Metropolitan pain center

3716 University Blvd South Ste 1
Jacksonville, FL 322016
Phone: 904-296-3611
Fax : 904-296-3617

DATE: _____ HOME PHONE:_____SS #:_____

PATIENT:_____
Last Name First Name Middle Initial

STREET/MAILING ADDRESS: _____

CITY: _____ STATE:_____ZIP CODE: _____

SEX: ☐ M ☐ F AGE: ____ DATE OF BIRTH: _____ MARITAL STATUS: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____ CITY:_____STATE:____ZIP:_____

WORK PHONE: _____OCCUPATION:_____

DO YOU HAVE MEDICAL INSURANCE? ☐ No ☐ Yes (please complete below)

INSURANCE PLAN: _____ SUBSCRIBER NAME: _____

ID #: _____ SUBSCRIBER'S DOB:_____

SUBSCRIBER'S SS#: _____

SECONDARY INSURANCE PLAN (If any): _____

SUBSCRIBER NAME: _____DOB: _____SS #:_____

EMERGENCY CONTACT: _____RELATIONSHIP:_____

EMERGENCY CONTACT PHONE: _____

WHO REFERRED YOU TO US?: _____

ASSIGNMENT & RELEASE

I, the undersigned, have insurance coverage with _____ and assign

directly to DR. ISMAIL SALAHI or METROPOLITAN PAIN CENTER all medical benefits, if any, otherwise payable to me for services / treatment rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ / _____
Signature of Insured / Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. ISMAIL SALAHI or METROPOLITAN PAIN CENTER for any services furnished me by that physician. I authorize the 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 understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ / _____
Signature of Beneficiary Date

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# CONSENT FORM

I understand that as part of my health care at Metropolitan Pain Center, MPMC creates and maintains records describing my physical and mental health history, symptoms, examinations, test results, diagnoses, treatment and plans for future care or treatment. I understand this information serves as:

- A basis for planning my care and treatment,
- A means for communicating among the staff at MPMC who contribute to my care,
- A means for verification of services to any insurance provider, and a
- A tool for healthcare operations, such as assessing quality and reviewing competence of healthcare professionals.

I understand that as a condition of receiving treatment from MPMC, they may use or disclose my personally identified health information for such treatment, payment and operations purposes. These uses and disclosures are more fully explained in the Privacy Notice that has been provided to me and which I have had the opportunity to review.

I understand the privacy practices described in the Privacy Notice may change over time and that I have a right to obtain any revised Privacy Notice by contacting the office to make such a request.

I also understand I have the right to request MPMC to restrict how my health information is used or disclosed by completing a Disclosure Restriction Request form. MPMC does not have to agree to my request for the restriction, but if it does agree, it is bound to abide by the restriction as agreed.

Finally, I understand I have the right to revoke/withdraw this consent, in writing, at any time. My revocation will be effective except to the extent that MPMC has taken action in reliance on my consent for use or disclosure of my health information. Provision of future treatment may be withdrawn if I withdraw my consent.

_____ _____

SIGNATURE DATE

_____ _____

PRINTED NAME WITNESS

If Personal Representative, describe authority to sign _____

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# FINANCIAL POLICY
Revised 10-02-06

Dear Patient:

Thank you for choosing the Metropolitan Pain Center for your health care needs. We hope that you understand that our financial policy is a necessary part of assuring the financial resources required to maintain our facility for the patients and our community. Therefore, we have instituted the following policies. We ask that you read them carefully and sign this prior to seeing the physician.

Payment for services is due at the time they are rendered. We accept cash, check and all major credit cards. We will be happy to process your insurance as long as you provide us with your current insurance cards and accurate insurance information for filing. We currently participate with Medicare and most major insurance company plans. If you are covered under a HMO plan, you must have a REFERRAL from your primary care physician. You must make sure we are listed as providers under your insurance plan. We must emphasize the following policies:

- Co-payments and deductibles are due at the time of service.
- If you belong to an HMO or POS plan, you must have a referral form with you each and every time you arrive for an office visit. Some referrals may include several visits. *If you do not obtain a referral and you are seen here in the office, you will be fully responsible for payment at the time medical care is rendered.*
- Not all services are covered as benefits with all insurance companies. Many companies select services that they will cover. *Any charges incurred that are not paid by your insurance company, are solely your responsibility (i.e. – Medicaid will NOT cover the Medicare deductibles or 20% coinsurance).*
- If your insurance company does not pay your balance in full within 45 days, we ask that you contact the customer service department (phone number found on your insurance card) to help expedite payment to us.
- If your insurance company does not pay in full within 60 days, we require you to pay the balance due immediately in cash, check or credit card.
- Returned checks will be subject to a $35 return check fee, and you will lose the privilege of writing checks here in the future.
- All balances over 90 days old will be reviewed and turned over to our collections department for payment which will result in an additional 35% penalty fee added to your balance, and you will no longer receive services from Metropolitan Pain Center.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate such problems to us so that we can assist you in the management of your account. Again, thank you for choosing us for your pain management needs and we appreciate the opportunity to serve you.

_____ _____

SIGNATURE DATE

By my signature, I indicate that I have read the above policies and agree to its provisions.

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# LABORATORY POLICY

Due to recent changes in our office policy and in an effort to remain compliant with the Federal and State Regulations regarding controlled substances, the following changes will be implemented effective immediately.

Any active patient will be required to undergo a random drug screen in the office without notice. These tests will be administered RANDOMLY, and all patients will be required to pay for these tests on the day that they are administered. Most PPO insurances will pay for these tests. Medicaid and some HMO insurances including Florida Blue and Avmed will NOT pay for these tests. We will be happy to file your insurance for the tests if it is a covered benefit. If your insurance does not allow for payment of these tests, you will be responsible for a fee at the time of service. No prescriptions will be administered without payment due.

We regret any inconvenience this may cause but it is necessary to maintain proper record keeping and reduce overhead costs to this medical facility while maintaining compliance with the regulatory boards. You have the right to refuse drug testing. We also reserve the right to refuse to prescribe to you. If you choose to decline the drug testing when offered, please notify the doctor. We appreciate your understanding and cooperation in making this a safe and legal avenue for obtaining narcotic medication. Please review your narcotic contract with us for additional information.

Thank you,

Metropolitan Pain Management Center

PATIENT SIGNATURE DATE

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# Narcotic Medication and Refill Policies

We at Metropolitan Pain Management Center understand that sometimes certain pain medications are necessary to provide you with an improved quality of life. Due to the circumstances beyond our control, we find it helpful to institute an agreement between you and your doctor regarding these medications. If you and your doctor decide to add certain medications to your regimen, it is important that you have a thorough understanding of what these medications are, including their expected benefits, side effects and potentials for becoming habit-forming. We will do our best to work with you to find an appropriate medication and dosage regimen that makes you more comfortable.

As part of your pain curriculum, you may be asked to have certain tests performed, given medications, injections and have procedures done in order to lessen your pain. You may also be asked to participate in other modalities including physical therapy, exercises, alternative medicine and psychological counseling. These suggestions are made by your doctor in order to improve your life and you will be expected to comply with all recommendations made and appointments given. If you have difficulty with anything your doctor prescribes, please discuss it openly and all questions will be answered to the best of our abilities. We ask you to place your trust in our care, as we have your best interests at heart always.

Certain pain medications are classified by the government as “controlled substances”, and as such are governed by strict laws designed to protect everyone. If you are given such a substance for your pain control, you must take it exactly as prescribed on the bottle. Failure to comply with this may result in your medication being withdrawn, and you may experience unpleasant effects by taking them in ways other than prescribed. If you experience problems with your medications, your doctor will discuss this with you and make alternative choices as needed.

Please take your medications seriously, as we do, and do not allow anyone else to take them. Keep them in a safe place. You will be responsible for them; should you lose them or run out of medication before the allotted time for a refill, you can not be given more. This is not only our policy, but a federal law as well. Requests for early refills can not be honored and telephone calls for this will not be returned. If you have to stop taking your pills for any reason, do not depose of them. Return them to your doctor on your next visit so he or she can properly account for them and dispose of them in a correct fashion.

Do not take alcohol or other non-prescription substance while you are taking these medications as serious and fatal interactions could result. You may be asked to have a random drug screen performed, and we routinely perform these on patients without notice. You have the right to refuse this test, but this may result in cessation of your medication and discharge from the clinic.

Please make your phone requests for refills during normal business hours, as they will not be accepted at other times. Prescriptions can not be mailed to you; you must physically pick them up at the office in order to have them filled. If you have difficulty with transportation, talk to your doctor about alternative arrangements. Please call us 2-3 days prior to being out of medication to allow your doctor time to write your refill and have it ready for you. Do not wait until the last minute, as these requests can not be honored.

If you are taking controlled substances for pain, you are asked to get them filled at one pharmacy only. Do not use multiple pharmacies because your medication may be stopped. Please give us the name and number of your pharmacy for our records. At this time, we are unable to phone-in refills for your medications, so please use them wisely.

You will be given a copy of this contract once you read it, agree to it and sign it. A copy will remain in your chart and one will be sent to your referring physician. Once you agree to accept pain medication from us, please do not ask other doctors for more. Failure to comply with this agreement gives your doctor the right to terminate this contract. If you have questions, please ask your physician.

_____ _____

PATIENT SIGNATURE DATE

_____

PHYSICIAN SIGNATURE

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**PRIVACY PRACTICES STATEMENT**
**ACKNOWLEDGEMENT OF RECEIPT**

**Patient Name:** _____

**Address:** _____

**Telephone:** _____

**E-mail:** _____

**Patient Medical Record Number:** _____

**Social Security #:** _____

**I, _____, acknowledge that I have read and received a copy of the Privacy Statement Form from METROPOLITAN PAIN CENTER.**

**Patient Signature: _____Date:_____**

**Personal Representative Signature: _____Relationship:_____**

**FOR OFFICE USE ONLY:**

**____ Patient refused to sign**

**____ Patient unable to sign due to communication / language barrier**

**____ Patient unable to sign due to emergency situation**

**____ Other (please explain below)**

_____

_____

_____

_____

_____

**Office Representative Signature: _____Date:_____**

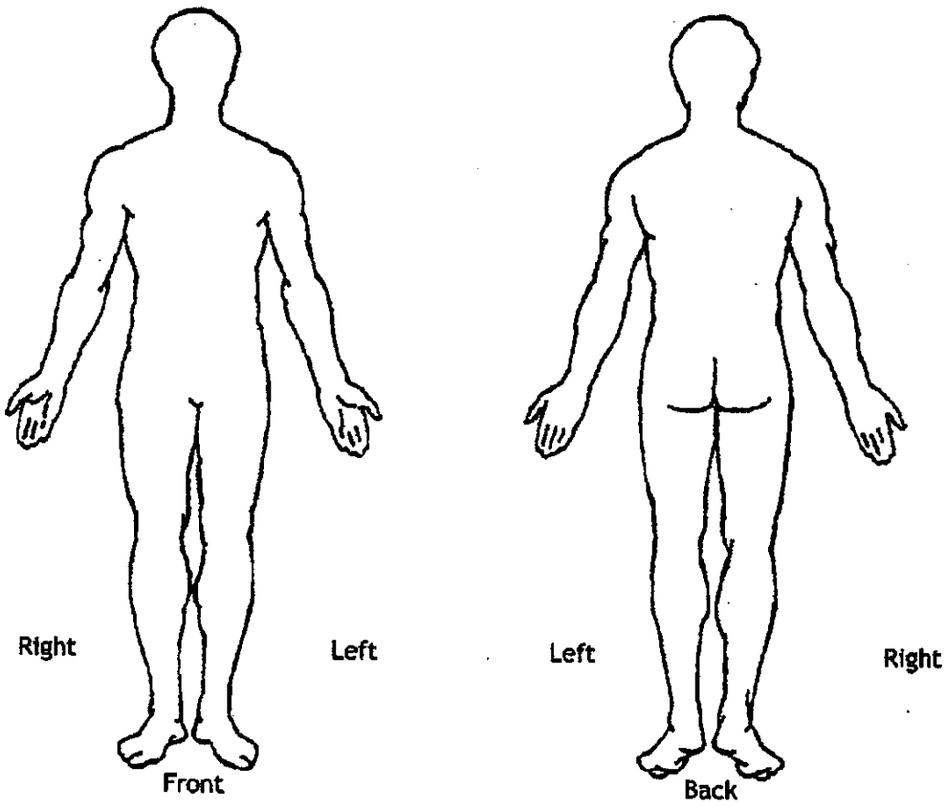
# Patient Pain Drawing

Name _____ Date _____

**Where is your pain now?**

- Mark the areas on your body where you feel the sensations described below, using the appropriate symbol.
- Mark the areas of radiation.
- Include all affected areas.
- To complete the picture, please draw in your face.

| Aching | Numbness | Pins and needles | Burning | Stabbing |
|---|---|---|---|---|
| ▲ ▲ ▲ | = = = | o o o | × × × | / / / |




**How bad is your pain now?**

- Please mark with an X on the body form where the pain is worst now.
- Please mark on the line how bad your pain is now:

No pain _____ Worst possible pain