Southern Pain Specialists

We would like to welcome you to Southern Pain Specialist.

Your appointment is scheduled on _____ with Dr. Kenneth Varley and Dr. Andrew Rozsa

During your initial visit you will have both, a physical examination to assess the cause of your pain, as well as a psychological evaluation to assess the impact your pain is having on your life.

We will call you with a time 1-2 business days before your appointment*

****If you need to cancel or reschedule this appointment, please provide us at least *24 hours* notice so we can offer the time to another patient. Please call 205-995-9967 extension 202.**

For the greatest benefit from your evaluation, please note the following:

- *Please complete the enclosed questionnaire **PRIOR** to arriving for your appointment. Bring the completed questionnaire with you to your appointment. Since the majority of information we request is kept at home, arriving **without** a **completed questionnaire** may result in having to **reschedule** your appointment. If there are questions you are unsure about, answer to the best of your ability.* ***Please use black ink*.**
- ***You need to arrive 15 minutes early to insure the questionnaire is completed and to fill out any additional paperwork that is necessary before we meet with you.***
- **Your visit will last 2-4 hours.**
- If you need glasses for reading, please be sure to bring them with you.
- **Please bring all insurance cards and your driver's license.**
- ***Please bring any MRI, CT scan, X-Ray films with you or arrange for them to be sent to our office prior to your appointment*.**
- **We do not write narcotic prescriptions at initial visit**. Prescriptions are only written in conjunction with treatment. We ***do not*** do primary medication management.

Please call us if you have any questions. We look forward to meeting you soon.

Sincerely,
Kristi Graham
Scheduling Coordinator
205-995-9967 ext. 202
Kristis@southernpain.com

Money due at your visit:

Copay for Dr. Varley: $_____ Copay for Dr. Rozsa: $_____ Procedure Copay: $_____

Deductible: $_____ Total Due at check in: $_____

PATIENT FACE SHEET

Patient Name: _____

DOB: _____ **Gender:** **Female** **Male**

Race: **African American** **Hispanic or Latino** **White** **Other**

SSN: _____

Address: _____

_____

Marital Status **Single** **Married** **Divorced** **Widowed**

Employment Status **Employed** **Unemployed** **Retired** **Disabled**

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Emergency Contact:

Name: _____

Phone: _____

Relationship: _____

Primary Care Provider: _____

Pharmacy Name: _____

Location: _____

Phone: _____

Primary

Insurance: _____

Effective Date: _____

Policy Holder: _____

Policy Holder Date of Birth: _____

Relationship: _____

Secondary

Insurance: _____

Effective Date: _____

Policy Holder: _____

Policy Holder Date of Birth: _____

Relationship: _____

Group No: _____

Insured ID: _____

INFORMATION RELEASE AND INSURANCE ASSIGNMENT—ALL PATIENTS

I hereby authorize Southern Pain Specialists, P.C., to release medical information to any insurance company or any public agency that may be assisting in payment of benefits to which I am entitled. In addition, I authorize the payment of any insurance benefits directly to Southern Pain Specialists, P.C. This signature shall suffice for all insurance forms on a continuing basis.

SIGNED:_____ DATE:_____
(Signed by patient or person legally authorized to sign for patient.)

MEDICARE ASSIGNMENT—MEDICARE PATIENTS ONLY

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER
(Extended Payment Request for Physician Services Applicable to Current and Future Treatment)

I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made either to me or on my behalf to P.C. and/or Physicians, for any services furnished me by or in the name of such providers. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable for related services. I recognize that this one-time authorization will permit P.C. and/or Physicians to submit any Medicare claim, on either an assigned or an unassigned basis, without obtaining any additional signature from me, and will remain in the files of P.C. for inspection by the Medicare carrier, and will continue in full force and effect unless cancelled by my request.

SIGNED:_____ DATE:_____
(Signed by patient or person legally authorized to sign for patient.)

FINANCIAL ASSIGNMENT—ALL PATIENT

I understand that I am directly responsible to Southern Pain Specialists, P.C., for all charges for medical services rendered to me regardless of insurance coverage. In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees.

SIGNED:_____ DATE:_____
(Signed by patient or person legally authorized to sign for patient.)

CONSENT FOR THE RELEASE OF MEDICAL INFORMATION TO SPECIFIED INDIVIDUALS

Southern Pain Specialists is committed to the protection of our patient's personal health information. However, we recognize that individuals other than themselves attend to many of our patient's healthcare needs. In accordance with new HIPAA regulations, we ask that you take a moment to give us the names of individuals with whom we are able to discuss your medical appointments, condition, treatment options, insurance/private payment information, or other information necessary to our responsibility in your treatment. Please list the names (and phone numbers, if readily available) of any individuals with whom we may have communication, which may include all, or part of your personal health information. If you fail to list any names, we will not discuss your medical information

Examples include: spouse, parent, child, brother/sister, friend, etc.

Patient's Signature: _____ Date: _____

Contact/Relationship to patient: Telephone number:

1. _____ _____
2. _____ _____
3. _____ _____

CONSENT FOR THE USE OF NON-IDENTIFYING PATIENT INFORMATION

It is the practice of Southern Pain Specialists to gather non-specific patient data for such purposes as teaching, marketing, and research. This data does not include any identifying information that would compromise the privacy of your identity, health condition, insurance or payment information. Examples include (but are not limited to): age, sex, race, treatment options, response to treatment and/or a non-identifying photograph or x-ray. Southern Pain Specialists is bound by the conditions of the Health Insurance Portability and Accountability Act and will not disclose further Personal Health Information beyond such non-identifying information without the express written consent of the patient. However, we request your permission to use your non-identifying patient information for such purposes as listed above.

I, (print name)_____ , grant permission to Southern Pain Specialists to use non-identifying patient information about me (exclusive of Personal Health Information) for such purposes that may include, but are not restricted to, teaching, marketing and/or research.

_____ _____

Signature Date

Southern Pain Specialists

POLICY REGARDING MISSED PROCEDURE/OFFICE APPOINTMENTS

PROCEDURE APPOINTMENTS

If you are scheduled for a procedure we want you to be aware of our cancellation and no-show policy.

If you need to cancel your scheduled procedure appointment, please call us at least **48 business hours** in advance, and we will be happy to reschedule your procedure to a more convenient time. This time period allows us to schedule another waiting patient in the time slot.

Should you fail to show up the day of your scheduled procedure, and you have not notified us at least **48 business hours** in advance of the scheduled time, you will be charged **$150.00**. This charge is not billable to your insurance and must be paid by you.

OFFICE APPOINTMENTS

Please call our office if you need to cancel an office visit at least **24 hours** in advance. If you do not show up for an office appointment or if you cancel with less than 24 hours notice, you will be charged **$25.00**. This charge is not billable to your insurance and must be paid by you.

Please call our office if you have any questions (205) 995-9967.

Thank you!

Patient Signature

Date

Authorization for Release of Medical Information

Date: _____

To: _____

_____

_____

Patient Name	Date of Birth	Social Security #

This is to authorize and request that you furnish all medical or hospital information, including any radiology reports, concerning your examination, treatments, and care of the patient listed above.

Southern Pain Specialists, P. C.
7191 Cahaba Valley Road, Suite 204
Birmingham, Alabama 35242

Attention: Medical Records

(205) 995-9967
FAX: (205) 995-0635
(888) 436-4560

WWW.SOUTHERNPAIN.COM

Patient (or Guardian) Signature: _____

Patient Name: _____

Extended History Form

Date of Birth: _____

Date: _____

Family History

Mother
☐ Alive, Age ____
☐ Deceased, Age ____ of _____
☐ Medical Conditions:_____

Father
☐ Alive, Age ____
☐ Deceased, Age ____ of _____
☐ Medical Conditions:_____

Sister(s)
☐ Alive, Age ____
☐ Deceased, Age ___ of _____
☐ Medical Conditions:_____

Brother(s)
☐ Alive, Age ____
☐ Deceased, Age ____ of _____
☐ Medical Conditions:_____

☐ Alive, Age ____
☐ Deceased, Age ___ of _____
☐ Medical Conditions:_____

☐ Alive, Age ____
☐ Deceased, Age ___ of _____
☐ Medical Conditions:_____

Patient Medical History

Do you have any known medical conditions?

_____ _____ _____

_____ _____ _____

Surgical History- Please list any surgeries (surgery and date) you have had.

_____ _____ _____

_____ _____ _____

Social History

Occupation(s) _____

Highest Level of School Completed _____

Tobacco
☐ No
☐ Yes _____ppd x_____years

Alcohol
☐ No
☐ Yes

Marital Status
☐ Single
☐ Married
☐ Civil Union
☐ Divorced
☐ Widow(er)

Level of Activity (Exercise)
☐ None ☐ Occasional
☐ Regular ☐ Vigorous

Illicit Drug Use ☐ No ☐ Yes

Types/Quantity/Frequency:_____

Patient Signature _____ *Date* _____

Patient Name: _____ Today's Date:_____

Date of Birth: _____

Current Medications

Please list **ALL** medications or drugs you ***are taking NOW*** for any reason, whether PRESCRIBED by a doctor or not (include home remedies; painkillers; over-the-counter medications; birth control pills).

Name of Medication	Dosage/Strength	How many per day/how often	Who prescribed it

Previous Medications

Please list **ALL** medications or drugs you have ***tried in the past*** for any reason, whether PRESCRIBED by a doctor or not (include home remedies; painkillers; over-the-counter medications; birth control pills).

Name of Medication	Dosage/Strength	How many per day/how often	Who prescribed it

Pharmacy Name: _____ Phone #: _____

Pharmacy Address: _____

_____

☐ **Check this box if you used the back for extra room for your medications.**

Patient Name: _____ Today's Date: _____
Date of birth: _____

REVIEW of SYSTEMS: Check the box for EACH symptom you have):

General/Constitutional

□Fever/ Chills □Fatigue □ Morning Stiffness □Weight loss
□Weight gain □ Loss of appetite □Mood Changes □Night Sweats
□Trouble falling asleep □ Trouble Staying Asleep

Head / ENT

□Headaches □Nose bleeds □Hoarseness □Sore Throat
□Problems with hearing □Ringing of the ears □Problems with vision
□Change in the color of the white in your eyes

Respiratory

□Shortness of breath when resting □Wheezing □Cough □Coughing up blood
□short of breath while exercising

Heart & Circulation

□Chest Pain □Skipped heart beats □ankle swelling
□poor circulation □short of breath when resting □heart flutter/palpitations
□cold hands/feet □pain in legs while walking

Gastrointestinal

□Difficulty swallowing □Nausea/vomiting □throwing up blood □stomach pain
□diarrhea □constipation

Musculoskeletal

□Joint pain □joint swelling □ joint stiffness □cramping
□weakness □tenderness □muscle twitches □restless legs

Psychiatric

□depression □anxiety □panic attacks □irritability □stress

Skin

□itching/dryness □rashes □bruises □change in skin color

Neurological

□dizziness □fainting □memory problems □loss of balance

Endocrine

□frequent urination □ frequent drinking □heat intolerance □cold intolerance

Hematologic

□Anemia □easy bleeding □swollen glands

Genitourinary

□Difficulty Starting stream □loss of bladder control □nighttime urination
□change in color of urine □discharge □painful urination

Male Genitalia

□erectile dysfunction □sexual problems

Female Genitalia

□Menopause □Nipple discharge □sexual problems