Summit Pain
1818 East 23RD Ave
Hutchinson, Ks 67502

Patient's Name: _____ SSN#: _____

Date of Birth: _____ Age: _____ Sex: ____ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Address: _____ P.O. Box: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Mobile Phone: _____ E-mail: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Race: ☐ Hispanic ☐ Asian ☐ Caucasian ☐Black/African American ☐ American Indian or Alaska Native ☐ Other

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Ethnicity (Nationality-cultural background): ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other

I give permission for Summit Pain Clinic to contact my pharmacy for a list of medications. ☐ Yes ☐ No

Is today's visit due to an injury accident or Workers' Compensation? ☐ Yes ☐ No

When did your pain problem begin? Month _____ Year _____

How did your pain first start? (For example, car accident, fall, job function, sports injury, etc.)

_____

Explain what you were doing at the time of injury? (For example, bending, lifting, stretching, etc)

_____

Are you involved in legal action or disability claim related to your pain problem, or considering legal action in the future? Yes _____ No _____

If yes, please describe the current state of litigation: _____

_____

Insurance Information
MUST PRESENT CARD

Primary Insurance: _____ Subscriber: _____ Date of Birth: _____

Secondary Insurance: _____ Subscriber: _____ Date of Birth: _____

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Subscriber/Person Responsible for Payment of Account

Name: _____ Date of Birth: _____ Relationship: _____

Address: _____ Home Phone: _____

City, St., Zip: _____ Other Phone: _____

Patient Preferences (where we will send orders and visit notes)

Primary Doctor: _____

Pharmacy: _____

Laboratory: _____

Imaging: _____

IMAGING

Have you had any imaging (**CT/MRI/Xray**) **completed related to your visit**? ☐ Yes ☐ No

Test Type	Body Part	Date Performed	Location
X-Ray			
MRI			
CT			
EMG/Nerve Conduction			
Myelogram			

Conservative Treatment History

	When	Where	Did it help?
Physical Therapy			
Chiropractor			
Injections			

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Health History

Do you have any medication allergies? ☐ Yes ☐ No

If yes, please list below with the reaction to the allergy:

Medication	Reaction

Please list ALL medications which you are currently taking:

Please include all vitamins, supplements, herbs, and all **OVER THE COUNTER** medications

☐ Currently taking **NO Medications** (including over the counter)

Medication Name	Why you take this medication?

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SURGICAL HISTORY

Please list previous surgeries and the approximate year:

☐ **I HAVE NOT HAD ANY SURGERIES**

Type of Surgery	Year

PHQ-2 Screening

Over the last two weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things:
   ☐ Not at all ☐ Several Days ☐ More than half the days ☐ Nearly every day
2. Feeling down, depressed, or hopeless:
   ☐ Not at all ☐ Several Days ☐ More than half the days ☐ Nearly every day

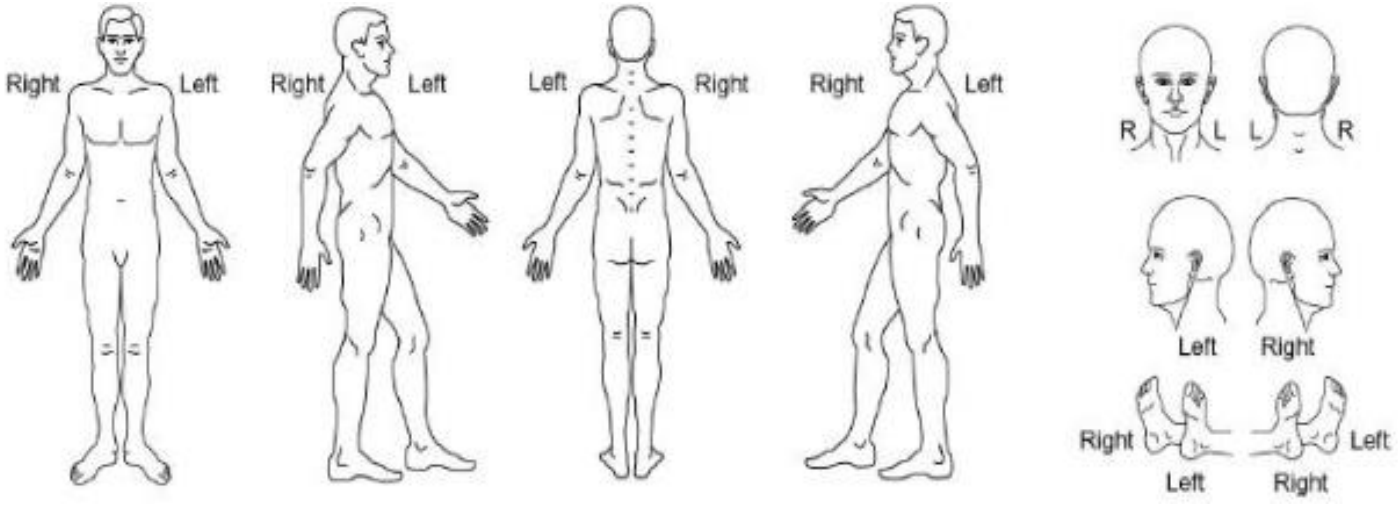
PEG Pain Score 0-10 (0 being no pain, 10 going to ER)

-What number best describes your pain on average in the past week: _____

-What number best describes how, during the past week, pain has interfered with your enjoyment of life: _____

-What number best describes how, during the past week, pain has interfered with your general activity: _____

Use the figures below to shade in and mark the areas where you have pain. If your pain moves around put an "x" where it starts and draw an arrow to where it spreads.



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Mark the following medical conditions for which you have a current diagnosis.

- ☐ Cancer – Type _____
- ☐ Anemia
- ☐ Heart Attack
- ☐ Coronary Artery Disease
- ☐ High Blood Pressure
- ☐ Peripheral Vascular Disease
- ☐ Stoke/TIA
- ☐ Heart Valve Disorders
- ☐ Presence of stent/pacemaker/defibrillator
- ☐ GERD (Acid Reflux)
- ☐ Gastrointestinal Bleeding
- ☐ Stomach Ulcers
- ☐ IBS/Crohns Disease
- ☐ Chronic Kidney Disease
- ☐ Kidney Stones
- ☐ Urinary Incontinence
- ☐ Dialysis
- ☐ Multiple Sclerosis
- ☐ Peripheral Neuropathy
- ☐ Seizures
- ☐ Balance Disorder
- ☐ Head Injury
- ☐ Headaches
- ☐ Migraines
- ☐ Glaucoma
- ☐ Vertigo
- ☐ Hearing Problems
- ☐ Nosebleeds

- ☐ Asthma
- ☐ Bronchitis/Pneumonia
- ☐ Emphysema/COPD
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Chronic Joint Pains
- ☐ Depression
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Bipolar Disorder
- ☐ ADD/ADHD
- ☐ PTSD
- ☐ Diabetes – Type_____
- ☐ Hyperthyroidism
- ☐ Hypothyroidism

Other Diagnosed Conditions

- ☐ _____
- ☐ _____

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-Acknowledgement of Receipt of Privacy Notice-

I acknowledge I have received a copy of Summit Surgical LLC, DBA Pinnacle Rehabilitation, DBA Mirage Imaging, DBA Summit Pain Notice of Privacy Practices effective April 2003.

-Authorization for Medical Care-

I hereby authorize Summit Surgical LLC, DBA Pinnacle Rehabilitation, DBA Mirage Imaging, DBA Summit Pain to provide me medical treatment for any and all conditions they deem appropriate. I understand the physician or other provider will review the recommendations for testing and/or treatment they deem appropriate for my medical needs based on their professional judgment.

-Referral Waiver-

I acknowledge in the course of my treatment, Summit Surgical LLC, DBA Pinnacle Rehabilitation, DBA Mirage Imaging, DBA Summit Pain may refer me to other health care facilities and/or providers for diagnostic tests, treatment, or consultation. Summit Surgical will notify me when such a referral occurs, Summit Surgical LLC, DBA Pinnacle Rehabilitation, DBA Mirage Imaging, DBA Summit Pain assumes no responsibility for knowing if the facility or provider I am referred to is contracted with my insurance plan. Should Summit Surgical LLC, DBA Pinnacle Rehabilitation, DBA Mirage Imaging, DBA Summit Pain make such a referral, it is my responsibility to verify my insurance coverage, eligibility, pre-certification (if applicable), and whether or not the facility or provider I am referred to contracts with my insurance company. Summit Surgical LLC, DBA Pinnacle Rehabilitation, DBA Mirage Imaging, DBA Summit Pain is not responsible should my insurance process claims at the non-contracting level for the referred service(s).

-Communication Preferences-

By signing below**, *I give permission to the person(s) listed to receive LIMITED information about my care***. I understand my healthcare provider will utilize their professional judgment to ensure that information is shared with family/friends in order to assist with my continuing care. **Any request for information not directly relevant to participation in care and any requests for copies of medical records will require a signed HIPAA compliant authorization.** This permission will be considered valid for one year unless otherwise revoked in writing.

Note: If you want to give an individual more access to your health information than offered below, you must complete a valid authorization form stating in detail the nature of the information you want released (see receptionist).

Please indicate your preferences below:

1. ☐ Do **NOT** share ANY information with anyone.
2. Please identify below individual(s) you would like us to share information with and mark the appropriate boxes regarding the type(s) of information we can share with each respective individual(s).

Name: _____ **Relationship:** _____

☐ Appointment Dates and Times ☐ Relevant Test Results & Treatment Recommendations ☐ Billing Information

Name: _____ **Relationship:** _____

☐ Appointment Dates and Times ☐ Relevant Test Results & Treatment Recommendations ☐ Billing Information

Physicians/Providers:

☐ You may also share information, including medical records, with the following physicians/providers who participate in my care:

Name: _____ **Name:** _____

College or High School Athletic Department: _____

☐ Appointment Dates and Times ☐ Relevant Test Results & Treatment Recommendations ☐ Billing Information

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* _____ _____ _____

Signature of Patient or Personal Representative **Printed Name/ relationship to patient** **Date**

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Patient Financial and Billing Consent Financial Policy

It is essential that you provide us with all pertinent insurance information: insurance card(s) and or workers compensation information, including the name and phone number for the adjuster and most importantly, the claim number. We will also ask for a photo ID.

1. Health plans. It is the responsibility of the patient to ensure the Summit Pain Clinic is an in-network provider and to determine your individual health plans co-pays, deductibles, co-insurances, and any other related fees you may be responsible for.
2. Demographic information. Patients are responsible to update the Summit Pain Clinic to all changes to insurance, address, phone numbers and other patient demographic information. Please present your ID card and all insurance cards at the time of check in.
3. Payments. Copays and outstanding balances are due upon check-in unless other arrangements have been made in advance. While our office can estimate your financial responsibility, it is ultimately the insurance company who determines your cost for your visit.
4. Payment Responsibility. I agree to pay for all services furnished to me by the Summit Pain Clinic, including, but not limited to charges that are not paid in full by my insurance, government program benefits or other third-party payers, except as prohibited by the Summit Pain Clinic's contract with my health plan or applicable law. I also agree to pay or reimburse the Summit Pain Clinic for all costs it may incur in collecting such amounts, including, but not limited to, attorneys' fees and collection agency fees.
5. Returned Checks. I acknowledge the $40 returned check fee on all checks returned to the Summit Pain Clinic for insufficient funds.
6. Responsibility for Services. Patients seen in an ambulatory surgical center or hospital may receive a separate bill from other facilities that also provided care. Keeping your insurance information up to date with our office ensures accurate billing. Certain procedures or services may not be included in your benefits package, or may be considered "not medically necessary", "experimental", or "investigative". Your insurance will not pay for these services, and you will be responsible for payment for any of those services. If we are in-network with your payer, we are required to notify you in advance of providing these services.
7. Payment plans: We understand that medical expenses can be a financial burden and our office is committed to working with you to establish a reasonable payment plan. Any patient with a balance of $500 or more will be required to pay their balance or set up a payment plan prior to scheduling an appointment.

Payment Authorization

1. Claim Billing. I authorize the Summit Pain Clinic to directly bill my health plan, third-party payer, or Medicare for services rendered to me by or on behalf of the Summit Pain Clinic but acknowledge that the Summit Pain Clinic is not obligated to submit claims to third-party payers on my behalf unless required by law or by its contract with a particular third-party payer. I also authorize my health plan, third-party payer, or Medicare to make payment directly to the Summit Pain Clinic for such services. I understand and agree that the Summit Pain Clinic is not responsible for collecting third-party payments or negotiating disputed settlements on my behalf. You may request an estimate of your charges prior to, during, or after receiving services from the Summit Pain Clinic.
2. Workers' Compensation. We require the Insurance Company Name, Name and Phone Number of Adjuster, Claim Number, Date of Injury, and Employer's Name and Address. We will submit your claim. If the claim is denied by the carrier or if the claim is in litigation, you will personally be responsible for payment of the charges.

Patient printed name: _____
Signature of Patient or Personal Representative: _____
If Representative, relationship to patient: _____
Date: _____