



**CONSULTANTS IN
PAIN MEDICINE**
DIAGNOSIS · TREATMENT · RELIEF

Dr. Thomas Runyan & Dr. Kevin Coyle

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Brunswick, GA 31520 Waycross, GA 31501 Vidalia, GA 30474
Phone (912) 466-9111 Phone (912) 283-6877 Phone (912) 537-4414

Date: _____

Dear _____,

Enclosed you will find new patient paperwork for you to complete and bring to your appointment on:

_____, _____ at _____ in _____
Day Month Date Time Location

If your papers are not completed, your appointment may be rescheduled.

The day of your visit, please **BRING - PICTURE ID, INSURANCE CARDS, ALL MEDICATIONS (Bottles not a list) AND ANY MRI/CTS/XRAYS YOU MAY HAVE. If you have an Advanced Directive (ie. Living Will) we must include a copy of the notification in our chart.**

You will have additional paperwork to fill out once you have checked in, so please **ARRIVE 15 minutes early** for your appointment. **If you need assistance filling out your paperwork plan accordingly and bring someone with you.**

It is also beneficial to call your insurance company to verify benefits, coverage, and copay amounts.

If you have any questions feel free to contact our office at (912) 466-9111 ext 301.

Thank you for your time and consideration.

Sincerely,



FINANCIAL POLICY, CONSENT FOR TREATMENT, AND RELEASE OF MEDICAL INFORMATION

Thank you for choosing us as your pain management provider. Please understand that payment of your bill is considered part of your treatment. All patients must complete the registration sheet and provide proper insurance information prior to seeing a physician. Full payment is expected as services are rendered. We accept cash, credit card, or check. Payment terms can be arranged with prior approval from our billing department. CO-PAYMENTS and DEDUCTIBLES are due at the time of service.

If you have insurance, as a courtesy to you, we will file your primary insurance and wait no more than 45 days from them to pay. If your account has reached 45 days, you will receive a letter from our office. The letter requests that you contact your insurance company and check on the status of your claim and call our office with the results, within 10 days. We will also file your secondary insurance claim once the primary carrier has paid.

Consultants in Pain Medicine is committed to providing the highest quality care for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of your insurance company's arbitrary determination of usual and customary rates. Your insurance policy is a contract between you and your insurance company. Any disagreement you have concerning the amount your insurance pay should be directed to your insurance company. We will follow the rules of the agreement for the insurance companies with whom we are contracted. At no time will co-insurance, co-payments, or deductibles be waived.

If you have an HMO, PPO, or equivalent policy, it is your responsibility to inquire with the insurance company to see if Consultants in Pain Medicine is a contracted provider. We try to become contracted providers for as many policies as we can. It is also the patient's responsibility to keep track of referral and referral dates and number of visits.

If your treatment is based on an accident or injury claim, our office will complete your paperwork at a **minimum cost of \$25 per form** depending on the time required. Payment must be received, as the forms are prepared.

Authorization: I hereby authorize Consultants in Pain Medicine to administer treatment and perform procedures as may be deemed necessary or advisable in my diagnosis. I further authorize the release of any medical information necessary to process my insurance claim and request payment of medical services to be assigned directly to Consultants in Pain Medicine. In the event my insurance does not cover services rendered, I agree to be personally and fully responsible for payment. I have read the office policy and understand and agree to its terms. This authorization is to remain in full force unless I revoke the same in writing.

Signature

Printed Name

Date



Medication Agreement & Refill Policy

As part of your treatment, our medical staff may prescribe medications for you. Many of these medications can have serious side effects if they are not managed properly. Your health and safety are very important to us, and we need your help to make sure your treatment follows our guidelines. **If Consultants in Pain Medicine has any questions regarding your healthcare, including medications, we reserve the right to contact your other treating physicians and pharmacies.**

1. I agree to follow the dosing schedule prescribed to me by my doctor or PA.
2. I agree to never share my medications with others, nor will I sell or exchange my medications for any reason.
3. I agree to always keep my medications safeguarded and within my control.
4. I agree to notify Consultants in Pain Medicine if I experience any adverse effects or dosage problems with my prescribed medications. I will not discard any unused medication. Before any new medication can be prescribed, I may be asked to bring any unused medication to Consultants in Pain Medicine for disposal.
5. I agree that if I receive narcotic prescriptions from Consultants in Pain Medicine, I am not allowed to receive the same type of medications from another physician without express consent or consultation with Consultants in Pain Medicine.
6. I agree to use only one pharmacy for my pain-related medication unless extenuating circumstances prevent this from being possible. In this event, I will notify Consultants in Pain Medicine of all pertinent information pertaining to additional pharmacies, mail-order, or other sources.
7. I understand that medication refill prescriptions involving narcotic pain medicine require a scheduled office visit when my doctor is on duty in the office. **Narcotic pain medication refills will not be called into a pharmacy, nor will they be increased over the telephone.**
8. **I agree to keep all scheduled appointments. I understand that no medications will be given for canceled or no-show appointments.** I understand that if I am more than 30 minutes late to my scheduled appointment time, I will have to reschedule.
9. I understand that medication refills cannot be made after hours, on the weekends, or on holidays. Consultants in Pain Medicine's phone triage hours are 1:00pm to 4:00pm, Monday, Tuesday, and Thursday.
10. I agree to bring all of my prescribed medications from any doctor's office to Consultants in Pain Medicine for my office appointments. I understand that pill counts may be necessary for controlled substances.
11. I understand that I should not drive or operate heavy machinery while I am taking medications that may cause drowsiness or impaired cognitive function.
12. I understand that I am solely responsible for the safekeeping of my medications and I must treat my medications as I would my money or valuable possessions. Consultants in Pain Medicine will have no obligation to replace LOST OR STOLEN prescriptions or medications.
13. I understand that my therapy at Consultants in Pain Medicine may require a monthly office visit so my doctor can properly evaluate my progress, and/or adjust appropriate narcotic pain medications every thirty (30) days.
14. I understand that abusive behavior or harassment toward any Consultants in Pain Medicine's staff will not be tolerated. Harassment includes, but is not limited to, more than two (2) phone calls to the office in one business day.
15. I understand that I cannot present to Consultants in Pain Medicine unannounced seeking medication refills.
16. I understand that dealing with a forged or falsified prescription will result in the immediate dismissal from Consultants in Pain Medicine.
17. I understand that I may be dismissed from Consultants in Pain Medicine if I do not abide by the terms of this medication agreement.
18. I understand that Consultants in Pain Medicine will not prescribe narcotic medications on my first office visit.
19. I understand that Consultants in Pain Medicine's office policy is to perform a URINE DRUG SCREEN AT THE FIRST VISIT AND FOLLOW UP TEST APPROXIMATELY EVERY 3 MONTHS . If my screen tests positive for un-prescribed substances or negative for medication that I have been prescribed. I understand that this is grounds for dismissal from the practice.
By signing the agreement, you affirm that you have the full right and power to be bound by this agreement and that you have read, understood, and accepted these terms. No medications will be prescribed without the acceptance of this agreement.

Pharmacy Name

Pharmacy Phone Number

Patient's Signature

Date

Print patient's name _____

Name of Practice: Consultants In Pain Medicine, LLC

Name of Patient (please print)

Date of Birth

Acknowledgment of Notice of Privacy Practices

I hereby acknowledge that I received Consultants In Pain Medicine's Notice of Privacy Practices.

Signature of patient or patient representative

Date

Documentation of Good Faith Efforts To obtain patient's acknowledgment that they received provider's Notice of Privacy Practices

(For use when acknowledgment cannot be obtained from the patient.)

The patient presented to the office/hospital on [insert date] and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- Patient refused to sign.
- Patient was unable to sign or initial because:

- The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.
- Other reason (describe below):

Signature of Employee Completing Form

Date



CONSULTANTS IN PAIN MEDICINE

DIAGNOSIS · TREATMENT · RELIEF

Consultants in Pain Medicine's Doctors and Physicians Assistants may utilize opiates (Narcotic medication) in the management of your pain condition. Important issues in opioid therapy revolve around the appropriate use of prescription opioids. Adherence monitoring is used to encourage the appropriate use of medications and to avoid abuse of medications. Our practice utilizes periodic monitoring and urine drug screens as part of our Adherence monitoring program. Urine drug screens help us determine appropriate intake of prescribed substances, uncover diversion and keep accurate records.

Our practice requires a baseline urine drug screen and then we perform random drug screens during your therapy. There is an **additional charge** for Urine Drug Screens.

Please initial you have read this notice.

Patient Initials _____

Print Patient Name _____

Date ____/____/____



Patient Acknowledgement Form

Patient's Name: _____ Date of Birth: _____

SSN: _____ Today's Date: _____

I understand that the patient's health information is private and confidential. I understand that Consultant's in Pain Medicine works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Consultant's in Pain Medicine may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care options. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that there may be situations where Consultants in Pain Medicine is required by law to release this information without my permission. One example would be if a patient threatened to hurt someone.

Consultants in Pain Medicine has a detailed document called the *Notice of Privacy Practices*. It contains more information about the policies and practices protecting the patient's privacy including other potential disclosures and uses of patient's health information. I understand that I can receive a copy of this document at any time of my choosing. One example would be disclosure of health information for research purposes. I understand that I have the right to read the *Notice of Privacy Practices* before signing this acknowledgement.

Consultants in Pain Medicine may update this acknowledgement and *Notice of Privacy Practices*. If I ask, Consultants in Pain Medicine will provide me the most current *Notice of Privacy Practices*.

Within this *Notice of Privacy Practices* is contained a complete description of my privacy/confidentiality rights. These rights include, but are not limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative locations.

Consultants in Pain Medicine has established procedures that help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgements, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist Consultants in Pain Medicine by following these procedures if I choose to exercise any of my rights described in the *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review a current copy of Consultant's in Pain Medicine's *Notice of Privacy Practices* at my discretion.

Patient or Legally Authorized Signature

Date

Relationship to patient: _____