THE NEXus
Pain Center of
Albany, LLC

2810 Meredyth Drive, Suite 100,
Albany, GA 31707
Phone: (229) 496-1874
Fax: (229) 496-1655

NEW PATIENT PACKET

Appointment Date: _____

Appointment Time: _____

Thank you for helping us process your information by bringing the following on your first visit:

- This new patient packet, completed
- All active insurance cards
- Your picture ID
- Current medication list (prescription medicines and non-prescription medicines, such as aspirin or antacids, vitamins, dietary or herbal supplements)
- Current MRI, X-rays reports of the affected area if available

If paperwork is not complete and /or insurance card(s) and ID are not provided, you may be asked to reschedule your appointment.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____, authorize **The NEXus Pain Center of Albany, LLC** to use, disclose and /or obtain all Protected Health Information in the medical record:

Patient Last Name: _____ First Name: _____ MI:_____
Street Address:_____
City: _____ State: _____ Zip Code: _____
Patient's Date of Birth: _____ SSN:_____ - _____ - _____

☒ disclose Protected Health Information to:
☐ obtain Protected Health Information from:

The NEXus Pain Center of Albany, LLC
Josiah S. Matthews IV, MD
2810 Meredyth Dr, Suite 100
Albany, GA 31707
Phone (229) 496-1874
Fax (229) 496-1655

☒ disclose Protected Health Information to:
☒ obtain Protected Health Information from:

MD Name:_____
MD Phone#: _____
MD Fax#: _____
Address: _____
_____
_____

Reason for release of information: _____
Please note specific dates of information to be obtained/disclosed: _____

I understand that this authorization is valid for one year unless I notify The NEXus Pain Center of Albany, LLC otherwise. I may revoke this authorization in writing at any time except to the extent the The NEXus Pain Center of Albany, LLC had already relied on this authorization. I may revoke it by mailing or faxing a written notice to The NEXus Pain Center of Albany, LLC to the address/fax number above stating my intent to revoke this authorization. I understand that the records released may include information relating to Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS): treatment for history of drug or alcohol abuse; or mental or behavioral health or psychiatric care. I understand my treatment will not be conditioned by my completion of this form. I understand that I may be billed per the fee schedule for medical records with the exception of records directly released from The NEXus Pain Center of Albany, LLC to another Professional Medical Facility. This information will be requested in a prompt manner according to the standards of The NEXus Pain Center of Albany, LLC provided all information has been supplied to The NEXus Pain Center of Albany, LLC correctly.

_____ _____
Signature of Patient (Parent/Legal Representative) Date

_____
Relationship (if other than patient)

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Payment Authorization Privacy Regulations

I request that payment of authorized benefits be made to **The NEXus Pain Center Albany, LLC**. I authorize any holder of my medical information to release to the **Centers for Medicare and Medicaid Services (CMS)** and its agents any information needed to determine the benefits or the benefits payable for related services.

DATE:____/____/_____ SIGNATURE:_____

I hereby authorize the release of any confidential medical information, including information related to psychiatric care, drug and alcohol abuse, and HIV/AIDS, necessary to process insurance claims or any other medical information that is required for any health care related to utilization review or quality assurance activities or to any healthcare professional requiring this information in order to treat me.

I hereby assign and authorize payment to **The NEXus Pain Center Albany, LLC** for all medical and/or surgical benefits, including major medical policies, to which I am entitled under any insurance policy or policies, any self-insurance program, or any other type of benefit plan.

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

PERSON PROVIDING THE AUTHORIZATION: _____

RELATIONSHIP TO THE PATIENT, IF NOT PATIENT: _____

DATE: ____/____/_____

Alternative Contact Information

I authorize **The NEXus Pain Center Albany, LLC** to contact me or leave messages for me at:

YES	NO	
____	____	place of work
____	____	answering machine at home
____	____	with relative or friend: _____

Date: ____/____/_____ Initials: _____

Ownership Statement

I am aware that Dr. Josiah S. Matthews IV has ownership in the NEXus of Albany Surgery Center, LLC.

Date: ____/____/_____ Signature: _____

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Patient Information and Expectations

Welcome to The NEXus Pain Center of Albany, LLC. Enclosed is a packet of information that you should complete in its entirety prior to your appointment. If you have any questions, a member of our staff will be available to help you at the time of your appointment.

What you need on your first visit with The NEXus Pain Center of Albany, LLC :

- A copy of medical records from any other physicians that you have seen regarding your current complaint(s).
- All of the medication(s) you are currently taking. (Please bring the actual bottles with you unless you have an accurate list and then you may just bring the list with you; this is only for your first visit with us).
- All active insurance cards. All co-payments and deductibles will be due at the time of service. Failure to pay your bill can result in discharge from the practice.
- Picture ID.

What to expect from your visit with The NEXus Pain Center of Albany, LLC :

- Prompt, professional, and courteous service from all The NEXus Pain Center of Albany, LLC employees.
- A thorough history of your pain will be obtained, as well as treatments you may have received in the past. You will then be examined by the physician.
- As a courtesy to our patients, your insurance will be filed for you by The NEXus Pain Center of Albany, LLC. You will then be responsible for any and all charges not paid by your insurance company. Worker's compensation will be filed for the full amount of our bill.
- There will be a **$25.00 No Show fee** for The NEXus Pain Center of Albany, LLC charged to your account if you fail to cancel or reschedule an appointment for an office visit by 12 noon on the day prior to the designated appointment time. Likewise, there will be a **$100 No Show fee** charged for failure to cancel or reschedule an appointment for a procedure by 12 noon on the day prior to its designated appointment time. A **late arrival greater than 15 minutes** past the appointment time is considered the same as a No Show for which a **No Show** fee will be charged. The appointment may have to be rescheduled. An accrual of three (3) **No Show** fees may result in discharge from the practice.

The Nexus Pain Center of Albany, LLC is not a primary care facility.

Acknowledgement of Patient Information and Expectations

By signing below, I, _____
have read and understand the information given to me from The NEXus Pain Center of Albany, LLC of the Patient Information and Expectations.

_____ ____/____/_____
Patient Signature Date

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PATIENT REGISTRATION FORM

Date:_____ (OFFICE USE ONLY: CHART #: _____ Dr. _____)

Patient Name: _____
First Middle Last

Address: _____ City:_____ State: _____ Zip_____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

Cell Phone: (____) _____ - _____ Email: _____

Social Security #: _____ - _____ - _____ Date of Birth: ____/____/_____ Age: _____
mo day year

Sex (Circle one): M F Race: _____ Marital Status: _____ Spouse's Name: _____

Patient's Employer: _____ Full Time (Circle one): Yes No

Employer Address: _____ City:_____ State: _____ Zip: _____

How long have you been employed at your current position? _____

Who is responsible for bill (if other than patient)?

Name: _____
First Middle Last

Address: _____ City:_____ State: _____ Zip_____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

Cell Phone: (____) _____ - _____ Email: _____

Employer: _____

Employer Address: _____ City:_____ State: _____ Zip: _____

INSURANCE INFORMATION

Primary Insurance (Please give card to receptionist to copy):_____

Address: _____ City:_____ State: _____ Zip_____

Insured's Name: _____ Insured's Date of Birth: ____ / ____ / _____

ID#: _____ Group #: _____ Group Name: _____

Primary Insurance (Please give card to receptionist to copy):_____

Address: _____ City:_____ State: _____ Zip_____

Insured's Name: _____ Insured's Date of Birth: ____ / ____ / _____

ID#: _____ Group #: _____ Group Name: _____

Name of physician who referred you to us: _____

Name of primary care physician: _____

Pharmacy Name and Address: _____ Phone Number: _____

Patient Signature: _____ Date: _____

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Emergency Contact:
In the event of an emergency, whom should we notify?

Name:_____ Relationship to Patient: _____

Address: _____ City:_____ State: ____ Zip: _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____, ext: _____

Cell Phone: (____) _____ - _____

I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply. Further, I understand I am responsible for my entire bill or any portion not covered by my insurance or third-party payer.

Signed: _____ **Date:** _____
If not signed by patient, please indicate relationship to patient (e.g. spouse)

Relationship: _____ **Witnessed by:** _____

Acknowledgement of Receipt of Notice of Privacy Practices
I have been presented with a copy of the Notice Privacy Practices for The NEXus Pain Center of Albany, LLC detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

Signed: _____ **Date:** _____

.....

INTERNAL USE ONLY:

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.
Presented on (date and time): _____
By (name): _____, *(title):* _____

.....

CONSENT FOR TREATMENT:

I consent to treatment ordered and performed by these physicians and/or their physician assistants under the physicians' direction within this office. I understand that treatment will be explained fully to me before the treatment is performed.

X_____ _____
(Patient's or Authorized Person's Signature) **(Date)**

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HIPAA Authorization Form

I (print your name), _____, acknowledge receipt of The NEXus of Pain Center of Albany, LLC's privacy practices, and give permission to The NEXus of Pain Center of Albany, LLC to disclose protected health information to the following person(s) (name/relation):

_____

_____

_____

Yes _____ No _____ Additionally, I grant permission to leave messages related to my care and appointments on the telephone numbers I have provided as my contact numbers.

I also acknowledge that my medical information may be used for coordinating medical treatment, consultation, claims billing, and care management.

If the person or entity receiving this information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

I understand that I have the right to revoke this authorization at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted on my authorization, or if my authorization was obtained as a condition of obtaining insurance coverage, since my insurance carrier has a legal right related to my claim.

I further understand that my treatment, payment, enrolment, or benefit eligibility is not conditional of my authorization.

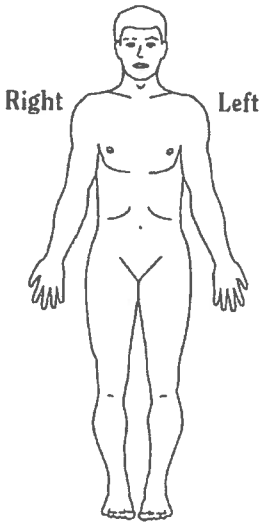
_____ _____

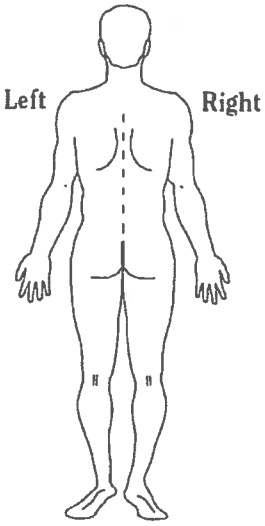
Signature of Patient or Legal Representative Date

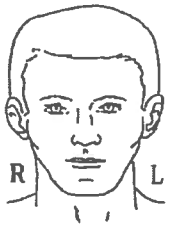
Yes _____ No _____ Do you have an Advance Directive (Living Will)? If "Yes", please provide a copy. If "No", you may request one from the receptionist.

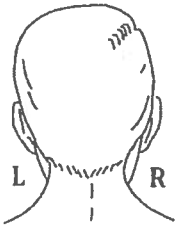
PAIN HISTORY:

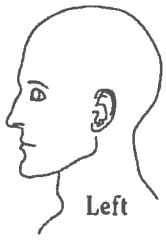
Location: Use the figures below to shade in the area where you have pain. If your pain moves around, put an "X" where it starts and draw an arrow to where it spreads.

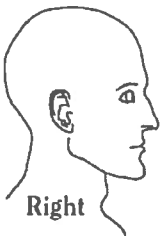












Duration:

When did your current pain problem begin (dates?): _____

Onset:

How did your pain first start? ☐ Job Injury ☐ Sports Injury ☐ Car Accident ☐ Disease ☐ Cancer ☐ Unknown ☐ Other: _____

Describe the speed of onset of your pain. ☐ Sudden/Abrupt ☐ Gradual

Under what circumstances did your pain begin?

☐ Accident/Injury at work ☐ Motor vehicle accident ☐ At work, but not an accident ☐ following surgery
☐ Accident/Injury ☐ Following illness ☐ Secondary to repetitive activity ☐ Unrelated to activity

If work injury, DATE OF INJURY: _____ Did you report injury? ..... ☐ YES ☐ NO
If car accident, DATE OF ACCIDENT: _____ Is there a police report?.. ☐ YES ☐ NO
Is there pending litigation?..... ☐YES ☐ NO
Is your claim being filed under your private insurance? ..... ☐ YES ☐ NO
Have you been to any other pain clinics in the past? ..... ☐ YES ☐ NO
If "YES", please specify: _____
Are you currently on disability?..... ☐ YES ☐ NO
If "YES", when did your disability start? _____
For what reason was your disability granted (*diagnosis on your disability*)? _____
_____

Frequency:

How often do you have this pain?	☐ Constantly	☐ Daily	☐ Weekly	☐ Monthly
What time of day is your pain the worst?	☐ Morning	☐ Afternoon	☐ Evening	☐ Night
What time of day is your pain the least?	☐ Morning	☐ Afternoon	☐ Evening	☐ Night

Severity:

Rate the severity of your pain RIGHT NOW by circling the corresponding number below.

0 1 2 3 4 5 6 7 8 9 10
(No Pain) *(Worst Pain Imaginable)*

Rate the severity of your pain RIGHT NOW by circling the corresponding number below.

0 1 2 3 4 5 6 7 8 9 10
(No Pain) *(Worst Pain Imaginable)*

Character:

Describe in your own words what your pain is like (*i.e., sharp, dull, burning, etc.*): _____
Does your pain travel anywhere? ☐ YES ☐ NO If "YES", where? _____

Effects on Activities of Daily Living:

Are there areas of your life that have been adversely affected by your pain problem (*check below all those that apply and please describe*)?

- ☐ Sleep _____
- ☐ Appetite _____
- ☐ Relationships _____
- ☐ Work _____
- ☐ Finances _____
- ☐ Physical Activity _____
- ☐ Use of Alcohol, or Recreational Drug _____
- ☐ Other _____

Physical Therapy:

Have you had physical therapy? ☐ YES ☐ NO

If "YES",

- what body region (*neck, back, etc.*) _____
- when? (*month/year*) _____
- how long did you go? _____
- was it helpful? ☐ YES ☐ NO
- name of the facility where you received physical therapy? _____

Diagnostic Testing:

Have you had any of the following tests performed within the past 24 months?

Test	Date	Facility Where Test Was Done	Results
X-ray Film			
CT Scan			
MRI			
Laboratory			
EMG			
Nerve Conduction			
Discogram			
Myelogram			
Other			

Medications:

Please list all of your current medications, including both prescription and "over-the-counter" medications.
List PAIN medications FIRST please.

Medication	Amount	Times Per Day	Effectiveness

Blood Thinners:

Have you been on any **blood thinners** recently (*i.e. Coumadin, Warfarin, Heparin, Aspirin, Plavix, Xarelto, Eliquis. Etc*) ☐ YES ☐ NO

If "YES", what is the name of the **blood thinner?** _____

Past Medical History:

Please check any of the following **medical problems** you have had or presently have:

☐Diabetes _____ ☐Arthritis _____

☐Cancer _____ ☐Ulcer _____

☐Heart Problems _____ ☐Kidney Problems _____

☐Respiratory Problems _____ ☐Bleeding Problems _____

☐Infectious Disease _____ ☐Seizures _____

☐High Blood Pressure _____ ☐Neurologic Disease _____

☐Migraines _____ ☐Head Injury _____

☐HIV/AIDS _____ ☐Hepatitis _____

☐Other _____

Allergies:

Please list all **medication allergies** below.

Medication	Reaction

Have you ever had a reaction to **IODINE, SHELLFISH** or **CONTRAST DYE**?
☐YES ☐NO If "YES", please explain: _____

Are you allergic to **LATEX**?
☐YES ☐NO

Past Surgical History:
Please list all past surgeries and hospitalizations:

Date	Procedure/Illness	Date	Procedure/Illness

Family History:

Please check below if you have a family history of any of the following.

	Brother	Sister	Mother	Father	Maternal		Paternal	
					Grandmother	Grandfather	Grandmother	Grandfather
Diabetes								
Cancer								
Heart Disease								
Stroke								
Hypertension								
Migraines								
Chronic Pain								
Anesthetic Problems								
Other:								

Social History:

Has your marital status changed since your pain problem began? ☐YES ☐NO

Number of children living with you: _____

Do you smoke? ☐YES ☐NO How many packs per day? _____ Number of years? _____

Do you drink alcoholic beverages? ☐ YES ☐NO How many drinks per day? _____

Do you drink beverages with caffeine? ☐ YES ☐NO How many drinks per day? _____

Do you use "recreational" or "street" drugs? ☐ YES ☐NO

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Informed Consent and Controlled Substances Agreement

(Printed Name) I, _____, understand and agree to follow the policies of The NEXus Pain Center of Albany, LLC (NPC) as set forth below. I understand that NPC is under no obligation to prescribe these medications to me. I also understand that there may be other, more reasonable treatment options available for my condition that my doctor may recommend instead of or in addition to the use of these medications.

DEFINITIONS OF OPIOIDS, BENZODIAZEPINES, AND OTHER CONTROLLED SUBSTANCES

I understand the definitions of these medications to be:

1. **Opioid** – An opioid medication is a derivative of morphine or similar compound and thus has strong pain-relieving properties.
2. **Benzodiazepine** – A benzodiazepine is a drug that is related to Valium. Their primary role is for the treatment of anxiety.
3. **Other Related Drugs** – For the purposes of this agreement, "other related drugs" includes medications such as muscle relaxants (e.g., Flexeril), membrane stabilizers (e.g., Neurontin), and non-narcotic analgesics (e.g., Ultram). These medications may cause sedation, altered mental status, occasionally dangerous withdrawal effects when stopped abruptly, and may have medication interactions similar to or different from opioids or benzodiazepines.
4. **Controlled Substance** – For the purposes of this agreement, a controlled substance will apply to opioids, benzodiazepines, or other related medications as described above.

RISKS OF OPIOIDS, BENZODIAZEPINES, AND OTHER RELATED MEDICATIONS ("CONTROLLED SUBSTANCES")

I understand the definitions of the possible effects of these medications to be:

1. **Physical Dependence** - the abrupt discontinuation of controlled substances could lead to withdrawal symptoms such as abdominal cramping, diarrhea, anxiety, hypertensive crisis, cardiac arrest or other cardiac dysfunction, seizures, and death.
2. **Psychological Dependence or Addiction** – the use of these medicines may lead to behavior focused on the obtaining and misuse of the controlled substances.
3. **Overdose** – may lead to respiratory arrest and death.
4. **Altered Mental Status** – These classes of medications may cause confusion, sedation, drowsiness, problems with coordination, changes in thinking ability. This may make it unsafe for you to drive a motor vehicle, operate hazardous equipment and machinery, or perform dangerous activities. Other side effects may include, but are not limited to the following: nausea, constipation, unsteadiness, decreased appetite, difficulty urinating, depression, and loss of sexual drive with testicular atrophy (in males).

CONDITIONS OF AGREEMENT

(Initials)

1. _____ I understand that Controlled Substances may be prescribed by my physician only if he determines that such treatment has a reasonable chance of improving my quality of life, ability to participate in work activities and social activities.

2. _____ I do not currently have problems with substance abuse (drugs and/or alcohol).

3. _____ I am not involved in the use, possession, diversion, or transport of illegally obtained controlled substances or illicit drugs.

4. _____ I agree to use these medications only as prescribed to me and will not take more of these medications than instructed. I agree to not allow other individuals to take my medication nor will I take medication prescribed to another person.

5. _____ I understand the risk of controlled substances to unborn children and will notify NPC if I am or become pregnant.

6. _____ I will obtain controlled substance only from NPC and not from any other source unless a true medical emergency exists. I will notify NPC in advance of any anticipated acute needs (dental work or surgery).

7. _____I agree to accept generic brands of my controlled substances if available.

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CONDITIONS OF AGREEMENT (*continued*)
(Initials)

8. _____ If it appears to my physician that the use of controlled substances is not providing a demonstrable therapeutic benefit such as improvement in daily function or improved ability to participate in the treatment program, if the controlled substances being prescribed are expected to e the mainstay of pain treatment when other medical options exist and are practical, or that addiction, rapid loss of effect, or significant side effects are developing, I agree to gradually taper my medication as directed. If a substance abuse problem is suspected, I understand that I may be referred for evaluation and management of the problem.

9. _____ I agree to keep my scheduled appointments prepared to provide a urine sample. Failure to provide a sample may result in suspension of treatment with controlled substances and possibly discharge from NPC.

10. _____ I agree to bring my medications to the office for random pill counts to assess compliance with treatments. Failure to provide medication for inspection may result in suspension of opioid treatment.

11. _____ I agree to comply with my physicians' request for additional imaging studies, lab test, diagnostic procedures (with separate informed consent), and referrals to additional specialists as recommended by my physician.

12. _____ I understand that NPC is a specialty consulting practice. The NPC staff will communicate with my Primary Care Provider, Specialists, Pharmacists, Therapists, and Family to assist in determining the best course for continued treatment for chronic pain. My care may be transferred back to my Primary Care Provider for continued prescriptions of controlled substances one my medical regimen has been optimized.

13. _____ All of my controlled substance prescriptions will be filled at the same pharmacy. Should I choose to change pharmacies, I will notify NPC immediately.

14. _____ Early refills are not provided. Medications may be prescribed at office appointments only. The NEXus Pain Center of Albany, LLC will not prescribe any medication after hours or on weekends. The NEXus Pain Center of Albany, LLC will not prescribe replacement medications should they become misplaced, stolen or destroyed.

15. _____ I am seeking treatment for pain. The NEXus Pain Center of Albany, LLC is under no obligation to treat or prescribe medication for any other medical or mental condition to include: diabetes, high blood pressure, bronchitis, pneumonia, anxiety, depression, or any chronic medical condition. If I am referred to a Primary Care Provider or other specialist for a medical or mental condition, I will make and keep that appointment in a timely manner.

I understand that any violation of this agreement may pose a health risk to myself and others and may result in a discontinuation of treatment with controlled substances if deemed medically prudent. Violation of this agreement may result in a dismissal from the care of The NEXus Pain Center of Albany, LLC as well as reporting any illegal activities to appropriate law enforcement agencies. All patients who demonstrate difficulties managing their controlled substance medications will be referred to an Addiction Psychiatrist and/or a Clinical Psychologist for further evaluation.

I have read this document, understand it, have had all questions regarding risks and conditions of the agreement answered satisfactorily, and I agree to all of its elements.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

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Billing Policy

Our goal is to provide and maintain a positive physician-patient relationship. Providing you with our financial policy in advance allows for a good flow of communication and enables us to operate efficiently. To prevent misunderstanding between patients and our practice, The NEXus Pain Center of Albany, LLC (the "Practice") adheres to the following financial policy. Your complete understanding of your financial responsibilities is important to the physician-patient relationship and your continued medical management. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

- **Full payment is due at the time of service for co-pays, deductibles, and co-insurance**. For your convenience we accept cash, personal check, most major credit cards, Care Credit, and money orders. The Practice is required to collect these based on your benefit contract and the Practice's contractual agreement with your insurance carrier. The Practice must collect co-pays at the time of service and is required to report to the carrier any enrollees failing to pay the co-pay.
- It is your responsibility to provide the Practice with current, accurate insurance information at the time of check-in and to notify the Practice of any change in this information. A valid insurance card(s), picture ID, and Social Security number of the adult insured (policy holder and guarantor of bill) must be presented at the time of service.
- It is the patient's responsibility to understand insurance carrier coverage limitations (i.e. preventive, place of service restrictions, out-of-network benefits, and prior authorization and referral requirements) and member out-of-pocket financial requirements (co-pay, deductible, co-insurance). The amount of your co-pay may be different for specialists than for primary care.
- If the Practice doe not participate with your insurance, you are expected to pay in full for our services at the time of visit. The Practice may provide assistance in filing the charges to your insurance company; however, payment is expected up front.
- If you do not have medical insurance, payment for services is required at the time of the visit. Self-pay patients are given a discount on all services.
- If you have Medicare PART B, only you are responsible for your Medicare deductible and your 20% co-insurance at the time of service.
- It is the patient's responsibility to ensure that an authorization and/or referral is obtained prior to your appointment if required by your insurance (ex. Tricare Prime, HMO, Medicaid plans). For insurance plans that require referrals or authorization, if we do not have a valid referral on file for your scheduled appointment, your appointment will either be rescheduled or you will be asked to pay for services in full until such time the referral is obtained and payment is received from your carrier. Prior authorization or referral is not a guarantee of payment. Patient is responsible for any bill not paid by your insurance carrier.
- Patients may receive a separate bill for laboratory services. Questions about these bills are directed to the respective lab.
- The Practice does not accept post-dated checks.
- Checks written to the Practice that are cancelled or returned for non-sufficient funds are assessed a **$30 fee**. To rectify your account, you will be required to pay with cash, money order, cashier's check, or credit card.
- There may be a charge for completion of FMLA or disability forms. Payment must be made prior to picking up the completed forms.
- Patients are billed for any patient responsibility not collected at the time of service (c0-insurance/deductibles/non-covered services) as determined on the Explanation of Benefits (EOB) from your carrier. Payment plans are available for balances over $100. Patients will receive two (2) statements for any patient balance due after insurance payment. Patients that have not made payment prior to the second statement being mailed are placed in a collection status. Patients with a delinquent balance may be sent to an outside collection service. In this event, a collection's fee equal to 35% of the outstanding balance may be added to the account. Patients are responsible for all collection's expenses, including attorney's fees, should any portion of an account by referred to an attorney for collection.
- The Practice will make reasonable effort to collect from your insurance company; however, if your insurance company has not paid after 90 days, the Practice will bill you with the outstanding claim, and it will become your responsibility to follow up with your carrier.
- The Practice reserves the right to charge a **$25 fee** for patients not cancelling a scheduled office visit and **$100 fee** for patients not cancelling a scheduled procedure by 12:00 noon the day prior to the office visit or procedure. A **late arrival greater than 15 minutes** is considered the same as a **No Show** for which the heretofore mentioned fees apply.
- Patients with collection balance, whether internal or external, will not be permitted to schedule appointments until their account balances are brought current.

My signature below confirms that I have read these billing polices and my financial obligations as pertains to the Practice.

Legal Signature/Relationship to Patient Date (06/2019)LMM

THE NEXus
Pain Center of
Albany, LLC

2810 Meredyth Drive, Ste. 100
Albany, GA 31707
229.496.1874 – phone
229.496.1655 - facsimile

PATIENT RESPONSIBILITIES

The patient has the responsibility for:

a. providing complete and accurate information to the best of his/her ability about his/her health (I.D., complaints, past illnesses, hospitalizations, and other health-related issues), any medications, including over-the-counter products and dietary supplements and any allergies or sensitivities;
b. making it known whether the planned surgical procedure/treatment risks, benefits and alternative treatments have been explained and understood;
c. following the treatment plan established by the physician, including instructions by nurses and other health care professional, given by the physician;
d. providing a responsible adult to transport him/her from the pain center and remain with him/her for 24 hours, if required by his/her provider;
e. refusal of treatment and/or not following directions;
f. assuring that the financial obligations of his /her care are fulfilled as promptly as possible
g. being respectful of all the health care providers and staff, as well as other patients;
h. following facility policies and procedures;
i. inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.

PATIENT COMPLAINTS

Patients have the right to register a complaint, in writing, to the Administrator of The NEXus Pain Center of Albany, LLC. Please submit complaint to: 2810 Meredyth Drive, Suite 100, Albany GA 31707.

If the complaint is not resolved to the patient's satisfaction, he/she has a right to file a grievance with the Georgia Composite Medical Board concerning the physician or the Professional Licensing Boards Division, Georgia Board of Nursing with concerns against any of the nursing staff. The patient should either call any of the complaint units or send a written complaint. The patient should provide the physician or nursing staff name, address, and the specific nature of the complaint.

COMPLAINTS AGAINST THE PHYSICIAN:

Georgia Composite Medical Board
Enforcement Unit
2 Peachtree Street, N.W., 36th Floor
Atlanta, Georgia 30303

P: (404)657-6494; (404) 463-8903; F: (404) 656-9723
ONLINE: https://medicalboard.georgia.gov/file-complaint

COMPLAINTS AGAINST NURSING STAFF:

Professional Licensing Boards Division
Georgia Board of Nursing
237 Coliseum Drive
Macon, Georgia 31217-3858

P: (478) 207-2440
ONLINE: https://secure.sos.state.ga.us/myverification/SubmitConplaint.aspx

ISSUES REGARDING MEDICARE: www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

Patient Name (Printed): _____ Date: _____

Patient Signature: _____

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PATIENT RIGHTS

1. Patients are treated with respect, consideration and dignity.
2. Full consideration of patient privacy concerning consultation, examination treatment and surgery.
3. To have considerate and respectful care, provided in a safe environment.
4. To become informed of his/her rights as a patient in advance of, or when discontinuing, the provision of care. The patient may use an appointed representative.
5. Have a family member or representative/surrogate of his/her choice be involved in his/her care.
6. Have all patient's rights apply to the person who has legal responsibility to make decisions regarding medical care on behalf of the patient.
7. Remain free from seclusion or restraints of any form that are not medically necessary.
8. Coordinate his/her care with physicians and healthcare providers they will see; patients have the right to change their provider if other qualifies providers are available.
9. Patients are provided, to the degree known, complete information concerning their diagnosis, evaluation, treatment, and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
10. Patient will receive information about any proposed treatment or procedure as needed to give informed consent or to refuse treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate course of treatment or non-treatment and the risks involved.
11. Patients are given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.
12. Be informed by physician or designee to the continuing healthcare requirements after discharge.
13. Confidential treatment of all communications, disclosures and records pertaining to patient care; patients will be given the opportunity to approve or refuse their release except when release is required by law.
14. Access information to his/her medical record within reasonable time from (48 hours).
15. May leave the facility even against medical advice.
16. Informed about procedures for expressing suggestions, complaints and grievances including those required by state and federal regulations.
17. Examine and receive an explanation of the bill regardless of source of payment.
18. Exercise these rights without regard to race, sex, cultural, educational, or religious background or the source of payment for care.
19. Informed regarding: patient conduct and responsibilities, services available at the surgery center, provisions for after-hours and emergency care, fees for service, payment policies, right to refuse participation in experimental research, charity and indigent care policy, charges for services not covered by third-party payors, and credentials of health care professionals.
20. Patients have the right to have copies of their "Advance Directives" and "Living Wills" in their medical records and to have Center staff honor these wishes to the extent feasible. However, due to the Center's limited capabilities, in the event of an emergency, the patient will be transferred to the nearest hospital at which attending physician has privileges. Hospital staff will be informed of the existence of the Advance Directives and such will be provided if the Center has copies.

Patient Name: _____ Date: _____
(print please)

Patient Signature: _____

Cardiovascular				
Chest pain with exertion	O	Yes	O	No
Dizziness	O	Yes	O	No
Irregular heartbeat	O	Yes	O	No
Shortness of breath	O	Yes	O	No
Endocrine				
Difficulty sleeping	O	Yes	O	No
General/Constitutional				
Change in appetite	O	Yes	O	No
Chills	O	Yes	O	No
Fatigue	O	Yes	O	No
Fever	O	Yes	O	No
Lightheadedness	O	Yes	O	No
Night sweats	O	Yes	O	No
Headache	O	Yes	O	No
Musculoskeletal				
Joint stiffness	O	Yes	O	No
Leg cramps	O	Yes	O	No
Muscle aches	O	Yes	O	No
Pain in shoulder(s)	O	Yes	O	No
Painful joints	O	Yes	O	No
Sciatica	O	Yes	O	No
Swollen joints	O	Yes	O	No
Weakness	O	Yes	O	No
Neurologic				
Balance difficulty	O	Yes	O	No
Coordination	O	Yes	O	No
Gait abnormality	O	Yes	O	No
Loss of strength	O	Yes	O	No
Loss of use of extremity	O	Yes	O	No
Low back pain	O	Yes	O	No
Tingling/Numbness	O	Yes	O	No
Gastrointestinal				
Constipation	O	Yes	O	No
Psychiatric				
Anxiety	O	Yes	O	No
Depressed mood	O	Yes	O	No
Eating disorder	O	Yes	O	No
Loss of appetite	O	Yes	O	No
Mental or Physical abuse	O	Yes	O	No
Substance abuse	O	Yes	O	No
Difficulty sleeping	O	Yes	O	No
Suicidal thoughts	O	Yes	O	No

Alcohol Screen , Drugs and Tobacco Use:
How often did you have a drink containing alcohol in the past year?
O Never
O Monthly
O 2 to 4 times a monthly
O 2 to 3 times a week
O 4 or more times a week

Have you used drugs other than those for medical reasons in the past 12 months?
O Yes O No

Are you a Tobacco User? O Yes O No

Surgical History

hip replacement, left	O Yes	O No
hip replacement, right	O Yes	O No
inguinal hernia repair	O Yes	O No
knee replacement, left	O Yes	O No
knee replacement, right	O Yes	O No
kyphoplasty	O Yes	O No
mastectomy, left	O Yes	O No
mastectomy, right	O Yes	O No
nephrectomy	O Yes	O No
neck surgery	O Yes	O No
back surgery	O Yes	O No