146 Medical Park Road, Suite 108
Mooresville, NC 28117

Phone: 704-662-0877
Fax: 704-662-0875

LAKE NORMAN
ANESTHESIA ASSOCIATES
&
PAIN MANAGEMENT

NEW PATIENT DEMOGRAPHICS AND INSURANCE AUTHORIZATION

Name: _____ Date of Birth: _____ Age: _____

Height: _____ Weight: _____ Sex: M F Marital Status: M S D W

Address/City/State/Zip: _____

Social Security #: _____ Home Phone: __(_____)_____

Employer: _____ Work/Other Phone: __(_____)_____

Email: _____

Pharmacy: _____Pharmacy Phone: ___(_____)_____

Is this visit a result of a work-related injury or an accident? Y N If yes, date of injury/accident: _____

Person to notify in case of emergency: _____

Relationship: _____ Day Time Phone: _____

Address/City/State/Zip: _____

Nearest relative not living with you: _____

Relationship: _____ Day Time Phone: _____

Address/City/State/Zip: _____

Primary Insurance: _____ ID: _____ Group #:_____

Secondary Insurance: _____ ID:_____ Group #:_____

Subscriber's Full Name on Insurance _____

If your insurance is under your spouse's name, you must complete the following information in order for us to bill your insurance properly:

Spouse's Date of Birth: _____ Spouse's Social Security #: _____

Spouse's Employer: _____ Spouse's Work Phone: _____

INSURANCE/MEDICARE AUTHORIZATION

I, the undersigned, authorize use of this form on all of my insurance submissions. I authorize release of all medical information necessary to secure payment of benefits to all my insurance companies. I understand that I am financially responsible for all charges whether or not paid by my insurance companies. I authorize payment directly to Lake Norman Anesthesia Associates and for them to act as my agent in helping me obtain payment from my insurance companies.

_____ _____

Signature **Date**

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PATIENT QUESTIONNAIRE

Name: _____ DOB: _____

1. Date _____/_____/_____ Age _____ Sex: M F Height _____ Weight _____

2. Doctor who referred you to the Pain Clinic _____ Family Doctor_____

3. What other doctors have treated you for pain in the past?

_____ _____ _____

4. When did you first have the pain for which you are now seeking help? Month _____ Year _____

5. How did the pain begin? (Check one and note date of accident/illness)

[ ] Accident at work ___/___/___
[ ] Accident at home ___/___/___
[ ] Following surgery ___/___/___
[ ] Motor vehicle accident ___/___/___
[ ] Pain just began ___/___/___
[ ] Other, please specify ___/___/___

6. If you were injured at work, please list: (SKIP TO 7 IF NOT WORK-RELATED)

Place of employment _____Type of work _____

Length of employment there _____ When did you first seek treatment for the pain you have now? _____

7. In what part(s) of the body did the pain begin? _____

_____

8. What percentage of time is pain present? (Circle one) 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

9. What time of day is your pain worst? _____

10. How would you describe your pain? (Circle all words that apply)

Throbbing	Shooting	Stabbing	Cramping	Sharp	Nagging
Burning	Tingling	Dull	Tender	Aching	Intense

11. If a zero (0) means "no pain" and a ten (10) means "the worst pain possible", circle your level of pain:

On good days	0 1 2 3 4 5 6 7 8 9 10
On bad days	0 1 2 3 4 5 6 7 8 9 10
Today	0 1 2 3 4 5 6 7 8 9 10

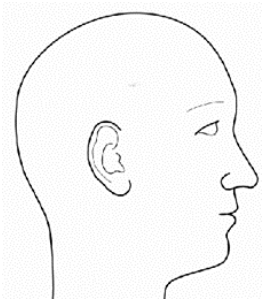
12. Circle any of the following which make your pain worse:

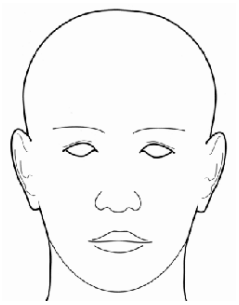
Coughing Sneezing Lying Down Sitting Physical Activity Walking Standing Lifting
Eating Bathing Sexual Activity Dressing Rising up from chair or bed Using the Toilet

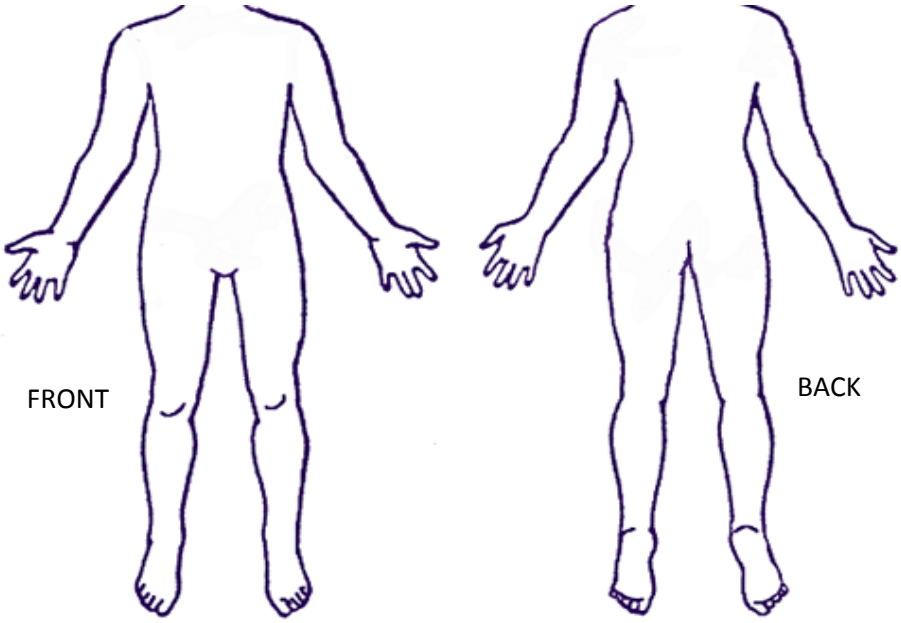
13. Circle any of the following which make your pain better:

Relaxation Lying Down Sitting Walking Sexual Activity
Standing Heat Cold Alcohol Medicines Other: _____

14. On the following diagrams, shade in the areas where you feel pain. Put an "X" on the area that hurts the most.







15. What specifically does your pain keep you from doing? _____

16. Have you been hospitalized for your pain? If so, when and where? _____

_____

17. Have you had surgery for your pain? If so, what and when? _____

_____

18. Do you have any family history of Rheumatoid Arthritis or Osteoarthritis? Yes No

19. Do you or anyone living with you have a history of medication or alcohol abuse/addiction? Yes No

Please list names and relationship if not yourself _____

20. Have you or anyone living with you ever been discharged from a physician's office for medication abuse/addiction? Yes No

21. Which of the following tests have you had regarding your pain?

[ ] X-Rays	[ ] MRI Scan	[ ] Electromyogram (EMG)	[ ] Nerve Conduction Study (NCT)
[ ] CT Scan	[ ] Bone Scan	[ ] Myelogram	[ ] Other

22. Circle the result of any of the following treatments you have had for your pain:

Epidural Steroid Injections	Improved	Made Worse	No Change
Physical Therapy	Improved	Made Worse	No Change
Trigger Point Injections	Improved	Made Worse	No Change
Facet Joint Blocks	Improved	Made Worse	No Change
Surgery	Improved	Made Worse	No Change

NSAIDS/Medications: _____

Dates: _____

23. Please rate your pain by circling the number that best describes your pain level in the last week:

(0 = No Pain; 10 = Pain As Bad As You Can Imagine)

Your pain at its **Worst**	0	1	2	3	4	5	6	7	8	9	10
Your pain on **Average**	0	1	2	3	4	5	6	7	8	9	10
Your pain **Right Now**	0	1	2	3	4	5	6	7	8	9	10

REVIEW OF SYSTEMS

Please answer the following to the best of your ability.

CONSTITUTIONAL

Fever	Yes	No
Chills	Yes	No
Rash	Yes	No

EYES

Blurred Vision	Yes	No
Double Vision	Yes	No

EARS

Pain	Yes	No
Difficulty Hearing	Yes	No

THROAT

Sore Throat	Yes	No
Normal Swallowing	Yes	No

CARDIOVASCULAR

Irregular Heartbeat	Yes	No
Chest Pain	Yes	No
Swelling	Yes	No

RESPIRATORY

Wheezing	Yes	No
Frequent Cough	Yes	No
Shortness of Breath	Yes	No

GASTROINTESTINAL

Nausea	Yes	No
Vomiting	Yes	No
Diarrhea	Yes	No
Constipation	Yes	No
Abdominal Pain	Yes	No
Black stools	Yes	No
Blood per rectum	Yes	No

HEMATO-IMMUNOLOGIC

Easy Bruising	Yes	No
Nose Bleeding	Yes	No
Other Bleeding	Yes	No
Recurrent Infections	Yes	No

GENITOURINARY

Burning w/urination	Yes	No
Urgency	Yes	No
Hesitancy	Yes	No
Straining	Yes	No

PSYCHIATRIC

Depression	Yes	No
Anxiety	Yes	No
Substance Abuse	Yes	No
Weight Loss/Gain	Yes	No

MUSCULOSKELETAL

Joint Pain	Yes	No
Muscle Pain	Yes	No
Back Pain	Yes	No

NEUROLOGICAL

Tremors	Yes	No
Dizziness	Yes	No
Tingling	Yes	No

Patient _____ ___/___/___ Physician _____ ___/___/___

Signature Signature

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PATIENT MEDICATION LIST

Name: **DOB:**

Smoker: **Alcohol:**

Past History:

Allergies:

Pharmacy:

MEDICATION	DOSING	STAFF/DATE						

SOAPP® Version 1.0-14Q

Patient Signature: _____ Date: _____

Patient Name (Print): _____ Date of Birth: _____

The following are some questions given to all patients at Lake Norman Anesthesia and Pain Management who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 + Very Often

1.	How often do you have mood swings?	0 1 2 3 4
2.	How often do you smoke a cigarette within an hour after you wake up?	0 1 2 3 4
3.	How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	0 1 2 3 4
4.	How often have any of your close friends had a problem with alcohol or drugs?	0 1 2 3 4
5.	How often have others suggested that you have a drug or alcohol problem?	0 1 2 3 4
6.	How often have you attended an AA or NA meeting?	0 1 2 3 4
7.	How often have you taken medication other than the way that it was prescribed?	0 1 2 3 4
8.	How often have you been treated for an alcohol or drug problem?	0 1 2 3 4
9.	How often have your medications been lost or stolen?	0 1 2 3 4
10.	How often have others expressed concern over your use of medication?	0 1 2 3 4
11.	How often have you felt a craving for medication?	0 1 2 3 4
12.	How often have you been asked to give a urine screen for substance abuse?	0 1 2 3 4
13.	How often have you used illegal drugs (Ex: marijuana, cocaine, etc.) in the past five years?	0 1 2 3 4
14.	How often, in your lifetime, have you had legal problems or been arrested?	0 1 2 3 4

Please include any additional information you wish about the above answers. Thank you.

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HIPAA AUTHORIZATION FORM

It is the office policy of Lake Norman Anesthesia Associates and Pain Management and staff not to release confidential, protected health information and/or unauthorized information by home telephone, answering machine, work telephone, voicemail, cell phone and/or pager. Whenever returning telephone calls, we will not leave a message if the name or telephone number is not on the recorded message to identify the residence. Our staff will not leave any information with an unauthorized person who may answer the telephone.

I authorize Lake Norman Anesthesia Associates and Pain Management and staff to leave information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

Home Telephone/Answering Machine	Yes	No
Work Telephone	Yes	No
Cell Phone and/or Voicemail	Yes	No
Pager	Yes	No
Fax Medical Records to other healthcare providers	Yes	No

If you authorize to have protected health information or other information such as appointment dates/times released to someone other than yourself, please provide the names of authorized individuals:

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

I, the undersigned, confirm I have received a copy of the Notice of Privacy Practices for Lake Norman Anesthesia Associates and Pain Management, understand my rights as a patient, and confirm the above authorizations in regards to my protected health information:

Signature: _____ Date: _____

Print Name: _____ DOB: _____

Relationship to Patient: _____

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FINANCIAL AND CANCELLATION POLICY

Thank you for choosing Lake Norman Anesthesia Associates and Pain Management as your healthcare provider. Our main concern is that you receive the proper and optimal care needed to maintain/restore your health.

We ask that you show our practitioners and our other patients consideration by calling at least 24 hours prior to your appointment if you are unable to attend. This will allow us the opportunity to offer that appointment to another patient. As a result, after **two** cancellations, rescheduled appointments or no-shows, you will be discharged from our office. In the event that you are discharged from our care, your referring provider or case manager will be notified of the reason for discharge from our office. Late cancellations due to illness or family emergency are excluded from this policy.

Failure to give the 24 hours notice necessary prior to cancellation, will result in a "No-Show Fee" of **$51.00, for office appointments and $100.00 for Surgical Center appointments**. This fee cannot be billed to your insurance company and will be your direct responsibility.

Please present your current insurance ID card at your visit and if anything changes we ask that you contact us immediately. In the event we do not participate with your insurance plan **you will be responsible for the entire bill**. As a service to you, our office makes every reasonable effort to obtain payment according to your coverage. Regardless of the type of insurance you have, you are ultimately responsible for paying your medical bills. If your insurance company rejects the claim or denies payment, the office will bill you for the entire amount. It is, at all times, your responsibility to follow up on all requests from your insurance company regarding claims and to question your insurance company about any unpaid claims. Failure to provide necessary referrals and/or authorizations will result in all charges for services becoming the sole responsibility of the patient/responsible party.

All co-payments and deductible amounts should be paid at the time of service in accordance with legal requirements for collecting patient responsibility amounts and if you are unable to pay these amounts, we will need to reschedule your appointment. Our staff will inform you of these amounts prior to your procedure. Unresolved balances may be placed with an outside collection agency and may also be subject to **finance charges, attorney fees and collection agency fees**, which will be owed **in addition** to the remaining balance. In the case of an unpaid balance you will be dismissed from our practice. Our practice accepts Visa, MasterCard, Discover, HSA debit cards, or Care Credit for your convenience. We also accept personal checks and cash. A **$35.00** fee will be charged for all checks that are returned to us by your financial institution.

Authorization: I agree to abide by the terms of the above financial and cancellation policy and accept responsibility for any balance not covered by my insurance company(s). I authorize my insurance company(s), attorney or other parties to pay Lake Norman Anesthesia Associates and Pain Management and /or provide any information regarding payment of my bill. If my account becomes delinquent, I agree to pay all costs incurred in collection of the account, including any necessary collection, attorney and finance fees. I also agree to pay all costs incurred with returned checks as well as any fees applied for failure to give 24 hours notice of cancellation for my appointments. I authorize Lake Norman Anesthesia Associates and Pain Management to administer medical care as is necessary, including allowing release of records or medical reports on my condition to any party involved in my treatment.

Signature: _____ Date: _____

Print Name: _____ DOB: _____

Relationship to Patient: _____

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AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Information:

Name of Patient _____ Date of Birth _____

Address _____

City, State, Zip _____ Phone _____

At my request, the following information may be released:

- ○ Most Recent Office Visit Note
- ○ Diagnostic Studies_____
- ○ Other as listed_____
  _____
- ○ Financial Records
- ○ On site record review by the patient
- ○ Marketing (financial compensation is received for this communication)
- ○ Psychotherapy Notes-(if this box is checked, only psychotherapy notes may be released)

Entity or person who will receive the information:

Name ____Lake Norman Anesthesia Associates and Pain Management_____

Address ____146 Medical Park Road, Suite 108, Mooresville, NC 28117_____

Phone _____(704) 662-0877_____ Fax _____(704) 662-0875_____

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand that released information may include a communicable disease diagnosis such as HIV.

_____ Date _____
Signature of Patient or Personal Representative

_____
Description of Personal Representative's Authority (attach necessary documentation)