Your completed intake forms help our providers get to know you and your medical history. Our staff can assist you with questions during your appointment if needed.

PATIENT INFORMATION

Patient Name	Mailing Address	City/State/Zip
Home Phone	Cell Phone	Email
Emergency Contact	Emergency Contact Phone	Relationship
Date of Birth	Gender	Social Security Number
Marital Status	Race	Ethnicity

Please list if you would like appt reminders to be called or text to you along with best contact number. _____

PREFERRED PHARMACY

Name:	City:

CONSENT FOR TREATMENT

I authorize Mississippi Pain Institute Oxford and any associates, assistants, and other healthcare providers it may deem necessary to treat my condition. I understand that 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. I give my consent for Mississippi Pain Institute Oxford to retrieve and review my medication history. I understand this will become part of my medical record.

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services or its intermediary any information needed for this or a related Medicare claim. I request that payment or authorized benefits be made on my behalf. I assign the benefits payable for covered Medicare services to Mississippi Pain Institute Oxford as a provider furnishing services.

AGREEMENT TO PAY

I understand that payments made to Mississippi Pain Institute Oxford are for my medical evaluation and care. I have not been promised any specific medication or treatment by any provider or associate in exchange for payment. Additionally, no other doctor has signified to me that such medications would be prescribed for me in exchange for these payments. I understand that I am responsible for payment for all such supplies and services provided by Mississippi Pain Institute Oxford. Balances released to our attorney or collection agency

for non-payment may incur additional fees, which will also be the responsibility of the patient or responsible party. Patient is responsible to pay co-pay/co-insurance at the

time of service. I certify that I have read and understand Mississippi Pain Institute Oxford Patient Responsible Party Financial Policy.

ASSIGNMENT OF BENEFITS

Assignment of Benefits The undersigned hereby authorizes Mississippi Pain Institute Oxford to request on my behalf and to collect directly all public and private insurance coverage benefits or patient assistance funds due for supplies and services supplied by Mississippi Pain Institute Oxford. In the event payments for insurance benefits or patient assistance funds are made directly to any of the undersigned, the payee will endorse to Mississippi Pain Institute Oxford all checks for such payments.

RELEASE OF INFORMATION

I acknowledge that I have had the opportunity to review Mississippi Pain Institute Oxford Notice of Privacy Practices. This describes how may protected health information may be used and disclosed and how I may access my health records. I authorize Mississippi Pain Institute Oxford to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, physicians and healthcare practitioners involved in my care, and any physician, therapist, or healthcare practitioner to whom I may be referred. I also authorize Mississippi Pain Institute Oxford to release any information required in obtaining procedure authorization or the processing of any payment claims. Mississippi Pain Institute Oxford will not release my Protected Health Information to any other (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" Form.

Notice of Privacy Practices

I acknowledge I have received the Mississippi Pain Institute Oxford notice of privacy in full as contained in the patient information packet. The packet also contains patient rights and responsibilities, and I am responsible to read the information provided. The undersigned certified that he/she has read the foregoing and received a copy, as well as a copy of the patient rights and responsibilities documented above. The undersigned also certifies that he/she is the patient or is duly authorized by the patient as patient's general agent to execute and accept its items.

Patient's Signature_____ Date_____

Responsible Party Signature_____ **Date**_____

If this form is not signed by patient, please explain. Reason_____

MPI

Authorization for Release of Information

Your Name_____ **Date of Birth**_____

Under the requirements of **HIPAA** (Patient Privacy Act) we cannot discuss your health or billing information or otherwise correspond with any other individual without written patient consent. Signing this form will allow for communication about your care with those individuals listed below.

I authorize Mississippi Pain Institute Oxford to release my medical/billing information to and/or discuss my treatment with the following individual(s):

1._____Relation to Patient and Phone #: _____

2._____Relation to Patient and Phone #: _____

3._____Relation to Patient and Phone #: _____

Patient Information: I understand I have the right to revoke this authorization at any time. I have the right to inspect or copy the protected health information being disclosed. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient. You have the right to revoke this consent in writing (see below).

Signature: _____**Date:** _____

Revoked: I choose to revoke the above release- effective on date below:

Signature: _____**Date:** _____

MPI

Mississippi Pain Institute Oxford **Patient Policies**

- *Cancelled Appointments*: Cancellation of an *office visit* must be made 24 hours in advance, or a ***$50 cancellation fee*** will be charged to the patient. Cancellation of a *procedure* must be made 48 hours in advance, or a ***$125 cancellation fee*** will be charged to the patient. Three consecutive cancelled or rescheduled appointments may result in being marked as "**ineligible for reschedule**". _____ Initials

- *Worker's Comp*: All workman's compensation cases must be approved by the workman's compensation carrier. If your workman's compensation case closes/settles during your treatment at our facility, you must notify our office immediately. _____ Initials

- *Motor Vehicle Accident*: We do not file any MVA cases to your health insurance. We do not file Liability Claims. If you are in a lawsuit or become involved in a lawsuit, please notify our office immediately with your attorney's information. _____ Initials.

- *Phone Calls*: If our staff is unavailable to take your call, please leave a detailed message with a working phone number. Your call will be returned as a staff member becomes available. Please refrain from multiple calls in one day. We do not have "after hours". If you are having urgent problems when our office is closed, you should go to the nearest Emergency Room or walk-in clinic for evaluation. _____ Initials

- *Medication Calls*: Your call will be returned by a nurse the same day if received before 4pm. You must leave a working number and be available to answer when the nurse returns your call. There is no after-hours number. If you are having urgent problems when our office is closed, you should go to the nearest Emergency Room or walk-in clinic for evaluation. _____ Initials

- *Appointments*: There are no walk-in appointments. Please contact us for our earliest available appointment. We will not be able to see you without an appointment. _____ Initials

- *Primary Care Doctor*: You are required to have a primary care doctor that takes care of all your non-pain problems. If you have an accident, a fall or other injury, you must be evaluated by your primary care doctor or go to the ER for evaluation. We do not treat new injuries or acute pain. Your pain provider does not admit people to the hospital. Chronic pain is treated on an outpatient basis. _____ Initials

- *Patient Behavior:* Patients/Patient representatives cannot bring firearms in the clinic. We are unable to see armed patients. We expect our patients to be cooperative and pleasant. Inappropriate or abusive behavior toward our staff or other patients may result in our inability to care for you. _____ Initials

- *Minority Ownership Disclosure Statement*: Your MPI provider might have an ownership interest in BMH North Mississippi Imaging Services, LLC, d/b/a/ Oxford Diagnostic Center. You have the freedom to choose any facility available for the purpose of obtaining the procedure or test being performed. _____ Initials

- *Right to Refuse:* Providers have a right to refuse treatment or to give prescriptions if a patient is non-compliant with their personally prescribed treatment. _____ Initials

I have read, understand and have been given a copy of the patient policies. I agree to follow them.

_____ _____

Signature Date

_____ _____

Printed Name Date of Birth

MPI

Patient/Responsible Party Financial Policy

Patient Name: _____DOB: _____Date: _____

To establish a complete understanding of the financial responsibilities associated with the care provided, these financial policies are provided for your review. If you have any questions, please feel free to ask our staff.

We would like to assist you in receiving the maximum allowable benefit from your health insurance. To do this, we need you to provide complete and accurate personal and insurance information on our registration form. Please complete this information completely and provide your insurance card to be copied.

We will verify your insurance as a courtesy to you. We will also submit any claims to your insurance company. When coming in for an office visit or procedure, your co-payment/co-insurance is due at the time of service. Insurance companies will not tell us exactly what your portion will be until they receive the claim and review it; therefore, the payment you make will apply to your balance for that specific date of service. Then you will be responsible for only the remaining balance. We accept cash, Visa, MasterCard, Discover and American Express. **NO CHECKS.** Payment for all services rendered are the responsibility of the patient or guarantor regardless of insurance. In some situations, your insurance company may mail a payment to you directly instead of to our billing agency. If you receive a payment from your insurance company, please contact our billing agency for instructions 662-710-1035.
_____Initials

Your insurance company may consider our Providers out-of-network. Most insurance carriers have out of network coverage. Out-of-network benefits may mean payments made are done so in a different ratio than in-network and may have a separate deductible. You may owe additional money if your insurance doesn't cover the entire cost of your visit. _____ Initials

Our clinic uses an independent lab for monitoring our medication compliance. You may receive a separate bill from them for processing your sample. Our office provides the drug screening company with the insurance information you provide. All charges incurred monitoring compliance are the patient's responsibility. _____Initials

If a patient's account is turned over to a collection agency for further collection actions, the patient will be responsible for all collection, legal, and court costs related to the patient's account and unpaid balances.
_____ Initials

PATIENT COMFORT ASSESSEMENT

Circle the words that describe your pain
(If multiple sites, report on the most concerning area)

NECK	BACK	HIP	KNEE	FOOT	HAND	OTHER

Aching	Sharp	Penetrating	Occasional	Throbbing
Tender	Nagging	Shooting	Burning	Numbness
Stabbing	Exhausting	Miserable	Gnawing	Tiring
Continuous	Unbearable			

ONSET OF SYMPTOMS

Approximately when did this pain begin? _____

What caused your current pain episode (surgery, accident, nothing specific)? _____

Did your current pain begin gradually or suddenly? _____

What time of day is your pain the worst?

Morning	*Afternoon*	*Evening*	*Nighttime*	*Varies*

Pain score with activity

0 1 2 3 4 5 6 7 8 9 10
No Pain — Pain as bad as you can imagine

What makes your pain better? _____

What activity makes your pain worse? _____

Pain score at its worst (without medication)

0 1 2 3 4 5 6 7 8 9 10
No Pain — Pain as bad as you can imagine

Pain score at its best (i.e., after rest, medication)

0 1 2 3 4 5 6 7 8 9 10
No Pain — Pain as bad as you can imagine

MEDICAL HISTORY

Check all that apply

General/Medical

___Cancer Type: ____ ___RA ___ Kidney Failure ___Diabetes: I or II

___Lupus ___ HIV ___ Liver Failure ___ Hepatitis Type ___

Head/Eyes/Ears/Nose/Throat

___ Migraines ___ Head Injury ___ Hyperthyroidism ___ Hypothyroidism

___ Glaucoma

Gastrointestinal

___ Bowel Incontinence ___ Gerd (acid reflux) ___ GI Bleeding ___ Constipation

___ Stomach Ulcer

Cardiovascular/Hematologic

___ Anemia ___Bleeding disorder/Type ___ ___ Heart Attack/Date: _____

___ High Blood Pressure ___ High Cholesterol ___ Artificial Heart Valve

___ Blood Clot ___ Poor Circulation ___ Stroke/Date: _____

___ CAD/Stent Date: _____ ___ Cong. Heart Failure

Musculoskeletal

___ Amputation ___ Bursitis ___ Carpal Tunnel ___Chronic Back Pain

___Chronic Neck Pain ___ Fibromyalgia ___ Joint pain/injury ___ Osteoarthritis

___Osteoporosis ___Phantom ___ Rheumatoid Arthritis ___ Tendonitis

___ Vertebral Compression Fracture ___ Scoliosis

Neuropsychological

___Bipolar Disorder

___ Schizophrenia ___Alzheimers/Dementia ___ Multiple Sclerosis

___ Peripheral Neuropathy ___ Depression ___ Anxiety

___ Seizure Disorder ___ Paralysis ___ Reflex Sympathetic Dystrophy/CRPS

Respiratory

___ Asthma ___ Emphysema/COPD ___Obstructive Sleep Apnea ___ Home Oxygen

ALLERGIES

Allergies to medication? YES or NO If yes, please list the DRUG and the REACTION to it below:

Drug: _____ Reaction: _____

Drug: _____ Reaction: _____

Drug: _____ Reaction: _____

SURGICAL HISTORY

Spine

Yes or No: ____ Neck ____ Back

Heart/Lung

___ CABG (heart bypass) Year: _____ ____ Stent (heart) Year: ____ ___ Pacemaker/defibrillator

___Valve replacement ___ Lung Surgery

Gastric

___ Type: _____

SOCIAL HISTORY

Do you drink alcohol? YES or NO

# of drinks per Week _____

___ Alcohol Abuse/Past or Present:

Do you smoke cigarettes? YES or NO

Packs per day? _____

___ History of Drug Abuse?
____ Personal ____ Family

WELLNESS SCREENINGS

Pneumonia Vaccination? YES/NO Prostate Screening? YES/NO Colonoscopy? YES/NO

Mammogram? YES/NO Influenza Vaccination? YES/NO

REVIEW OF SYSTEMS

Check if you currently have any of the following:

General/Constitutional

___ Insomnia ___Fatigue ___Fever

Cardiovascular

___Chest pain ___ Fluid accumulation in the legs ___ SOB walking short distance

___Irregular heartbeat ___Palpitations

Musculoskeletal

___ Back pain ___Joint pain ___Leg cramps ___ Muscle spasms

___ Neck pain ___ Joint stiffness ___Muscle weakness

Neurological

___Headaches ___ Difficulty speaking ___ Dizziness ___ Fainting ___Fall frequently

___ Paralysis ___ Numbness ___ Loss of Strength ___ Memory Loss

Psychiatric

___ Anxiety ___ Auditory/visual hallucinations ___ Suicidal plans ___ Depressed mood

___ Mental or physical abuse ___ Suicidal thoughts

TREATMENTS

___ I have not had any prior treatments for my current pain complaints

Treatment	*No Relief*	*Temporary Relief*	*Excellent Relief*	*Year*
Acupuncture				
Botox Injections				
Chiropractic				
ESI Injections Circle: Cervical/ Thoracic/Lumbar				
Facet Joint Injections Circle: Cervical/Thoracic/Lumbar				
Heat (Heating Pad, Hot Bath)				
Ice Packs				
Joint Injections: Which Joint: _____				
Massage				
Nerve Blocks: Which Nerve: _____				
Physical Therapy				
Vertebroplasty/Kyphoplasty				
Radiofrequency/Ablation (AKA “Nerve burning”) Location: _____				

Treatment	*No Relief*	*Temporary relief*	*Excellent Relief*	*Year*
Spinal Cord Stimulator Circle: Trial or Permanent Implant				
Stretching				
TENS Unit				
Traction				
Trigger Point Injection Where: _____				
Home Exercise Program				