THE PAIN CENTER

VIRGINIA - WEST VIRGINIA - MARYLAND

COMPREHENSIVE PAIN CARE

** PLEASE BRING COMPLETED PACKET TO YOUR APPOINTMENT. DO NOT MAIL BACK!**

Today's Date:_____
Appointment Date:_____
Appointment Arrival Time:_____

Dear, _____

We welcome you to our practice and appreciate the opportunity to be of service to you. Our staff us a group of well-qualified professionals, who work as a team to provide you with the highest level of treatment in a professional and caring environment. Your appointment is scheduled with _____ on _____. We ask that you arrive at _____ to allow us time to update your information and copy your insurance card((s). Please bring a complete list of medications that you are currently taking, allergies to any medications, and your surgical history. Per office policy, prescriptions and injections are NOT given at your new patient appointment.

Referrals: If your insurance is an HMO, a referral from your Primary Care Physician (PCP) is REQUIRED for you to be treated by our providers. You are responsible for providing us with the referral before you are able to be scheduled and seen. If you fail to provide us with a referral, you will be responsible for your charges.

Workers Comp: Please bring ALL claim information and case number.

Personal Injury: Please bring ALL claim and attorney information.

Medicare: We do participate with Medicare. We will file your claim for you and accept what Medicare allows. If you have a secondary carrier, we will submit any unpaid balances to them. ALL payments from Medicare and secondary carriers should be sent to OUR office. Please keep in mind that you may be responsible for any charges that are not covered by Medicare or secondary insurance such as deductibles, co-payments, and co-insurances.

Commercial Insurance: We do participate with a number of insurance carriers. Please see attached insurance list to find out if we participate with your particular insurance. If so, we will be glad to submit the charges to your insurance for your visit and accept the allowed coverage amount. Please keep in mind that you will be responsible for co-payments (due at the time of service), deductibles, and co-insurances.

If you do not have insurance or have an insurance we do not participate with, we will expect your payment of service rendered at the time of your appointment. You will receive two copies of the fee ticket to use when submitting your claim to your insurance company for reimbursement. Please note that the charge for your visit depends on the level of service rendered to you. Prices may be higher if diagnostic/surgical procedures are required. Feel free to discuss charges with our billing department prior to having these services. Narcotics are NOT prescribed for SELF-PAY visits.

Forms of Payment We Accept:
- Cash
- Check
- Visa
- Mastercard
- Discover
- American Express

1839 W. Plaza Drive
Winchester, VA 22601
Phone (540) 773-2689
Fax (540) 486-4166

1000 Tavern Road, Suite 300
Martinsburg, WV 25401
Phone (304) 263-6165
Fax (304) 263-6536

19638 Leitersburg Pike, Suite 204
Hagerstown, MD 21742
Phone (240) 850-3210
Fax (240) 513-4536

ThePainCenterUS.com

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VIRGINIA WEST VIRGINIA

COMPREHENSIVE PAIN CARE

Name: (Last) _____(First)_____(M.I.)_____ **Date:**____/_____/_____

Address: _____

City: _____ **State:**_____ **Zip:**_____

Home Phone: _____/_____/_____ Cell Phone: _____/_____/_____ Work Phone: _____/_____/_____

Email Address: _____ ☐ Do not have email ☐Do not wish to provide

Date of Birth: _____/_____/_____ Gender: ☐Male ☐Female

Social Security Number _____/_____/_____

Emergency Contact:_____ Relationship:_____

Home Phone:_____/_____/_____ Cell Phone:_____/_____/_____

PCP Physician: _____Referring Physician: _____

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Employment: ☐Employed ☐Unemployed ☐Disabled ☐Retired

Employer:_____Occupation:_____

Employer Address:_____

Guarantor (if patient is under 18 _____

Relationship:_____Home Phone:_____/_____/_____ Cell Phone:_____/_____/_____

Is this a: ☐Workers Compensation Injury ☐Accident Related Injury ☐Neither

Primary Insurance Carrier:_____

Policy #: _____ Group #: _____

Subscribers Name:_____

Subscribers Date of Birth: _____/_____/_____ Relationship to Patient:_____

Secondary Insurance Carrier:_____

Policy #: _____ Group #: _____

Subscribers Name:_____

Subscribers Date of Birth: _____/_____/_____ Relationship to Patient:_____

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Chief Complaint

_____

_____

_____

Smoking Status (circle)

☐Current every day smoker ☐Current some day smoker ☐Former smoker ☐Never smoked

What is your usage per day? _____

Alcohol Use (circle)

☐Non-drinker ☐Drink socially ☐Drink daily ☐History of alcohol abuse

How much do you drink per week? _____

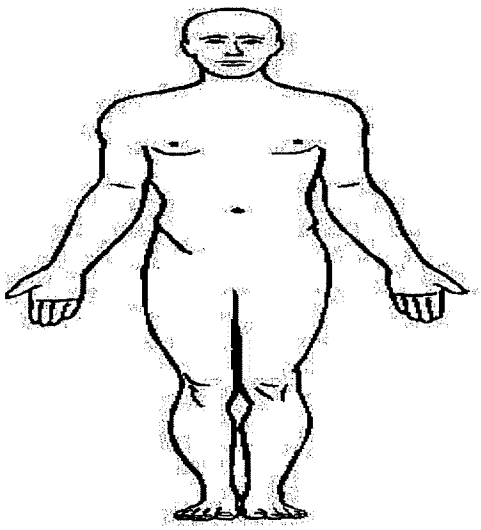
Illicit Drug Use

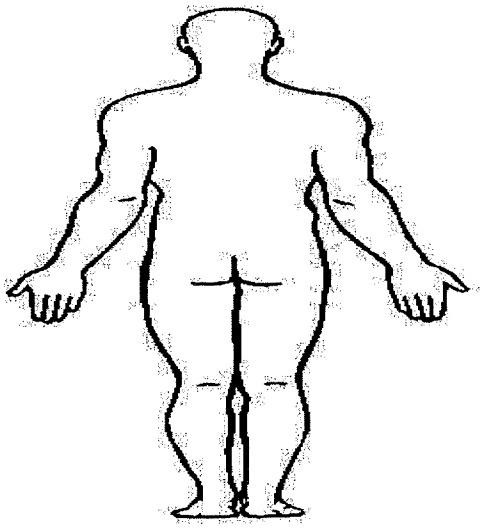
Do you use any illicit drug? ☐Yes ☐No

If yes, please specify ☐Marijuana ☐Cocaine ☐Heroin ☐Methamphetamines

☐Opioids ☐Inhalants ☐Other: _____

Location of pain. Draw X to indicate areas of deep pain. Draw Z to indicate areas of tingling and numbness. Use arrows to show areas that pain or tingling radiates/travels.





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What makes your pain better?

☐Standing ☐Sitting ☐Bending Forward ☐Bending Backwards

☐Walking ☐Medications ☐Exercise ☐Injections

☐Cold ☐Heat ☐Rest ☐Change Positions Frequently

☐Other:_____

_____

What treatments have you tried for your pain?

☐Medications ☐Physical Therapy ☐Acupuncture ☐Injections ☐TENS Unit

☐Chiropractic Care ☐Pain Management Service Elsewhere ☐Psychology/Counseling

Please specify your response (examples list names of medications tried, name of previous pain management, type of injections, etc.)

_____

_____

_____

Are any of the following symptoms associated with your pain?

☐Numbness ☐Swelling ☐Joint Pain ☐Muscle Pain ☐Tingling ☐Nausea

☐Palpitations ☐Dizziness ☐Vomiting ☐Seizures ☐Fainting

☐Shortness of Breath ☐Radiating Pain

Are you allergic to any medications, food, etc. Please specify (example Penicillin causes rash)

_____

_____

_____

Are you currently taking a blood thinner medication for a blood clotting disorder?

☐Yes ☐No If yes, specify the name of medication: _____

Fracture Repair (specify where the fracture was located)

_____

_____

Arthroscopy (specify the joint and the side)

_____

_____

Joint Replacement (specify the joint and the side)

_____

_____

Have you ever had surgery on your spine?

☐Yes ☐No If yes, please specify the location of the spine

☐Cervical (neck) ☐Thoracic ☐Lumbar

Please list any other surgeries you have undergone

_____

_____

What diagnostic testing have you undergone related to this pain?

☐MRI ☐CT Scan ☐XRAY ☐Nerve Conduction Study

Please specify the name of facility where testing was done:

_____

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Patient Name: _____

Please check all CURRENT symptoms

General Health **All Normal**
- ☐ Fever
- ☐ Chills
- ☐ Change in appetite
- ☐ Lack of energy
- ☐ Unexplained weight loss/weight gain

Ophthalmologic **All Normal**
- ☐ Vision changes
- ☐ Blurred vision

ENT **All Normal**
- ☐ Sore throat
- ☐ Sinus pain
- ☐ Hoarseness
- ☐ Swollen glands
- ☐ Difficulty swallowing

Endocrinology (Glands) **All Normal**
- ☐ Intolerance to heat or cold
- ☐ Weakness

RESP (LUNGS & BREATHING) **All Normal**
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing

Cardiovascular **All Normal**
- ☐ Chest pain
- ☐ Palpitations

GI (Stomach and Intestines) **All Normal**
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Abdominal pain

(MUSCLES BONES & JOINTS) **All Normal**
- ☐ Radiating leg pain
- ☐ Loss of bowel/bladder control
- ☐ Radiating arm pain
- ☐ Numbness/tingling
- ☐ Lower extremity weakness
- ☐ Upper extremity weakness
- ☐ Shoulder pain
- ☐ Neck pain
- ☐ Low back pain

Peripheral Vascular **All Normal**
- ☐ Cold extremities
- ☐ Decrease sensation in extremities

Integ (Skin Hair Breast) **All Normal**
- ☐ Discoloration
- ☐ Rash
- ☐ Nail changes

Neurologic (brain and nerves) **All Normal**
- ☐ Dizziness
- ☐ Balance difficulty
- ☐ Headache
- ☐ Loss of strength
- ☐ Loss of use of extremity

Psychiatric (Mood & Thinking) **All Normal**
- ☐ Depressed mood
- ☐ Feelings of depression
- ☐ Anxiety
- ☐ Difficulty sleeping2

THE PAIN CENTER

VIRGINIA WEST VIRGINIA

COMPREHENSIVE PAIN CARE

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to the providers at The Pain Center. When you schedule an appointment with The Pain Center we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Effective immediately, any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hour notice** will be considered a No Show and charged a **$50.00 fee** (office visit) / **$100 fee** (procedure).
- Any established patient who fails to show or cancels/reschedule an appointment with no 24 hour notice a **second time** will be charged a **$75.00 fee** (office visit) / **$150 fee** (procedure).
- If a **third,** No Show or cancellation/reschedule with no 24 hour notice should occur the patient may be **dismissed** from The Pain Center.
- Any new patient who fails to show for their Initial Visit will not be rescheduled.
- The fee is charged to the patient, not the insurance company, and is **must be paid in full before any further appointments can be made.**

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office.

You may contact The Pain Center at the numbers below. Should it be after regular business hours Monday through Friday or a weekend, you may leave a message. Messages left at either location are acceptable.

The Pain Center of West Virginia 304-263-6165 located in Martinsburg, WV
The Pain Center of Virginia 540-773-2689 located in Winchester, VA
The Pain Center of Maryland 240-850-3210 located in Hagerstown, MD

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

I hereby consent to and authorize The Pain Center to apply the benefits on my behalf for the services rendered by Dr. Waheed Baksh, Kristen Williams PA-C, and Staff. I request payment from my insurance or responsible party be made to The Pain Center. I certify that all information I have provided is correct to the best of my knowledge. I authorize the release of any medical information for this claim or any related claim. I permit a copy of this authorization be used in place of the original. I may revoke this authorization at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay the medical services proved to me. I understand that payment is due when the statement is rendered.

_____ _____

Signature Relationship to Patient

_____ _____

Printed Name Date

THE PAIN CENTER

VIRGINIA

WEST VIRGINIA

COMPREHENSIVE PAIN CARE

HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April, 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. By signing this form you acknowledge that you have received a copy of our Notice of Privacy Practices to read.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified on your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Dept. of Health and Human Services. www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition of information which is not already a matter of public record. The normal course providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination rooms, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
3. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
4. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
5. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
6. We agree to provide patients with access to their records in accordance with state and federal laws.
7. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

1839 W. Plaza Drive • Winchester, VA 22601
Phone (540) 773-2689 • Fax (540) 486-4166

1000 Tavern Road, Suite 300 • Martinsburg, WV 25401
Phone (304) 263-6165 • Fax (304) 263-6536

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VIRGINIA

WEST VIRGINIA

COMPREHENSIVE PAIN CARE

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Dr. Waheed Baksh @ The Pain Center. When you schedule an appointment with The Pain Center we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Effective immediately, any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hour notice will be considered a No Show and charged a $25.00 fee (office visit) / $100 fee (procedure).
- Any established patient who fails to show or cancels/reschedule an appointment with no 24 hour notice a second time will be charged a $50.00 fee (office visit) / $100 fee (procedure).
- If a third No Show or cancellation/reschedule with no 24 hour notice should occur the patient may be dismissed from The Pain Center.
- Any new patient who fails to show for their Initial Visit will not be rescheduled.
- The fee is charged to the patient, not the insurance company, and is must be paid in full before any further appointments can be made.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our office.

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The Pain Center of Virginia 540-773-2689 located in Winchester, VA

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

You will be asked to sign this form electronically at the Front Office.

A copy for your records can be provided at your request.

If you have any questions, please ask.

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Providing quality health care is a complex task which requires close cooperation between patients and health facility personnel. Patients can take responsibility for their care by helping the medical team give the best possible care. These patient responsibilities are:

1. *Providing Information.* The responsibility to provide, to the best of their knowledge, accurate and complete information about complaints, past illness, hospitalizations, medications, and other matters relating to their health. A patient has the responsibility to let his/her health care provider know whether he or she understands the treatment and what is expected of him/her.
2. *Respect and Consideration.* The responsibility for being considerate of the rights of other patients and health care personnel and for assisting in the control of noise, smoking, and the number of visitors. The patient is responsible for being respectful of the property of other persons and of the facility.
3. *Compliance with Medical Care.* The responsibility for complying with the medical and nursing treatment plan, including follow-up care recommended by health care providers. This includes keeping appointments on time and notifying the health facility when appointments cannot be kept.
4. *Pain Management.* Patients and/or their family members have the responsibility to ask the health care provider what to expect regarding their pain management and to participate in discussion and decisions. Patients should ask for pain relief when the pain first begins and notify the health care provider if the pain is not relieved; share the concerns.
5. *Rules and Regulations.* The responsibility for following the rules and regulations affecting patient care and conduct.
6. *Reporting of Patient Concerns.* The responsibility for helping the health facility commander to provide the best possible care to all beneficiaries. Patient's recommendations, questions, or concerns, should be reported to our Patient Representative at 304-263-6165.

9.1. Each pain management clinic shall have policies and procedures that guarantee the following rights to patients:9.1.a. The right to be informed, both verbally and in writing, of clinic fees, rules and regulations and patient's rights and responsibilities in advance of the clinic providing care. The rights and responsibilities shall be posted prominently and reviewed with the patient at the initial visit and at any time changes in the rights and responsibilities occur. The rights shall be explained to the patient in a manner in which the patient can understand, including the use of interpreters and personnel experienced in communication with vision and hearing impaired individuals;

9.1.b. The right to receive treatment provided in a fair and impartial manner regardless of race, sex, age, sexual orientation and/or religion;

9.1.c. The right to participate in the development and implementation of his or her plan of care and to make decisions regarding that care. The written plan of care shall be reviewed at least every ninety (90) days by the patient's physician and shall be maintained in the patient's chart;

9.1.d. The right to be informed that prior to dispensing or prescribing a controlled substance, the treating physician must access the Controlled Substances Monitoring Program database maintained by the West Virginia Board of Pharmacy to ensure that the patient is not seeking controlled substances from multiple sources. The treating physician shall also review the database at each patient examination, or at least every ninety (90) days during the course of ongoing treatment;

9.1.e. The right to be informed that the patient may be required to submit to drug testing and that the collection of specimens may be observed, if deemed necessary;

9.1.f. The right to treatment at a pain management clinic that provides an adequate number of competent, qualified and experienced professional staff to implement and supervise the written plan of care;

9.1.g. The right to be informed of the extent of confidentiality, including the conditions under which information can be released without consent, the use of identifying information for the purposes of clinical evaluations, billing and statutory requirements for reporting abuse; and

9.1.h. The right to care in a safe setting.

9.2. The clinic shall establish a patient grievance process which shall be displayed in the patient care area. A grievance may be verbal or written. The grievance process shall include:

9.2.a. Who to contact to file a grievance;

9.2.b. Time frames for review of the grievance;

9.2.c. Provision of a response to the grievant that contains the name of the clinic contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process and the date of completion of the investigation;

9.2.d. The right of a patient to initiate grievance procedures without fear of reprisal; and

9.2.e. The address and telephone number of the Office of Health Facility Licensure and Certification

9.3. The clinic shall have policies and procedures which address safety and security issues for patients and staff, including training staff to handle physical or verbal threats, acts of violence, inappropriate behavior or other escalating and potentially dangerous situations, with emphasis on when security guards or police need to be summoned. In regards to security personnel, the use of guns, handcuffs and mace is prohibited.