ST. LOUIS NEUROPATHY AND PAIN RELIEF CENTER

Patient Basic Information

STOP: ARE YOU WORKING WITH A LAWYER OR DO YOU HAVE A PENDING CASE?

I certify I have NOT been involved in in a personal injury lawsuit (ex. an auto accident or slip-and-fall) and that I am NOT working with a lawyer in relation to the pain I am being seen for today.

I certify that I am **NOT** involved in a Worker's Compensation claim or any type of other insurance claim and I am **NOT** working with Worker's Compensation or any other type of insurance comapny(ies).

If you have a question regarding this section, ask at the front desk.

We will follow up with you in your exam regarding a lawyer or Workers Compensation claim.

Patient Signature: _____ Date:_____

PERSONAL INFORMATION:

Last Name:	First Name:	Mid Init:
Address:	City/State/Zip:	
Home Phone:	Cell Phone:	
Email Address (required) will NOT EVER be used for soliticitation:		
Social Secuity No.:	Date of Birth:	
Prefered language:	Race/Ethnicity:	
Primary Care Doctor:	Doctor Phone:	

PHARMACY INFORMATION:

Pharmacy Name:	Pharmacy Phone:
Cross Streets:	City:
Any prescriptions are sent electronically. Without pharmacy information your cannot be prescribed medication.	

EMERGENCY CONTACT:

Name:_____ Relation:_____

Phone #:_____ Work #:_____

[ ] OPTIONAL I give consent for my emergency contact to recieve information regarding my treatment or care at this facility.

ST. LOUIS NEUROPATHY AND PAIN RELIEF CENTER

Payment Agreement and Assignment of Benefits

THIS AGREEMENT is made and entered into by and between the below named PATIENT (Assignor), and St. Louis Neuropathy and Pain Relief Center, the PROVIDER (Assignee). WHEREAS, PATIENT desires to receive services from this PROVIDER and therefore desires to assign certain rights and benefits to ASSIGNEE. It is hereby agreed:

A. PATIENT assigns to ASSIGNEE any and all benefits payable to PATIENT'S insurance or health care plan(s) as a result of charges incurred by PATIENT for services rendered by this PROVIDER. PATIENT also assigns to ASSIGNEE any and all contractual rights PATIENT has against any insurance company, health care benefit plan, or any other party contractually liable to PATIENT for payment of health care costs incurred by PATIENT as a result of services rendered by this PROVIDER. This assignment of benefits and contractual rights relating to those benefits includes, but is not limited to, the following described policies or plans:

B. PATIENT directs all insurers and others responsible payor(s) for health care services rendered by this PROVIDER directly to PROVIDER.

C. PATIENT agrees to be financially responsible for all charges incurred and not paid by insurance as a result of incorrect or out-of-date information provided by PATIENT about PATIENT's insurance plan, benefits, or coverage amounts – including deductible amounts and co-pays.

D. PATIENT agrees that in the event PATIENT receives any check, draft, or other payment subject to this Agreement, such monies will be held in trust for ASSIGNEE. PATIENT will immediately deliver said check, draft or payment to ASSIGNEE. ASSIGNEE agrees to apply the proceeds from said check, draft or payments to PATIENT'S debt for services rendered. Any violation of this agreement will immediately terminate PATIENT'S charge privileges with the PROVIDER and bring any balance owed by PATIENT to PROVIDER immediately due and payable.

E. This assignment of benefits and contractual rights shall not exceed the total amount of charges incurred by PATIENT for services rendered by this PROVIDER. PATIENT agrees that payment for services rendered by PROVIDER is due upon receipt of said services and acceptance of PATIENT'S assignment of benefits is a convenience to PATIENT, and that ASSIGNEE may revoke this assignment at any time.

F. PATIENT authorizes PROVIDER to release and permit the examination and/or copying of any of PATIENT'S medical records to such persons as PROVIDER deems appropriate. Patient also hereby authorizes this provider to request obtain and examine any patient medical records, imaging, and lab results as the provider deems necessary. PATIENT may terminate this section, in writing, at any time.

G. PROVIDER shall submit a copy of this Assignment with the initial claim form(s) which ASSIGNEE submits to third party payor(s) as notice of the assignment and other agreements contained herein. A scan of this document shall be as binding as the one bearing original signatures.

H. In order to collect payment from insurance or health care plans, PATIENT hereby appoints PROVIDER as to act on PATIENT'S legal behalf to ask, demand, sue for, collect, endorse, sign, and receive any such insurance and other benefits and claims against other parties for PATIENT'S injuries and/or illnesses. Although PROVIDER is granted such powers contained herein, PROVIDER is not obligated or compelled to do so. PATIENT agrees to cooperate with PROVIDER in collecting any such amounts. PATIENT further empowers PROVIDER to request and receive from any insurer, employer, or other third party payor any and all information and documentation pertaining to PATIENT'S policies or plans including a copy of such policies or plans, and any information or supporting documentation concerning or touching upon the handling, calculation, processing, or payment of any claims arising from services rendered by PROVIDER. The PATIENT agrees to pay all attorney fees and court cost attached to trying to collect a debt.

I. PATIENT agrees to be responsible for insurance or health plan deductibles and co-payments, and for the cost of services not covered by said insurance or health care plan(s). With the above exception, PROVIDER agrees to accept as payment in full, for services rendered, the proceeds of all applicable insurance benefits, health care plan benefits and third party claims.

1. This section is void if applicable insurance or health care plans do not provide coverage for medical services.
2. This section is void if prohibited by law or the terms of PATIENT'S insurance policy or health plan.
3. Both PROVIDER and PATIENT have the right to terminate the provisions of this section at any time by providing written notice to the other. Such termination shall have no effect on assignments, assumptions, or payments due, prior to said notice of termination.

J. PATIENT agrees to for all services rendered a collection fee of not more than thirty-percent (30%) of the principal balance if PROVIDER employs a collection agency to attempt collection of an unpaid balance. PATIENT consents to be called on any number provided, including a cellular telephone number, using an automatic telephone dialing system in attempt to collect this debt.

K. PATIENT understands that PATIENT is financially responsible for ALL charges for services rendered by PROVIDER. We may check your credit, employment, and income records. We may report to credit reporting agencies the status and payment of your account.

L. In the event that more than one payment is received, resulting in an overpayment, I authorize PROVIDER to apply this overpayment to any other of my unpaid amounts.

M. In the event that any section or provision of this Agreement is legally void, invalid, or unenforceable, all others shall remain in full force and effect.

N. With exception of Section F, agreements contained herein may not be revoked by PATIENT without express written consent of the ASSIGNEE.

PROVIDER (Assignee):

St. Louis Neuropathy and Pain Relief Center, LLC

10777 Sunset Office Drive, Ste. 40, St. Louis, MO 63127

314-222-0060

PATIENT (Assignor):

Signature:_____

Print Name: _____

Social Security Number: _____

ST. LOUIS NEUROPATHY AND PAIN RELIEF CENTER

Acknowledgement of Office Policies

MEDICATION POLICY

1. You will not be issued a prescription for narcotics on the first visit, for any reason.
2. Refill requests must be made AT LEAST 3 DAYS in advance.
3. Call your pharmacy directly for refills of non-narcotic medications. Do not call our office.
4. Prescriptions for narcotics will be electronically sent to your pharmacy via encrypted communication (EPCS). Should you miss or reschedule an appointment for any reason, you must wait until your next scheduled appointment to receive a refill. You must be compliant with your treatment plan in order to receive a medication refill.
5. If you must call our office to speak with the staff, please allow ample time to get feedback from the practitioner regarding your situation. Only one phone call is needed. Return calls will be made on the same day usually between 4 pm-5 pm.

LATE APPOINTMENT, NO SHOWS, AND CANCELLATION POLICY

1. We strive to keep our appointments on time for both our patients and providers. To keep the wait time as little as possible, we don't take late appointments.
2. By signing below, you understand that if you are more than 15 minutes late to any appointment, you will not be seen that day and must be rescheduled.
3. If you cancel your appointment with less than 24-hours notice, or do not show up for a scheduled appointment, you may be billed a **$25.00 service charge**.
4. Repeatedly no-showing, arriving late, or cancelling appointments may result in discharge.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

1. You acknowledge that you have reviewed a copy of the NOTICE OF PRIVACY PRACTICES of this clinic. You understand that signing this acknowledgement is not a requirement to receive treatment by St. Louis Neuropathy and Pain Relief Center.

CONSENT FOR REMINDER PHONE CALLS AND/OR TEXT MESSAGES

1. I acknowledge and consent to receive an automated appointment reminder telephone calls and/or text messages. My phone number will never be used for solicitation or sold.

By signing below, understand and acknowledge all four of the policies listed on this page.

_____ _____

Patient's Signature *Date*

_____ _____

Clinic Representative *Date*

ST. LOUIS NEUROPATHY AND PAIN RELIEF CENTER

HIPAA Authorization for Disclosure of Protected Health Information

10777 Sunset Office Drive, Suite 40, St. Louis, MO 63127 ● Phone (314) 222-0060 ● Fax: (314)222-0111

I, the patient identified below, authorize clinical records to be released to St. Louis Neuropathy and Pain Relief Center at the address and fax number above. The purpose for need of these records is the adequate and ongoing care and treatment of the patient referenced. I understand I have the right to revoke this release, in writing, at any time. If not revoked, this release will expire within two years from the date of my signature below. I understand that by signing this authorization there is a potential these records may be shared with other providers in the future should I allow, in writing, St. Louis Neuropathy and Pain Relief Center to disclose my information.

INFORMATION TO BE RELEASED:

- ☐ All records, progress notes, diagnostic testing, etc. (including all dates of service for past 18 months, drug/alcohol use or abuse, HIV/AIDS testing and/or results, communicable diseases, and mental health status and/or changes).
- ☐ Specific Dates of Service (list) _____
- ☐ Diagnostic testing results only ☐ Radiographs/MRI/CT scan reports only

PATIENT IDENTIFICATION:

Patient Name: _____ DOB: _____ SSN: _____

Address: _____ City, State, Zip:_____

SIGNATURE: (PATIENT OR LEGAL GUARDIAN)

Name:_____Date:_____

Legal guardian relationship to patient: _____

Guardian Reason: Patient is... ☐ Minor ☐ Deceased ☐ Incompetent ☐ Disabled

Legal Authority: ☐ Next of Kin ☐ Legal Guardian ☐ Power of Attorney

RELEASE OF INFORMATION FROM: **(THIS SECTION FOR OFFICE USE ONLY)**

Physician Name/Healthcare Facility:_____

Address: _____

Phone No.: _____ Fax No.: _____

Patient Intake Form
Review of Systems

Patient information contained within this form is considered strictly confidential.

Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

St. Louis Pain Relief
PAIN, NEUROPATHY & VEIN CENTER

Name: _____ **Date:** _____ (dd/mm/yr)

Date of Birth: _____

Check ☑ to indicate if you CURRENTLY have any of the following:

General
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Nervousness
- ☐ Tremors
- ☐ Weight loss / gain

Muscle / Joint
- ☐ Arthritis / rheumatism
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain

Skin
- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives or allergies
- ☐ Itching
- ☐ Rash
- ☐ Varicose veins

Eye, Ear, Nose & Throat
- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Ringing of the ears
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Tonsillitis
- ☐ Vision problems

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis / Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulosis
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful deification
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Genitourinary
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Pus in urine
- ☐ Stress incontinence

Urination
- ☐ Overnight more than twice
- ☐ More than 8x in 24hrs
- ☐ Decreased flow/force
- ☐ Painful urination
- ☐ Urgency to urinate

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pulse
- ☐ Pain over heart
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Shortness of breath
- ☐ Spitting up phlegm / blood
- ☐ Wheezing

Women only
- ☐ Congested breasts
- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause
- ☐ Vaginal discharge

Menstrual flow
☐ Reg. ☐ Irreg. ☐ Pain / cramps
Days of flow: ____ Length of cycle: _____
Date - 1st day last period: _____
Are you pregnant? ☐ yes, ☐ no
If yes, how many months? _____
How many children do you have? _____
Birth control method: _____
Date of last PAP test: _____
☐ normal, ☐ abnormal
Date of last mammogram: _____
☐ normal, ☐ abnormal

Check any of the conditions you have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

Patient Intake Form (side 2)

Give a brief detailed description of the problem you are currently experiencing: _____

_____

_____

_____

_____

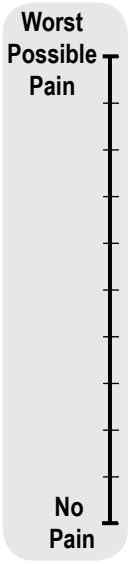
How long have you had this condition? _____ Is it getting worse? □ yes, □ no _____

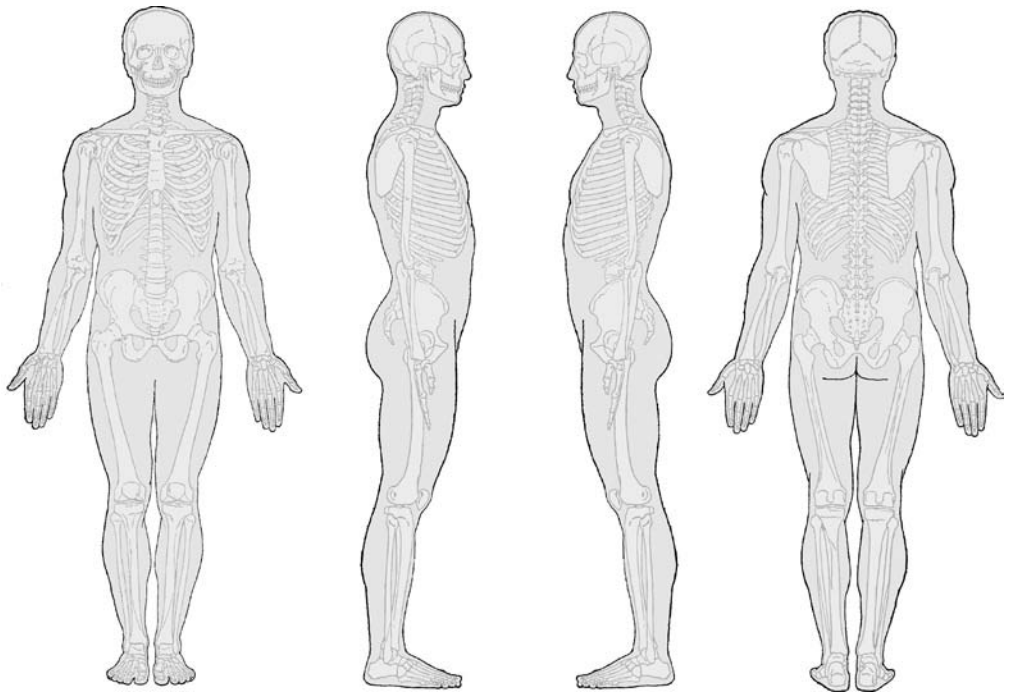
Does it bother you (check appropriate box): □ work, □ sleep, □ other: _____

What seemed to be the initial cause: _____ □ unknown

Please mark you area(s) of pain on the figure below

Please place a mark at the level of your pain on the scale below:





Past health history

Have you...	Yes	No	If yes, explain briefly
... been hospitalized in the last 5 year?	□	□	_____
... had any mental disorders?	□	□	_____
... had any broken bones?	□	□	_____
... had any strains or sprains?	□	□	_____
... ever used orthotics?	□	□	_____

How is most of your day spent? □ standing, □ sitting, □ other: _____

How old is your mattress? _____

When was your last physical exam? _____

Habits	none	light	mod.	heavy
Alcohol	□	□	□	□
Coffee	□	□	□	□
Tobacco	□	□	□	□
Drugs	□	□	□	□
Exercise	□	□	□	□
Sleep	□	□	□	□
Soft drinks	□	□	□	□
Salty foods	□	□	□	□
Water	□	□	□	□
Sugar	□	□	□	□

Family history

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

□ Alcoholism	□ Cancer	□ High blood pressure
□ Anemia	□ Diabetes	□ High cholesterol
□ Arteriosclerosis	□ Emphysema	□ Multiple sclerosis
□ Arthritis	□ Epilepsy	□ Osteoporosis
□ Asthma	□ Glaucoma	□ Stroke
□ Bleed easily	□ Heart disease	□ Thyroid disease

Do you have any other health issues or concerns that our staff should be made aware of? _____

_____

ST. LOUIS NEUROPATHY AND PAIN RELIEF CENTER

Patient Medication List

It is important we know what medications you currently take as some may have unwanted interactions. Please fill out this sheet accurately and completely. **If you brought your own list, please give it to the Front Desk personnel, check the box below and sign this form.**

MEDICATION NAME	DOSAGE	QUANTITY	INSTRUCTIONS

☐ Instead, I have provided a written or printed copy of my current prescriptions.

By signing below I attest that the medication list I have provided is as accurate and complete as possible. If any of my medications change, I will notify this office as soon as possible.

_____	_____	_____
Patient's Name	*Patient's Signature*	*Date*