ADVANCED MEDICAL SPORTS AND SPINE, PLLC
NEW PATIENT KIT

Please complete this form in its entirety and return to us via fax, email, or mail.

Address: 2002 Orange Road, Suite #201 Culpeper, VA 22701
Phone: (540) 423 6239
Fax: (540) 738 0105
email: info@mypaincenter.org

WELCOME!

Thank you for choosing Advanced Medical Sports and Spine, PLLC as your comprehensive pain care center. We know how disabling pain can be and we feel honored that you are entrusting us in the care of your symptoms. We promise to do all we can to help alleviate your pain and to help provide you with a better quality of life and improved functional status.

We truly wish to excel in providing your care and to exceed all of your expectations. Part of this is providing you with outstanding customer service and to treat you with the utmost respect. With this in mind, Advanced Medical Sports and Spine, PLLC has developed a Patient Bill of Rights that we would like to make you aware of. Please familiarize yourself with these rights and know that our office policy binds us to them. It is our job to abide by them at ALL times. However, if you find us in violation of any of these rights, it is your job to inform us so we can immediately address and remedy the situation.

ADVANCED MEDICAL SPORTS AND SPINE, PLLC
PATIENT BILL OF RIGHTS

1. You have the right to be treated with respect at all times.
2. You have to right to receive care from a competent person.
3. You have the right to every consideration for your privacy regarding all aspects of your health care.
4. You have the right to have all of your records pertaining to your healthcare to be treated as confidential except as otherwise provided by law or third party contractual arrangements.
5. You have the right to receive good quality care and high professional standards that are continually maintained and reviewed.
6. You have the right to have all medical information concerning diagnosis, treatment and prognosis, including information about alternative treatments and possible complications be explained to you in terms you can fully understand. When it is not possible or medically advisable to give you such information, the information shall be given on your behalf to your designee.
7. You have the right, with the exception of emergency situations, to receive the necessary information for you to give your informed consent prior to the start of any procedure, treatment, or both.
8. You have the right to refuse any drugs, treatment or procedure offered by our facility, to the extent permitted by law, and to be informed of your right to refuse any drugs, treatment or procedures and of the medical consequences of your refusal of any drugs, treatment or procedure.
9. You have the right to assistance in obtaining consultation with another physician at your request and expense.
10. You have the right to medical and nursing services without discrimination based upon race, color, religion, sex, sexual preference, national origin or source of payment.

ADVANCED MEDICAL SPORTS AND SPINE, PLLC
MEDICAL HISTORY

PATIENT NAME ________________________________ **DOB** ____________________

1. History of Present Illness:

Where is your pain located: ________________________________

Does it travel and if so, where: ________________________________

How would you describe it *(sharp, dull, burning, etc.):* ________________________________

Rate your pain on a scale of 0-10 *(0=pain free / 10=worst pain in life): Averages=*______ *At its worst=*______

How long has it been going on for: ________________________________

What caused it to occur (accident, injury, etc.): ________________________________

Is it constant or does it come and go: ________________________________

If it comes and goes, how often does it come and go? ________________________________

What makes it better: ________________________________

What makes it worse: ________________________________

Is it associated with anything such as numbness or insomnia: ________________________________

Is there anything else you would like us to know: ________________________________

Please circle what you have tried: gabapentin, tylenol, NSAIDS (e.g., Aleve, ibuprofen) phyiscal therapy, rest, ice, heat, other: ________________________________

2. Major events (hospitalizations and surgeries):

Event:	Month/Year

3. On-going (current) medical problems:

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4. Family Medical History ***(do you have or have you had any family members with any of the following:)***

Bleeding or blood clotting disorders	NO	YES	if yes, please explain: ____________
Drug Addiction	NO	YES	if yes, please explain: ____________
Cancer	NO	YES	if yes, please explain: ____________
Rheumatoid disorder (RA, Lupus)	NO	YES	if yes, please explain: ____________

5. Social History:

What is or was your employment: ________________________________

Full Time, Part Time, Retired, Unemployed: ________________________________

Last day worked was: ________________________________

Have you ever or are you currently using illegal substances such as illegal drugs: NO YES

Please list all substances ever used: ________________________________

When was the last day used: ________________________________

How many alcoholic beverages do you consume per week: ________________________________

6. Diagnosis History ***(please list previous medical problems, if any, you have had – can approximate dates)***

Medical Problem	Date Began	Date Ended

7. Medications

Name	Dose	Freq (e.g., 1x/day)	Start Date	End Date

8. Allergies:

Allergy	Severity *(very mild, mild, moderate, severe)*	Reaction

9. Lifestyle:

Have you ever smoked: NO YES

If yes, how many packs per day: ______________________________

For how many years: ______________________________

Are you currently smoking: NO YES

If no, when did you quit smoking: ______________________________

Are you experiencing any of the following symptoms?

1.Constitutional:	**Yes**	**No**
unintentional weight loss		
If yes, how many pounds and over how much time:		
fevers, chills or sweats		
how long has this been going for:		
2.Eyes:		
photosensitivity (does light hurt your eyes)		
3.Ears/Nose/Throat:		
easy nose bleeds		
4.CV:		
abnormal heartbeats *please explain:*		
heart conduction (arrhythmias) problems *please explain:*		
5.Resp:		
breathing difficulties		
oxygen requirements		
6.GI:		
constipation		
diarrhea		
difficulty controlling your stool		
7.GU:		
difficulty urinating		
difficulty controlling your urine		
8.MSK:		
Pain or stiffness?		
Neck		
Shoulder		
Elbow		
Wrist		
Mid Back		
Low Back		
Buttock		
Hip		
Knee		
Ankle		
Other:		

9.Integumentary:	**Yes**	**No**
rashes *If yes, where:*		
blisters *if yes, where:*		
lumps *if yes, where*		
10.Neurological:		
numbness *if yes, where:*		
tingling *if yes, where:*		
weakness		
If yes, where:		
11. Psychiatric		
depression		
anxiety		
hours of sleep per night:		
12.Endocrine:		
diabetes		
13.Hem/Lymph:		
easy bruising or bleeding		
blood clotting disorders		
blood borne illnesses such as HIV, Hepatitis C		
Are you taking any blood thinning medication?		
14.Allergic/Immunological:		
oral ulcers (mouth sores)		
joint swelling *which one(s):*		
joint stiffness *which one(s):*		
if yes, when does it occur: (circle) *morning | afternoon | evening | night*		
if yes, how many minutes does it last for:		
if yes, how does it respond to the following: (circle) *rest: better | worse | unchanged* *activity: better | worse | unchanged*		

Prior to comprehensively evaluating and developing a treatment plan for you, there are many policy and administrative issues that you must be made aware of. In order to provide the highest quality of care to you and to remain compliant with all respective laws and policies, please carefully read and abide by the following information.

Please arrive 30 minutes prior to your initial appointment on your initial visit. This way, the appropriate administrative work can be addressed and we can help minimize waiting times for all patients. We will strive to always see patients on time but can only achieve this with your help.

Please bring your insurance card, secondary insurance information, as well as a state-issued I.D. such as a Virginia driver's license or Virginia identification card or a passport.

Please wear loose, comfortable clothing. This will help facilitate the physical exam. For example, please make sure that pant leg can be raised above the knee, pant waist can be lowered below the hip, and that shirt sleeve can be raised above the shoulder. Please refrain from wearing jeans or tight clothes as this can interfere with the physical exam. Shorts, sweat pants, and a t-shirt allow for a more thorough exam.

Please bring all previous medical records including visit notes with all other providers and imaging findings such as x-rays and MRIs related to your condition. These records can be faxed to us at (540) 738-0105, emailed to us at info@mypaincenter.org, or mailed to us at 2002 Orange Road, Suite #201, Culpeper, VA 22701.

Please bring a list of all medications currently and previously being taken regardless of whether or not they have been prescribed for the condition you are seeking help with from our center.

Please bring a list of all other physicians currently involved in your care, along with their address, and phone and fax number, regardless of whether or not they are seeing you for the condition you are seeking help with from our center.

Please realize that no opioid pain medications will be prescribed upon the first visit and there will be no guarantee that opioid pain medications will be prescribed throughout any of your visits. Prescribing opioid pain medications is a big responsibility for both Advanced Medical Sports and Spine, PLLC and you and will require a significant commitment from both parties. If opioid pain medications are prescribed, please know that random drug testing and pill counts will be implemented.

Please bring whatever monies are necessary to cover all co-payments, co-insurances, and deductibles as these will be due at time of visit. You will be responsible for all payments of your medical care provided by Advanced Medical Sports and Spine, PLLC and you must agree to our payment policy prior to being seen. Due to office policy and federal law, all co-payments, co-insurances and deductibles are due PRIOR to seeing a provider. We do accept most insurances and will work with you as a courtesy to file insurance claims on your behalf. However, please realize that your insurance policy is a contract between you and your insurance company and only your insurance policy can tell you if the services provided are covered under your benefit plan.

Please bring all necessary referrals from your primary care physician that are required by your insurance policy. It is your responsibility to check with your insurance policy to verify whether or not a referral is required. Should one be required and you do not have it, you will be responsible for payment in full of all office charges for that day. Should you decide to reschedule, you will be responsible for the rescheduling fee of $25.

ADVANCED MEDICAL SPORTS AND SPINE, PLLC
POLICY FORM

Please be sure to read, understand, and sign at the bottom of the form prior to being seen. Please be sure to ask any question(s) you may have regarding these policies and/or forms.

BLOOD TESTING POLICY: I am aware that I will always be treated in the safest way possible and at no time will I ever be exposed to the blood or bodily fluids of another patient or provider. I am aware that Advanced Medical Sports and Spine, PLLC will never reuse a needle and all needles used are disposed of immediately following each procedure.

I also am aware that Advanced Medical Sports and Spine, PLLC wishes to carry the same protection for its providers and employees. I understand that therefore, it is the policy of Advanced Medical Sports and Spine, PLLC that in the event that a health care worker is accidentally exposed to my blood or other bodily fluid such as through a needle stick, I will receive testing of my blood and/or other bodily fluid for infectious disease which will include HIV/AIDS and hepatitis.

This policy is in place in the interest of maintaining a safe workplace for the providers and employees of Advanced Medical Sports and Spine, PLLC.

RELEASE OF INFORMATION FOR BILLING: I authorize release of information, including financial information, confidential health information, and medical records, for services rendered regarding my injury, or any other services which may include records related to treatment for substance abuse, to my insurance carrier(s), managed care plan or other payor, including past or present employer(s), authorized private review entities or entities acting on their behalf, authorized chart reviewers, billing agents, collection agents, attorneys or insurance companies, the Social Security Administration, the Health Care Financing Administration, the Peer Review Organization acting on behalf of the federal government, and/or any other federal or state agency for the purpose of satisfying billed charges and/or facilitating utilization review and/or otherwise complying with obligations of state or federal law.

RELEASE OF INFORMATION FOR COORDINATION OF CARE: I hereby authorize Advanced Medical Sports and Spine, PLLC to release medical information to my referring physician, primary care doctor, case manager, and any other individual involved in my medical care for the sole purpose of facilitating treatment. I understand that my medical information is confidential and that I have a chance to request that my physician not share my medical records with any of the above individuals. Should I choose to exercise this right, I will provide in writing to my physician and any the individuals involved in my care whom I do not wish to receive my medical records. I agree that a copy of this release may be used in place of the original. I am aware that I may request that this Release of Medical Information may be revoked at any time by providing the physician's office with a dated and signed letter.

CONSENT FOR PHOTOGRAPH: In connection with the medical services that I am receiving from Advanced Medical Sports and Spine, PLLC, I consent that a photograph may be taken of me under the following conditions:

1. The photograph may be taken only with the consent of my physician or provider and under such conditions and at such times as may be approved by my physician provider.
2. The photograph shall be taken by my physician, provider, or staff of Advanced Medical Sports and Spine, PLLC.
3. The photograph shall be used only for my medical records and to help confirm identification.

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIAN AND PATIENT (FOR MEDICARE PATIENTS ONLY): I request that payment of authorized Medicare benefits be made on my behalf to Advanced Medical Sports and Spine, PLLC for any service furnished to me by Advanced Medical Sports and Spine, PLLC. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits payable for related services.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I understand that Advanced Medical Sports and Spine, PLLC is required to provide me with a copy of its Notice of Privacy Practices, which states how Advanced Medical Sports and Spine, PLLC or its employees may use and/or disclose my health information. I understand that it is my right to refuse to sign this acknowledgment, if I so wish. I also understand that Advanced Medical Sports and Spine, PLLC reserves the right to change the terms described. Should this happen, I will receive a revised copy either by mail or in person. By initializing above and signing this form below, I acknowledge that I have received a copy of and that I fully understand and agree to the contents of the Advanced Medical Sports and Spine, PLLC Notice of Privacy Practices.

ASSIGNMENT OF BENEFIT: I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Advanced Medical Sports and Spine, PLLC rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

CREDIT CARD PROCESSING: I hereby authorize Advanced Medical Sport and Spine, PLLC to use my signature below in place of all future signatures required for any of my credit card transactions conducted by Advanced Medical Sports and Spine, PLLC or its employees unless otherwise noted at time of payment. My signature below is my “signature on file” that will be used for all of my credit card transactions processed by Advanced Medical Sports and Spine, PLLC which require my signature. This agreement will remain in effect until Advanced Medical Sports and Spine, PLLC receives written notification from me or my financial institution noting otherwise.

TAPING OR RECORDING OF VISIT: I hereby agree and fully understand to refrain from any type of video, audio or electronic recording at any location within these offices, as any type of video, audio or electronic recording at any location within these offices is strictly prohibited. I understand that this policy helps ensure confidentiality and privacy. I also agree to not allow any visitor(s) who accompanies me to my visit to participate in any type of electronic recording at any location within these offices.

By my signature below I attest that I am capable of reading and comprehending this form without assistance, and I have signed the form of my own free will. I agree that I have been made aware of the availability of assistance and/or an interpreter to help me in completing this form, and declined any aid. By my signature below, I hereby authorize the health care physicians and providers of Advanced Medical Sports and Spine, PLLC with the assistance of other health care providers and assistants selected by them, to provide medical care and treatment to me.

By initializing above and signing below, I have read, understand, and agree to the policies noted above. I also agree that I was able to have all of my questions answered regarding these policies.

Printed Name: ____
Signature: ____
Date of Birth: ________/________/________
Today's Date: ________/________/________

ADVANCED MEDICAL SPORTS AND SPINE, PLLC
PAYMENT POLICY

Thank you for choosing us as your comprehensive pain care center. We are committed to providing you with quality and affordable health care. Because some patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. Your signature indicates that you have read, familiarized yourself with, understand, and agree to each policy. A copy of this form will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles and balances. All co-payments, deductibles, and balances must be paid at the time of service and prior to seeing a provider. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. We accept most credit cards except American Express, cash, and checks. Please note, returned checks will be processed with a service charge of $35.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver’s license or passport and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30 day period, our physician(s) will only be able to treat you on an emergency basis. Please be aware that partial payments will not be accepted unless otherwise negotiated.

8. Missed appointments. Our policy is to charge $50 for missed appointments not canceled within a reasonable amount of time, being at least 24 hours prior to appointment. These charges will be your responsibility and billed directly to you. Your insurance company will not cover this cost. Please help us to serve you better by keeping your regularly scheduled appointment. Missed appointments take an appointment away from a patient that requires our help. Two or more missed appointments will result in us being unable to schedule you for future appointments.

9. Late Arrival or Rescheduling Policy. Our policy is to charge $25 for late arrivals or rescheduling that occurs within a 24 hour time frame prior to appointment. The appointment time you are given is when you are expected to be in the exam room or operating room. We require that new patients come in 30 minutes early, and established patients 15 minutes early to complete paperwork. Patients coming for a procedure must arrive 30 minutes early if they require sedation, and 15 minutes if they do not. Patients who arrive late to an appointment will not be guaranteed to be seen and cannot demand to do so. This can cause a backlog in the schedule which can affect all patients throughout the rest of the day. You must account for all situations such as parking, getting lost, or traffic.

10. Form Completion Policy: In the event that we are asked to complete a form for you, it is our policy to assess a minimum non-refundable charge of $15. This charge must be paid in full prior to completion and release of the form. Please note, that in no way does payment for completion of the form influence the way in which the form shall be filled out.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

Assignment and Release:

I have read and understand the payment policy and agree to abide by its guidelines. I fully acknowledge that I have been given ample opportunity to discuss this policy in full with all of my questions answered to my complete satisfaction by the staff of Advanced Medical Sports and Spine, PLLC such that I fully accept full financial responsibility for all charges for services provided to me by Advanced Medical Sports and Spine, PLLC not covered by my healthcare insurance. I fully assign directly to Advanced Medical Sports and Spine, PLLC all benefits, otherwise payable to me necessary to secure the payment of benefits to Advanced Medical Sports and Spine, PLLC. I fully authorize the use of my signature below on all manual or electronic insurance submissions. Certain test(s) may be ordered by Advanced Medical Sports and Spine, PLLC; in which, I fully agree to be financially responsible for these services should they be considered “non-covered” or “not medically-indicated” by my healthcare insurance. If my treatment is involved with a work-related injury and Advanced Medical Sports and Spine, PLLC is to file Workers' Compensation claims on my behalf, I fully authorize Advanced Medical Sports and Spine, PLLC to discuss the plan of treatment, care, and appointment information with the claims payers or caseworkers. Should my account become delinquent >30 days, I fully authorize an additional 1.5% finance charge be added monthly to my account until collection by Advanced Medical Sports and Spine, PLLC. In the event that my delinquent account is forwarded to an attorney/agent for collection by Advanced Medical Sports and Spine, PLLC, I fully authorize an additional payment by me equaling 30% of the highest outstanding balance and/or all attorney/agent fees and costs incurred to collect the unpaid debt as reasonable fees for an attorney/agent to collect my delinquent account for the services provided for me by Advanced Medical Sports and Spine, PLLC.

____
Name of patient or responsible party

____ ______________________
Signature of patient or responsible party Date

ADVANCED MEDICAL SPORTS AND SPINE, PLLC
PATIENT REGISTRATION FORM

Patient Name:					D.O.B:	Age:
Home Address:			City:		State:	Zip:
Occupation:	Social Security No.	Marital Status:	Sex:	Home Phone:		
Employer:	Address:	Work Phone:	Cell Phone:			
Spouse's Name(or Parent):	Spouses or Parents Employer:	Spouse's or Parent work Phone:				
Spouse's or Parent's Address: (if Different)						
Emergency Contact:	Phone:					
Referring Physician:	Address:	Phone:	Fax:			

BILLING AND INSURANCE INFORMATION

Primary Insurance:	ID or Policy No.:	Group/code:
Address:	Subscriber's Social Security:	Insurance Phone:
Subscriber's Name:	Subscriber's D.O.B:	Relationship:
Secondary Insurance:	ID or Policy No.:	Group/code:
Address:	Subscriber's Social Security:	Insurance Phone:
Subscriber's Name:	Subscriber's DOB:	Relationship:

Please list your email address: ____

Government agencies require us to ask you the following demographic information:

Are you: ☐ Hispanic ☐ Non-Hispanic ☐ Not specified

What race do you consider yourself to be: ______________________________

What is your preferred language: ______________________________

Marital Status: (please circle) Married Single Divorced Separated Widowed Partnered