Dear New Patient: _____

Your New Patient appointment is scheduled for: _____

Location: **440 B High Street**, **Bowling Green, KY 42101**

Welcome to the Center for Pain Management. We look forward to your upcoming new patient appointment.

We have enclosed the new patient forms for your initial visit to our practice. Prior to your visit please fill out the following forms and bring them with you to your scheduled appointment. Completing the forms entirely will help us in serving you better.

Please bring any reports of diagnostic testing (MRI, CT SCAN, X-RAY, MYELOGRAM, EMG etc.) with you to your scheduled visit.

Please note, if you need to reschedule, or cancel your appointment, please do so at least 24-48 hours in advance. Failure to notify our office of your absence will result in a delay of rescheduling.

Directions to our Office:

Address: 440 B High Street
Bowling Green, KY 42101

From I-65:

Take exit 26 (Bowling Green/Cemetery Road) Turn Left off the exit ramp if on 65 North and turn Right off the ramp if on 65 South. Travel on Cemetery Road which turns into Fairview Avenue for about 3 miles till the intersection with US 31 W Bypass. After crossing the traffic light at US 31 W Bypass on Fairview, cross one more traffic light at Lehman Ave and look for a Hospital Sign on the Right side. Immediately after crossing the Hospital sign, make a Right onto High Street. After traveling for a block on High Street, make a Right onto 5th Ave and our building is on the Left Side. We are at the High Street Medical Plaza- 440 High Street, Suite B- the building at the intersection of High Street and 5th Ave.

From Medical Center of Bowling Green:

Turn onto High Street from US 31 W Bypass going toward Medical center. Pass the ER of the Medical Center on the Left and go underneath the walkway and proceed further on High Street. We are located on the left side at the High Street Medical Plaza- 440 High Street, Suite B-the building at the intersection of High Street and 5th Ave.

CENTER for PAIN MANAGEMENT

PATIENT INFORMATION

Name: _____ Birth Date: _____

Address: _____ Social Security #: _____ - _____ - _____

City: _____ Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Other

State: _____ Zip: _____ Sex: [ ] Female [ ] Male

Home Phone: _____ Referring Physician: _____

Mobile/Other: _____ Primary Physician: _____

Work Phone: _____

GUARANTOR (Person Statement will be mailed to)

[ ] Same as Patient

Name: _____ Birth Date: _____

Address: _____ Social Security #: _____ - _____ - _____

City: _____ Home Phone: _____

State: _____ Zip: _____ Work/Other Phone _____

PRIMARY INSURANCE

[ ] Same as Patient [ ] Same as Guarantor [ ] Other

Company: _____ Policyholder: _____

Phone Number: _____ Relation to Patient: _____

ID Number: _____ Social Security #: _____ - _____ - _____

Group Number: _____ Birth Date: _____

SECONDARY INSURANCE

[ ] Same as Patient [ ] Same as Guarantor [ ] Other

Company: _____ Policyholder: _____

Phone Number: _____ Relation to Patient: _____

ID Number: _____ Social Security #: _____ - _____ - _____

Group Number: _____ Birth Date: _____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Address: _____

City/State/Zip: _____

Home Phone: _____

Work/Other Phone: _____

PATIENT EMPLOYMENT

[ ] Employed [ ] Retired [ ] Unemployed [ ] Other

Employer: _____

Address: _____

City/State/Zip: _____

Work Phone: _____

Position: _____

IS YOUR CONDITION CONNECTED WITH WORKMAN'S COMPENSATION? □ YES □ NO

If so, please include the following:

Name of Employer: _____

Employer's Phone: _____ Date of Injury: _____

Contact: _____ Claim #: _____

How did accident occur? _____

IS THIS RELATED TO AN AUTO ACCIDENT? □ YES □ NO

If so, please include the following:

Insurance Company: _____ Address: _____

Phone #: _____ Contact: _____

Policyholder's Name: _____ Relationship to Patient: _____

Date of Accident: _____ Policy #: _____

Claim #: _____ How did accident occur? _____

INSURANCE AUTHORIZATION (All patients must sign authorizing us to bill your insurance carrier)

I understand and authorize Center for Pain Management to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company to be made directly to the above practice. I authorized any holder of medical information about me to release to the health financing administration and its agents any information needed to determine these benefits. I understand that I am financially responsible for any information necessary to secure payment of benefits, which includes providing current insurance information. Without this current information, I understand that I will be billed for any services that are rendered by the above practice.

Signature: _____ Date: _____

PAYMENT POLICY (All patients must sign acknowledging co-pay responsibilities and returned check fees)

Co-payment is due at the time of service. If you do not have your co-pay, please let the receptionist know so she can reschedule your appointment. There is a $25 returned check fee, and a $20 fee for missed appointments.

Signature: _____ Date: _____

ATTORNEY AUTHORIZATION (Only patients with attorneys must sign)

Who is your attorney:_____ Atty phone number: _____

I understand and authorize my medical bills and records to be sent to the above listed attorney to these dates of treatment. If my case is not settled, or if the amount settled does not cover my medical bills, I will pay for these services.

Signature: _____ Date: _____

RELEASE OF INFORMATION/COLLECTIONS POLICY

I authorize Ram Pasupuleti, MD, to release my insurance company any information required for services provided. I also assign any insurance benefits to Ram Pasupuleti, MD on any unpaid medical bills. I understand that I remain responsible to Ram Pasupuleti, MD for any and all charges not met by the insurance company. I , the undersigned, herby agree that in the event of default in payment of any amount due, and if his account is placed in the hands of an agency or attorney for collection or legal action, to pay an additional charge equal to the cost of the collection including the agency and attorney fees and court costs incurred and permitted by laws governing these transactions.

Signature: _____ Date: _____

By signing each of the above statements, I acknowledge that I fully understand the content, and agree to all of the above conditions.

NOTICE OF PRIVACY PRACTICES

TO OUR PATIENTS:

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by this Practice in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: Treatment, Payment and Health care operations:

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing, or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspect of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified to you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means of at alternative locations.
- The right to inspect and copy your protected health information (our normal copying fee will be required)
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

PATIENT ACKNOWLEDGEMENT

I have received, read and understand your Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information. I understand that this Medical Practice has the right to change its Notice of Privacy Practices from time to time and that I may contact the office at any time at the address noted in this notice to obtain a copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Signature: _____ Date: _____

MEDICATION USAGE AGREEMENT

Anyone receiving chronic controlled substances from the Center for Pain Management, PLLC will have to sign a Medication Usage Agreement.

By signing this agreement I, _____, agree to abide by the following conditions and terms when using any and all medications prescribed to me by the staff at this practice:

1. I will take my medication(s) only as directed. Any changes in taking my medication(s) will need to be discussed with the office practitioners prior to the change.

2. I agree to take full responsibility for my medication(s) and understand that:

a. Lost or stolen medications will not be replaced.

b. I will not share my medication(s) with anyone.

c. Early refills will not be given if I have accelerated my medication usage and run out before I am due another refill.

3. State law prohibits obtaining medications under false pretenses. If this occurs, we are obligated to report these situations to local law enforcement agencies. Misuse or abuse of these medications is a Class D felony. If the below occurs we will be required to discharge you from the practice immediately. Such false pretenses include, but are not limited to:

a. "Doctor shopping" to obtain multiple prescriptions.

b. Multiple emergency room visits to obtain prescriptions and medications.

c. Use of false identification or any other subterfuge in order to obtain medications.

4. It is important that patients receive their medications from only one doctor. This is not only to prevent possible legal penalties, but also to avoid dangerous side effects and interactions that your medication can have with other medicines that we may not be aware that you are taking. Therefore if you receive any medication(s) from another treating physician, it is **imperative** that you let us know what these medications are.

5. Please be aware that it is not a medical obligation to prescribe controlled substances to a patient at any time.

6. We strongly encourage all of our patients to refrain from using tobacco and alcohol. We also strongly discourage the use of illicit drugs – either illegal substances or prescription medications that are bought from illegal sources.

7. I understand that random urine and/or serum drug testing and random pill counts are done at the Center for Pain Management at Cumberland Brain & Spine. I understand that failing a random drug test can be defined as:

a. The presence of illegal drugs in the sample.

b. The presence of legal drugs that should not be in the sample.

c. The absence of the drugs we prescribe when there should be evidence of that particular medication.

d. Attempting to pass off someone else's sample as my own.

e. Attempting to alter the sample that I leave in order to disguise the results.

8. I understand that refusing or failing a random drug screen may result in one or more of the following occurring:

a. I may be required to repeat the screen.

b. I may not be prescribed any medications.

c. I may be discharged as a patient.

d. I may be referred to a drug rehabilitation program.

9. I understand that requests for medications and/or refills are done as follows:

e. Refills may be requested Monday through Friday from 8:30am until 3 pm

f. Refill requests generally take 2 business days to process.

g. No refills will be done on weekends, after normal business hours or on holidays. There will be no exceptions.

h. All controlled substances received from our office must be written on a prescription. These medications will not be called into pharmacies.

10. I agree to use _____ pharmacy located at _____, phone number _____ for all of my controlled substances. If I change my pharmacy for any reason, I will notify the practitioner at the time I receive my prescriptions.

If you have any questions or concerns about this policy, please do not hesitate to discuss it with our practitioners.

I have read the above agreement and agree to abide by the terms set above.

_____	_____	_____	_____
Patient Name (Printed)	**Patient Signature**	**Date**	**Witness Signature**