Republic Spine and Pain, PA

9707 Anderson Mill Road, Ste 230
Austin, Texas 78750

9707 Anderson Mill Road #230
Austin, TX 78750
T: (512) 219-8787
F: (512) 219-8788

Dear Patient,

We appreciate the confidence and trust you have placed in us by scheduling an appointment with Republic Spine and Pain and we look forward to seeing you. If you are able to complete this paperwork prior to your appointment time please arrive 5-10 minutes prior to your scheduled appointment time to scan your Drivers License and Insurance Card. For whatever reason, you are unable to print and complete the paperwork, please arrive 30 minutes PRIOR to your appointment time for us to provide you the forms and to ensure you are ready for your appointment. The philosophy of our practice is to best help you manage your chronic or current pain symptom. We shall make every effort to see that your experience with Republic Spine and Pain is as comfortable as possible.

Please note that if all of the required information is not completed and with you by your scheduled appointment time, our office staff will have to reschedule for another appointment.

What to send in prior to appointment date:

- If required, referral or authorization from insurance carrier

What to bring with you to your first appointment:

- New Patient forms
- Medical insurance card(s)
- State or government issued identification (example: driver's license)
- Payment for visit (We unfortunately don't accept check)

We will be happy to discuss anything with you in an open manner and welcome any questions or concerns you may have. We look forward to seeing you

Dr Mahan Ostadian. & Dr Clement Yeh

PLEASE ONLY PRINT PAGES 2-10

WE DO NOT NEED A COPY OF THE WELCOME LETTER

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Personal Information

Name ____________________________________ Date of Birth ________ /_________/________

Home Address ____

City ____________________ State __________ Zip Code _____________

Home Phone _______________ Cell / Alt. Phone # _________________ Email : _________________________________

Social Security Number: ____ - _____ -_____ Driver's Lic. __________________ State _____

Sex ☐ Male ☐ Female Marital Status ☐ S ☐ M ☐ W ☐ D

Emergency Contact _________________________ Phone # _______________________________

Referring Doctor/Source _____________________ Phone # _______________________________

Family Doctor if different from above : ____________________ Do you want appointment reminders emailed to you? Y/N

Medical Insurance Information

Primary Insurance ________________________ Insurance Phone # ______________________

Name of Subscriber _________________________ Relationship to Patient ____________________

Subscr. DOB ___/___/____ Subscr. Employer _________________ Subscr. SSN _____-____-______

Employer: ___________________________________ Occupation ___________________________

Employer's Address: ____

Member/Policy Number ______________________ Group Number __________________________

Secondary Insurance ______________________ Insurance Phone # ______________________

Name of Subscriber _________________________ Relationship to Patient ____________________

Subscriber's DOB ________/_________/_________ Subscriber's Employer ____________________

Employer's Address: ____

Member/Policy Number ______________________ Group Number __________________________

Pharmacy Information – Please provide ONE Pharmacy which all you medications are faxed, e-prescribed or called in.

Preferred Pharmacy: ________________________ Pharmacy Phone #: ______________________

Pharmacy Address: ____

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Republic Spine and Pain, PA for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

____ ____________________

Patient, Parent or Guardian Signature (if child is under 18 years old) Date

*** Thank you for allowing us the opportunity to care ***

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MEDICAL HISTORY

Reason for Visit ________________________________

Is today's visit due to a work related injury? []Yes []No

Have You notified your personnel department? []Yes []No

What injury was sustained? _________________________________

Date of Last Visit ____________________

Are you currently or have you been under the care of a pain management healthcare provider in the last 3 years? Yes No

If yes, please state reason: ____

Name of health care provider: ____

Provider's Address ______________________________

Provider's Phone # (_____)____________

Medications

Please list prescription medications you are taking.

Name	Dosage	Frequency

Please list over-the-counter medications, vitamins or herbal supplements you are taking.

Name	Dosage	Frequency

Have you EVER taken any prescription weight loss drugs, including Fen-Phen (fenfluramine-phentermine), Redux (dexfenfluramine) and/or Pondimen (fenfluramine)? Yes No

Allergies

Please list drugs and adverse reactions to medicine or latex.

Name	Reaction (hives, rash, swelling, etc.)

Hospitalizations & Surgeries

Please list surgeries and hospitalizations you have undergone.

Reason	Date

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Tobacco, Alcohol, and Drug Use

Use of Tobacco (type and how long) ____

Do you want to quit?	Yes	No
Have you tried to quit in the past?	Yes	No
• If so, how did you quit and how successful were you? ______________________________		
Use of Alcohol (type and how long) ____		
Have you ever felt the need to cut back or quit?	Yes	No
• If so, have you tried to quit?	Yes	No
• Have friends or family members suggested you quit?	Yes	No
Use of Recreational and Non-Prescription Drugs (type and how long) _________________________		
Have you ever been treated for drug or alcohol dependency?	Yes	No

For Female Patients Only

Are you currently pregnant	Yes	No
Are you nursing	Yes	No
Are you taking birth control Approx date last menstrual cycle began ______/_____/_____	Yes	No

Acknowledgement of Receipt of Privacy Notice

I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand Republic Spine and Pain, PA reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy. I may request a copy of the updated Notice of Privacy Practices by calling my physician's office or requesting a copy in person at my appointment.

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to disclosure of any medical information.

Patients Printed Name : ____ Date of Birth

Patient/ Legal Representative Signature : ________________________________ Date / /

Witness: ____ Relationship to patient: ________________________

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Republic Spine and Pain, PA to share my protected health information with:

Name:____ Relationship:________________________________

Name:____ Relationship: ________________________________

I wish to be contacted in the following manner ? (Please circle) 1. Home Ph 2. Cell Ph 3. Work Ph

Is it ok to leave a message with detailed information? If so, which phone number? Home, Cell or Work?

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true, and accurate.

____ ____________________

Patient, Parent or Guardian Signature (if child is under 18 years old) Date

Reviewed by: ____________________________________ **Review date:**

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Review of Systems

Indicate if you have or have EVER had the following:

Allergy/ENT
- ☐ Hay Fever
- ☐ Seasonal Allergies
- ☐ Sinus Problems

Cardiovascular
- ☐ Artificial Heart Valve
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Attack or MI
- ☐ Heart Surgery (CABG, Heart Catheterization, etc.)
- ☐ High Blood Pressure-Hypertension
- ☐ Pacemaker
- ☐ Swollen Ankles

Endocrine
- ☐ Diabetes
- ☐ Polycystic Ovarian Syndrome
- ☐ Thyroid Disorders
- ☐ Hirsutism-Excessive Hair

Gastrointestinal
- ☐ Liver Problems
- ☐ Ulcers
- ☐ Reflux-GERD

Hematology
- ☐ Abnormal Bleeding
- ☐ Bruise Easily
- ☐ Anemia
- ☐ Blood Diseases
- ☐ Blood Transfusion
- ☐ Hemophilia
- ☐ Sickle Cell Disease
- ☐ Spider or Varicose Veins

Infections
- ☐ Rheumatic Fever
- ☐ Hepatitis A B C
- ☐ HIV Positive
- ☐ AIDS
- ☐ Shingles

Musculoskeletal
- ☐ Arthritis (Rheumatoid Arthritis/Osteoarthritis)
- ☐ Artificial Joints (hip, knee, etc.)
  If yes, when? ______________
- ☐ Chronic Back Problems
  If yes, have you had surgery? ______
  When was the surgery? ______________

Neurologic
- ☐ Epilepsy/Seizures
- ☐ Fainting/Dizzy Spells
- ☐ Frequent Headaches
- ☐ Stroke or TIA
- ☐ Other Neurological Disorders ___________

Oncology
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Radiation Therapy

Ophthalmology
- ☐ Cataracts
- ☐ Glaucoma

Psychiatric Care
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Schizophrenia
- ☐ Psychiatric Care

Renal/Urologic
- ☐ Kidney Stones
- ☐ Frequent Urination (day or night)
- ☐ Frequent Bladder Infections
- ☐ Blood in the Urine
- ☐ Prostate Problems (BPH)
- ☐ Kidney Problems

Respiratory
- ☐ Asthma
- ☐ Chronic cough
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Tuberculosis

Skin
- ☐ Cold Sores/Fever Blisters
- ☐ Change in moles

General
- ☐ Unplanned Recent Weight Gain/Weight Loss of 10 lbs or more

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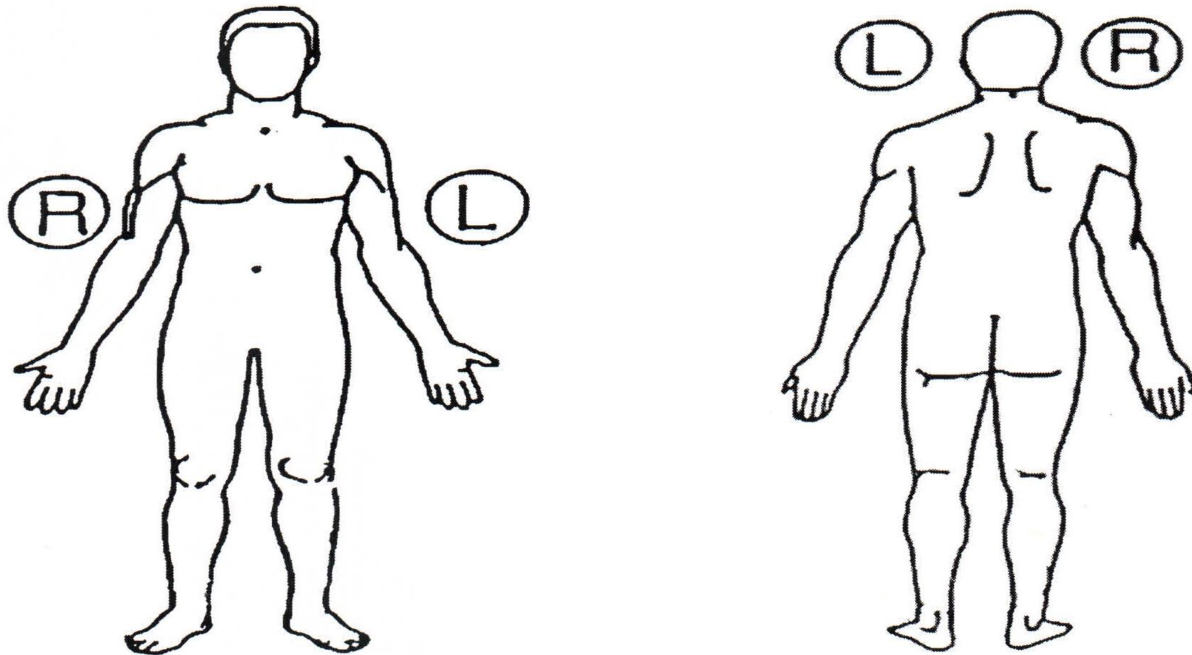
Use this diagram to indicate the location and type of pain. **Mark the drawing with the following letters that best indicate your symptoms.**

"N" = Numbness "S"= Stabbing pain "B"= Burning pain "P"= Pins and Needles "A"= Aching Pain



Please mark all the following treatments you have used for pain relief:

	Helped Pain	Worsened Pain	No Change
Massage therapy			
Hot or cold packs			
Biofeedback			
Physical therapy			
Chiropractic			
Acupuncture			
Traction			
Brace support			
TENS unit			
Injection therapy			
Medications			

If your injury/pain is the result of an accident or some other incident, please provide the following details:

- Date of the injury, location of the injury and treatment at the time of injury
- Describe how the injury occurred

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OFFICE POLICIES AND PROCEDURES PART 1

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please read and sign our financial policy prior to treatment.

Please take note of the following office policies:

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.

How May I Pay?

We accept payment by cash, VISA and MasterCard.

- **IF YOU ARE CONTRACTED WITH AN HMO, PPO, POS, OR THIRD PARTY INSURANCE COMPANY, THEN CO-PAYMENT/CO-INSURANCE DOES APPLY.**
- **ALL CO-PAYS ARE COLLECTED UP FRONT TO ASSIST IN A SMOOTHER CHECK-OUT TIME.**
- **YOU ARE RESPONSIBLE FOR PROVIDING US WITH ANY UPDATED INSURANCE INFORMATION PRIOR TO TREATMENT. OTHERWISE; YOU WILL BE RESPONSIBLE FOR BALANCE.**

REGULAR INSURANCE

We require all patients who are contracted with regular indemnity insurance to pay at the time of service unless other arrangements have been made with the office manager. We will provide you with the necessary documentation at the end of your visit.

MEDICARE INSURANCE

After your yearly deductible has been met, we will accept assignment of benefits as set forth in your Medicare Part B. Medicare sets the fees that we may charge and Medicare requires all patients to pay their 20% of the approved amount at the time of service. If you have supplemental coverage (MEDIGAP), we may be able to file this for you as well if it is a plan that we participate in. Please provide us with your secondary insurance information so that we may appropriately inform you. Medicare does not cover all services. Our staff is aware of most of the non-covered services and will alert you prior to your treatment if possible.

HMO – PPO – POS – THIRD PARTY INSURANCE

All co-payments, co-insurance and deductibles are due at the time of treatment. In the event your insurance coverage changes, please advise us immediately. If your plan requires a primary care physician referral, it is your responsibility to obtain the appropriate referral prior to the appointment. We will attempt to assist in reminding you when you need a referral. PLEASE BE ADVISED THAT SOME, AND PERHAPS ALL OF THE SERVICES PROVIDED MAY BE NON-COVERED SERVICES UNDER YOUR PLAN AND THEY MAY BECOME YOUR RESPONSIBILITY REGARDLESS OF WHAT TYPE OF COVERAGE YOU HAVE.

MINOR PATIENTS

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full patient. For the unaccompanied minors, non-emergency treatment will be denied unless appropriate consent has been received and charges have been pre-authorized and payment has been made prior to treatment.

MISSED APPOINTMENTS

Unless cancelled at least 24 hours in advance, our policy is to charge ½ of the normal office visit fee. We do understand circumstances do arise where 24 hours advance notice is not possible and we will take that into consideration.

DELIQUENT ACCOUNTS & RETURNED CHECKS

All accounts that are past due NINETY (90) days or more will be charged a cumulative interest rate of 12% or $30.00 collection fee whichever is greater on all outstanding charges. Please keep your account current and if this is possible, please alert us immediately. We are always able to come to an amicable solution. All checks returned by the bank for "Non-Sufficient Funds" will be charged a $25.00 processing fee and we do require the check to be replaced by cash or money order within 7 days.

REFUNDS OF SUPPLIED

There will be no refund of supplies. Unfortunately, every supply prescribed may not work for all patients; however, we strive to ensure we make every effort to have a satisfactory outcome.

I HAVE READ THE ABOVE FINANCIAL OFFICE POLICY ON THIS PAGE. I UNDERSTAND AND AGREE TO COMPLY WITH THIS FINANCIAL POLICY.

X ____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

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OFFICE POLICIES AND PROCEDURES PART 2

ADDITIONAL FEES

Disability forms that need to be completed by our office will incur a $15.00 charge and will be mailed for you. FMLA is $25.00
Medical records for copies we require 30 days written notice and there is a $1.50 charge per page.

RELEASE OF RECORDS

If you want your records released to another physician or facility you must sign a Release of Information form indicating who we are Releasing records to, as well as, which relevant information you would like us to release. If you wish to receive a copy of your records for Personal files, you must send us a written request. Please allow 7-10 business days to have your records available.

REFERRAL:

If your insurance company requires a referral, it is your responsibility to obtain it. The contract is between you and your insurance carrier. Therefore, we are not responsible to obtain your referral. If you present to the office without your referral you will be required to reschedule your appointment or you may opt to pay out of pocket for services rendered. Referrals must be generated from your primary care physician or referring doctor.

INSURANCE : Your insurance coverage is a contract between you and your insurance company. We are not a party to this contract. We will bill your insurance company (primary and secondary, if applicable) as a courtesy. Your insurance company does not guarantee payment for services rendered. Your insurance company makes the final determination of benefits and eligibility at the time the claim is reviewed. By signing the line below you hereby agree that you understand you are solely responsible to pay any portion of charges not covered by your insurance carrier.

Verification of Benefits: You as the policyholder are primarily responsible to know your insurance benefits. The insurance DOES NOT guarantee payment of benefits quoted and subsequently you will be responsible for any coinsurance or deductibles for services not covered by your insurance carrier. We must have a copy of your insurance card and photo ID in order to process your claim. Therefore, please give your cards to the receptionist. If you are a first-time patient, or if your insurance information has changed, we must be notified. Failure to cooperate will mean that you will be responsible for the charges incurred.

Required Payments: You will be responsible to pay any co-payment, deductible, coinsurance, or fees not covered by your insurance carrier at the time services are rendered. We do not accept letters of protection. Any outstanding balances greater than 60 days must be paid prior to being seen by the physician or you will be required to reschedule your appointment. You may choose to pay cash or Credit Card.

Monthly Statements: You will receive a statement only if you have an outstanding balance on your account. The statement will reflect any balance pending with your insurance carrier as well as an outstanding balance for services not covered by your insurance company. We request that if you receive a statement, that you make payment within 30 days of receipt. If your balance becomes delinquent past 60 days, your account will be referred to a collection agency.

Consent for Treatment: I understand that I have a choice in the facilities and/or products used to provide treatment of my condition(S). I also acknowledge and agree that in rendering care of me, my physician and his designee may choose to use products in which they have ownership interest. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as the result of examination or treatment in this facility.

With the ever changing environment of healthcare, it is necessary we set guidelines for our patients to ensure no future misunderstandings. We all must work together to make sure your experience with our office is a good one. Thank you for your understanding of our financial policy. Please let us know if you have any questions or concerns.

I HAVE READ THE ABOVE FINANCIAL OFFICE POLICY. I UNDERSTAND AND AGREE TO COMPLY WITH THIS FINANCIAL POLICY.

X ____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

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REPUBLIC SPINE AND PAIN (RSP) NARCOTIC CONTRACT

Republic Spine and Pain understands that your pain is a significant hindrance to the quality of life you desire. In order to help you achieve your goals we may utilize oral narcotics or other medications supplemented with the procedures you receive here. Narcotics have a long history of safety when used in the proper manner. Side effects can include, but not limited to, constipation, urinary retention, itching, nausea, and sometimes confusion. Addiction to narcotics may occur with use over several weeks; therefore, we must weigh the risks versus benefits before using these medications. We will discuss these with you when they are prescribed and your pharmacist will also give you more information. It is important to take all medications in the way that they are prescribed by your RSP physician. **Taking more medication than is prescribed for you can result in, but not limited to, respiratory failure, cardiac arrhythmias, GI bleed and/or death. Please be certain to take your medications as prescribed.**

Listed below are the conditions you must adhere to in order to be under the care of the RSP**. If any of these rules are broken, we reserve the right to dismiss you from our care:**

- I agree to take my medication as prescribed. If pain level increases such that I need to increase my dosage, I will call the RSP and discuss this with a nurse or physician. If given narcotic medications from RSP, I will receive these only from RSP for the duration of my care. _____
- I will take no other pain medications until I speak with a nurse or physician at the RSP. "I agree to receive my prescriptions only from one pharmacy, to be recorded in my chart at the RSP. _____
- I will protect my prescriptions and medications. Only one lost prescription or medication will be replaced in a single year with a copy of a police report. When I travel or go on trips I will not take my entire prescription with me _______________
- If I am requesting early refills I will consent to random drug testing. ________________
- I understand that I will be financially responsible for my urine drug testing ________________
- I will keep my scheduled appointments. If I need to cancel an appointment, I will give 24 hours notice and will call 512.219.8787 to cancel or reschedule. If not then I may be charged my co pay or half the visit fee if self pay. _______
- Appointments should be made 1-2 days prior to prescription ending so patient don't encounter days without medication..If I am calling early, I will allow 48 hours for a refill request and my medications will not be refilled after office hours, on weekends or holidays. ______
- I understand my pain medications may be stopped if one of the following occurs:
  - my physician feels that narcotics are not helping to relieve my pain ______
  - my ability to function has not improved ______
  - I develop rapid tolerance to the treatment or the treatment fails to be effective ______
  - I develop side effects that are of concern to my physician ______
  - I give, sell, or misuse the narcotics ______
  - I obtain narcotics from any other sources without notifying RPS *(includes any ER visits)* ______
  - I understand that RSP will randomly call pharmacies to ensure this contract is still valid. ______
- An important part of my pain management plan may include non-narcotic treatment. If I do not follow through with all aspects of my care (including non-narcotic meds), my narcotic treatment may be re-evaluated or terminated. ______
- If I have questions or concerns about my pain management, I will call RSP at 512.219.8787

THIS CONTRACT WILL REMAIN IN EFFECT FOR THE DURATION OF MY CARE. I **understand the above information and agree to abide by this contract:**

____ (Print Name)

Pharmacy name and number (to be recorded in chart at initial visit): ________________________

______________ ________________________________ _______________________________

Date ***Signature*** ***Printed Name***

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Authorization for Release of Medical Information

Patient Full Name: ___________________________________ DOB: __ __/__ __/__ __

Previous/Other Name: ___________________________________ (If different than patient listed above)

This will authorize : (Whomever has the bulk of your records. Usually Family Doctor, Surgeon, Previous Pain Doctor)

Name: ___________________________________

Address:___________________________________

City, State, Zip: ___________________________

Phone, Fax: ______________________________

To Release to:

Republic Spine and Pain, PA
9707 Anderson Mill Road
Suite 230
Austin, Texas 78750
512-219-8787
512-219-8788 fax

GENERAL INFORMATION REQUESTED

Medical Information Requested:

- ☐ Complete medical records
- ☐ Lab reports
- ☑ (Last 3) Progress notes + medication list
- ☑ Imaging in the last 12 months

Reason for Release:

- ☐ To update my regular doctor (provider)
- ☐ I have been referred to another doctor
- ☐ I want/need a second opinion
- ☐ I am changing doctor (provider)
- ☐ Dissatisfaction with care
- ☐ My insurance changed
- ☐ I am moving (New Address)
- ☐ Other ___________________________

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION
PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of data and information relating to (Note, you must mark yes or no):

Yes	No	
☐	☐	Substance Abuse (alcohol/drug abuse)
☐	☐	Mental Health/Depression (includes psychological testing)
☐	☐	HIV-Related Information (AIDS related testing)

This consent may be revoked at any time by notifying the above named provider of information.
Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosed information may be reviewed by contacting the provider of information.
RESTRICTIONS:
The authorization is being given with the understanding that the receiver may not further use or
Disclose the medical information unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law.

_______________________________________ _______________________________________

Signature of patient or authorized representative:
Date: __ __/__ __/__ __

Witness
Date: __ __/__ __/__ __