Cedar Rapids Pain Associates

PATIENT INFORMATION

PATIENT NAME: **DATE OF BIRTH:**

SOCIAL SECURITY #

ADDRESS: **CITY:** **STATE:** **ZIP:**

HOME PHONE: ____________________ **CELL PHONE:** ____________________ **WORK PHONE:** ____________________

Please Circle the best number for us to reach you: HOME CELL WORK May we leave a message? YES NO

EMAIL ADDRESS: ____

Race: Caucasian___ Black___ Asian___ Native American___ Asian Pacific American___ Pacific Islander___
Subcontinent Asian American___ American Indian or Alaskan Native___ Native Hawaiian___ Other Race___
Not Reported - Refused___ Not Reported - Unknown___

Ethnicity: Latino/Hispanic___ Non Latino/Hispanic___ Not Reported - Refused___

Primary Language: English___ Spanish___ Other (Please specify): __________________

INSURANCE INFORMATION

SUBSCRIBER:

PRIMARY INSURANCE: **MEMBER ID#:**

SUBSCRIBER: «SecPlanSubscriberName»

SECONDARY INSURANCE: **MEMBER ID#:**

CARE TEAM: (Please List any Doctors you currently see and their Specialty)

Name: ______________________________ Phone: ______________________ Specialty: _____________________________

Name: ______________________________ Phone: ______________________ Specialty: _____________________________

Name: ______________________________ Phone: ______________________ Specialty: _____________________________

EMERGENCY CONTACT:

Name: ____________________________ Phone: ______________________ Relationship: ____________________________

Complete the following if accident-related

☐ Work Accident ☐ Auto Accident ☐ Other Accident Date of Accident: ____________________

Insurance Carrier Name: _________________________ Carrier Billing Address: _____________________________________

Claim Number: ______________________________ Adjuster Name & Phone Number: _______________________________

Employer Name- if work- related: ___________________________ Address/Phone: __________________________________

CONSENT TO OBTAIN INFORMATION

4205 Glass Road N.E. Cedar Rapids, Iowa 52402
Phone: 319-294-0094 Fax: 319-294-0095

Please PRINT all (except signature at bottom) and provide complete information in each section.

Patient's Legal Name____ Date of Birth_______________________________________

By signing this form I am authorizing Advanced Spine & Rehab Center/Cedar Rapids Pain Associates to obtain medical information concerning the above named patient from the person/facility listed below.

____
Name of Person and/or Institution requesting information from

____ ____
Complete Mailing Address/Street/P.O. Box City, State, Zip Code

Check the information to be disclosed (include dates where indicated): ❑Minimum necessary or specify below

- ❑ Entire Record
- ❑ Medication list
- ❑ Most recent history and physical or specify date(s)
- ❑ Clinical notes related to visit(s), specify visits or date(s)
- ❑ CD of Images (X-ray, MRI, CT), specify type and date(s)
- ❑ Report of test results (i.e. lab, X-ray, etc.), specify type and date(s)
- ❑ Billing information
- ❑ Other, specify ________________________________

As per my request, the reason for obtaining information is:

❑ Continued medical care ❑ Legal ❑ Insurance ❑ Personal ❑ Other (specify) ______________________

I understand that this authorization is voluntary and that I may cancel this consent to release information at any time by sending written notice to Cedar Rapids Pain Associates, 4205 Glass Road N.E., Cedar Rapids, IA 52402 I understand that any release which was made prior to my cancellation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized re-disclosure, and once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting the Office Manager at the above address.

I understand that Cedar Rapids Pain Associates may not require completion of this form as a condition of treatment. However, when the provision of services is solely for the purpose of creating a medical report (protected health information) for a third party, refusal to sign may result in a denial of those services.

I understand that the information to be released may include information in the following categories unless I specifically deny the release (***initial*** any category ***not*** to be released).
Substance Abuse ________________ Mental Health ________________ HIV-related information ________________

This agreement will expire one year from the date of signature, unless previously revoked or otherwise indicated (specify number of days or months) ___________________________

____ ___________________________________
Signature of Patient or Legal Guardian **Date**

____ ____
Address/Street/P.O. Box City, State, Zip Code

____ ____
Relationship, if Not the patient Witness Signature

CRPA use only:

Form Sent: ______________________________________
Name Date

Original – medical record
Copies – deliver as requested above
– to patient

CONSENT TO RELEASE INFORMATION

4205 Glass Road N.E. Cedar Rapids, Iowa 52402
Phone: 319-294-0094 Fax: 319-294-0095

Please PRINT all (except signature at bottom) and provide complete information in each section.

Patient's Legal Name_________________________ Date of Birth_________________________

By signing this form I am authorizing Advanced Spine & Rehab Center/Cedar Rapids Pain Associates to release medical information concerning the above named patient to the person/facility listed below.

____
Name of Person and/or Institution releasing information to

_____________________________________ _____________________________________
Complete Mailing Address/Street/P.O. Box City, State, Zip Code

Check the information to be disclosed (include dates where indicated): ❑Minimum necessary or specify below

Entire Record

- ❑ Medication list
- ❑ Most recent history and physical or specify date(s)
- ❑ Clinical notes related to visit(s), specify visits or date(s)
- ❑ CD of Images (X-ray, MRI, CT), specify type and date(s)
- ❑ Report of test results (i.e. lab, X-ray, etc.), specify type and date(s)
- ❑ Billing information
- ❑ Other, specify _________________________

As per my request, the reason for release of information is:

❑ Continued medical care ❑ Legal ❑ Insurance ❑ Personal ❑ Other (specify) ________________

I understand that this authorization is voluntary and that I may cancel this consent to release information at any time by sending written notice to Cedar Rapids Pain Associates, 4205 Glass Road N.E., Cedar Rapids, IA 52402 I understand that any release which was made prior to my cancellation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized re-disclosure, and once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting the Office Manager at the above address.

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Signature of Patient or Legal Guardian **Date**

_____________________________________ _____________________________________
Address/Street/P.O. Box City, State, Zip Code

_____________________________________ _____________________________________
Relationship, if Not the patient Witness Signature

CRPA use only:

Form Sent: _________________________________
Name Date

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Copies – deliver as requested above
– to patient

Patient Authorization

CEDAR RAPIDS PAIN ASSOCIATES/ADVANCD SPINE AND REHAB CENTER FINANCIAL POLICY
As a courtesy, Cedar Rapids Pain Associates/Advanced Spine and Rehab Center will verify your insurance benefits; however, it is ultimately your responsibility to be aware of your specific coverage. We will also bill your insurer on your behalf. If your insurer designates that a copayment, deductible, and/or co-insurance is your responsibility, we are obligated to collect it. The ultimate payment responsibility is yours – you will be billed for any balance not paid by your insurance.

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION / FINANCIAL RESPONSIBILITY

I authorize my insurer to pay benefits directly to Cedar Rapids Pain Associates/Advanced Spine and Rehab Center. I authorize Cedar Rapids Pain Associates/Advanced Spine and Rehab Center to release all information necessary to secure payment including documentation on the medical record which may include present or past history of mental illness, alcohol abuse, drug abuse or HIV/AIDS related information. In understand that I am financially responsible for all charges incurred at Cedar Rapids Pain Associates/Advanced Spine and Rehab Center. Any portion of these charges not covered by my insurer must be paid by me. I further understand that copayments are due at the time of my Cedar Rapids Pain Associates/Advanced Spine and Rehab Center visit and that payment of any deductibles and coinsurance are my responsibility as stated by my contract with my insurer.

HIPAA NOTICE OF PRIVACY PRACTICES

I understand that Cedar Rapids Pain Associates/Advanced Spine and Rehab Center and its staff will make every effort to keep my protected health information confidential and private. My signature below acknowledges that: I understand that Cedar Rapids Pain Associates/Advanced Spine and Rehab Center may use and disclose my protected health information for treatment, billing to obtain payment, and for related health care operations; I have been offered a copy of, read or received Cedar Rapids Pain Associates/Advanced Spine and Rehab Center's Notice of Protected Health Information Practices (Privacy Notice); and I may obtain a copy of the Privacy Notice at any time or view it on the Cedar Rapids Pain Associates web site at www.crpainfree.com.
I have read and agree to the terms to the information stated above.

____ ___________________________
Signature of Patient or Patient Representative or Parent/Legal Guardian of Minor Date

If signed by patient representative or parent/legal guardian, indicate relationship to patient____

CONSENT FOR TREATMENT OF MINOR PARTY
In the event that I am unable to accompany my minor child (under 18 years of age) to his/her Cedar Rapids Pain Associates/Advanced Spine and Rehab Center appointments, I permit Cedar Rapids Pain Associates/Advanced Spine and Rehab Center to render treatment to my child while I am not present.

____ ___________________________
Signature of Patient or Patient Representative or Parent/Legal Guardian of Minor Date

If signed by patient representative or parent/legal guardian, indicate relationship to patient____

MEDICAL HISTORY AND CONSENT FOR TREATMENT
I certify the medical information I have provided is accurate, complete and true.

I authorize Cedar Rapids Pain Associates/Advanced Spine and Rehab Center and any associates, assistants and other health care providers it may deem necessary to treat my condition. I understand in no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

____ ___________________________
Signature of Patient or Patient Representative or Parent/Legal Guardian of Minor Date

If signed by patient representative or parent/legal guardian, indicate relationship to patient____

Cedar Rapids Pain Associates

Late Appointment Policy

Here at Cedar Rapids Pain Associates we strive on keeping our appointments on time for both our patients and providers.

In order to keep our providers on schedule and the wait time for our patients as little as possible, we do not take late appointments.

By signing this, you understand that if you are late to any appointment, you will not be seen and will need to be re-scheduled.

_________________________________ __________________

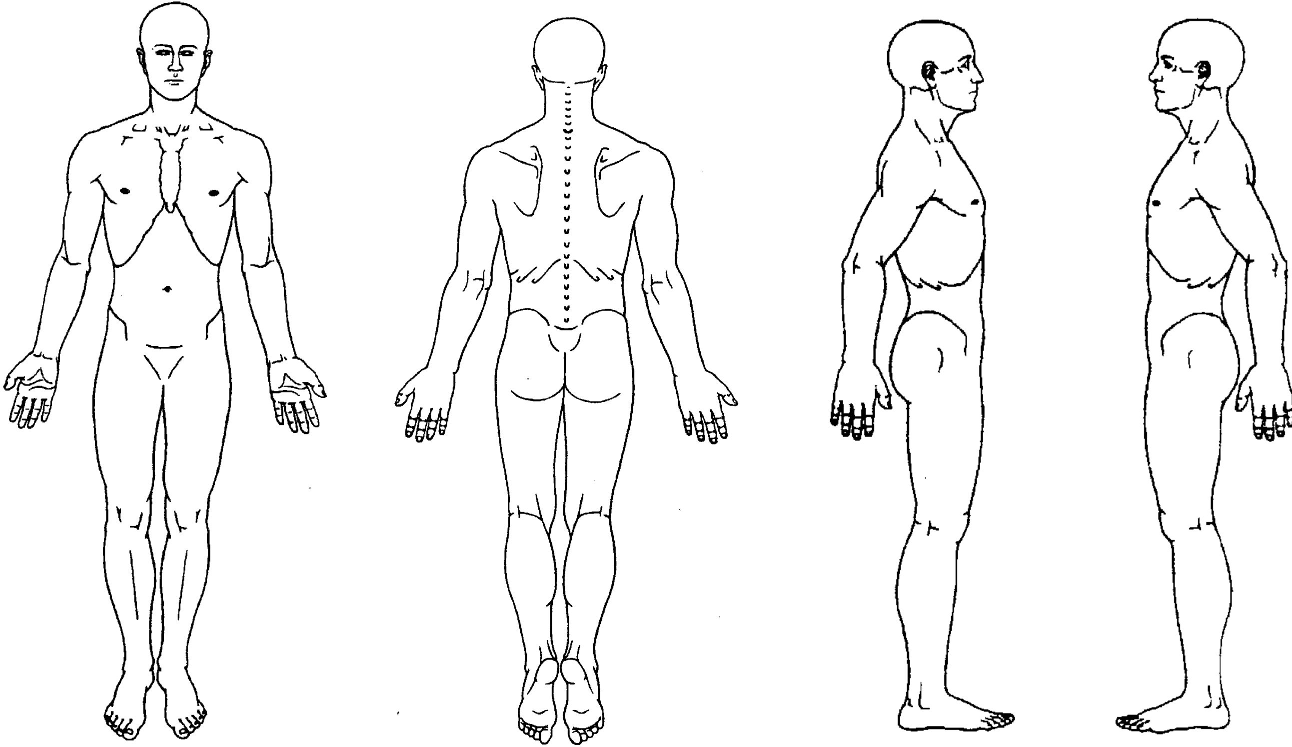
Patient Signature Date

_________________________________ __________________

Witness Signature Date

CURRENT PROBLEM

Please shade in where your primary pain is located using the diagrams below:



When did the pain begin? ____

Did it begin gradually or suddenly? __________________________If suddenly, is it the result of an injury? _____Yes _____No

If result of an injury, describe the injury____

____

If not a result of injury, what do you think caused your pain?

____

Since your pain started is it (Circle one) Worse Unchanged Intermittent Better N/A

Please describe your pain in as much detail as possible:

____

____

____

Do you have any other symptoms such as numbness, weakness, or pins and needles sensation? Please describe.

____

____

Review of Systems

Patient Name:____ _Date:_______________________

Primary Care Physician:____

PLEASE INDICATE BELOW. ARE YOU CURRENTLY EXPERIENCING ANY OF THESE SYMPTOMS:

GENERAL, CONSTITUTION

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes

EYES AND VISION

Eye disease or eye injury	No	Yes
Blurred or double vision	No	Yes

EARS, NOSE AND THROAT

Hearing loss	No	Yes
Ringing in ears	No	Yes
Nosebleeds	No	Yes

HEART AND CARDIOVASCULAR

Chest pains	No	Yes
Sudden heartbeat changes	No	Yes
Swelling of feet, ankles, hands	No	Yes

RESPRITORY

Frequent coughing	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Wheezing	No	Yes

GASTROINTESTINAL

Loss in appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movements/constipation	No	Yes
Blood in stool	No	Yes
Stomach pain	No	Yes

GENITOURINARY

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Incontinence	No	Yes
Sexual difficulty	No	Yes

Date of last menstrual period

____/____/___

Reviewed By:

____

MUSCULOSKELETAL

Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles/joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes

SKIN

Rash or itching	No	Yes
Skin Infections	No	Yes

NUEROLOGICAL

Frequent or recurrent headaches	No	Yes
Light headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Paralysis	No	Yes

PSYCHIATRIC

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes

ENDOCRINE

Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts	No	Yes
Easily bruise or bleed	No	Yes

OTHER:

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Health/Family History

Patient Name: ______________________________________ Date: ____________________

Please complete the following form about you and your family member's health history. Please mark all boxes that apply.

Condition	Patient	Child	Parent	Sibling
Asthma				
COPD				
Deafness		xxxxxxxx	xxxxxxxx	xxxxxxxx
Blindness		xxxxxxxx	xxxxxxxx	xxxxxxxx
Cataracts		xxxxxxxx	xxxxxxxx	xxxxxxxx
High Cholesterol				
High Blood Pressure				
Heart Attack				
Heart stents				
Congestive Heart Failure				
Cardiac Pacemaker/Defibrillator				
Stroke				
Liver Disease				
Renal Failure				
GERD/Ulcers		xxxxxxxx	xxxxxxxx	xxxxxxxx
Colitis		xxxxxxxx	xxxxxxxx	xxxxxxxx
Anemia				
Bleeding Disorders				
Diabetes				
Hyper/hypothyroidism				
Adrenal Insufficiency				
Headache Syndrome/Migraines		xxxxxxxx	xxxxxxxx	xxxxxxxx
Seizures Date of last __/__/__				
Arthritis		xxxxxxxx	xxxxxxxx	xxxxxxxx
Osteoporosis/Osteopenia		xxxxxxxx	xxxxxxxx	xxxxxxxx
Tuberculosis		xxxxxxxx	xxxxxxxx	xxxxxxxx
Cancer **Type**:_____________________				
Fibromyalgia		xxxxxxxx	xxxxxxxx	xxxxxxxx
Immunosuppression				
HIV/AIDS		xxxxxxxx	xxxxxxxx	xxxxxxxx
Mental Illness				
Mental Handicap		xxxxxxxx	xxxxxxxx	xxxxxxxx
Drug/Alcohol Abuse		xxxxxxxx	xxxxxxxx	xxxxxxxx
Pregnant currently Y / N		xxxxxxxx	xxxxxxxx	xxxxxxxx
Other Conditions: (please list) ____________________________ ____________________________ ____________________________ ____________________________				

Reviewed By ____ Date: ______________