Patient Name: _____ D.O.B: _____Date: _____

3070 College Street, Suite 300
Beaumont, TX 77701

2014 S. Wheeler, Suite 130
Jasper, TX 75951

Phone: (409) 892-4600 Fax: (877) 671-0221

TO OUR PATIENTS

Thank you for choosing Coastal Spine and Pain Institute. Please complete this entire packet prior to your appointment time. This information is vital to our plan of care for you. You may return this packet to our office any time before your appointment or at your appointment. If you need any assistance completing these forms, please arrive 30 minutes prior to your appointment time and promptly notify our staff for assistance.

You MUST bring the following items to your appointment:

- Photo Identification (must be valid and current)
- Insurance Cards
- Completed New Patient Packet
- Current List of Medications

Failure to bring any of the items listed above will result in your appointment being rescheduled.

Note: All patients are subject to random urine drug screens in the office at any time. (**THIS IS NOT OPTIONAL**)

This practice utilizes the service of specially trained NURSE PRACTITIONERS. Most of your follow ups will be scheduled with one of the following nurse practitioners:

Physicians: Daniel L. Harris, M.D. Joshua Allen, M.D.

Nurse Practitioners: Dennis Griffiths, FNP-C Stacy Dominy, FNP-C Angela Ford, FNP-C
Dana Rogers, FNP-C Tristan Hargraves, FNP-C

Daniel L. Harris, M.D.
Joshua A. Allen, M.D.
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PATIENT REGISTRATION FORM

Patient Name: _____ **Date**: _____

Date of Birth: _____ Age: _____ **SS#:** _____-_____-_____ **Gender**: M / F

Marital Status: ☐Single ☐Married ☐Divorced ☐ Separated ☐Widowed

Address: _____ City: _____ State: _____**Zip**: _____

Mailing Address:*(if different than physical address)* _____

Home #: _____**Cell #:** _____**E-Mail:** _____

Preferred Contact: ☐ Home ☐ Cell **May we contact you by text/e-mail/portal:**☐ Yes ☐ No

Race: _____ **Ethnicity:** _____ **Preferred Language:** _____

Occupation: _____ **Employer Name:** _____

Employer Address: _____ **Employer Phone:** _____

Primary Physician: _____ **Phone#:** _____

Referring Physician: _____ **Phone#:** _____

Emergency Contact: _____ **Relation:** _____

Address: _____ **Phone:** _____

INSURANCE INFORMATION

Primary Insurance: _____ **ID#:** _____**Group#:** _____

Policyholder's Name: _____ **SS#:** _____-_____-_____ **DOB:** _____

Name of Employer: _____

Employer Address: _____ **Employer Phone:** _____

Secondary Insurance: _____ **ID#:** _____**Group#:** _____

Policyholder's Name: _____ **SS#:** _____-_____-_____ **DOB:** _____

Patient Signature: _____ **Date:** _____

Patient Name: _____ D.O.B: _____Date: _____

IMPORTANT POLICIES

CANCELLATION AND NO-SHOW POLICY

As our goal is to meet the needs of our patients, we will make every effort to schedule your appointments as efficiently as possible. In return, **it is your responsibility to make every effort to keep your appointment and to arrive promptly at the time you are instructed**.

In any event you need to cancel your office appointment, you will need to contact us **AT LEAST 24 HOURS PRIOR TO YOUR APPOINTMENT.** Failure to give a 24-hour notice will result in a cancellation fee. For any procedure you will need to contact us **AT LEAST 48 HOURS PRIOR TO YOUR PROCEDURE**. Please note that you will need to cancel your procedure with our office, please do not call the facility to cancel. Keep in mind to cancel any appointments that will be scheduled for your procedure such as post-op visit, these appointments are not automatically cancelled when you cancel your procedure. **This fee is not covered by your medical insurance policy and MUST be paid prior to being seen again in our office.**

Appointment Cancellation/No Show Fee: $25.00
Procedure Cancellation/No Show Fee: $100.00

**RESCHEDULING APPOINTMENT & PROCEDURE POLICY

In the event you need to call our office and reschedule your scheduled appointment with less than 24 hours' notice there will be a $25 rescheduling fee charged. This fee must be paid prior to being seen again. If you need to cancel or reschedule a procedure with less than 48 hours' notice, there will be a $100 fee charged prior to being rescheduled. If you must cancel because of a sickness or hospitalization you will need to provide a doctor's excuse or hospital records to have the fee waived.

If you arrive **15 minutes or more late** for your appointment you will be rescheduled and charged a rescheduling fee of $25. The fee must be paid before you can reschedule your appointment.

IF YOU FAIL TO SHOW ON 3 OCCASIONS you will be **discharged** from the practice for non-compliance and an appropriate note will be sent to your referring physician.

Initial _____

FINANCIAL POLICY

It is our desire that payment to your account is as easy and convenient as possible. We will assist you in any way we can to facilitate the settling of your account. In order for us to be able to keep billing fees at a minimum, it is absolutely necessary for you to provide us with accurate and up to date insurance information at each of your visits. **If your insurance status changes from one visit to the next, it is your responsibility to notify us so that your insurance can be filed correctly.**

Upon referral to our facility, appropriate insurance information will be obtained so that we can verify your coverage and obtain approval when necessary. On your initial visit you will be provided with a patient information sheet. This form must be filled out completely with the correct insurance information. A copy of your insurance card and driver's license is required. As your insurance company will tell you, approval from your insurance company for any service that COASTAL SPINE AND PAIN INSTITUTE may render, does not guarantee payment. **The patient is fully and ultimately responsible for the entire payment of services.**

You will receive a bill for services provided on each of your visits. Please note that physician's services are different from facility charges. The bill that you receive from Coastal Spine and Pain Institute is for physician services only. When you have a procedure, you will receive a separate bill from the facility (i.e. Hospital). This is customary and is to cover the cost of the facility for supplies, equipment, medications, personnel, use of the procedure room, and observation following the procedure. **As a courtesy we will file the claims for physician services to your insurance company.**

Initial _____

PAYMENT POLICY

In accordance with the agreement, you have with your insurance company, any deductible or copay is required at the time services are rendered. **Required co-pays and deductibles are expected at each visit and failure to keep your account current in this regard may prohibit future services until your account is made current. If you are unable pay your copay at the time of visit you will be required to reschedule your appointment and you will be charged a reschedule fee of $25, which must be paid before you can reschedule your appointment.** If you have a balance of $100 or more and you are unable to pay in full at your appointment, you will be required to set up a payment plan with a credit/debit card to be charged each month until the balance is paid in full. Payments may be made by cash, money order, or accepted credit cards. A credit card convenience fee will be charged at 3.50%. For any questions or assistance with your account, please call our office at (409)892-4600.

Initial _____

ASSIGNMENT OF INSURANCE BENEFITS AND STATEMENT OF SERVICE

I hereby authorize and assign payment made directly to COASTAL SPINE AND PAIN INSTITUTE for the covered insurance benefits, whether payable to me by Blue Cross/Blue Shield, Medicare, Worker's Compensation, and /or commercial insurance companies. I understand that my health insurance provider may not cover part, or all of the medical services rendered, and I fully understand that I am financially responsible for and agree to pay all charges not paid by my health insurance coverage, including deductibles, co-insurance and payments for insurance companies sent directly to me.

The assignment shall apply to all medical services now rendered and to be rendered in the future until the organization and assignment is revoked.

I have listed below the names of all my health insurance providers including tie-in coverage and I represent that such health care coverage is in full force and in effect at this time.

Prior authorization of certification for medical information may be required to process the claims for payment of the medical services rendered and it is expressly understood that the right of such information to be privileged is hereby waived.

I agree to promptly notify your office of any change of address.

A copy of this agreement shall be as valid as the original.

Print Patient Name: _____D.O.B:_____

Primary Insurance: _____ Policy #_____ Group: _____

Secondary Insurance: _____ Policy #_____ Group: _____

Medicare # (If applicable) _____

Policyholder Name (*if not patient*):_____ SS#_____

DOB:_____ Policyholder Employer:_____ Employer Address:_____

This assignment covers the physician's charges for service. Surgical Center or Hospital Charges are billed separately.

Patient Signature: _____ Date: _____

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PATIENT MEDICATION AGREEMENT

Opioid Agreement Policy

The purpose of this agreement is to allow us to prescribe for you to treat your chronic pain. Because these drugs have potential for abuse, strict accountability is necessary. You are entitled to dignified, sensitive care for a serious medical condition. Complete pain relief is not likely, but our goal for you is to have reduced pain and a better quality of life. Treatment with medication has both risks and side effects, please review the following and sign the form indicating your understanding.

RISKS AND SIDE EFFECTS

- There is a risk of physical dependence and in some cases, addiction to the medication.
- There are some serious risks in mixing mind altering drugs or substances (including alcohol, marijuana, narcotics, sedatives and sleeping pills) with controlled substances.
- Taking other drugs or substances while in therapy could result in excessive drowsiness and over sedation and could lead to serious injury or death.
- If you take controlled substances while pregnant, your child may be born with a physical dependency on those substances or otherwise be physically harmed.
- It is impossible to predict which opioid side effects you may experience. Having side effects from one opioid does not necessarily mean you will have side effects on another opioid.
- Drowsiness is a common side effect of opioids. Other common, usually temporary side effects include: upset stomach, itching, and sweating. Psychological depression and lowered hormone levels may also occur. Sleep apnea if present may be worsened by opioids. Constipation commonly occurs and often does not improve with time.

DISCONTINUING OR CHANGING MEDICATION

- Opioid medications may need to be discontinued under these circumstances: not enough pain relief, persistent side effects, not achieving goals of opioid treatment (such as improvement of function), problematic dose escalation, or inability to comply with the treatment agreement.
- Physical dependence may develop with regular use and withdrawal symptoms may develop if you stop your medication abruptly.
- Symptoms of withdrawal include pain, nausea, diarrhea, anxiety, sweating, and tremor seizures. A slow taper may avoid these symptoms.

I AGREE TO THE FOLLOWING:

- I authorize both Dr. Harris and Dr. Allen (and their staff) to cooperate fully with city, state, and federal law enforcement agencies to investigate any possible misuse, sale, or other diversion of my prescribed medications.
- I authorize both Dr. Harris and Dr. Allen (and their staff) to obtain prescription history report(s).
- I will be responsible for making sure that I do not run out of my medication on the weekends or holidays because abrupt discontinuation of these medications can cause severe withdrawal symptoms.

- No early refills will be given unless my refill date falls on a weekend or holiday.
- No refills will be given if I fail to keep my scheduled appointments. Two (2) no-show appointments may constitute grounds for immediate termination of this agreement.
- I understand that my doctor is under no obligation to provide these medications to me, and that he or she reserves the right to discontinue these medications at any time.
- I agree to cooperate with random drug testing, which may be requested at any time. If I refuse to provide a drug screen, I understand the medication may be discontinued. **This includes urine drug screens and confirmations**.
- I will not use any illegal substances, including marijuana, cocaine, etc. while being prescribed medications.
- I understand Dr. Harris or Dr. Allen can be the only prescribing physicians for any pain medications. I will not obtain or take any previously or currently prescribed medications from any other physicians (including dentist, ER, and PCP).
- I agree to take these medications as prescribed and not change the amount or frequency without the approval from the prescribing physician.
- I understand that there is a small risk that opioid addiction could occur, and I may become psychologically dependent on the medication, using it to change my mood, or unable to control my use of it.
- In addition to the above understanding, I accept the right of my doctor and medical staff to terminate this agreement for any of the following reasons:
    - If I seek or obtain any narcotic medications from any other source other than Coastal Spine and Pain Institute.
    - If I alter or forge any prescription in any way.
    - If I fail to maintain proper responsibility for storing my medication.
    - If I share, trade, give, or sell my medications to anyone else.
    - If I develop side effects considered significant as viewed by my physician.

By signing this agreement, I am acknowledging that I have read and understood the following agreement and am willing to abide by Coastal Spine and Pain Institute policies listed in the agreement above. I understand any violations of any item listed above may result in my permanent discharge (dismissal) from this practice.

Print Name	DOB
Patient Signature	Date

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MEDICAL RECORDS RELEASE

Patient Name: _____ D.O.B. _____
SS#_____/_____/_____ Daytime phone Number (_____) _____

This is a request that my medical records be forwarded to Coastal Spine and Pain Institute and that my medical health information may be shared with other healthcare providers or pharmacies to ensure continuity of care.

PLEASE LEAVE THIS SECTION BLANK

REQUEST RECORDS FROM

Facility or Physician: _____
Records Needed: _____
Address: _____ City: _____ State: _____
Phone: _____ Fax: _____
Date Requested: _____

This is a request that my medical records be forwarded to the provider listed below that my medical health information may be shared with other healthcare providers or pharmacies to ensure continuity of care.

Provider Name or Self: _____
Address: _____
Phone #: _____ Fax#: _____

PATIENT RELEASE OF INFORMATION

In addition to speaking to your referring provider, your primary care provider, your insurance companies and any outpatient facility we refer you to, this will allow our office to release your information to those you list below.

I _____, give Coastal Spine and Pain Institute and its representatives permission to speak with following persons listed below regarding my personal information. This is effective for one year from signature date.

Name	Relationship to Patient	Phone #
-		
-		
-		

□ I elect not to give out my information

**Patient Signature : _____D.O.B: _____ Date: _____

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NOTICE OF PRIVACY

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

PLEASE REVIEW CAREFULLY

The Health Insurance Portability and Accountability Acts of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable information used by us in any form, whether electronically, on paper, or oral are kept confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information. As required by HIPPA, 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 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 coordination or managing health care or related services by one or more health care providers. An example would be teeth cleaning services.
- *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 aspects 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 disclosers 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 relaying your information.

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.

- To request restrictions on certain uses and disclosures of protected health information, including those related disclosures to family members, other relatives, close personal friends, or another person identified by you. We are, however, not required to agree to a requested restriction. If we do not agree to a restriction, we must abide by it unless you agree in writing to remove it.
- To request to receive confidential communications of protected health information from us by alternative means or at an alternative location.
- To inspect and copy your protected health information.
- To amend your protected health information.
- To receive an accounting of disclosures of protected health information.
- To obtain (and we have the obligation) to provide you with a paper copy of this notice from us at your first service delivery date.
- To provide (and we are obligated to receive) a written acknowledgement that you have received a copy of our notice of privacy Practices.

We are required by law to maintain the privacy of your protected health information, and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of privacy Practices and to make the new notice prevision effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from the office.

You have recourse if you feel that your privacy protection has been violated. You have the right to file a formal, written complaint with us, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provision of this notice or the policies and procedures in our office. We will not retaliate against you for filing a complaint.

PATIENT SIGNATURE: _____D.O. B: _____ DATE: _____

Patient Name: _____ **D.O.B:** _____ **Date:** _____

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○

Patient Name: _____ **D.O.B:** _____ **Date:** _____

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

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

PainEDU.org

Medicare and Medicare Advantage Patients Only

Coastal Spine and Pain Institute - Policy for Medicare Patients and Anesthesia

This policy outlines the coverage for anesthesia during pain interventional procedures at Coastal Spine and Pain Institute for Medicare patients.

Medicare Coverage:

Medicare only finds anesthesia medically necessary for the following three pain interventional procedures:

- Radiofrequency neurotomy
- Spinal cord stimulator placement or revision
- Mild Procedure

Other Procedures:

For all other pain interventional procedures, Medicare does not cover the cost of anesthesia. Patients will be given the option to choose:

1. Cash Payment for Anesthesia:Patients can choose to receive anesthesia for a cash fee. The fees are as follows:
    - $12.00: For procedures with minimal sedation and medication.
    - $150.00: For procedures requiring moderate sedation and medication.
2. No Anesthesia: Patients can opt to proceed without anesthesia.

Payment Requirements:

- Payment for cash-pay anesthesia is due in full before the procedure unless other arrangements are made in advance.
- Patients are responsible for confirming their financial responsibility and any applicable costs before the procedure.

Additional Information:

- We encourage patients to discuss their individual circumstances and any questions they may have with their physician or Coastal Spine and Pain Institute staff.
- This policy is subject to change without prior notice.

Please note: This policy applies to Medicare and Medicare Advantage patients only.

PATIENT SIGNATURE: _____D.O. B: _____ DATE: _____

Consent to Telemedicine Services

Patient Name: _____ Date: _____

I hereby consent to receive telemedicine services from Coastal Spine and Pain Institute and its affiliated healthcare providers.

Telemedicine services include:

- Consultation and diagnosis via video conferencing or other communication technologies.
- Treatment and medication management through telehealth consultations.
- Electronic prescription and refill services.

I understand that telemedicine services have potential benefits and risks, including:

Benefits:

- Increased access to healthcare services, especially for patients in remote locations or with limited mobility.
- Reduced travel time and costs.
- Improved convenience and flexibility for scheduling appointments.
- Enhanced communication and collaboration between patients and healthcare providers.

Risks:

- Limited physical examination capabilities.
- Potential technical difficulties that may disrupt communication or data transmission.
- Dependence on technology and internet access.
- Reduced privacy and confidentiality compared to in-person consultations.
- Possible misdiagnosis or delayed diagnosis due to limitations of telemedicine technology.

I understand that I have the right to:

- Refuse or revoke my consent to telemedicine services at any time.
- Request an in-person consultation at any time.
- Discuss any concerns I have about telemedicine with my healthcare provider.
- Ask questions and receive clear explanations about my diagnosis, treatment plan, and potential risks and benefits of telemedicine.

I have read and understood this consent form and agree to the terms and conditions outlined above.

Signature: _____Date: _____