North Georgia Pain Clinic

PAIN MANAGEMENT SPECIALIST

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CANTON, GA 30114

TELEPHONE
770.479.2322

FACSIMILE
770.720.7695

Thank you for choosing North Georgia Pain Clinic

Your appointment is ____/____/2024 @ ____:____ at the

_____ location (see attached directions)

PLEASE ARRIVE 30 MINUTES EARLY

You **must** have the following with you at your appointment:

- ✓ Georgia Photo ID
- ✓ Current Insurance Cards
- ✓ Completed Paperwork
- ✓ **ALL** Medication
- ✓ Face Mask Required

For the "first visit" we do not accept checks (credit card, Master card or Visa only, cash or money order. Be prepared to pay your copayment or office visit (Self-pay patients $350).

Unfortunately, we WILL have to reschedule you if you do not have **all** the requested information.

North Georgia Pain Clinic

FINANCIAL AGREEMENT

If we participate with your insurer, we will abide by our contract with them in terms of the fee schedule and write-offs required. Payment is due at the time of service. Failure to provide correct insurance information*, in a timely manner, will result in you being responsible for our fees, in full. Every effort will be made by this office to have all services and procedures preauthorized by your health insurance company.

Self-Pay: By law, we are required to randomly drug screen all patients treated for pain management. Currently, urine drug screens are included in the self-pay rate. You will be charged $100 for *all* inconsistent urine drug screens.

Check Policy: We do NOT accept checks on your initial office visit. We will accept cash, MasterCard or Visa. We do not take 3rd Party checks. **Bad Checks**: A $35.00 NSF will be incurred for all returned checks. Returned checks and fees must be paid in cash or by certified funds. Stopped payment on checks is grounds for discharge. After the second (2nd) returned check you will be **CASH ONLY.**

Referrals: Should any services we provide, such as office visit or urine drug screens, require a PCP referral; it is your responsibility to obtain this. Your failure to obtain this means you will be responsible for payment for services rendered.

Authorizations: If your insurer requires authorization for procedures and/or injections we will obtain these, if possible. However, these do take time and we need at least two week notice in order to do so. If you insist on having a procedure without an authorization you will be required to make payment at time of service for the procedure. Some insurers limit the number of certain procedures during a calendar year. If you feel that you require one after this limit has been reached you may schedule one once payment, in full, has been made. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service. Prior authorization is NOT a GUARANTEE OF PAYMENT.

I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denied payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does not make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies

ASSIGNMENT AND RELEASE STATEMENT

By signing below, I understand the billing practices for North Georgia Pain Clinic, PC. I authorize payment of medical benefits to the North Georgia Pain Clinic and authorize them to release any medical information necessary to process claims. I understand that I am financially responsible for any copay, coinsurance, deductibles, non-referred and non-covered services as outlined in my health plan.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Witnessed: _____ Date: _____

**Under Georgia Law it is considered "Theft of Services" to obtain care by providing false insurance information.*

North Georgia Pain Clinic

CONSENT FOR TREATMENT

Patient Printed Name_____ DOB: _____ Date: _____

Nerve blocks and trigger point injections are a time tested modality for chronic pain management. Nerve blocks are relatively safe techniques that have been used over the past seventy plus (70+) years for surgical/obstetrical anesthesia and control of chronic pain. The medications used in these blocks will be a combination of Marcaine, Lidocaine (local anesthetics), sterile saline and a low dose steroid. If, you have an allergy to any of these medications, please notify the staff now.

The local anesthetics often numb the area as well as areas that are supplied by nerves near the injection site. Local anesthetics generally wear off within 24-hours after the injection.

Notify the physician and staff if you:

- Are diabetic
- on Coumadin or any blood thinning therapy
- Prone to fainting during minor medical procedures

Possible Consequences of Nerve Blocks

- Feeling of warmth, numbness/weakness in the body region which has been blocked.
- Stellate ganglion blocks, because they involve the face, may cause eyelid droop, hoarseness, or nasal stuffiness.
- Soreness in the area of the body where the needle was introduced.
- Anxiety about the procedure, which may cause dizziness, shaking, or sweating. Intense anxiety can cause fainting and may be avoided by relaxing.
- Even the low-dose steroids we use can affect the blood sugar level of patients with diabetes.
- Bleeding problems can occur with nerve blocks with patients on blood thinners.

All of these are temporary reactions and should resolve shortly after the block.

Infrequent Consequences of Nerve Blocks

- Disturbances in breathing, blood pressure, and state of awareness.
- Body rash, increased appetite, reddened face, possible sensitivity to medications
- Seizures
- Spinal headaches can occur occasionally after the procedure. This can resolve spontaneously or can be treated at the office.

These responses should be reported immediately; with appropriate treatment, they are not life-threatening.

North Georgia Pain Clinic

CONSENT FOR TREATMENT (CONTINUED)

Rare Consequences of Nerve Block

- Internal bleeding
- Isolated cases of infection/abscess formation have been reported
- Paralysis

Should any of the above occur you should go to the Emergency Room immediately and have their staff contact our office or our physician on call.

Please understand there is a difference between side effects and a true allergic reaction to medications. A true allergic reaction will occur almost immediately or shortly after exposure to the allergic substance (generally a medication). A true allergic reaction will cause your throat to swell to the point where breathing will become restricted and/or impossible and can be life threatening. Should this occur, please call 911 immediately and then notify our office. Side effects are generally NOT life threatening and can be treated conservatively or with medications.

I understand the PHYSICAIN, MEDICAL PERSONAL, and OTHER STAFF members of the North Georgia Pain Clinic will rely on statements made by the patient, the patient's medical history and other information in determining the course of treatment.

I understand the practice of medicine is NOT an exact science and that NO guarantees or assurances have been made to me concerning the results of treatment.

By signing this form, I acknowledge that I have read this form or had the form read and/or explained to me.

Patient Printed Name: _____ **Signature:** _____

DOB: _____ **Date:** _____

NORTH GEORGIA PAIN CLINIC, PC

NOTICE OF PRIVACY PRACTICES AS REQUIRED BY THE PRIVACY REGULATIONS CREATED BY HIPAA

Our practice is dedicated to maintain the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide to you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI.

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend the Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice had created or maintained in the past for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our office in a visible location at all times, and you may request a copy of our most recent Notice at any time.

We may use or disclose your IIHI in the following ways:

Treatment: Our practice

We may use your IIHI to treat you. Many of the people who work for our practice including but not limited to, our doctors and nurses, may use or disclose your IIHI in order to treat you or assist others in your treatment. We may disclose your IIHI to others who may assist in your care, such as your spouse, children, and/or parents. We may also disclose your IIHI to other health care providers for purposes related to your treatment.

***Payment*:** Our practice may use and disclose your IIHI in order to bill and collect payment for services rendered. This may be released to your insurer, third parties who may be responsible for payment, or other health care providers and entities to assist in their billing and collection efforts.

Health Care Operations: We may use and disclose your IIHI in order to operate our business, conduct cost management, and business planning activities. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

***Release of Information to Family/Friends*:** Our practice may release your IIHI to a friend or family member who is involved in your care, or who assists in taking care of you. For example, a family member who calls to verify appointments or address a billing issue.

Disclosures Required By Federal, State, or Local Laws.

Use and Disclosure of your IIHI and Certain Special Circumstances:

-Serious Threats to Health and Safety -Military/Veterans -Workers Compensation
-National Security & Intelligence Activities -Inmates & Individuals in Custody

Public Health Risk: Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information.

Health Oversight Activities: Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. These include but are not limited to: investigations, audits, licensure, disciplinary activities, and criminal procedures, activities necessary for the government to monitor government programs, compliance with civil right laws, and the health care system in general.

Law Enforcement: We may release the IIHI if asked to do so by law enforcement officials regarding criminal conduct at our office, in response to a warrant, summons, court order, subpoena, in an emergency to report a crime, or concerning a death we believe has resulted from criminal conduct.

Prescription Medications: It is a FELONY in the State of Georgia to obtain narcotics from more than one physician at a time without making all other physicians aware. In this circumstance, we may release your IIHI to the patient's pharmacy or physician/staff involved in the patient's care in order to ascertain that this is not being done.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services: We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Business Associates: We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

All request, questions, and/or breaches should be submitted to: **HIPAA Compliance Officer C/O *North Georgia Pain Clinic, PC 1320 Oakside Drive Suite 203 Canton, GA 30114.* (770) 479-2322.**

North Georgia Pain Clinic

RECEIPT FOR NOTICE OF PRIVACY PRACTICES/ WRITTEN ACKNOWLEDGEMENT FOR HIPAA PRACTICES

I, _____, acknowledge I have been provided a copy of the ***Notice of Privacy*** **Practices** and that I have read (or had the opportunity to read if I so choose) and understood the Notice.

For health information disclosure:

I authorize North Georgia Pain Clinic (physicians and staff) permission to discuss and/or disclose my health information with the following person/persons listed below: I understand that my personal health information may be re-disclosed the person(s) or organizations (s) and may no longer be protected by law.

1. _____ Phone: _____Relationship_____
2. _____ Phone: _____Relationship_____
3. _____ Phone: _____ _____Relationship_____

I understand that this information **may include** any and all treatment plans, medication issues, history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care and evaluations; treatment for alcohol and/or drug abuse; or similar conditions. You have the right to take back ("revoke") your authorization at any time, in writing, except to the extent North Georgia Pain Clinic has acted based on your permission. The following **information *should not* be released:** _____.

For oral communications: Please *initial* the following:

_____ I authorize North Georgia Pain Clinic to leave information on my provided home/cell phone answering machine/voicemail.

_____ I do not authorize North Georgia Pain Clinic (physicians and staff) permission to discuss my medical treatment with any family member or friends.

_____ Patient refused to sign acknowledgement.

Patient Name: _____

SSN # _____ DOB: _____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

All calls are routed through our Canton Office
Mon-Thurs 9:00 a.m. - 4:30 p.m. and Fri 9:00 a.m. - 12:00 p.m.

ATLANTA – 285 BOULEVARD NE, SUITE 640, ATLANTA, GA 30312

FROM 75S: From 75S: Take exit 248C (John Lewis Pkwy). At the light take a left onto Boulevard. At the next light go straight. (Intersection of Boulevard and Highland Ave.) Go past our building and turn right into the parking deck.

From I20 W: Take Exit 57 to I75 N (Macon/Chattanooga). Take exit 248C. At the light turn left onto Boulevard. At the next light go straight. (Intersection of Boulevard and Highland Ave.) Go past our building and turn right into the parking deck.

CANTON - 1320 OAKSIDE DRIVE, STE. 203, CANTON, GA 30114

FROM 575N: Take exit 20 (Riverstone PKWY), at the light take a left, turn right onto Hospital Drive (2nd street on the right after the Days Inn). Continue to Oakside Dr. and our office is on the left (2-story brick).

FROM HWY 20E*:* Take 20E to Canton, take a left onto Marietta Hwy, and continue to Riverstone PKWY, turn left on Hospital Drive (at the Exxon Station), continue to Oakside Dr., our office is on left (2-sotry brick).

FROM 575 S: Take exit 20 (Riverstone Parkway) and turn right off of the exit. Turn right on Hospital Drive (2nd street on the right after the Days Inn). Continue to Oakside Dr., our office is on the left (2-story brick).

CARTERSVILLE – 17 BOWEN'S COURT CARTERSVILLE, GA 30120

FROM 75S: Take exit 290 turn right off of the exit ramp on to GA-20, (from 20 Cross 75 then left). At the next light turn left onto Roving Rd. At stop sign, turn Right onto Felton Rd. At light turn left onto Joe Frank Harris Parkway (Old 41). Turn Right onto Collins Dr. (between Bank of America and SunTrust Bank), then left onto Bowens Ct. (Doctor's Hospice). Office will be the third driveway on the left.

FROM 75N: Take exit 290 (toward Rome), turn left on GA-20, and turn left at Roving Rd. At stop sign turn right on Felton Place. At light turn left onto Joe Frank Harris Parkway (Old 41)then turn right on Collins Dr SE,(between SunTrust Bank and Bank of America) Turn left on Bowen Ct., our office will be on the left.

FROM ROME: Head east on GA-20/Shorter Ave NW toward Hamilton Ave/Hamilton Lane, slight right on N 2nd Ave SW, take the ramp onto GA-1/GA-20/GA-53/US-27, take the US-41/GA-20 ramp on the left to Cartersville/Atlanta, merge onto Floyd Memory Gardens/GA-20/GA-344/GA-411 continue to follow GA-20/GA-344. Take the ramp onto GA-20/GA-3/Joe Frank Harris Pkwy SE/US-41, turn right on Collins Dr SE, turn left at Bowen Ct, our office is on the left.

OFFICE LANDMARKS - turn off Joe Frank Harris between bank of America and Sun Trust onto Collins
See Owen's funeral on right take left onto Bowen's Court (between hospice and Dr. Bennie Smith); 3rd drive on left (17 Bowen's Court.

CUMMING: 304 WEST MAIN STREET, CUMMING, GA 30040

400N: Take Exit 15 (Bald Ridge Marina) toward Cumming and turn left off of exit ramp. Bald Ridge Rd. will turn into Pirkle Ferry and continue onto GA-20 W/GA-9N, Continue to follow GA-20W, turn left into Holbrook square and our office will be on the left, #304.

400S: Exit 15 (Bald Ridge Marina) toward Cumming and turn right off of the exit ramp. Bald Ridge Rd. will turn onto Pirkle Ferry Rd. and Continue onto GA-20 W/GA-9N, Continue to follow GA-20W, turn left into Holbrook square and our office will be on the left, #304.

VIA CUMMING HIGHWAY AND GA-20 E: Take Ga-20 East toward Downtown/Cumming. Continue on GA-20 East and left at Hardee's restaurant. Our office will be on the left.

OFFICE LANDMARKS – Directly across the street from the Foster House and Hardee's Restaurant

LAGRANGE – 208 SMITH STREET, LAGRANGE, GA 30240

FROM I85S: Take Exit 18 (LaGrange), right on Lafayette Parkway/GA 109 towards the square in Downtown LaGrange, turn right onto North Morgan Street, turn left on new Franklin Road, Make a slight right onto Franklin Street (Franklin becomes Smith Street, our office is across from Clark Holder and IN THE RHANEY BUILDING next to Rhaney Eye Clinic.

OR FROM I-85 S: Take Exit 18, Take a **Right** onto Lafayette Parkway/GA 109 towards the square in Downtown LaGrange

Turn **Right** onto North Morgan Street, Turn **Left** onto New Franklin Road, Make a slight **Right** onto Franklin Street (Franklin becomes Smith Street), North Georgia Pain Clinic is across from Clark Holder and next to Rhaney Eye Clinic.

North Georgia Pain Clinic

PHARMACY RELEASE

_____ I authorize the release of my diagnosis as pertains to my prescriptions written by the North Georgia Pain Clinic to my pharmacy. I understand that this is not a Georgia state law nor a DEA regulation but the policy of my pharmacy.

_____ I do not authorize the release of my diagnosis as pertains to my prescriptions written by the North Georgia Pain Clinic to my pharmacy. I understand they may not fill my prescriptions.

Patient Printed Name: _____ **DOB: _____**

Patient Signature: _____ **Date: _____**

North Georgia Pain Clinic

PAIN MEDICATION POLICY

Our first and foremost concern is the well-being of our patients. Due to the addiction potential and legal issues involved, pain medicine and management of pain medications will be under the following guidelines.

Please initial <u>each</u> item to indicate that you have read and understand it and sign your name at the bottom of this page. FAILURE TO COMPLETE THIS FORM WILL RESULT IN NOT BEING SEEN BY THE PHYSICIAN!

_____ Medications will last a specific number of days and NO medication will be called in prior to that date.

_____ Narcotics will NOT be phoned in after hours or on weekends. Our office closes at NOON on FRIDAYS.

_____ If you find that a specific pain medication does not work for you, we will only exchange pill for pill with a new prescription. The remainder of your old prescription must be returned to our office or pharmacist.

_____ Patients may be terminated from the practice with thirty (30) day notice for non-compliance in the taking of medications.

_____ Replacement of lost or misplaced prescriptions is solely at the discretion of your physician and will be done on a case by case basis. You must take responsibility for keeping up with your medications. If your physician does make the decision to replace your medications this will be a **ONE** time occurrence only and will be enough medication until your next appointment.

_____ Replacement of stolen medications will NOT be considered without a valid police report. If the physician allows a replacement, this will only be done **ONE** time.

_____ Failure to show for a pill count may result in patient discharge.

_____ **CBD products** are not approved by the FDA for any condition. All CBD products contain THC which will lead to a failed drug screen. Continued use will lead to either discharge or discontinuation of all narcotics.

CONDITIONS FOR IMMEDIATE TERMINATION FROM THIS PRACTICE

_____ Obtaining narcotics from **<u>any</u>** other physician while under our care.

_____ Altering or forging a prescription is a **FELONY** and will be reported to the proper authorities.

If you are taking prescription narcotics/controlled substances (oral or with a drug infusion pump) muscle relaxants, or tranquilizers, for which the manufacturer of the drug recommends not to operate heavy equipment, (this includes ANY motorized vehicle) we do not recommend that you act against the manufacturer's recommendations and will assume no liability should YOU choose to drive while on medication. *PLEASE BE AWARE THAT SHOULD YOU CHOOSE TO DRIVE WHILE ON MEDICATION, YOU CAN LEGALLY BE CHARGED WITH A DUI*.

Your signature on this form will also constitute a release which allows our office to obtain your prescription history/information from any pharmacy we may call on your behalf.

Patient Printed Name: _____ **DOB: _____**

Patient Signature: _____ **Date: _____**

North Georgia Pain Clinic

REGISTRATION FORM

Name: Last: _____ First: _____ MI:_____

Preferred: _____ Date Of Birth: _____ SSN:_____ Marital Status: S M W D OTHER

Race: Caucasian/African American/Asian/Other_____ Ethnicity: Hispanic/ Non-Hispanic

Phone: Home: _____ Work: _____ Cell:_____

Preferred Communication: Home/Work/Cell/Email Email: _____

Mailing Address: _____ST:_____Zip:_____

Street Address: _____ST:_____Zip:_____

Emergency Contact: _____Phone:_____ Relation: _____

Emergency Contact: _____Phone:_____ Relation: _____

Preferred Pharmacy: _____ City: _____ Phone: _____

Referring Physician:_____ Phone:_____

Primary Care Physician: _____ Phone:_____

Primary Insurance: _____ ID: _____

Secondary Insurance: _____ ID:_____

Is Visit Related to MVA or Work Comp Injury: Yes/No Date of Injury: _____

Adjuster's Name: _____ Adjuster's Phone #: _____

We are excited to invite you to join our patient portal, an easy way to stay connected and communicate with us about your healthcare

- **View your upcoming appointments**
- **Securely communicate with your care team and get faster responses than calling the office**
- **View your health information**
- **Receive "Blast" Notifications of office closures due to inclement weather**

To get started, we will send you an email invitation to join; this link is valid for 48 hours (check your spam for your invitation). Simply follow the link to verify your identity by confirming your last name and date of birth. When you have verified your identity successfully, create a new password.

This is a secure site that will allow you to access and request your personal information. *You will not receive any spam and we will not give out your email.*

North Georgia Pain Clinic

PATIENT PORTAL

Please be aware that we offer a *patient portal for you to communicate* with our office for *appointments, forms, refills on medication and requests for lab results*. This will be the ***preferred communication in 2023.***

In order to do so, please provide the office staff with a ***current email*** so we may send you a registration link.

Once you receive the registration link, the prompts will instruct you on what steps you need to take. This link is valid 24 hours. Please check your spam for the invitation.

Please inform our office staff of any problems or questions. You will not receive any spam and we will not give out your email.

Thank you!

Patient's Name _____

Date of Birth _____

Email Address _____