



# TRIDENT PAIN CENTER, PA

9267-G Medical Plaza Drive, North Charleston, SC 29406  
Phone (843) 797-3636 Fax (843) 797-3637

Dear \_\_\_\_\_:

Thank you for scheduling an appointment with Trident Pain Center, PA.

Your Established Patient Evaluation has been scheduled for \_\_\_\_\_.

*If you are more than 20 minutes late, your appointment will be rescheduled. If you need to reschedule or cancel your appointment, please give 24 hour notice so we may offer the appointment to another patient. **All appointments cancelled without a 24 hour notice and all missed appointments will result in a \$35.00 fee.** This fee must be paid in full by the patient before any further appointments are scheduled.*

Attached you will find the following paperwork to be completed:

- Patient Information Form
- Established Patient Clinical Questionnaire
- Financial Policy Agreement
- Notice of Privacy Practices (for your records)
- Authorization of Use and Disclosure of Protected Health Information
- Patient's Rights and Responsibilities

*Having your paperwork completed prior to arrival will significantly decrease the wait time for your appointment.*

Along with your completed paperwork, please bring the following with you on the day of your appointment:

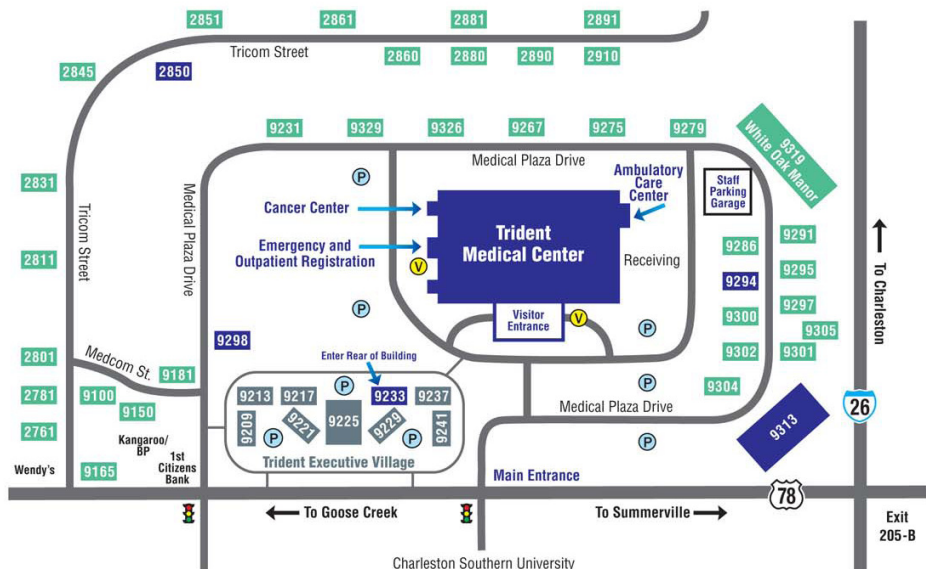
- \_\_\_\_\_ Insurance cards and a photo ID
- \_\_\_\_\_ List of all medications (prescription and otherwise) you are currently taking
- \_\_\_\_\_ Licensed Driver

*Should you receive an injection you will not be permitted to drive yourself home. For your safety, **the driver must remain in the building throughout the appointment, approximately 2-3 hours.** If your driver is not in the building when your evaluation is complete, the procedure will be rescheduled.*

If you have any questions regarding this letter or the attached forms, please feel free to contact me (843) 797-3636 ext. 207. I am available to assist you Monday – Friday 8:00am to 5:00pm.

Sincerely,

Charlene Mullineaux  
Referral Coordinator



**PATIENT INFORMATION FORM:**

**PATIENT**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_  M  F  
Mailing Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

**SPOUSE**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_  M  F  
Mailing Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Phone #: \_\_\_\_\_

**INSURANCE**

Primary: \_\_\_\_\_  
ID: \_\_\_\_\_ Group ID: \_\_\_\_\_ Policy Holder: \_\_\_\_\_  
Coverage Dates: \_\_\_\_\_ to \_\_\_\_\_ Insured thru Employer:  Yes  No Pre-Certification Required:  Yes  No  
 Secondary: \_\_\_\_\_  
ID: \_\_\_\_\_ Group ID: \_\_\_\_\_ Policy Holder: \_\_\_\_\_  
Coverage Dates: \_\_\_\_\_ to \_\_\_\_\_ Insured thru Employer:  Yes  No Pre-Certification Required:  Yes  No  
 Tertiary: \_\_\_\_\_  
ID: \_\_\_\_\_ Group ID: \_\_\_\_\_ Policy Holder: \_\_\_\_\_  
Coverage Dates: \_\_\_\_\_ to \_\_\_\_\_ Insured thru Employer:  Yes  No Pre-Certification Required:  Yes  No

**OTHER**

Worker's Compensation Carrier: \_\_\_\_\_  
Claim #: \_\_\_\_\_ Date of Injury: \_\_\_\_\_ Employer: \_\_\_\_\_  
Claims Adjustor: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Attorney: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_ Email: \_\_\_\_\_

**Emergency Contact (someone NOT living with you):**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

**PATIENT NAME (PLEASE PRINT/TYPE)** \_\_\_\_\_  
**RESPONSIBLE PARTY (IF OTHER THAN PATIENT)** \_\_\_\_\_ **RELATIONSHIP** \_\_\_\_\_  
**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**ESTABLISHED PATIENT CLINICAL QUESTIONNAIRE:**

NAME: \_\_\_\_\_ AGE \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ SEX: M / F

1. Have you had any of the following for Pain Management?  
(Please check all that apply and indicate the pain relief experienced with each. 0=NONE)

- Physical Therapy                      0 1 2 3 4 5 6 7 8 9 10
- TENS (Electrical Stimulation) 0 1 2 3 4 5 6 7 8 9 10
- Acupuncture                              0 1 2 3 4 5 6 7 8 9 10
- Chiropractic Treatment                0 1 2 3 4 5 6 7 8 9 10
- Traction                                    0 1 2 3 4 5 6 7 8 9 10
- Heat Therapy                              0 1 2 3 4 5 6 7 8 9 10

2. Have you had any of the following diagnostic procedures performed?  
(Please check all that apply and indicate where the procedure was performed.)

- X-rays                                      \_\_\_\_\_
- Myelogram                                \_\_\_\_\_
- EMG/Nerve Conduction Studies      \_\_\_\_\_
- CAT scan                                  \_\_\_\_\_
- MRI Scan                                  \_\_\_\_\_
- Bone Scan                                  \_\_\_\_\_
- Other (describe)                        \_\_\_\_\_

3. Are you currently, or have you ever been involved in a lawsuit because of your pain?

- No
- Yes                      Lawyer: \_\_\_\_\_ When: \_\_\_\_\_

4. Please list any medical problems you have now or have experienced in the past:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Do you consider yourself:     Healthy     Unhealthy     Disabled

6. Do you take antibiotics for procedures?     No     Yes

7. Please list ALL drug, dye, and/or latex allergies:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Have you had a reaction to IV radiology dye in the past?  No  Yes

9. Were you injured at work?  No  Yes

10. Marital Status:

Single  Married  Divorced  Widowed

11. Do you have any children?

No

Yes          How many? \_\_\_\_\_ Do any live at home with you? \_\_\_\_\_

12. Do you or did you ever smoke?

No

Yes          Number of packs per day? \_\_\_\_\_ Number of years? \_\_\_\_\_ Quit: \_\_\_\_\_

13. Do you drink alcohol?

No

Yes          Number of drinks per day? \_\_\_\_\_ Number of years? \_\_\_\_\_ Quit: \_\_\_\_\_

14. Do you drink alcohol to relieve your pain?

No

Yes

15. Is your mother living?  No  Yes

16. Health problems your mother experienced:

\_\_\_\_\_

\_\_\_\_\_

17. Is your father living?  No  Yes

18. Health problems your father experienced:

\_\_\_\_\_

\_\_\_\_\_

19. Please list chronic health conditions of any immediate family members:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PAST SURGICAL HISTORY:**

20. Please list ALL surgeries you have had:

_____	Date: _____
_____	Date: _____
_____	Date: _____
_____	Date: _____
_____	Date: _____
_____	Date: _____

**MEDICATIONS:**

21. Please list ALL medications you are currently taking for pain:  
(Indicate relief experienced from each. 0=NONE)

_____	0	1	2	3	4	5	6	7	8	9	10
_____	0	1	2	3	4	5	6	7	8	9	10
_____	0	1	2	3	4	5	6	7	8	9	10
_____	0	1	2	3	4	5	6	7	8	9	10
_____	0	1	2	3	4	5	6	7	8	9	10
_____	0	1	2	3	4	5	6	7	8	9	10

22. Please list ALL OTHER medications you are currently taking:

_____	_____
_____	_____
_____	_____

23. Please list all medications you have taken IN THE PAST for pain:  
(Indicate relief experienced from each. 0=NONE)

_____	0	1	2	3	4	5	6	7	8	9	10
_____	0	1	2	3	4	5	6	7	8	9	10
_____	0	1	2	3	4	5	6	7	8	9	10
_____	0	1	2	3	4	5	6	7	8	9	10
_____	0	1	2	3	4	5	6	7	8	9	10
_____	0	1	2	3	4	5	6	7	8	9	10

**SOCIAL HISTORY:**

24. Highest level of education completed:

Grade School    High School    College    Post-graduate

25. What is/was your occupation? (Please describe job duties/responsibilities.)

\_\_\_\_\_  
\_\_\_\_\_

26. Most recent place of employment:

\_\_\_\_\_

27. Present work status:

Full Time    Part Time    Retired    Disabled    Sick Leave

**REVIEW OF SYSTEMS:**

If you have experienced any of the following problems, please fill in the bubble completely.  
(No check marks or cross marks.)

**Constitutional**

- Recent fever  Yes
- Recent fatigue  Yes
- Night sweats  Yes
- Recent weight loss  Yes
- Recent weight gain  Yes

**Eyes**

- Glaucoma  Yes
- Problem with eyes  Yes
- Spots, floaters  Yes
- Cataracts  Yes

**ENT**

- Nose problems  Yes
- Hearing problems  Yes
- Mouth problems  Yes

**Cardiology**

- Chest pain (angina)  Yes
- Irregular heartbeats  Yes
- Heart attack /angina  Yes

**Respiratory**

- Shortness of breath  Yes
- Lung problems  Yes
- Chronic cough  Yes
- Wheezing  Yes

**Gastroenterology**

- GERD  Yes
- Abdominal pain  Yes
- Ulcers  Yes
- Recent blood in stool  Yes
- Recent constipation  Yes
- Recent diarrhea  Yes

**Genitourinary**

- Urinary tract infections  Yes
- Bladder problems  Yes
- Kidney disease  Yes
- Prostate problems  Yes

**Dermatology**

- Recent skin rash  Yes
- Recent skin sores  Yes
- Skin cancer  Yes

**Musculoskeletal**

- Muscle pain  Yes
- Joint problems  Yes
- Walking problems  Yes
- Arthritis  Yes
- History of fractures  Yes

**Endocrinology**

- Diabetes  Yes
- Recent decreased appetite  Yes
- Recent increased appetite  Yes
- Thyroid problems  Yes

**Psychology**

- Any psychiatric condition  Yes
- Alcohol abuse  Yes
- Drug abuse  Yes
- Depression  Yes
- Panic attacks  Yes

**Neurology**

- History of seizures  Yes
- Stroke  Yes
- Memory loss  Yes
- Headaches  Yes
- Speech/language  Yes
- Dizziness  Yes

**Hematology/Lymph**

- Anemia  Yes
- Bleeding/bruising  Yes
- Blood transfusion  Yes

**Allergy**

- Seasonal allergies  Yes
- Hives/itching  Yes
- Frequent sneezing  Yes

**PATIENT NAME (PLEASE PRINT/TYPE)** \_\_\_\_\_

**RESPONSIBLE PARTY (IF OTHER THAN PATIENT)** \_\_\_\_\_ **RELATIONSHIP** \_\_\_\_\_

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**WITNESS INITIALS** \_\_\_\_\_



# TRIDENT PAIN CENTER, PA

9267-G Medical Plaza Drive, North Charleston, SC 29406  
Phone (843) 797-3636 / Fax (843) 797-3637

## FINANCIAL POLICY AGREEMENT

**It is important that you read this policy carefully before you receive treatment.**

We would like to thank you for choosing Trident Pain Center for your health care needs. Our primary concern is that you receive the most appropriate treatment to restore and maintain your good health. Understanding your financial responsibilities and expectations will save you worry and stress later. If you have any questions or concerns about our payment policies, please ask to speak with a financial counselor either by telephone or in person.

Insurance copayments and deductibles are due prior to receiving treatment. Payment for all services not covered by insurance is due at the time of service. We accept cash, check, and, for your convenience, Visa and MasterCard.

We will bill your insurance carrier as a courtesy to you. If you are not covered by Medicare, Medicaid, or a health maintenance organization (HMO) plan contracted with Trident Pain Center, you must understand the provisions set forth below:

- a. Your policy is an agreement between you and the insurance company. At times, even insurance companies that have a contract with TPC do not pay in a timely manner.
- b. If the insurance company has not paid your bill in full within 45 days, we ask that you contact them to facilitate payment.
- c. All charges are your responsibility whether the insurance company pays or not. Not all services are a covered benefit. Our primary contract is with you and not the insurance company.

We understand that things do happen and financial problems may affect your ability to pay the bill in full. We will always do everything we can to work with you. However, we ask that you contact us as soon as possible to work out an arrangement that is satisfactory for everyone.

Due to an increase in patients not attending scheduled appointments, we feel it necessary to strictly enforce our No Show Policy. As a patient, you are required to **contact our office 24 hours in advance** of a scheduled appointment to cancel or reschedule. In the event that you contact us the day of your scheduled appointment, please know that you will be charged a No Show Fee. **You will be required to pay this fee before we schedule your next appointment.** Our No Show Fees are as follows:

Office Visits and Procedures	\$35.00
Radiofrequency Appointments	\$150.00
Massage Therapy Appointments	\$60.00

We appreciate your faith and trust in us and thank you for the opportunity to serve your health care needs.

**ASSIGNMENT AND RELEASE:** I hereby authorize Trident Pain Center, PA to release information acquired during the course of my examination and treatment to Health Care Financing Administration and its agents, MediGap, or any other third party carrier as necessary to secure the payment of any benefits due. I hereby assign payment of said benefits to include Medicare and MediGap directly to Trident Pain Center, PA for any medical procedures performed. I understand that I am responsible for all charges, regardless of insurance status, as well as any associated cost for collection if such actions should become necessary. I agree that this authorization shall be valid until rescinded in writing or replaced by an updated form at a later date. A photocopy of the assignment shall be considered valid as the original. **I have read and fully understand the terms thereof.**

**PATIENT NAME (PLEASE PRINT/TYPE)** \_\_\_\_\_

**RESPONSIBLE PARTY (IF OTHER THAN PATIENT)** \_\_\_\_\_ **RELATIONSHIP** \_\_\_\_\_

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**WITNESS INITIALS** \_\_\_\_\_



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## AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Trident Pain Center, PA may use your information to remind you of upcoming appointments. Typically, appointment reminders are a brief non-specific message left on your answering machine. Appointment reminders may also be mailed in a sealed envelope to your home address. If you do not approve of these methods and would prefer alternative reminder methods please indicate in the space provided below.

How may we contact you regarding appointment reminders? (Check all that apply.)

- Regular Mail     
  Home Telephone     
  Work Telephone     
  Appointment Cards  
 Other (Please Specify) \_\_\_\_\_

May we leave messages regarding appointment reminders, treatment, and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Trident Pain Center, PA? (Check one.)

- No  
 Yes      Restrictions (Please Specify) \_\_\_\_\_

Please list any persons you authorize Trident Pain Center, PA to speak to in the event you are unavailable. (For example, a spouse or relative who may call for appointment or treatment information on your behalf.) Include the name of each and their relationship to you and initial the statement below.

\_\_\_\_\_ I authorize the following person(s) to receive **all health information** about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at Trident Pain Center, PA.

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
 NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

You have the right to request restrictions of use and disclosure of your health information. Please list any restrictions regarding the use and disclosure of your health information and initial the statement below.

\_\_\_\_\_ I DO NOT authorize the following information to be disclosed to any other parties except to me as the patient. \_\_\_\_\_

**RIGHT TO TERMINATE OR REVOKE AUTHORIZATION:** If you change your mind after authorizing use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before notification of your decision. You should contact the PRIVACY OFFICIAL or other authorization representative with any questions regarding this authorization.

**POTENTIAL FOR RE-DISCLOSURE:** The person or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

**EXPIRATION:** This authorization is effective through **12/31/2011** unless revoked or terminated by the patient or patient's personal representative.

**PATIENT NAME (PLEASE PRINT/TYPE)** \_\_\_\_\_  
**RESPONSIBLE PARTY (IF OTHER THAN PATIENT)** \_\_\_\_\_ **RELATIONSHIP** \_\_\_\_\_  
**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**WITNESS INITIALS** \_\_\_\_\_



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### NOTICE OF PRIVACY PRACTICES

Trident Pain Center, PA is committed to protecting your health information. This notice describes how medical information collected by Trident Pain Center, PA may be used and disclosed. This notice describes your rights as they relate to your protected health information and how you may access this information. **Please review carefully.**

**Protected Health Information (PHI) includes but is not limited to name, address, Social Security number, date of birth, treatment, diagnosis, history, and insurance information.** We will use and/or disclose this information for the purpose of daily healthcare operations, treatment, payment of services, appointment reminders, public health reporting, law enforcement, teaching and training. Any other disclosures not listed above will require your written consent. Psychological information will **not** be released under any circumstances. The request for this type of information must be made to the Psychologist with whom the notes originated. Protected Health Information shared by phone includes but is not limited to appointment confirmations, prescription notifications, balance due information, messages requesting a return phone call.

You will be required to sign a release authorizing disclosure of this information prior to your initial visit at Trident Pain Center, PA. You will also be required to maintain a current disclosure release as long as you are receiving treatment from Trident Pain Center, PA.

**Patients have the right to:**

- Request restrictions to Protected Health Information (must be in writing)
- Receive confidential communication (must be in writing)
- Inspect and copy Protected Health Information (\$15.00 charge for copies)
- Amend or submit corrected information about Protected Health Information (must be in writing)
- Receive an accounting of disclosures and uses (1 free copy per year)
- Receive a paper copy of this notice

Trident Pain Center, PA is required by law to maintain the privacy of Protected Health Information and to provide this notice of legal duties and privacy practices. Trident Pain Center, PA is required to abide by the terms of this notice and privacy practices. We are required to notify you if we are unable to agree with a request for restriction or amendments.

**Concerns and complaints regarding privacy practices may be addressed to:**

J. Edward Nolan, MD  
Medical Director  
(843) 797-3636 ext. 201

Amanda Deleon  
HIPAA Officer  
(843) 797-3636 ext. 227

Office for Civil Rights  
US Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201

Trident Pain Center, PA reserves the right to make changes to its notice and provisions by revising this document based on office policy changes and/or State and Federal Law requirements. You will be notified in writing of any changes at your next scheduled office visit.

# PATIENT'S RIGHTS AND RESPONSIBILITIES

Trident Pain Center protects the rights and responsibilities of our patients. The practice recognizes that patients have a fundamental right to considerate care that safeguards their personal dignity and respects their cultural, psychosocial, and spiritual values. Our patients are treated in a manner that reflects recognition of their basic human rights.

## **Patient's Bill of Rights:**

- The patient has the right to receive treatment at Trident Pain Center without regard to race, color, religion, sex, age, disability, genetic information, or national origin, and in a safe setting.
- The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequence of his/her action.
- The patient has a right to obtain from his/her physician complete, current information concerning their diagnosis, treatment, and prognosis.
- The patient will be a participant in decisions regarding the intensity and scope of treatment.
- The patient has the right to receive from his/her physician, information necessary to give informed consent prior to the start of any procedure and/or treatment.
- The patient has the right to obtain his/her medical records.
- The patient has the right to expect that all communications and record pertaining to his/her care should be treated as confidential, and to expect personal privacy.
- The patient has the right to expect reasonable continuity of care.
- Patients have the right to know that the practice personnel who care for the patient are qualified through education and experience to perform the services for which they are responsible.
- Patients have the right to be informed that he/she may change primary or specialty physicians if other qualified physicians are available.
- The patient has the right to know that he/she is responsible for providing to his/her caregivers the most accurate and complete information.
- The patient has the right to be advised if the practice proposes to engage in or perform human experimentation affecting his/her care or treatments and has the right to refuse participation.
- The patient has a right to have an Advanced Directive, such as a living will or health care proxy.
- The patient has the right to be fully informed before any transfer to another facility or organization.
- The patient or patient's representative has the right to participate in the consideration of ethical issues that arise in the care of the patient.
- Patients have the right to know about the practice's rules and regulations that apply to his/her conduct as a patient.
- The patient has the right to be free from all forms of abuse or harassment at the practice, and know that this practice affirms that mistreatment, and physical, sexual and verbal/psychological abuse is prohibited.
- The patient has the right to be informed if a health care provider does not have liability coverage.
- The patient has the right to exercise these rights without being subject to discrimination or reprisal.

The care a patient receives at Trident Pain Center depends partially on the patient himself/herself. Therefore, in addition to the Bill of Rights, a patient has certain responsibilities as well. These responsibilities are presented to our patients in the spirit of mutual trust and respect.

## **Patient's Responsibilities:**

- Patients must provide accurate and complete information concerning his/her present complaints, past medical history, and other matters about their health.
- Patients are responsible for making it known whether they clearly comprehend the course of their medical treatment and what is expected of them.
- Patients are responsible for following the treatment plan established by their physician, including instructions of nurses and other health professionals when carrying out the physician's orders.
- Patients are responsible for keeping appointments and for notifying the practice when they are unable to do so.
- Patients are responsible for assuring that the financial obligations of their care are fulfilled as promptly as possible.
- Patients are responsible for following the practice's policies and procedures.
- Patients are responsible for being considerate of the rights of other patients and practice personnel.
- Patients are responsible for being respectful of their personal property and that of other persons in the practice.
- Patients are responsible for following all expected contracts or directives including any narcotics contract they have signed.