CONSULTANTS IN
PAIN MEDICINE
DIAGNOSIS · TREATMENT · RELIEF

◯Dr. Kevin Coyle
Brunswick
3221 Glynn Avenue
Brunswick Ga, 31520

Phone (912) 466-9111

Date: _____

Dear _____,

Enclosed you will find new patient paperwork for you to complete and bring to your appointment on:

_____, _____ at _____ in _____
Day Month Date Time Location

If your papers are not completed, your appointment may be rescheduled.

The day of your visit you will need to bring the following items:

- **PICTURE ID**
- **INSURANCE CARDS**
- **ALL PRESCRIBED MEDICATIONS (Bottles, not a list)**
- **ANY MRI'S , CT'C OR XRAYS (ON DISK)**

If you have an Advanced Directive (ie. Living Will) we will need to include a copy of the notification in our chart.

You will have additional paperwork to fill out once you have checked in, so please **ARRIVE 15 MINUTES EARLY** for your appointment.

If you need assistance filling out your paperwork plan accordingly and bring someone with you.

It is also beneficial to call your insurance company to verify benefits, coverage, and copay amounts.
AMOUNT DUE AT TIME OF VISIT: _____

If you have any questions feel free to contact our office at **(912) 466-9111**

Thank you for your time and consideration.

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FINANCIAL POLICY, CONSENT FOR TREATMENT, AND RELEASE OF MEDICAL INFORMATION

Thank you for choosing us as your pain management provider. Please understand that payment of your bill is considered part of your treatment. All patients must complete the registration sheet and provide proper insurance information prior to seeing a physician. Full payment is expected as services are rendered. We accept cash, credit card, or check. Payment terms can be arranged with prior approval from our billing department. CO-PAYMENTS and DEDUCTIBLES are due at the time of service.

If you have insurance, as a courtesy to you, we will file your primary insurance and wait no more than 45 days from them to pay. If your account has reached 45 days, you will receive a letter from our office. The letter requests that you contact your insurance company and check on the status of your claim and call our office with the results, within 10 days. We will also file your secondary insurance claim once the primary carrier has paid.

Consultants in Pain Medicine is committed to providing the highest quality care for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of your insurance company's arbitrary determination of usual and customary rates. Your insurance policy is a contract between you and your insurance company. Any disagreement you have concerning the amount your insurance pay should be directed to your insurance company. We will follow the rules of the agreement for the insurance companies with whom we are contracted. At no time will co-insurance, co-payments, or deductibles be waived.

If you have an HMO, PPO, or equivalent policy, it is your responsibility to inquire with the insurance company to see if Consultants in Pain Medicine is a contracted provider. We try to become contracted providers for as many policies as we can. It is also the patient's responsibility to keep track of referral and referral dates and number of visits.

If your treatment is based on an accident or injury claim, our office will complete your paperwork at a **minimum cost of $25 per form** depending on the time required. Payment must be received, as the forms are prepared.

Authorization: I hereby authorize Consultants in Pain Medicine to administer treatment, obtain my pharmacy records and perform procedures as may be deemed necessary or advisable in my diagnosis. I further authorize the release of any medical information necessary to process my insurance claim and request payment of medical services to be assigned directly to Consultants in Pain Medicine. In the event my insurance does not cover services rendered, I agree to be personally and fully responsible for payment. I have read the office policy and understand and agree to its terms. This authorization is to remain in full force unless I revoke the same in writing.

_____	_____	_____
Signature	Printed Name	Date

Medication Agreement & Refill Policy

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As part of your treatment, our medical staff may prescribe medications for you. Many of these medications can have serious side effects if they are not managed properly. Your health and safety are very important to us, and we need your help to make sure your treatment follows our guidelines. **If Consultants in Pain Medicine has any questions regarding your healthcare, including medications, we reserve the right to contact your other treating physicians and pharmacies and obtain their records. We will occasionally obtain pharmacy profiles to assure you are taking your medication correctly.**

1. I agree to follow the dosing schedule prescribed to me by my doctor or PA.
2. I agree to never share my medications with others, nor will I sell or exchange my medications for any reason.
3. I agree to always keep my medications safeguarded and within my control.
4. I agree to notify Consultants in Pain Medicine if I experience any adverse effects or dosage problems with my prescribed medications. I will not discard any unused medication. Before any new medication can be prescribed, I may be asked to bring any unused medication to Consultants in Pain Medicine for disposal.
5. I agree that if I receive narcotic prescriptions from Consultants in Pain Medicine, I am not allowed to receive the same type of medications from another physician without express consent or consultation with Consultants in Pain Medicine.
6. I agree to use only one pharmacy for my pain-related medication unless extenuating circumstances prevent this from being possible. In this event, I will notify Consultants in Pain Medicine of all pertinent information pertaining to additional pharmacies, mail-order, or other sources. Records can be obtained from your current and any prior pharmacies.
7. I understand that medication refill prescriptions involving narcotic pain medicine require a scheduled office visit when my doctor is on duty in the office. **Narcotic pain medication refills will not be called into a pharmacy, nor will they be increased/changed over the telephone.**
8. **I agree to keep all scheduled appointments. I understand that no medications will be given for canceled or no-show appointments.** I understand that if I am more than 15 minutes late to my scheduled appointment time, I will have to reschedule.
9. I understand that medication refills cannot be made after hours, on the weekends, or on holidays.
10. I agree to bring all of my prescribed medications from any doctor's office to Consultants in Pain Medicine for my office appointments. I understand that pill counts may be necessary for controlled substances.
11. I understand that I should not drive or operate heavy machinery while I am taking medications that my cause drowsiness or impaired cognitive function.
12. I understand that I am *solely* responsible for the safekeeping of my medications and I must treat my medications as I would my money or valuable possessions. Consultants in Pain Medicine will have no obligation to replace LOST OR STOLEN prescriptions or medications.
13. I understand that my therapy at Consultants in Pain Medicine may require a monthly office visit so my doctor can properly evaluate my progress, and/or adjust appropriate narcotic pain medications every thirty (30) days.
14. I understand that abusive behavior or harassment toward any Consultants in Pain Medicine's staff will not be tolerated. Harassment includes, but is not limited to, more than two (2) phone calls to the office in one business day.
15. I understand that I cannot present to Consultants in Pain Medicine unannounced seeking medication refills.
16. I understand that dealing with a forged or falsified prescription will result in the immediate dismissal from Consultants in Pain Medicine.
17. I understand that Consultants in Pain Medicine will not prescribe narcotic medications on my first office visit.
18. I understand that Consultants in Pain Medicine's office policy is to perform a URINE DRUG SCREEN AT THE FIRST VISIT AND FOLLOW UP TEST APPROXIMATELY EVERY 3 MONTHS . If my screen tests positive for un-prescribed substances or negative for medication that I have been prescribed, I understand that this is grounds for dismissal from the practice.

By signing the agreement, you affirm that you have the full right and power to be bound by this agreement and that you have read, understood, and accepted these terms. No medications will be prescribed without the acceptance of this agreement.

19. I understand that I may be dismissed from Consultants in Pain Medicine if I do not abide by the terms of this medication agreement.

_____ _____

Pharmacy Name Pharmacy Phone Number

_____ _____

Patient's Signature Date

Print patient's name _____

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Consultants in Pain Medicine's Doctors and Physicians Assistants may utilize opiates (Narcotic medication) in the management of your pain condition. Important issues in opioid therapy revolve around the appropriate use of prescription opioids. Adherence monitoring is used to encourage the appropriate use of medications and to avoid abuse of medications. Our practice utilizes periodic monitoring and urine drug screens as part of our Adherence monitoring program. Urine drug screens help us determine appropriate intake of prescribed substances, uncover diversion and keep accurate records.

Our practice requires a baseline urine drug screen and then we perform random drug screens during your therapy. There is an **additional charge** for Urine Drug Screens.

Patient Signature_____ Date _____/_____/_____

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Patient Acknowledgement Form

Patient's Name: _____ **SSN:** _____ **Today's Date:** _____

I understand that the patient's health information is private and confidential. I understand that Consultants in Pain Medicine works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Consultants in Pain Medicine may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care options. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that there may be situations where Consultants in Pain Medicine is required by law to release this information without my permission. One example would be if a patient threatened to hurt someone.

Consultants in Pain Medicine has a detailed document called the *Notice of Privacy Practices*. It contains more information about the policies and practices protecting the patient's privacy including other potential disclosures and uses of patient's health information. I understand that I can receive a copy of this document at any time of my choosing. One example would be disclosure of health information for research purposes. I understand that I have the right to read the *Notice of Privacy Practices* before signing this acknowledgement.

Within this *Notice of Privacy Practices* is contained a complete description of my privacy/confidentiality rights. These rights include, but are not limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative locations.

Consultants in Pain Medicine has established procedures that help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgements, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist Consultants in Pain Medicine by following these procedures if I choose to exercise any of my rights described in the *Notice of Privacy Practices*.

Please list the names of individuals that you would like to access or retrieve personal health information, documents, telephone calls, or other items on your behalf. (Physicians and other health care professional do not need to be listed)

_____

_____

_____

_____

_____

☐ I decline to have anyone receive my personal health information.

_____ _____

Patient Signature **Date**

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PLEASE UPDATE US WITH YOUR CURRENT INFORMATION

NAME: _____ **DOB:** _____
FIRST MIDDLE LAST

PHONE#'S HOME _____ **CELL** _____ **OTHER** _____

MAILING ADDRESS:

_____

WHAT COUNTY DO YOU LIVE IN: _____

MARITAL STATUS: SINGLE / MARRIED / WIDOWED / DIVORCED

ARE YOU EMPLOYED? YES / NO IF SO, ARE YOU: FULL TIME / PART TIME

NAME OF EMPLOYER: _____

ARE YOU RETIRED? YES / NO

ARE YOU A STUDENT? YES / NO IF SO, ARE YOU FULL TIME / PART TIME

NAME OF SCHOOL: _____

DO YOU HAVE A PRIMARY PHYSICIAN OR FAMILY DOCTOR? YES / NO

NAME OF PHYSICIAN: _____

WERE YOU REFERRED TO US? YES / NO BY WHOM? _____

- **IS YOUR VISIT RELATED TO A WORK COMP INJURY? YES / NO**
- **IS YOUR VISIT RELATED TO A CAR ACCIDENT INJURY? YES / NO**
- **IS YOUR VISIT RELATED TO A PERSONAL INJURY CLAIM? YES / NO**

IF THE ANSWER TO ANY OF THE LAST 3 QUESTIONS IS YES AND YOU ARE FILING YOUR MEDICAL INSURANCE, PLEASE CALL THE OFFICE IMMEDIATELY AT 912-466-9111 EXT 301

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INFORMATION CONFIRMED BY: _____ / _____