PHYSICIAN'S PAIN AND SPINE CENTER, LLC.

3227-F Sunset Blvd. Suite 102

West Columbia, SC 29169-3201

803-724-2336 (P) 803-724-2317 (F)

Last name: _____ First Name: _____

Social Security #:_____ Date of Birth: _____

Patient E-Mail:_____

Marital Status: Single Married Separated Divorced Widowed

Home Phone: (_____)_____ Cell Phone: (_____)_____

Work Phone: (_____)_____

Contact Preference: Phone: Home: _____ Cell: _____ Email: _____

Primary Physician: _____

Phone: _____

Ken Grosslight, MD, JD
PHYSICIAN'S PAIN AND SPINE CENTER, LLC.
3227-F Sunset Blvd. St. 102
West Columbia, S.C. 29169
Phone 803-724-2336

Patient Name: _____

Date: _____

1. Family History of Substance Abuse:	Alcohol	_____
	Illegal Drugs	_____
	Prescription Drugs	_____
2. Personal History of Substance Abuse	Alcohol	_____
	Illegal Drugs	_____
	Prescription Drugs	_____
3. Age (check if 18-45)		_____
4. History of Preadolescent Sexual Abuse		_____
5. Psychological Disease	Attention Deficit Disorder	_____
	Obsessive Compulsive Disorder	_____
	Bipolar	_____
	Schizophrenia	_____
	Depression	_____

PHYSICIAN'S PAIN AND SPINE CENTER, LLC

Name: _____ Date of Birth: _____

Chief Complaint/Reason for Visit: _____

_____

Pharmacy: _____ Phone #:_____

Address: _____

Any Known Drug Allergies: _____

Surgical History: (List procedure and Month/Year)

_____

_____

Past/Current Medical History: (Such as: diabetes, hypertension, anxiety, arthritis…)

_____
_____
_____
_____
_____

Family Medical History:

Mother: _____

_____

Father: _____

_____

Medications you are CURRENTLY taking: (If you brought a list or have your medications- skip this section:

_____
_____
_____
_____

Smoking status: Never Former Current

Alcohol Intake: None Occasional Moderate Heavy

Caffeine Intake: None Occasional Moderate Heavy

Exercise Level: None Occasional Moderate Heavy

Are you Left: _____ OR Right handed: _____ or Both _____

Diet: Regular Vegetarian Vegan Carbohydrate Cardiac Diabetic Gluten Free Specific

History of Illicit Drug Use: Yes _____ NO

Occupation: _____ Highest Level of Education: _____

Currently Employed: Yes No

If so-Where; _____

Live alone or with others? _____

General Stress Level: Low Medium High

Is this work related? (Did you get hurt on the job?) Yes No

Is this auto related? (Were you in a car wreck?) Yes No

Physician's Pain and Spine Center

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803-724-2336(P) 803-724-2317(F)

MEDICAL RECORDS RELEASE

Patient Name: _____

Date of Birth: _____Social Security Number: _____

I, or my authorized representative, request that health/medical records regarding my care and treatments be released to Physician's Pain and Spine Center, LLC. In accordance with South Carolina State Law and the Privacy Rule of Health Insurance Portability Act of 1996 (HIPAA), I understand that this authorization may include disclosure of Information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, expect psychotherapy notes, and CONFIDENTIAL HIV RELATED INFORMATION only if I place my initials on the appropriate line. All records which includes doctors' offices and clinics, MRI'S, CT scans, hospitals, health clinics (which include chiropractors, physiotherapists, massage therapists), HMOs, Medicare and Medicaid.

I specifically authorize release of such information to: Physician's Pain and Spine Center, LLC.,

Kenneth Grosslight, MD., JD.

I have the right to revoke this authorization at any time by writing to the health care provider listed above. I understand that signing this authorization is voluntary. My treatment, payments, enrollment in a health plan; or eligibility for benefits will not be conditioned upon my authorization of this disclosure. This authorization does not authorize you to discuss my health information or medical care with anyone OTHER than other health care providers, attorney, and governmental agency.

Name of provider: Phone: Fax:

_____
_____
_____
_____
_____

Please release all my medical records to Physician's Pain and Spine Center, LLC 803-724-2317- fax

_____

Patient or Legal Guardian Signature Date

_____

Witness Date

PHYSICIAN'S PAIN AND SPINE CENTER, LLC.

3227-F Sunset Blvd. Suite 102 West Columbia, SC 29169-3201

803-724-2336 Phone 803-724-2317 Fax

Patient Authorization Release of Information

Name of Patient: _____ Date of Birth: _____

PHYSICIAN'S PAIN AND SPINE CENTER, L.L.C. is authorized to release health information about the above patient to the entities names below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information Check each person that you approve to receive information.	Description of information to be released Check each that can be given to person on the left in this section.		
Spouse Name: _____	Medical	Financial	All
Other: _____	Medical	Financial	All
Other: _____	Medical	Financial	All
Other: _____	Medical	Financial	All
Other: _____	Medical	Financial	All

Patient Information:

I understand the disclosed information may include information and records protected by Federal Law (such as alcohol and drug treatment) and/or State Law (such as mental health, AIDS, or HIV).

I understand that I have the right to revoke this authorization at any time and I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward,

I understand that information that is disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. THIS AUTHORIZATION SHALL BE IN EFFECT UNTIL REVOKED BY THE PATIENT.

_____

Signature of Patient Date

Physician's Pain and Spine Center

3227-F Sunset Blvd., Suite 102, West Columbia, SC 29169-3201
803-724-2336 (P) 803-724-2317 (F)

Hours Monday thru Thursday 9:00 AM to 4pm Friday 9 AM to 2 PM
Closed for Lunch 12:00 to 1:00 (phones go to voice mail)

WELCOME TO PHYSICIAN'S PAIN AND SPINE CENTER

Thank you for choosing us!!!! My staff and I are dedicated to providing you with the BEST possible medical care and service. Please be assured that we understand acute and chronic pain and we will give you our very best personal attention to work with you and improve your health and general well-being.

I regard your understanding of our financial policy as an essential element of your care and treatment. Please, if you have any questions about our professional fees, financial policy, or YOUR payment responsibility; just ask us. Please read the following information carefully so that we can best serve you.
Co-Pays for Office visits are due PAYABLE AT THE TIME of your appointment, before seeing the provider. If you do not have your co-pay you WILL be rescheduled. For your convenience, we accept payment by Visa Card, Master Card, American Express, Discover, Debt Cards, and Cash. Sorry, NO CHECKS!

YOUR INSURANCE: Our office has agreements with insurance companies and will bill those plans. If you have insurance coverage with a plan we Do NOT have an agreement with, we will send the claim in, however the rate paid will be as "Out Of Network". YOU WILL be responsible for your portion of the charges as an "Out of Network" patient. YOU ARE responsible for the bill.

HMO/POS Insurance:	You must have a current HMO card and a referral sheet from your Primary Care Physician, and pay your applicable co-pay or deductible. If you do not have your referral; your visit will be rescheduled. Your applicable co-pay or deductible is due at the time of check-in.
PPO Insurance:	You must have a current PPO card. Your applicable co-pay or deductible is due at the time of check-in.
Private Insurance:	We expect you to pay your deductible and/or 20% at the time of check-in. We will file a claim with your insurance carrier.
No Insurance/Self Pay:	We ask for payment in full at the time of check-in. If you have a procedure, you will be asked to pay for the procedure Before scheduled.
Current Insurance:	If the information you give is at the time of your visit is NOT correct, YOU WILL BE HELD RESPONSIBLE for paying the entire charges and you will file your own insurance.

(OVER)

Please understand that your insurance plan is a contract Between You and Your Insurance Company. We are NOT an involved party to that contract. We recommend that you familiarize yourself with your benefits and the responsibilities of your plan as you are ultimately responsible for ALL balances.
Your insurance may apply money to you to pay if you have not met your deductible. This balance is yours to pay. PLEASE REMEMBER THAT REGARDLESS OF INSURANCE COVERAGE, YOU ARE RESPONSIBLE FOR YOUR BILL. IF YOUR INSURANCE CARRIER HAS NOT PAID YOUR CLAIM IN 60 DAYS, YOU WILL BE ASKED TO MAKE THE PAYMENYT. Any balance more than 30 days overdue MUST be paid in FULL before you, the patient, will be scheduled for additional appointments. Please check the patient portal to see your balance. IF the balance enters a collection status; You the patient will be responsible for all charges and fees incurred by Physician's Pain and Spine Center, LLC during collection procedures which is 50% of the amount past due plus court costs. Please note there are some services treated by pain specialists which are NOT covered by some insurance companies and Medicare. Therefore the fees for these services would be your responsibility. In the event your health plan determines a service is NOT covered YOU WILL be responsible for the charge.

MEDICATION AND PRESCRIPTIONS:
Your medications are YOUR responsibility and you need to be aware of your supply and arrange for refills. Again this is YOUR responsibility, NOT THE STAFF OR PHYSICIAN. Controlled medications such as narcotic pain relievers, Gabapentin, Lyrica, many muscle relaxants; etc. can only be refilled with a written script. If you need a refill between office visits for non-controlled medications, these can often be refilled by phone; however you MUST CALL at least 4 business days prior to needing the medication. When calling for a refill, please have this information to supply to the staff:
Your name, DOB, name and phone number of pharmacy, name of medicine, dosage, how taken.
PRESCRIPITION REFILLS WILL NOT BE CALLED IN AFTER HOURS, WEEKENDS, HOLIDAYS, OR WHEN THE PHYSICIAN IS OUT OF TOWN!!!!!!!

Pain Medicine Procedures: Often pain needs to be treated by diagnostic or therapeutic procedures. When a procedure is scheduled you will be asked for a 20% copay according to the fee schedule. This will be paid for before you are scheduled.

Any specimen done in office and not covered by your insurance will be your responsibility. Some specimens will be sent to an outside lab, any non-covered amount by your insurance company you will be responsible for the fees to the outside lab.

TELEPHONE MESSAGE: If the need arises and you must speak with the physician, call during office hours, inform the staff or leave a message of the nature of your call, Please leave a number where you can be reached. It is often difficult for the physician to stop and speak with you, so your call may NOT be returned until the end of the day or the following business day. If you have caller ID please expect a call that has a blocked calling number, so be sure to answer if you are expecting to speak to the physician. Do not expect a message to be left on your voicemail or answering machine.

MEDICAL TREATMENT, RELEASE OF INFORMATION, AND AUTHORIZATION OF PAYMENT:

I give consent for treatment to be rendered by Physician's Pain and Spine Center, L.L.C. I authorize reports of my evaluation, treatments, procedures, testing to be sent to the referring physician, my primary physician, as well as any other care providers, hospitals, outpatient facilities that need. I understand the disclosed information may include information protected by Federal Laws (such as alcohol and drug treatment) and/or State Law (such as mental health, AIDS, or HIV). I authorize the release of any medical information necessary to process any insurance claims and hereby authorize payment of medical benefits to Physician's Pain and Spine Center, L.L.C. for services rendered. I also authorize medical information about me be released to any agents requesting medical information to determine the services payable

You will receive a pre-recorded appointment reminder at the number YOU have given us. Appointments that are missed without a 24 hour notification will be subject to a fee of $100.00 that WILL be payable before any future appointments.

****INSURANCE CARDS ARE REQUIRED AT EVERY VISIT ALONG WITH PICTURE ID.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY OF PHYSICIAN'S PAIN AND SPINE CENTER, L.L.C. AND AGREE TO BE BOUND BY ITS TERMS.

Print Name: _____ Date of Birth: _____

_____ _____

Signature Date

PHYSICIAN'S PAIN AND SPINE CENTER, LLC

Pain Medication Policies and Patient Compliance Contract

1. I, _____ will receive prescriptions for pain medications

   ONLY FROM DR. KENNETH GROSSLIGHT or Leslie Sykes, PA-C - Physician's Pain and Spine Center, LLC.

2. I will NOT receive any pain medications from other physicians, with the possible exception of VALID EMERGENCY ROOM Visits or Hospital admissions. If this occurs you MUST inform the staff, in a timely fashion of:
   a. The reason for the ER visit.
   b. Name of the treating physician at ER or Hospital
   c. Type and quantity of the pain medication given
3. I will use my prescribed medications from Physician's Pain and Spine Center, LLC, ONLY as written on the prescriptions
4. I do not have any drug addiction or substance condition, including ALCOHOL, illegal or street drugs (but exclusive of tobacco,) OR
   a. I have informed the Center of any drug or substance abuse conditions past or present AND
   b. Any drug or alcohol related arrests, past or present.
5. I understand that these medications can affect judgment, coordination, concentration or alertness, and that it is not advisable to operate machinery, automobiles or make important decisions when starting or adjusting these medications.
6. These medications can cause death especially when combined with alcohol or other sedatives such as Ativan, Xanax or other Benzodiazepines. Do not use alcohol or other sedative drugs unless given express permission by Dr. Grosslight.
7. I am responsible for monitoring the use of my medication so that I do not run out over a weekend or holiday, or before the next prescription refill or dispense date.
8. I will protect my medications and store them SECURELY IN A LOCKED METAL BOX. These medications may ONLY be used by you and may not be given to any other person for any reason. Selling medications is illegal and will result in a police report and dismissal from the center as a patient.
9. Medications that are lost, stolen, damaged or used prior to the refill date WILL NOT BE REPLACED. NEVER CARRY THE ENTIRE PILL CONTAINER!!
10. I agree to provide a blood sample OR a witnessed urine sample at any time if and when requested by the center.
    a. Testing positive for any non-prescribed drugs, legal or illegal, is grounds for IMMEDIATE discharge from the Center and termination of all medical care by the Center.
11. I will bring my Medication (s) in the original containers to each appointment ONLY if requested.
12. Prescriptions will only be renewed with an appointment. DO NOT call asking for a refill.
13. These medications may cause withdrawal and should not be stopped abruptly.
14. I authorize the Center to exchange information with physicians and pharmacies that I use.

I have read and understand the terms of this agreement and I have had an opportunity to discuss this with a healthcare provider. I agree that if I violate ANY PART of this contract I may be discharged from the Center and I will have to find another physician on my own to prescribe medications and manage my pain conditions.

_____		_____	
Patient	Date	Kenneth Grosslight, MD, JD	Date
_____		_____	
Patient	Date	Leslie Sykes, PA-C	Date