiropractic Care: YES / NO

Injections: YES / NO

Surgery: YES / NO

Timing of pain (circle all that apply):

Morning Afternoon Night

Previous Imaging and Name(s) of Facility:

Activities limited by the pain (circle all that apply):

Bathing/Showering Dressing Grooming
Using the toilet Walking Eating
Getting in/out of bed, chair, car

ALL Current Medications / Dose / How often taken

Name of Pharmacy & Address

REVIEW OF SYSTEMS

If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed. If you are not experiencing any of these symptoms, do not circle any items.

Diabetes (high blood sugar): *YES / NO*

Bleeding Disorder: *YES / NO*

Cancer: Yes/No; Type: _____

Other Medical Conditions:

General / Constitutional: Fevers, chills, night sweats, weight gain, weight loss.

Other: _____

Medication Allergies and Reaction:

Allergy / Immunology: Congestion, hives, cough, itching, rash, recurrent serious infections, wheezing. Other: _____

Are you on blood thinners? *YES / NO*

If yes, which one(s)? _____

Ophthalmologic: Blurry vision, change in vision, dry eye(s), loss of vision.

Other: _____

Previous Hospitalizations/Surgeries and Dates:

Ears, Nose, and Throat: Decreased sense of smell, difficulty swallowing, sinus pain, ringing in ears, sore throat. Other: _____

Family History

Circle any of the following that run in your family:

- Similar pain* *Arthritis*
- Depression* *Bleeding disorder*
- Cancer*

Endocrine: Cold intolerance, excessive sweating, excessive thirst, frequent urination, heat intolerance. Other: _____

Social History

Do you use tobacco products? *YES / NO*

Do you drink alcohol? *YES / NO*

Do you use illicit drugs? *YES / NO*

Do you use/smoke Marijuana? *YES / NO*

Respiratory: Chest pain, cough, shortness of breath. Other: _____

Cardiovascular: Chest pain, cyanosis, chest pain with exertion.

Other: _____

Gastrointestinal: Abdominal pain, blood in stool, diarrhea, nausea, rectal bleeding, vomiting.

Other: _____

Hematology: Easy bleeding, bleeding problems, easy bruising.

Other: _____

Genitourinary: Blood in the urine, frequent urination, painful urination.

Other: _____

Peripheral Vascular: Absent pulses in feet, absent pulses in hands.

Other: _____

Psychiatric: Suicidal thoughts, auditory / visual hallucinations, delusions.

Other: _____

CERTIFICATION

I certify that the above information is accurate, complete, and true. I understand that this will become part of my medical record.

Patient Signature (Patient, Guardian, or Representative)

Printed Name

Date

THE REVISED OSWESTRY PAIN DISABILITY QUESTIONNAIRE

Patient Name: _____

Date _____

Please read: This questionnaire is designed to enable us to understand how much your pain has affected your ability to manage your everyday activities. Please answer each section by circling the one choice that applies to you. We realize that you may feel that more than one statement may relate to you, but please, just circle the one choice which most closely describes your problem right now.

<p>SECTION 1- Pain Intensity</p> <p>A. The pain comes and goes and is very mild. B. The pain is mild and does not vary much. C. The pain comes and goes and is moderate. D. The pain is moderate and does not vary much. E. The pain comes and goes and it is severe F. The pain is severe and does not vary much.</p>	<p>SECTION 6- Standing</p> <p>A. I can stand as long as I want without pain B. I have some pain on standing but it does not increase with time C. I cannot stand for longer than one hour without increasing pain D. I cannot stand for longer than 1/2 hour without increasing pain E. I cannot stand for longer than 10 minutes without increasing pain F. I avoid standing because it increased pain straight away</p>
<p>SECTION 2- Personal Care</p> <p>A. I do not have to change my way of washing or dressing in order to avoid pain. B. I do not normally change my way of washing or dressing even though it causes some pain. C. Washing and dressing increases the pain but I managed not to change my way of doing it. D. Washing and dressing increases the pain and I find it necessary to change my way of doing it. E. Because of the pain I am unable to do some washing and dressing without help. F. Because of the pain I am unable to do any washing and dressing without help.</p>	<p>SECTION 7- Sleeping</p> <p>A. I get no pain in bed B. I get pain in bed but it does not prevent me from sleeping well C. Because of pain my normal night's sleep is reduced by less than 1/4 D. Because of pain my normal night's sleep is reduced by less than 1/2 E. Because of pain my normal night's sleep is reduced by less than 3/4 F. Pain prevents me from sleeping at all</p>
<p>SECTION 3- Lifting</p> <p>A. I can lift heavy weights without extra pain. B. I can lift heavy weights but it causes extra pain. C. Pain prevents me from lifting heavy weights off the floor. D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table. E. Pain Prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. F. I can only lift very light weights at the most.</p>	<p>SECTION 8- Social Life</p> <p>A. My social life is normal and gives me no pain B. My social life is normal but increases the degree of my pain C. Pain has no significant effect on my social life apart from limiting my more energetic interests e.g., dancing, etc. D. Pain has restricted my social life and I do not go out very often E. Pain has restricted my social life to home F. I have hardly any social life because of the pain</p>
<p>SECTION 4- Walking</p> <p>A. I have no pain walking B. I have some pain on walking but it does not increase with distance C. I cannot walk more than one mile without increasing pain D. I cannot walk more than 1/2 mile without increasing pain E. I cannot walk more than 1/4 mile without increasing pain F. I cannot walk at all without increasing pain</p>	<p>SECTION 9- Travel</p> <p>A. I get no pain while traveling B. I get some pain while traveling, but none of my usual forms of travel make it any worse C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel D. I get extra pain while traveling, which compels me to seek alternative forms of travel E. Pain restricts all forms of travel F. Pain prevents all forms of travel except that done lying down</p>
<p>SECTION 5- Sitting</p> <p>A. I can sit in any chair as long as I like without pain B. I can sit only in my favorite chair as long as I like C. Pain prevents me from sitting more than 1 hour D. Pain prevents me from sitting more than 1/2 hour E. Pain prevents me from sitting more than 10 minutes F. I avoid sitting because it increases pain straight away</p>	<p>SECTION 10 – Changing Degree of Pain</p> <p>A. My pain is rapidly getting better. B. My pain fluctuates, but overall is definitely getting better. C. My pain seems to be getting better, but improvement is slow at present. D. My pain is neither getting better nor worse. E. My pain is gradually worsening. F. My pain is rapidly worsening.</p>



 Phone (301) 841-6600
 Fax (301) 841-6500
 Web capitalpaincenter.com

Medical Treatment Consent Form

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. The consent will remain fully effective until it is revoked in writing. You have the right to discontinue services at any time.

CONSENT FOR TREATMENT & EVALUATION

I voluntarily request that Capital Interventional Pain and Spine Center, LLC provide pain management care, treatment, and services to me, as deemed reasonable and necessary by the assigned healthcare provider(s). I consent to reasonable and necessary medical examination, evaluation, testing, and treatment, which may include diagnostic, radiology, and laboratory procedures. I understand I may be asked to provide urine, oral swab, and/or blood samples. I have the right to refuse specific tests but understand this may impact my pain management treatment. If minimally invasive interventional treatment is recommended, I will be informed of the nature and purpose of the treatment with an explanation of benefits and risks prior to performance of such treatment and will be provided with a separate consent form outlining such benefits and risk.

RELEASE OF INFORMATION

I specifically authorize the uses and disclosures of my health information as described in the Notice of Privacy Practices, which I have full access to view. I authorize Capital Interventional Pain and Spine Center, LLC physicians, and/or their staff, to obtain my medication history and other relevant health care information, verbally, written, or electronically, that is deemed necessary for my treatment. I consent to release of my health information to federal or state health plans, insurance companies, collection agencies, employers or other organizations responsible for payment of services, as appropriate. I understand that this may include information relating to my diagnosis, care, payment for my care, or demographic information.

BY SIGNING BELOW, I AM AGREEING TO THE CONSENTS AND RELEASES DESCRIBED ON THIS FORM. I HAVE READ THIS CONSENT AND HAVE BEEN ABLE TO ASK QUESTIONS.

Patient Signature (or Parent, if Patient is a minor)

Date

Printed Name



Phone (301) 841-6600
Fax (301) 841-6500
Web capitalpaincenter.com

You are financially responsible for the medical services you receive at the Capital Interventional Pain and Spine Center, LLC (hereafter referred to as "CIPSC"). Please carefully review this Financial Policy, initial each section, and sign the agreement to indicate your acceptance of its terms.

APPOINTMENTS

1. Copayments, Deductibles, and Coinsurance.

Copayments, deductibles, and coinsurance for clinic visits are due at the time of service, in accordance with the carrier's plan. If you are unable to pay at the time of services, CIPSC reserves the right to reschedule your appointment until such time that you are able to make your payment. Deductibles and coinsurances are calculated as an estimate and may be adjusted after treatment based on any changes to services rendered or medications used.

2. Procedure Prepayment.

CIPSC may collect your payment for a procedure at the time the procedure is scheduled. Your prepayment is an estimate of your expected financial responsibility. We reserve the right to reschedule your procedure until prepayment arrangements have been made. You are responsible for any unpaid balance after your insurance carrier has processed your claim. In the event of overpayment, you may request a refund.

3. Self-Pay.

If you do not have health insurance, if your health insurance will not pay for services rendered, or if you notify us not to bill your insurance company, you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule. Payment is due in full at time of service.

4. Missed Appointments, Late Arrivals, and Cancellation.

Missed appointments and cancellations within 48 hours will result in a \$50.00 fee for each incident for a clinic visit, and a \$100 fee for each incident for a procedure visit. The charges are your personal responsibility and will not be charged to your insurance carrier. If you arrive more than 10 minutes late for your appointment, you may be rescheduled to the next available time slot.

Initial: _____

INSURANCE PAYMENTS

1. **Financial Responsibility.** Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment, in full, for all medical services provided. Any charges not paid by the carrier will be your responsibility, except as limited by the Practice's specific network agreement with your insurance carrier, if such an agreement is in place.

2. **Coverage Changes and Timely Submission.** It is your responsibility to timely inform us of any change to your billing or insurance information. Your insurance carrier places a time limit within which a claim can be submitted on your behalf. If CIPSC is unable to process your claim within this period due to incorrect insurance information or not responding to insurance carrier inquiries, you will be responsible for all charges.

Initial: _____

BENEFITS AND AUTHORIZATION

1. Insurance Plan Participation.

CIPSC has specific network agreements with many insurance carriers, but not all. It is your responsibility to contact your insurance carrier to verify that your assigned provider participates in your plan. Your insurance carrier's plan may have out-of-network charges that have higher deductibles and copayments, which you will be responsible for.

2. **Referrals.**

Referral and prior authorization requirements vary among insurance carriers and plans. If your insurance carrier requires a referral for you to be seen by CIPSC, it is your responsibility to obtain this referral prior to your appointment. Without a referral, you will hold financial responsibility for the visit and subsequent services rendered. Although, your referring health care provider, and CIPSC, are expressly permitted to disclose your Protected Health Information (PHI) for your treatment, under HIPAA, you have the right to request restrictions on the disclosure of your PHI. Under HIPAA, CIPSC is not required to agree with you. As a matter of course, CIPSC will inform your referring physician of your patient care plan and progress either by using any secure electronic transmission or by an employee of CIPSC.

3. **Prior Authorization and Non-Covered Services.**

CIPSC may provide services that your insurance carrier's plan excludes or requires prior authorization. CIPSC, as a courtesy to our patients, will make a good-faith effort to determine if services we provide are covered by your insurance carrier's plan, and, if so, determine if prior authorization for treatment is required. If prior authorization is required, we will attempt to obtain such authorization on your behalf. Ultimately, it is your responsibility to ensure that service provided to you are covered benefits and authorized by your insurance carrier.

4. **Out-of-Network Payments and Direct Insurer Payments.**

You are personally responsible for all charges. If we are not part of your insurance carrier's network (out-of-network) or your insurance carrier pays you directly for services rendered, you are obligated to forward the payment to CIPSC immediately.

Initial: _____

ACCOUNT BALANCES AND PAYMENTS

1. **Reassignment of Balances.**

If your insurance carrier does not pay for services within a reasonable time, we may transfer the balance to your sole responsibility. Please follow up with your insurance carrier to resolve non-payment issues. Balances are due within 10 days of receiving an initial statement.

2. **Collection of Unpaid Accounts.**

If you have an outstanding balance over 90 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney for collection and a 30% penalty fee of your balance will be applied. This may result in adverse reporting to credit bureaus and additional legal action. CIPSC reserves the right to refuse treatment to patients with outstanding balances over 30 days old. You agree, in order for us to service our account or to collect any amounts you owe, we may contact you at any telephone number associated with your account, including cellular numbers, which could result in charges to you. We may also contact you by text message or e-mail. Methods of contact may include using pre-recorded voice messages or use of an automatic dialing device.

3. **Returned Checks.**

You will be charged a service fee of \$35.00 for all returned checks.

4. **Refunds.**

Refunds for overpayment are processed only after full insurance reimbursement of all medical services has been received. Please submit a written refund request and allow 6 weeks for your request to be processed. Send requests to: Capital Interventional Pain and Spine Center, LLC, 3204 Tower Oaks Ste 440, Rockville, MD 20852

5. **Statements.**

Charges shown by statement are agreed to be correct and reasonable unless protested in writing within 10 days of receipt.

Initial: _____

ADDITIONAL FEES

1. **Medical Records Requests.**

The Privacy Rule allows you to receive a copy of your personal medical and billing records. CIPSC requires individuals to complete and sign an Authorization for Disclosure and Release of Medical Records Form. If you are unable to visit the office, CIPSC will make every effort to accommodate your request. A processing fee may apply.

Initial: _____

2. **Other Forms.**

At the provider's discretion, the Practice will respond to requests for the completion of certain medical forms, provided the patient is in good standing with CIPSC. Other forms not listed may also be considered. A fee for medical form completion will be determined by CIPSC, and all requests require an office visit.

Initial: _____

3. **Notice of Privacy Practices & Statement of Patient's Rights.**

A copy of the Notice of Privacy Practices and Statement of Patient's Rights is available upon request from the front desk and can be downloaded on our website: www.CapitalPainCenter.com. By initialing this section, I acknowledge that I have received a copy of the practice's Notice of Privacy Practices and Statement of Patient's Rights.

Initial: _____

PRACTICE CODE OF CONDUCT

We are pleased to serve you and glad that you chose the Capital Interventional Pain and Spine Center as your new pain management provider. We will always strive to provide exceptional care for you.

Reasons that CIPSC may ask you to seek health care services elsewhere might include:

- Rude or violent behavior to staff via in-person or telephone encounters. This also applies to your family members and/or friends
- Repeated no shows, cancellations, or continual late arrivals for office visits or procedures as this adversely limits our availability and care for other patients
- Refusal to adhere to the plan of care as outlined by your Clinician or to follow health insurance or government guidelines
- Failure to adhere to the Opioid / Pain Management Agreement
- Unwarranted requests for disability paperwork

Our goal is to help you. Therefore, we ask that you schedule and keep all follow up appointments and participate in all treatments and diagnostic testing.

Initial: _____

AGREEMENT AND ASSIGNMENT OF BENEFITS

I have read and understand the Financial Policy and Consent of Capital Interventional Pain and Spine Center, LLC, and I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to CIPSC. I understand that I am financially responsible for all services I receive from CIPSC. This financial policy is binding upon me and my estate, executors and/or administrators, if applicable.

Patient Signature (or Parent, if Patient is a minor)

Date

Printed Name



CAPITAL
INTERVENTIONAL
PAIN & SPINE CENTER

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(By signing this form, you can allow our office to obtain your medical records from your other physicians.)

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that, by initialing this form, I am specifically authorizing that release of this information.

Patient Name: _____

Date of Birth: _____ Phone Number: _____

By signing this form, I authorize the requested facility to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below:

Capital Interventional Pain & Spine Center

Fax: (301) 841-6500

Phone: (301)841-6600

www.capitalpaincenter.com

3204 Tower Oaks Blvd, Suite 440

Rockville, MD 20852

I do give permission for these records to be faxed to the above entity. Please forward:

____ Office Visit Notes & Operative Reports

____ Initial History and Physical

____ MRI, CT, Xray, and other Imaging Reports

____ Lab Reports

____ Correspondence

____ Insurance Information

Other (please specify): _____

Patient Signature: _____ Date: _____