GEORGIA PAIN & SPINE SOLUTIONS

Marcus Polk, MD

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

PATIENT INFORMATION
Informacion del paciente

Patient's last name (*Apellido*):	First(*Nombre*):	Middle(*Segundo nombre*):	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.
Birth Date(*Fecha de nacimeinta*):	Age (*Edad*):	Social Security Number (*Seguro Social*):	
Marital Status (circle one): Single (*Soltero/a*) Married (*Casado/a*) Divorced (*Divorciado/a*) Separated (*Separado/a*) Widowed (*Viudo/a*)		Sex: ☐ M ☐ F	Home phone (*Telefono*): ( )
Street address (*Direccion*):			Cell phone (*Cellular*) ( )
P.O. Box:	City (*Ciudad*):	State(*Estado*):	Zip Code(*Codigo postal*):
Occupation (*Ocupacion*):	Employer (*Empleo*):		Employer phone no.(*Telefono del empleo*): ( )
Referred to clinic by (*Referido por*): ☐ Dr. ☐ Other:			Email:

IN CASE OF EMERGENCY
En caso de emergencia

Name (*Nombre):*	Relationship to patient (*Relacion al paciente*):	Telephone Number (*Numero de telefono*): ( )

INSURANCE INFORMATION
Informacion de su a seguranza

Insurance Company(*Aseguranza):*	Subscriber's Name (*Nombre del suscriptor*):	Subscriber's SSN (*Seguro social del suscriptor*):	Birth date (*Fecha de nacimiento*):
Policy number (*Poliza*):	Group number (*Numero de grupo*):	Patient's relationship to subscriber (*Relacion al paciente*): ☐ Self ☐ Spouse ☐ Child ☐ Other:	
Occupation (*Occupacion*):	Employer (*Empleo*):	Employer phone number (*Telefono del empleo*): ( )	
Name of secondary insurance (*Segunda aseguranza*):	Subscriber's name (*Nombre del suscriptor*):	Subscriber's SSN (*Seguro social del suscriptor*):	Birth date (*Fecha de nacimiento*):
Policy number (*Poliza*):		Group number (*Numero de grupo*):	

ATTORNEY INFORMATION
(Informacion de su abogado)

Attorney's name (*Nombre del abogado*):	Phone Number (*Numero de telefono*):	Date of accident (*Fecha del accidente*):

** Our standard policy requires us to bill your health insurance unless you, the patient, specifically request by signature below, not to do so.

I, **DO NOT** want my health insurance billed : _____ ____ / ____ / _____
Signature Date

Please be advised that if you later decide to bill Health Insurance it will be billed from that time and date only.

PLEASE CHECK MARK HERE IF YOU ARE A: ☐ **SELF PAY/ CASH PAY**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize my attorney or insurance company to release any information required to process my claims.

Patient/Guardian signature
(Firma del paciente o guardian)

Date *(Fecha)*

_____ _____

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Date of injury (if applicable): _____How did it start? Have _____

you been treated for you present problem? ☐Yes ☐No When?Indicated _____ By whom: _____

which of the following you have tried for you pain and if it helped:

_____Pain Clinic/Anesthesiologist _____Anti-inflammatory/Anti-Depressant
_____Trigger Point Injections _____Epidural Steroid Injection
_____Chiropractic Therapy _____Physical Therapy

How long are you able to sit/stand comfortably?_____ How far are you able to walk?_____

Circle the words that describe your pains:

☐ACHING	☐ SHARP	☐ PENETRATING	☐ THROBBING	☐ GNAWING
☐TENDER	☐ NAGGING	☐ SHOOTING	☐ BURNING	☐ UNBEARABLE
☐NUMBNESS	☐ STABBING	☐ OCCASIONAL	☐ MISERABLE	☐ CONTINUOUS

Do you use tobacco (smoke/chew)? ☐ Yes☐ No If yes, how much and for how many years?_____

Do you drink alcohol?☐ Yes ☐ No If yes, how many drinks per day/week:_____

Do you or have you used recreational drugs? ☐ Yes ☐ No If yes, which ones?_____

What is your occupation?_____

What is you employment status now?☐Full-Time☐Part-Time☐Retired☐Unemployed ☐ Unable to work due to pain/injury

Height:_____ Weight:_____ Have you experienced any sudden weight loss or gain?_____

Are you or could you be **Pregnant/Nursing**?_____ Date of last Period?_____

Do you have any **ALLERGIES** (ex: medication, latex gloves, tape?) ☐ Yes ☐No If yes, please list: _____

_____

Prior Medical History (list ALL previous illness type and date): _____

_____

_____

Prior Surgical History (list previous surgeries, type and date): _____

_____

_____

List previous **Serious Injuries** (ex. Fractures with date): _____

_____

_____

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76 Highland Pavilion Ct. Ste. 133 Hiram, GA 30141

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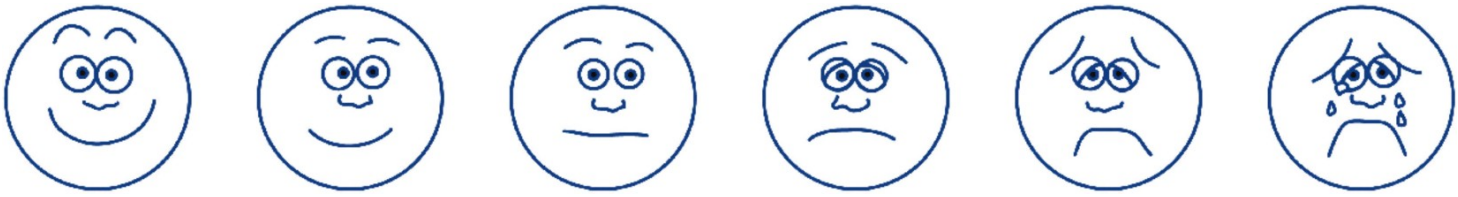
Please rate your pain based how you feel and function!



0-1	2-3	4-5	6-7	8-9	10
☐	☐	☐	☐	☐	☐
No Pain	Tolerable; able to perform normal active passive	Tolerable, but unable to do anything or Incapacitated; (running, sports, weight lifting, activities requiring much physical effort)	Intolerable and prevents some daily activities (working, house chores, walking, activities requiring some physical effort)	Intolerable and prevents many active activities (talking on the phone, watching TV, reading)	prevents all active activities and many speak due to pain

Patient Signature: _____ **Date:** _____

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MEDICATION LIST

Please include all prescribed medications, over the counter medication, vitamins, herbals, and supplements taken. This list will be updated at each visit.

Patient Name:_____ DOB:_____ Date:_____

DATE	MEDICATION/DOSE	FREQUENCY TAKEN	DISCONTINUED

Pharmacy Name: _____

Location: _____

Phone: _____ **Fax:** _____

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MEDICATION POLICY

If you are prescribed a controlled substance during your treatment, there are several guidelines you must follow.

Please initial and sign the following:

If I am prescribed a controlled substance, I understand and agree that:

_☐_ I will not take the medication other than how it is prescribed by my doctor. I will not use the medication for any other purposes other than for what it is prescribed. I will not give, share, or sell the medication to any other person, for any reason; I am aware that doing so is a felony under the law.

_☐_ I am consenting to the use of random prescription drug monitoring by my doctor (i.e. urine drug screening, random pill counts, saliva drug screening, etc.).

_☐_ I am made aware that the following side effects are associated with opioid use: drowsiness, impaired judgment, constipation, nausea/vomiting, tolerance, dependence, addiction, fatal overdose, depression/anxiety, worsened pain (opioid-induced hyperalgesia), opioid-induced bowel dysfunction (cramping, bloating, spasms), sleep disturbances, heart attack/heart failure, bone fractures, risk of falling, hormone imbalances, and weakened immunity.

_☐_ I will report any side effects of the medication to my doctor.

_☐_ I will inform my doctor of any other controlled substances I am taking, or if I use any form of drugs, alcohol, or marijuana.

_☐_ I can only obtain a refill of the medication no more than once per month, even if this medication is lost, stolen, consumed, or destroyed in any way. It is my responsibility to schedule a follow-up appointment appropriately so I do not run out of medication.

_☐_ Except in cases of emergency or surgery, I will only obtain this medication (or similar controlled substances) from one doctor/provider.

_☐_ Violation of any part of this agreement may result in discontinuation of treatment with a controlled substance.

_____ _____

Print Patient Name **Date of Birth**

_____ _____

Patient Signature (Parent or Guardian if patient is a minor) **Date**

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MEDICATION REFILL POLICY

1. Requests for medication refills will only be considered during regular office hours in clinic; Monday – Thursday 9:00 a.m. to 5:00 p.m. No refills will be given after hours, weekends, or holidays. All refill requests must be received by Thursday to be refilled for the weekend.
2. Requests for medication refills should be called to your pharmacy who will, in turn, call our office. Please allow 48 hours for this procedure. No refills of medications will be given if you have not been seen for 3 months. Your refill will need to be reviewed by your physician and might not be refilled until you have been reevaluated. It is your responsibility to make a follow-up appointment with your doctor. This will be strictly enforced.
3. If you call for medication or refills outside regular office hours, you will be instructed to go to the emergency room. There, you will be evaluated by an emergency room physician who will decide whether or not to refill your medication. Emergency Department Policy regarding medication refills is typically very strict and there is no guarantee that you will get your refill. If the Emergency Department is busy, you may be required to wait a long period of time to be seen.
4. Telephone requests for prescription renewals are accepted only during regular business hours. In some instances, there is a 48 to 72 hour waiting period before prescriptions will be refilled, so call your refills accordingly. We are very cautious about refilling your medications too early, so follow your instructions carefully.

Print Patient Name _____ **Date of Birth** _____

Patient Signature (Parent or Guardian if patient is a minor) _____ **Date** _____

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GEORGIA PAIN & SPINE SOLUTIONS

Medical Lien Agreement

Patient:_____ DOB: _____

Date of Accident/Injury: _____ SSN: _____

I do hereby authorize Georgia Pain and Spine Solutions (GPSS) to furnish my attorney with a full report of his/her examination, diagnosis, treatment, prognosis, etc, of myself regarding the accident that I was recently involved.

I further authorize my attorney to pay directly to GPSS such sums that are due and owing for the medical services, treatment, care and examinations rendered by reason of this accident and by reason of any other bills that are due to GPSS, and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate GPSS. I hereby further give a lien on my case to GPSS against any and all processes of my settlement, judgment or verdict that may be paid to you, my attorney or myself as a result of the injuries that I have been treated or injuries in connection with my medical treatment.

I fully understand that I am directly and fully responsible to GPSS for all medical bills submitted by them for services rendered to me and that this agreement is made solely for the protection of GPSS and in consideration of GPSS awaiting payment. I further understand that my obligation to pay for the medical services, treatment, care and examinations I received is not contingent on any settlement, judgment or verdict related to my accident, which I may eventually secure a recovery. With this understanding, I agree to give GPSS information concerning any and all insurance policies that may cover the medical services, treatment, care and examinations I receive in relation to my accident.

In addition, I agree to promptly notify GPSS of any change or additions of an attorney used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien agreement to any such new or added attorney. It is further understood and agreed upon that in the event I choose to use a new or an additional attorney in the matter related to my accident, this lien agreement remains binding and in effect as if it had been signed by the new or additional attorney.

I willfully and voluntarily acknowledge that my signature below represents my complete understanding of the terms and conditions outlined in this lien agreement, and that my engagement of the medical services of GPSS is not made with deceiving GPSS and staff.

Date	Printed Patient Name	Patient Signature

The undersigned being the attorney of record for the above-mentioned patient does hereby agree to observe all the terms and conditions of the above-mentioned lien agreement and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate GPSS. The attorney further agrees that in the event that this lien agreement is litigated, the prevailing party will be entitled to the attorney's fees and costs associated with doing so.

Date	Printed Attorney Name	Attorney Signature

Attorney Phone	Attorney Fax

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PLEASE READ THE FOLLOWING CAREFULLY. IF YOU HAVE ANY QUESTIONS, PLEASE DO NOT HESITATE TO ASK FOR AN EXPLANATION FROM OUR OFFICE MANAGEMENT.

- Office hours are from 8:00 am to 4:00 pm Monday through Friday. All routine telephone calls to the office should be made during these hours.

Patient Initial:___

- I hereby authorize and request Georgia Pain and Spine Solutions to release my complete medical records (including x-rays) when referring to other facilities concerning my medical treatment.

Patient Initial:___

- I hereby assign to Georgia Pain and Spine Solutions all benefits for surgical and medical care payable under medical insurance policy and/or policies. I also authorize release of information from Georgia Pain and Spine Solutions to my insurance carrier for services billed.

Patient Initial:___

- I understand that I am financially responsible for all service rendered whether or not paid by insurance. Payment is expected at the time of service. Visa. MasterCard, American Express and Discover are accepted for my convenience. I understand that if my care is on a lien, it is my responsibility to notify Georgia Pain and Spine Solutions. If there are any changes in my legal representation. There will be a charge of $25 for all returned *checks.*

Patient Initial:___

Orthopedic or Spinal emergencies usually require hospital admissions. If you should find yourself in that emergency situation, please go to the nearest hospital emergency room.

PATIENT ACKNOWLEDGEMENT OF DISCLOSURE INFORMATION

My signature below acknowledges the following:

- I have received a copy and am aware of the Patient Bill of Rights; as required by law and have had an opportunity to receive assistance in understanding and exercising these rights.
- I have received a copy and am aware of this office's Notice of Privacy Practices, including the Private Health Information (PHI) designated at the time of visit.
- I am aware Dr. Polk has financial interest in Georgia Pain & Spine Solutions

I have read and fully understand the information that has been provided.

Signature of Patient/Representative:_____DOB:_____Date:_____

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GEORGIA PAIN & SPINE SOLUTIONS

AUTHORIZATION TO REQUEST MEDICAL RECORDS

Patient Name:	**Date of Birth:**	Date:
Address:		City:
State:	Zip:	Phone Number: ( )

THIS IS TO AUTHORIZE:

Georgia Pain & Spine Solutions 76 Highland Pavilion Ct. Ste. 133 Hiram, GA 30141

TO REQUEST INFORMATION FROM:

Name of Doctor, Insurance Co., or Individual:		
Address:	**City:**	**State:**
Zip Code:	**Phone Number:**	**Fax Number:**

(CHECK RECORDS TO BE REQUESTED)

- ☐ All Medical Records
- ☐ Operative Reports
- ☐ NCV/EMG Reports
- ☐ Xray/MRI Reports
- ☐ Lab Work
- ☐ Office Notes
- ☐ OTHER

I realize that I am entitled to a copy of this Authorization.

_____ _____

Signature of patient or responsible party Date

Office personnel requesting: _____

PLEASE FAX TO: (404) 745-8013

Marcus Polk,
MD

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

***You may refuse to sign this acknowledgment. ***

I, _____, have been provided the opportunity to review this office's Notice of Privacy Practices. I understand that a copy will be proved upon request.

_____
Please Print Name

_____
Signature

_____
Date

*****FOR OFFICE USE ONLY*****

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

___Individual refused to sign.

___Communication barriers prohibited obtaining the acknowledgment.

___An emergency situation prevented us from obtaining acknowledgment.

___Other:_____

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