Rao K. Ali, MD
Ph: 469-562-4188
Fax: 469-562-4166
admin@mypremierpain.com

NEW PATIENT INFORMATION

Last Name:_______________________________First Name:______________________________MI: __________

Address:____City/State: ____________________Zip Code: ________

Home Phone:______________________Work Phone:____________________Cell Phone: ___________________

SSN:________________________________Date of Birth:_____________________ Male______Female ______

Employer:______________________Occupation:_______________E-Mail________________________________

Emergency Contact: ____________________________Relationship: ____________Phone:_________________

Referring Physician____________________________Primary Care Physician: _____________________________

Marital Status: Married_____Divorced______Widowed______Single_____ Separated ______

Spouse's Name: ____Date of Birth: _______________________

Spouse Employer: ___________________________________Employer Phone: ___________________________

______________________________ Primary Insurance Carrier | ______________________________ ID#/Policy Holder/DOB

______________________________ Secondary Insurance Carrier | ______________________________ ID#/Policy Holder/DOB

NOTE: We will bill your secondary insurance as a courtesy. If claims are not paid within 60 days the balance will be transferred to the patient's responsibility.

It only applies to you if you are paying a visit to the office regarding any personal injury.

Are you a personal injury patient? ❑ Yes ❑ No

Name of Attorney______________________ Phone: ______________________

Please answer the questions below:

Nature of Accident: ☐ Auto ☐ Slip and Fall ☐ Assault ☐ Other.

Date of Accident:___________Time of Day:___________State: _____________

Where were you taken after the accident? ☐ Home ☐ Work ☐ Hospital ☐ Dr ☐ Other

By whom?________Did you have any physical complaints BEFORE THE ACCIDENT? ☐ YES ☐ NO

If yes, please describe: ____

In your own words, please describe the accident: ____
____
____
____
____
____
____

If Auto Accident:

Were you a: ☐ Driver ☐ Passenger ☐ on front Seat ☐ on back Seat?

Number of people in your vehicle:_______________Other Vehicle: __________________

Were you struck from: ☐ Behind ☐ Front ☐ Left Side ☐ Right Side?

Were you knocked unconscious? ☐ YES ☐ NO If Yes, for how long? _

Were you wearing your seatbelt? ☐ YES ☐ NO

Have you been involved in a previous auto accident? ☐ YES ☐ NO

Describe how you felt: Immediately after the accident:

____

What are your present complaints?

____

Is your pain: ☐ Same ☐ Worse.

Have you been treated by another physician since the accident? ☐ YES ☐ NO

If yes:

Physician's Name:____________________Phone:_______________________Address:________________

Have you ever been hospitalized? ☐ YES ☐ NO If yes: then!

Year:____________________________Reason: _________________________________

Have you had any broken bones after the accident? ☐ YES ☐ NO If yes, Which one(s): ____________

Did you have any injections after the injury? ☐ YES ☐ NO If yes, enlist injections and date

____

____

Did you have any procedures after the injury? ☐ YES ☐ NO If yes, enlist procedures and date.

____

____

My signature below indicates that I have been given the chance to read and review the following and understand and agree to their terms:

**Patient Acknowledgement Form*
**Financial Policy, Consent for Treatment, and Release of Medical Information form*
**Notice of Privacy Practices* at my discretion.

I agree that the above information is true, and I authorize Premier Pain Centers to use this information to obtain financial reimbursement. Additionally, I authorize Premier Pain Centers to administer treatment and perform procedures as may be deemed necessary or advisable in my diagnosis. I further authorize the release of any medical information necessary to process my insurance claim and request payment for medical services to be assigned directly to Premier Pain Centers. If my insurance does not cover services rendered, I agree to be personally and fully responsible for payment. This authorization is to remain in full force unless I revoke the same in writing.

Patient's Signature:______________________________ Date: _______________________

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NEW PATIENT INFORMATION

Your Name: ______________________________ **Today's Date** ________________

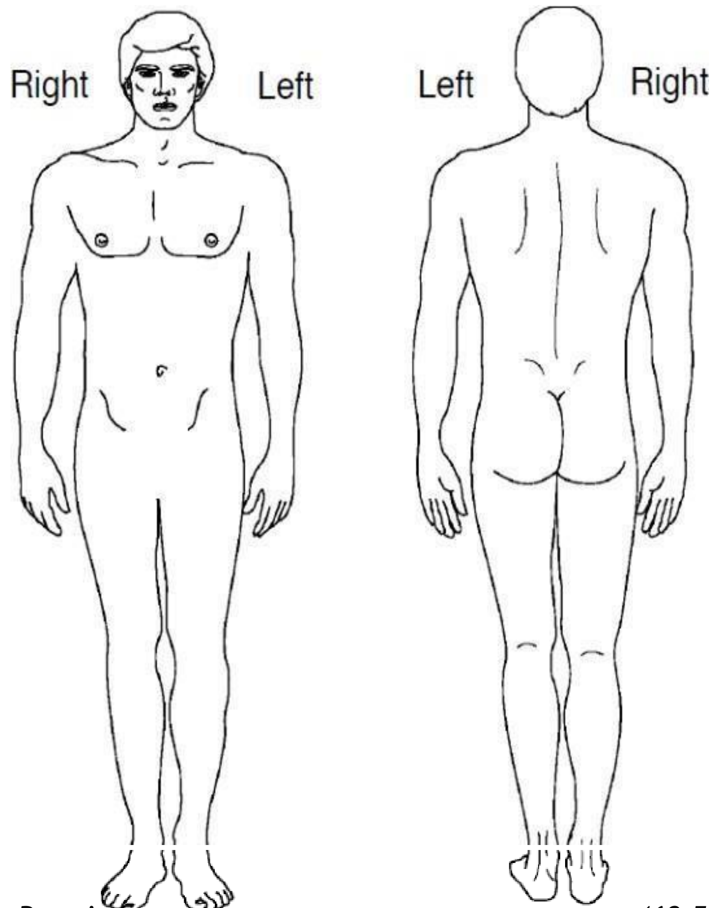
Were you referred to our clinic by another physician? If so, whom? ______________________

If not, how did you hear about us? ❑ TV ❑ Radio ❑ Insurance Company ❑ Family ❑ Friend ❑ PCP ❑ www.mypremierpain.com ❑ Facebook ❑ Twitter ❑ YouTube ❑ Other Website

Name: ____________________

1. Pain Description

Use this diagram to draw the location ofyourpainandcheckallthefollowingthatdescribeyourpain.



1.1 Back Pain

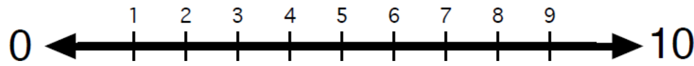
Where is your **worst** area of pain located? ❑ Low back ❑ Mid back ❑ Upper back

Does this pain radiate? ❑ Yes ❑ No. If so, where? ______________________________

Approximately when did this pain begin? ______________________________

How did your current pain episode begin? ❑ Gradually ❑Suddenly

Use the pain scale described below to rate your pain for the questions below:



❑ Aching ❑ Cramping ❑ Dull ❑ Burning ❑ Numbness ❑ Shock-like ❑ Spasming ❑ Constant
❑ Intermittent ❑ Stabbing/Sharp ❑ Throbbing ❑ Tingling/Pins & Needles ❑ Activity-only.

When is your pain at its worst? ❑ Mornings ❑ During the day ❑ Evenings ❑ All the time

What makes the pain worse? ______________________________

____

____

What makes the pain better? ______________________________

____

____

1.1.4 Pain Treatment History

Mark all the following pain treatments with date you have undergone before today's visit:

❑ Physical Therapy ❑ Psychological Therapy ❑ Podiatrist Treatment

❑ Chiropractic

❑ Epidural Steroid Injection – (circle proper levels) Cervical / Thoracic / Lumbar

❑ Joint Injection- Joint(s) ______________________________

❑ Medial Branch Blocks or Facet Injections – (circle proper levels) Cervical / Thoracic / Lumbar

❑ Pain Pump ______________________________

❑ Radiofrequency Ablation – (circle proper levels) Cervical / Thoracic / Lumbar

❑ Spinal Column Stimulator – (circle one) Trial Only / Permanent Implant

❑ Spine Surgery ______________________________

❑ Trigger Point Injection

❑ Vertebroplasty / Kyphoplasty- Level(s) ______________________________

❑ Other: ____________

❑ I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS: ____________

____

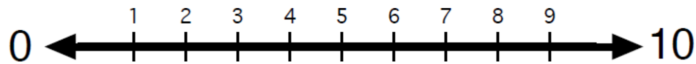
2. Neck Pain

Does this pain radiate? ❑ Yes ❑ No. If so, where? ____________________

Approximately when did this pain begin? ____________________

How did your current pain episode begin? ❑ Gradually ❑Suddenly

Use the pain scale described below to rate your pain for the questions below:



❑ Aching ❑ Cramping ❑ Dull ❑ Burning ❑ Numbness ❑ Shock-like ❑ Spasming ❑ Constant
❑ Intermittent ❑ Stabbing/Sharp ❑ Throbbing ❑ Tingling/Pins & Needles ❑ Activity-only.

When is your pain at its worst? ❑ Mornings ❑ During the day ❑ Evenings ❑ All the time

What makes the pain worse? ____________________

What makes the pain better? ____________________

2.1 Pain Treatment History

Mark all the following pain treatments with date you have undergone before today's visit:

❑Physical Therapy ❑ Chiropractic

❑ Epidural Steroid Injection__________ ❑ Joint Injection- Joint(s)__________

❑ Medial Branch Blocks or Facet Injections__________ ❑ Pain Pump __________

❑ Radiofrequency Ablation__________ ❑ Spinal Column Stimulator__________

❑ Spine Surgery__________ ❑ Trigger Point Injection__________

❑ Vertebroplasty / Kyphoplasty- Level(s)__________ ❑ Other:__________

❑ **I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS:** __________

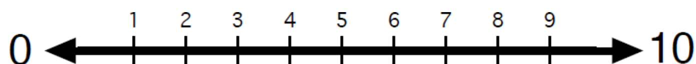
3. Joint Pain (Circle) Shoulder Elbow Wrist

Does this pain radiate? ❑ Yes ❑ No. If so, where? ____________________

Approximately when did this pain begin? ____________________

How did your current pain episode begin? ❑ Gradually ❑Suddenly

Use the pain scale described below to rate your pain for the questions below:



❑ Aching ❑ Cramping ❑ Dull ❑ Burning ❑ Numbness ❑ Shock-like ❑ Spasming ❑ Constant
❑ Intermittent ❑ Stabbing/Sharp ❑ Throbbing ❑ Tingling/Pins & Needles ❑ Activity-only.

When is your pain at its worst? ❑ Mornings ❑ During the day ❑ Evenings ❑ All the time

What makes the pain worse? ____________________

____

____

What makes the pain better? ____________________

____

____

3.3 Pain Treatment History

Mark all the following pain treatments with date you have undergone before today's visit:

❑Physical Therapy ❑ Chiropractic

❑ Epidural Steroid Injection____________ ❑ Joint Injection- Joint(s)____________

❑ Medial Branch Blocks or Facet Injections____________ ❑ Pain Pump ____________

❑ Radiofrequency Ablation____________ ❑ Spinal Column Stimulator____________

❑ Spine Surgery____________ ❑ Trigger Point Injection____________

❑ Vertebroplasty / Kyphoplasty- Level(s)____________ ❑ Other: ____________

❑ I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS: ____________

____

____

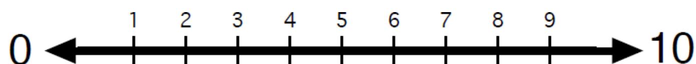
4. Hip Pain

Does this pain radiate? ❑ Yes ❑ No. If so, where? ___________________________

Approximately when did this pain begin? ___________________________

How did your current pain episode begin? ❑ Gradually ❑Suddenly

Use the pain scale described below to rate your pain for the questions below:



❑ Aching ❑ Cramping ❑ Dull ❑ Burning ❑ Numbness ❑ Shock-like ❑ Spasming ❑ Constant
❑ Intermittent ❑ Stabbing/Sharp ❑ Throbbing ❑ Tingling/Pins & Needles ❑ Activity-only.

When is your pain at its worst? ❑ Mornings ❑ During the day ❑ Evenings ❑ All the time

What makes the pain worse? ___________________________

____

____

What makes the pain better? ___________________________

____

____

4.3 Pain Treatment History

Mark all the following pain treatments with date you have undergone before today's visit:

❑Physical Therapy ❑ Chiropractic

❑ Epidural Steroid Injection___________ ❑ Joint Injection- Joint(s)___________

❑ Medial Branch Blocks or Facet Injections___________ ❑ Pain Pump ___________

❑ Radiofrequency Ablation___________ ❑ Spinal Column Stimulator___________

❑ Spine Surgery___________ ❑ Trigger Point Injection___________

❑ Vertebroplasty / Kyphoplasty- Level(s)___________ ❑ Other:___________

❑ I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS: ___________

____

____

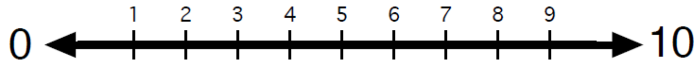
5. Knee Pain

Does this pain radiate? ❑ Yes ❑ No. If so, where? ______________________________

Approximately when did this pain begin? ______________________________

How did your current pain episode begin? ❑ Gradually ❑Suddenly

Use the pain scale described below to rate your pain for the questions below:



❑ Aching ❑ Cramping ❑ Dull ❑ Burning ❑ Numbness ❑ Shock-like ❑ Spasming ❑ Constant
❑ Intermittent ❑ Stabbing/Sharp ❑ Throbbing ❑ Tingling/Pins & Needles ❑ Activity-only.

When is your pain at its worst? ❑ Mornings ❑ During the day ❑ Evenings ❑ All the time

What makes the pain worse? ______________________________

____

____

What makes the pain better? ______________________________

____

____

5.3 Pain Treatment History

Mark all the following pain treatments with date you have undergone before today's visit:

❑Physical Therapy ❑ Chiropractic

❑ Epidural Steroid Injection____________ ❑ Joint Injection- Joint(s)____________

❑ Medial Branch Blocks or Facet Injections____________ ❑ Pain Pump ____________

❑ Radiofrequency Ablation____________ ❑ Spinal Column Stimulator____________

❑ Spine Surgery____________ ❑ Trigger Point Injection____________

❑ Vertebroplasty / Kyphoplasty- Level(s)____________ ❑ Other:____________

❑ I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS: ____________

____

____

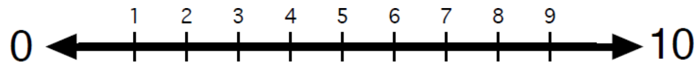
6. Other Pains

Does this pain radiate? ❑ Yes ❑ No. If so, where? ______________________________

Approximately when did this pain begin? ______________________________

How did your current pain episode begin? ❑ Gradually ❑Suddenly

Use the pain scale described below to rate your pain for the questions below:



❑ Aching ❑ Cramping ❑ Dull ❑ Burning ❑ Numbness ❑ Shock-like ❑ Spasming ❑ Constant
❑ Intermittent ❑ Stabbing/Sharp ❑ Throbbing ❑ Tingling/Pins & Needles ❑ Activity-only.

When is your pain at its worst? ❑ Mornings ❑ During the day ❑ Evenings ❑ All the time

What makes the pain worse? ______________________________

____

____

What makes the pain better? ______________________________

____

6.3 Pain Treatment History

Mark all the following pain treatments with date you have undergone before today's visit:

❑Physical Therapy ❑ Chiropractic

❑ Epidural Steroid Injection____________________ ❑ Joint Injection- Joint(s)____________________

❑ Medial Branch Blocks or Facet Injections______________ ❑Pain Pump ____________________

❑ Radiofrequency Ablation____________________ ❑ Spinal Column Stimulator________________

❑ Spine Surgery____________________ ❑ Trigger Point Injection________________

❑ Vertebroplasty / Kyphoplasty- Level(s)______________ ❑ Other:______________________________

❑ I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS: ____________________

____

____

7. Diagnostic Tests and Imaging

Is the most recent test(s) you have had that are related to your current pain complaints:

- ◻ MRI of the________________________ Date:__________ Area: _
- ◻ X-ray of the________________________ Date:__________ Area: _
- ◻ CT scan of the______________________ Date:__________ Area: _
- ◻ EMG/NCV study of the______________ Date:__________ Area: _
- ◻ Ultrasound of the_________________ Date:__________ Area: _
- ◻ Other diagnostic testing: ____

❑ **I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS**

8. Medications

Please list the medications you are taking, **Pain meds listed first.** Attach an additional sheet if necessary.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

*Please list ALL pain medications you have taken in the past and are now **not** taking.*

____

____

____

____

9. Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

GeneralMedical

❑Cancer -Type ______________
❑Diabetes - Type ____________
❑ HIV / AIDS

Head/Eyes/Ears/Nose/Throat

❑ Glaucoma
❑ Headaches
❑ Head Injury
❑ Hyperthyroidism
❑ Hypothyroidism
❑ Migraines

Cardiovascular / Hematologic

❑ Anemia
❑ Bleeding Disorders
❑ Coronary Artery Disease
❑ Heart Attack
❑ High Blood Pressure
❑ High Cholesterol
❑ Mitral Valve Prolapse
❑ Murmur
❑ Pacemaker/Defibrillator
❑ Phlebitis
❑ Poor Circulation
❑ Stroke

Respiratory

❑Asthma
❑ Bronchitis
❑ Emphysema / COPD
❑ Pneumonia
❑ Tuberculosis
❑ Exposure to mold

Gastrointestinal

❑ Bowel Incontinence/IBS
❑ Acid Reflux (GERD)
❑Gastrointestinal Bleeding
❑ Constipation

Musculoskeletal

❑ Amputation
❑ Bursitis
❑ Carpal Tunnel Syndrome
❑ Chronic Low Back Pain
❑ Chronic Neck Pain
❑Chronic Joint Pain
❑ Fibromyalgia
❑ Joint Injury
❑ Osteoarthritis
❑ Osteoporosis
❑ Phantom Limb Pain
❑ Rheumatoid arthritis
❑ Tennis Elbow
❑ Vertebral Compression fracture

Genitourinary/Nephrology

❑ BladderInfection(s)
❑ Dialysis
❑ Kidney Infection(s)
❑ Kidney Stones
❑ UrinaryIncontinence

Hepatic

❑ Hepatitis A (active/inactive / unsure)
❑ Hepatitis B (active/inactive / unsure)
❑ Hepatitis C (active/inactive / unsure)

Neuropsychological

❑ Alcohol Abuse
❑ Alzheimer Disease
❑ Bipolar Disorder
❑ Depression
❑ Epilepsy
❑ Prescription Drug Abuse
❑ Multiple Sclerosis
❑ Paralysis
❑ Peripheral Neuropathy
❑ Schizophrenia
❑ Seizures
❑ Complex Regional Pain Syndrome

❑ **Other Diagnosed Conditions**

____
____
____

10. Past Surgical History

Please indicate any surgical procedures you have done in the past, including the **date, type,** and any pertinent **details.**

____

____

____

❑ **I HAVE NEVER HAD ANY SURGICAL PROCEDURES DONE**

11. Family History

Mark all appropriate diagnoses as they pertain to your biological *MOTHER AND FATHER* only.

	Alcohol problems	Cancer	Diabetes	Drrug problems	Abnormal bleeding	Headaches	Heart Disease	High blood pressure	Kidney disease	Liver disease	Rheumatoid arthritis/Lupus	Smoking	Stroke
Mother													
Father													

Other medical problems: ____

❑ **I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY** ❑ **I AM ADOPTED (No Medical History Available)**

12. Social History

Areyoucapableofbecomingpregnant?❑Yes ❑No *Ifso*,are you pregnant? ❑Yes ❑No

Highestlevelof education: ❑ Grammar school ❑ High school ❑ College ❑ Post-graduate.

Are you currently working? ❑ Yes ❑ No What is/was your occupation?________________________

AlcoholUse: ❑Deniesalcoholuse ❑Currentalcoholuse Howmuch?________________________
❑ History of alcohol abuse

IllicitDrugUse: ❑DeniesanyIllicitdruguse ❑CurrentlyusingIllicitdrugs, Which? ________________
❑ History of illicit drug use

Have you ever abused narcotics or prescription medications? ❑ Yes ❑ No; *If so*, which________________
Are you currently in remission for alcohol or any other addictions ❑ Yes ❑ No ❑ not applicable

13. Allergies

Do youhaveanyknowndrugallergies? ❑Yes ❑No

If so, please list all medications you are allergic to:

Medication: **Allergic Reaction Type (What Happens?)**

Drug-Drug Interactions (If any)? ______

Adverse drug reactions (If any)?______

14. Review of Systems

Markthefollowingsymptomsthat you**currently** sufferfrom.

Constitutional: ❑ Weakness ❑ Fatigue ❑ Weight gain ❑ Weight loss ❑ Fever ❑ Chills ❑ Night sweats

Ears/Nose/Throat: ❑ Dental Problems ❑ Earaches ❑ Hearing problems ❑Nose bleeds.
❑ Recurrent sore throats ❑ Ringing in the ears ❑ Sinus problems.

Cardiovascular: ❑ Chest pain ❑Irregular heartbeat ❑ Murmur ❑ Rapid heartbeat ❑ Blood clots
❑ Swollen extremities❑ Palpitations ❑ Fainting.

Respiratory: ❑ Cough ❑Shortness of Breath on Exertion/Effort ❑Wheezing ❑Shortness of breath at rest

Gastrointestinal: ❑ Acid reflux ❑ Abdominal cramps ❑ Constipation ❑ Diarrhea ❑ Vomiting
❑ Coffee ground appearance in vomit ❑ Dark and tarry tools

Genitourinary/Nephrology: ❑ Blood in Urine ❑ Decreased urine flow/Frequency/Volume ❑ Flank pain
❑ Erectile dysfunction ❑painfulurination ❑ Incontinence

Integumentary/Skin: ❑ Change in skin color ❑ Rashes ❑ Puritis ❑ Dry skin

Musculoskeletal: ❑Joint swelling ❑Back pain ❑ Muscle spasms ❑Joint pain ❑Neck pain
❑ Pelvic pain ❑ Joint stiffness

Psychiatric: ❑ Depressed mood ❑ Anxiety ❑ Stress ❑ Suicidal Thoughts

Endocrine: ❑ Heat Intolerance ❑ Cold Intolerance ❑ Hair changes ❑ Excessive thirst

Neurological: ❑Dizziness ❑Seizures ❑Headaches❑Numbness/tingling ❑ Memory loss
❑ Difficultywith speech ❑ Difficulty walking

Hematologic/Lymphatic: ❑ Easy bruising ❑ Easy bleeding ❑Impairedwound healing ❑Lymphadenopathy

Allergic/Immunologic: ❑ Recurrent infection ❑ Hives ❑ Swelling ❑ Itching eyes or nose.

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I_________________________________, understand that that services or items that I have requested be provided to me by Premier Pain Centers may not be covered under my insurance as being reasonable or medically necessary for my care. I understand the health-insuring agent determines the medical necessity of the services or items I request and receive. I also understand I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable or medically necessary for my care.

Advanced Practitioner Consent for Treatment

Advanced Practitioner Consent for Treatment This facility has on staff a physician assistant and/or a nurse practitioner to assist in the delivery of medical care of pain management.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. A nurse practitioner is not a doctor. A nurse practitioner is a registered nurse who has received advanced education and training in the provision of health care. Under the supervision of a physician, a physician assistant and a nurse practitioner can diagnose, treat, and monitor acute and chronic disease as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of the supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided. A physician assistant and a nurse practitioner may provide such medical services that are within his/her education, training, and experience.

I have read the above, and hereby consent to the services of an advanced practitioner for my health care needs. I understand that at any time I can refuse to see the advanced practitioner and request to see a physician.

Acknowledgement of Drug Screening Policy

I understand that Premier Pain Centers reserves the right to perform random drug screening on any patient. I have the right to refuse the drug screen but may then not be prescribed any medications or given refills of medications.

Acknowledgement of Investigational Treatment

I am being informed that in certain circumstances the treatment being recommended may be considered investigational, experimental, and not FDA approved. By signing this document, I am giving consent to such treatments.

AGREEMENT OF FINANCIAL RESPONSIBILITY

Thank you for choosing Premier Pain Centers as your health care provider. We are committed to providing quality care and service to all our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

Insurance

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefit sand any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 daysfrom the time the claim is received by the insurance company. The patient will be responsible for any deductible, coinsurance, and co- payment amount. The patient isresponsible for payment of any non-covered service.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- Proof of payment and photo ID are required for all patients. We will ask you to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverage's have Out-of-Network benefits that have co- insurance charges, higher co-payment and limited annual benefits. If you receive services that are part of an Out-of-Network benefit, your portion offinancial responsibility may be higher than the In- Network rate.

Referrals: If a referral is required for your insurance policy, it is your responsibility to obtain this referral from the primary insurance company prior to any appointments. Failure to obtain a referral mayresult in a reduction of benefits.

Self-Pay: Patients are responsible for all visits, treatment and other related services covered by the Treating provider at Premier Pain Centers. While our office can try to estimate the cost of services, the patient agrees in advance to pay for all services, tests, and fees the providers feel is necessary for the patient's care.

Unpaid Balances: Patients typically receive a statement from our office after the insurance company has processed the claims. This will include charges that the insurance company has not paid. Payment is due within 30 days of the statement date. An account is considered past due if not paid by the due date listed on the billing statement unless prior arrangements have been made with our billing office.

Returned Checks: The charge for turned check is **$35.00** payable by cash or money order. This will be applied to your account in addition to the insufficient fund amount.

No Show/Cancellation: Policy No Show/Cancellation Policy: A charge of **$50** will be applied to your account if notification of cancellation is not made within 24 hours of the appointment time.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full. I authorize payment of medicalbenefits to my treating provider at Premier Pain Solutions and authorize my provider to release anyinformation requested by my insurance carrier. I understand and agree that the terms of this financial policy may be amended by the practice at any time without prior notification to the guarantor.

Signature of Patient/Responsible Party:	**Date:**
Name of Patient/Responsible Party (please print)	**Relationship to Patient:**

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Fax: 469-562-4166
admin@mypremierpain.com

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

PREMIER PAIN CENTERS recognizes the patient's right to confidentiality of protected health information ("PHI"). This form obtains permission to discuss and/or release information regarding your care at our practice to a person whom you designate as an authorized representative. Authorization is optional- you may opt to not designate any authorized representatives.

Please bear in mind, if you intend for anyone else to schedule your appointments, manage your prescriptions, or receive billing/account/medical record information on your behalf, you must authorize them on this form.

PATIENT NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

I AUTHORIZE PREMIER PAIN CENTERS TO DISCLOSE MY PHI TO THE LISTED PERSON(S):

NAME	PHONE NUMBER	RELATIONSHIP TO PATIENT

LIMITATIONS ON DISCLOSURE

I understand that by leaving this section blank, I am allowing all my PHI to be disclosed to my authorized representative(s).

Limitations:

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I UNDERSTAND THAT INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT IF THEY ARE NOT A COVERED ENTITY UNDER THE FEDERAL PRIVACY RULE. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFYING PREMIER PAIN SOLUTIONS IN WRITING TO BE EFFECTIVE ON THE DATE NOTIFICATION IS RECEIVED. I AGREE THAT MY AUTHORIZATION IS VOLUNTARY.

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PATIENT's SIGNATURE **DATE**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN SET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires all medical records and other.

Individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly 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 your 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, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

- **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 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.
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.

- The right to request restriction on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to receive an accounting of disclosure of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

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 January 1, 2013, 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 provisions 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 this office.

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

Please call us or contact the following website for more information. https://www.hhs.gov/hipaa/index.html

NOTICE OF PRIVACY PRACTICES AKNOWLEDGEMENT

Patient Name: ____

Date of Birth: ____

I acknowledge that Premier Pain Centers provided me with a written copy of the office 's Notice of Private Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

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Patient **Date**