**Consent for General Treatment for Ambulatory and Virtual Care:**

I understand and agree that as a patient I will receive general medical services and treatment. I understand I have the right to ask questions about and refuse these services. Providers may include advanced practitioners in your care.

I acknowledge that I have the right to refuse care or withdraw my consent for care, without affecting my right to future care or treatment.  I understand that it is my duty to inform my providers and clinicians regarding the care that I may have received with other healthcare providers. I authorize all clinical providers who provide care to me, along with any billing services or other agents who may work on their behalf to contact me on my cell phone and/or home phone using automated telephone dialing systems, email messages, text messages or other computer assisted technology. I further authorize them to leave a detailed voice message on my cell phone and/or home phone.

**Financial Responsibility Agreement:**

I understand that in consideration of the services provided I agree to pay charges according to Nerve and Pain Institute regular rates and terms. I understand and agree that Nerve and Pain Institute may make inquiries regarding insurance coverage and my financial responsibility from third party payors or other responsible parties. In addition, I give consent for these payors and/or references to release information to Nerve and Pain Institute. I understand that Nerve and Pain Institute reserves the right to require proof of my ability to pay and may require a payment prior to service. I further understand that payments collected will be applied to my total bill owed. I authorize direct payment to Nerve and Pain Institute and/or health care providers during this period of medical care any third party, insurance, or liability benefits otherwise payable to me. I also authorize direct payment to the surgeon and/or physician or anesthesiologist any third party/insurance benefits which may be due under this claim. If I am applying for payment under Medicare, Medicaid, or TRICARE, I certify that the information I give is correct. I request benefit payments be made directly to Nerve and Pain Institute. I further agree to pay for services denied or not covered by my insurance regardless of the reason for denial or non-coverage.

**Cancellation, late arrival and missed appointment:**

If you cancel your appointment with less than 24 hour notice or missed your appointment, we reserve the right to charge you a **$50 cancellation fee**.

**Authorization to Disclose Health Information:**

I authorize the use or disclosure my health information from/to my referring physician and other specialists involved in my care. The type and amount of information to be used or disclosed is the entire medical chart including medical records, office notes, hospital records, pharmaceutical records, laboratory records, X-ray and MRI films, CT scans, any other radiological films, and medical bills. I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, treatment for alcohol and drug abuse, pregnancy, and/or family planning.

**Virtual Care:** Nerve and Pain Institute utilizes video conferencing software to conduct virtual care visits. Nerve and Pain Institute may also utilize telephone and secure electronic messaging to conduct virtual care visits. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption and use.

**Virtual Scribe:** Nerve and Pain Institute utilizes video conferencing software stated above to conduct virtual scribing by a remote scribe. By signing, I agree to such arrangement.

**Email/Text Messages:** E-mails from health care providers will be encrypted. However, email and text messages can more easily be misdirected, resulting in increased risk of being received by unintended and unknown recipients. Nerve and Pain Institute cannot guarantee the security and confidentiality (privacy) of e-mail/text messaging communication, and will not be liable for improper use and/or disclosure of confidential information. I understand the risks associated with the communication of e-mail or text messages. I consent to e-mail and text messages for confidential information among health care provider and/or practice, other healthcare providers participating in my care, and me.

**Non-Discrimination Policy:** Nerve and Pain Institute provides services to all people. It does not discriminate against any patient because of race, religion, national origin, gender, sexual orientation, disability.

**Personal Property and Valuables – Patient Waiver of Liability:** Nerve and Pain Institute is not responsible for loss or damage to personal property or medications brought to the hospital. Patients are advised to leave valuable items at home or to send valuables home with a responsible person.

**I am the patient or the patient’s agent or authorized representative. I acknowledge that I have read this agreement and understand its purpose and contents. By signing here, I consent for health care services and accept the terms of the financial agreement.**

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

 Print Patient Name Signature Date

**DISCLOSURE OF PHYSICIAN OWNERSHIP FORM**

**Please carefully review the information contained in this notice.**

1. In order to allow you to make a fully informed decision about your health care, Dr. Ho would like to advise you that at some point during the course of your treatment, you may be referred to one of the following organizations, of which he has a financial interest.

For your reference, the following is a list of organizations of which Dr. Ho is an investor:

* Pearl SurgiCenter, L.L.C.
* Clear View MRI Cornell

2. Please note that you have the right to choose the provider of your healthcare service. Therefore, you have the option to use a healthcare facility other than those listed above for your services.

3. You will not be treated differently if you choose to use a different facility. If desired, we can provide information about alternative options.

4. If you have any questions concerning this notice, please feel free to ask our staff at Nerve and Pain Institute.

We welcome you as a patient and value our relationship with you.

By signing this Disclosure of Physician Ownership Form, you acknowledge that you have read the foregoing notice.

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

 Print Patient Name Signature Date

**Credit Card Policy**

Every patient must store a credit card on file. You credit card information will be held securely. We will submit a claim for every office visit and await payment from your insurance company. If a portion of the bill applies to the patients responsibility, your credit card will be used to secure that portion. Credit cards on file will be used to pay copays when you are seen in our office and televisits. Coinsurance will be automatically collected from your credit card after your insurance processes your claim. If your payment is declined, we will call you. If our reminder call is not returned within one week, a $35 declined payment fee will be applied and another statement will be mailed. Your account becomes delinquent if not paid within 30 days after the date of the original statement. The unpaid balance will be subject to a finance charge of 1.5% (18% APR) or $35, whichever is greater. Further delinquency will be subject to collections with additional finance fees.

You will receive a statement from our office in your patient portal for review. The Explanation of Benefits will be provided by your insurance company and it will provide all necessary details. Charges that do not successfully process or are denied through your credit card will remain your financial responsibility. Any charge that has not been paid within 30 days from the last visit, will incur a late charge of $35.00. Any account that has not been paid 120 days from the explanation of benefits, will be sent to collections. We will not be able to reverse any accounts that have been sent to collections.

If you choose to not leave your credit card on file:

* You must pay your estimated costs on the day of the visit. This will apply to all coinsurances and copay.
* Unless you prepay for the next visit, your follow up visits can only be done in person and not through televisits.

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

 Print Patient Name Signature Date

**PATIENT MEDICAL HISTORY**

Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI \_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_ Height \_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_ € Male € Female

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy (Name and Address) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT MEDICATIONS**

List all medications that you are taking (prescriptions and over-the-counter).

Medication Daily Dose How Often

1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

3\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

4\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

5\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

6\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

7\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

8\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

**PAST MEDICAL HISTORY (Medical problems, such as past surgeries, hypertension, diabetes, atrial fibrillation)**

1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 7\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 9\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 10\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES**

Medication or injection Reaction Year

1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

3\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

4\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY**

Do you smoke? € No € Yes How Long: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Much: \_\_\_\_\_\_\_\_\_\_\_\_

What do you smoke? € Cigarettes € Cigars € Pipe

Have you stopped? € No € Yes When: \_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? € No € Yes

How Much? € 1 drink/day € 2 oz./day € 4 oz./day € More

**PAIN HISTORY (only fill out if you have pain)**

Use this diagram to indicate the area of your pain. Mark the location with an “X”



Onset of Symptoms

On a scale from 0-10, 10 being the worst pain, what is your pain level?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approximately, when did this pain begin?

Any pain shooting down your arms or legs?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are the goals you wish to achieve with Pain Management?

**Conservative treatment**

Physical therapy € No € Yes (Month/year) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Massage Therapy € No € Yes (Month/year) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chiropractic Care € No € Yes (Month/year) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Acupuncture € No € Yes (Month/year) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diagnostic Testing:**

€ MRI cervical spine. Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

€ MRI lumbar spine. Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

€ EMG. Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

€ Other imaging studies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Interventional Pain Treatment history:** Did it help?

€ Epidural steroid injection: Cervical/Thoracic/Lumbar (circle all applied). € Yes € No

€ Medial Branch Blocks/Facet Injections - (circle levels) Cervical/Thoracic/Lumbar € Yes € No

€ Radiofrequency Nerve Ablation – (circle levels) – Cervical/Thoracic/Lumbar € Yes € No

€ Nerve Blocks – Area/Nerve(s) - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ € Yes € No

€ Spinal Cord Stimulator – Trial Only/Permanent Implant € Yes € No

€ Other treatments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PHQ 9 score****Over the last 2 weeks, how often have you been bothered by any of the following problems?** *(Circle your answer)* | **Not at all**  | **Several days**  | **More than half the days**  | **Nearly every day**  |
| **1.** Little interest or pleasure in doing things  | 0  | 1  | 2  | 3  |
| **2.** Feeling down, depressed, or hopeless  | 0  | 1  | 2  | 3  |
| **3.** Trouble falling or staying asleep, or sleeping too much  | 0  | 1  | 2  | 3  |
| **4.** Feeling tired or having little energy  | 0  | 1  | 2  | 3  |
| **5.** Poor appetite or overeating  | 0  | 1  | 2  | 3  |
| **6.** Feeling bad about yourself — or that you are a failure or have let yourself or your family down  | 0  | 1  | 2  | 3  |
| **7.** Trouble concentrating on things, such as reading the newspaper or watching television  | 0  | 1  | 2  | 3  |
| **8.** Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual  | 0  | 1  | 2  | 3  |
| **9.** Thoughts that you would be better off dead or of hurting yourself in some way  | 0  | 1  | 2  | 3  |

 Total Score \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

|  |  |  |  |
| --- | --- | --- | --- |
| **Not difficult at all**  | **Somewhat difficult**  | **Very difficult**  | **Extremely difficult**  |