Samuel J. Alianell, MD
3117 College Park Dr. ste 210
The Woodlands, TX 77384
Phone (936) 321-0214 Fax (936) 271-0219

Private Insurance- Patient Profile

Samuel J. Alianell, MD
Appt Date & Time: _____
Reason for visit: _____

Referring Physician: _____
Primary Physician: _____
Referral on file: ( ) Yes ( ) No

Patient Information

Name: _____ DOB: _____ Age: _____

Address: _____ SS#: _____

City, St, zip: _____ Sex: ( ) M ( ) F

Home Phone: _____ Employer: _____

Cell Phone: _____ Work Phone: _____

Email address: _____

Primary Insurance

Insurance Company: _____

Address: _____

City, St, zip: _____

Phone: _____

ID# _____

Group# _____

Policy Holder: ( ) same as patient

Name: _____
Address: _____
City, St, zip: _____
SS#: _____
DOB: _____
Employer: _____
Phone: _____

Secondary Insurance

Insurance Company: _____

Address: _____

City, St, zip: _____

Phone: _____

ID# _____

Group# _____

Policy Holder: ( ) same as patient

Name: _____
Address: _____
City, St, zip: _____
SS#: _____
DOB: _____
Employer: _____
Phone: _____

I authorize payment of medical benefits to the undersigned physician or supplier for services rendered.

Patient Signature: _____ Date: _____

CPRC
Samuel J. Alianell, MD

AUTHORIZATION TO RELEASE INFORMATION

PATIENT INFORMATION

Patient name:	Date of birth:	
Social Security Number:		
Street Address:		
City:	State:	Zip:
Day Phone:	Evening Phone:	

INFORMATION TO BE RELEASED

I would like Dr. Samuel Alianell to release the following selected medical information

All Records	Billing Records	X-Ray/MRI Films & Reports
History & Physical	Progress Notes	Lab Reports
Mental Health	HIV Related	Operative Reports
Other:		

INFORMATION TO BE RELEASED TO

Name:	Company:	
Street Address:		
City:	State:	Zip:
Phone:	Fax:	

ACKNOWLEGEMENT

Dr. Samuel Alianell is hereby released from legal responsibility or liability for the release of the records to the extent indicated and authorized herein. I also understand that I may revoke this authorization at anytime and that in any event this authorization will automatically expire as described below.

This authorization will expire **ONE YEAR** from the date of my signature or as otherwise specified by the date, event, or condition as follows.

_____ _____

Signature of Patient, Parent/ Guardian *Date*

RELEASE TO DR. SAMUEL ALIANELL

I hereby authorize (doctor, clinic, or hospital) _____ to release my medical information to Dr. Samuel Alianell

_____ Copy of complete medical record. _____ Other: _____

_____ Please include all clinical notes, operative reports, imaging reports, and lab reports.

_____ Please exclude HIV status and testing results.

_____ Please include HIV status and testing results.

_____ _____

Signature of Patient, Parent/ Guardian *Date*

Chronic Pain Recovery Center (CPRC)
Samuel Alianell, M.D.

Patient name: _____ SS#_____
Insurance company: _____

Release of information: I hereby authorize CPRC to release any or all information acquired in the course of my examination and/or treatment that may be required to process claims for payment. I also authorize the release of information to another doctor or health care facility to which the patient may be transferred or referred.

Medicare Patients Certification: I certify that the MEDICARE information given by me is correct. As this office does accept assignment with Medicare, this information will be used for the purpose of processing my Medicare claims for payment. I understand, due to government regulations, that if Medicare coverage is available to me, I must inform my physician. I also understand, if in addition to Medicare, I am covered under an EMPLOYER GROUP HEALTH INSURANCE, LIABILITY, NO-FAULT WORKER'S COMPENSATION, or any other insurance which may be responsible for payment, I must inform this office.

I have read and understand the above statement regarding MEDICARE coverage.

_____ MEDICARE is my Primary coverage. _____ This is NOT a Work Related condition.

_____ MEDICARE is my Secondary coverage. _____ This IS a Work Related condition.

_____ I do not have MEDICARE/HMO.

_____ I do not have MEDICAID/HMO.

ASSIGNMENT OF BENEFITS: I hereby authorize payment to Dr. Samuel Alianell of the surgical and/or medical benefits, if any; otherwise payable to me for services I have received.

FINANCIAL OBLIGATION: The undersigned hereby unconditionally guarantees full and prompt payment of all charges incurred as a result of services rendered to me during the course of my medical treatment.

FINANCIAL DISCLOSURE: Dr. Alianell has a small ownership interest in Health Scripts Specialty Pharmacy and Global Molecular Labs. He also is an owner/shareholder in Compliance Toxicology LLC and Chronic Pain Recovery Center Holdings LLC.

_____ _____
Signature of Insured/Guardian Date Witness Date

Patient: _____ DOB: _____ Date: _____

General Medical History

Emergency contact name, relation, and phone number(s):_____

Please give first and last name of the doctors below. If you don't know the first name, please try to give initial.

Primary Care Physician: _____

Referring Physician: _____

History of present illness (circle all that apply):

You are: R Handed L Handed Ambidextrous

Where are you having pain? _____

How long have you had this problem? _____

Is this a legal or third person liability case? No Yes Potential

Date of Injury: _____

Work Comp Motor Vehicle Accident Where did you get hurt? Home / School / Work / Store / Car

Do you have any lifting restrictions?_____

How did you get hurt? _____

My pain is: ( ) sharp ( ) dull/achy ( ) burning ( ) tingling ( ) shooting

I have:
- ( ) Weakness (from pain) in my: ( ) R arm ( ) L arm ( ) R leg ( ) L leg
- ( ) Specific weakness in my: ( ) R arm ( ) L arm ( ) R leg ( ) L leg
- ( ) Numbness of my: ( ) arms ( ) hands ( ) legs ( ) feet
- ( ) Tingling of my: ( ) arms ( ) hands ( ) legs ( ) feet
- ( ) Leg pain when I walk: ( ) less than a block ( ) 1-3 blocks ( ) >3 blocks
  ( ) this pain improves if I stand still
  ( ) this pain improves only if I sit or lean forward
- ( ) Bladder (urine) trouble ( ) Loss of urine (accidents) ( ) Can't empty
- ( ) Bowel trouble ( ) Loss of control (accidents) ( ) Constipation
- ( ) Pain worst at night

Treatment:

( ) None

( ) I have previously seen these physicians: _____

_____

I have had the following:		Did it help?	Y	N
Medications:	( ) Anti-inflammatory _____		( )	( )
	( ) Muscle relaxers _____		( )	( )

( ) Pain Pills _____ ( ) ( )
( ) Others _____ ( ) ( )

( ) Traction
( ) Injections (describe) _____
( ) Physical Therapy
( ) Chiropractor
( ) Spine Surgery (age, who was the surgeon, what was done?)

_____

_____

		Date		Date
Tests:	( ) X-rays	_____	( ) EMG	_____
	( ) MRI	_____	( ) Discogram	_____
	( ) CAT Scan	_____	( ) Myelogram	_____

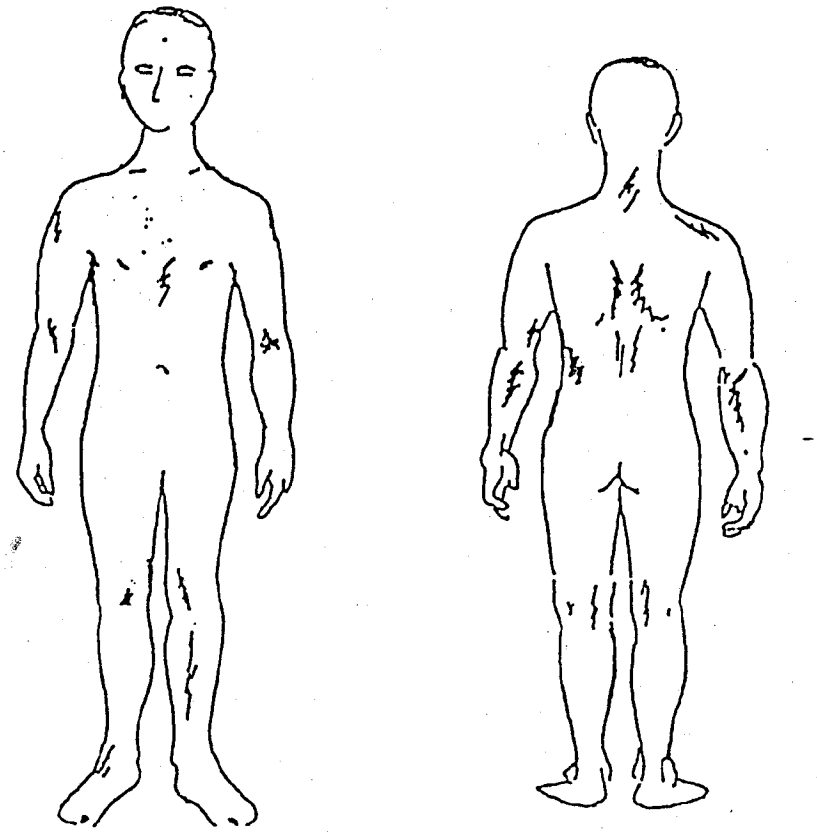
I feel better with: ( ) bed rest ( ) reducing activities ( ) bending forward
( ) heat ( ) massage ( ) bending backward
( ) ice ( ) other: _____

I feel worse with: ( ) activity ( ) sitting ( ) standing ( ) walking
( ) bending forward ( ) bending backward
( ) sneezing ( ) going to the bathroom ( ) other: _____

Past Medical History / Conditions / Disease (circle all that apply)

Anemia	Diabetes	Hypothyroidism	Poor Circulation
Angina	Diabetic Foot Ulcer	Irregular Heart Beat	Pregnant? Circle 1 Yes No
Anxiety	Dialysis	Kidney Failure	Pulmonary Embolism
Asthma	Diverticulitis	Liver Problems	Reflux
Bleeding Disorder	Emphysema	LMP:	Rheumatoid
Blood Clot	GI Bleed	Lupus	Seizures
Cancer: Type/Status	Heart Attack	Migraines	Sleep Apnea
Chronic Back Pain	Hepatitis A, B, C	Neurological Disorder	Stroke
Congestive Heart Failure	High Blood Pressure	Numbness/Tingling	Ulcers
Depression	HIV	Urinary Tract Infection	Other:

Mark an “X” wherever you feel the pain.



Medications/Supplements or Over the Counter Drugs

Name Of Medication	Strength/Dose	Reason For Medication

Allergies to medications/medical equipment, YES or NO? If yes, list item and type of reaction it caused:

_____

_____

Surgical History

Surgeries or Hospitalization	Year	Complications (if any)

Medical History: Overall level of physical health is: Excellent, Very Good, Good, Fair, Poor

Immunizations up to date? Yes No

Have you ever had any complications from surgery? Yes No

Have you ever had any problems with anesthesia? Yes No

If yes, describe: _____

Family History

Has anyone in you family had: (circle all that apply):
Diabetes, Heart Attack Female under age 65, Bleeding disorder, Anesthesia problem
Cancer, Rheumatoid arthritis, Osteoporosis, Heart Attack Male under age 55

Social History
Marital status: circle: Single Married Divorced Separated Widowed
Children: Yes No

Do you live alone? No Yes If no, who do you live with? _____
Do you wear glasses or contacts? Yes No, which one? _____
Occupation: _____
What kind of work? Physical, Sedentary, Retired, Homemaker
Regular Duty Light Duty Off Work since _____ Reason: _____

Risk Factors:
Current Smoker? No Yes _____# of packs/day for _____ years
Quit Smoking? This year over 1 year ago
Previously smoked? _____#packs/day for _____ years
History of substance/drug abuse? No Yes, what? _____
Drink alcohol?No Occasionally Frequently
Exercise? Daily Weekly Monthly Rarely Never
What type of exercise? _____

Review of systems: Are you currently having or have you had problems with your:
Please circle all that apply and explain if necessary.

General Health:	Fever/Chills	Fatigue	Sleep Problems	
Eyes:	Blurry vision	Double vision		
Ears/Nose/Throat:	Decreased hearing	Sore throat	Ears ringing	
Cardiovascular:	Chest pain	Fainting		
Respiratory:	Shortness of breath	Cough		
Gastrointestinal:	Heartburn/Constipation	Nausea/Vomiting/Diarrhea	Rectal Bleeding	
Genitourinary:	Pain on urination	Incontinence	Increased frequency	
Musculoskeletal:	Joint Swelling	Cramps	Weakness	
Dermatological:	Rash	Itching		
Neurological:	Numbness/Tingling	Loss of balance	History of Seizures	
Psychological:	Anxiety	Depression		
Endocrine:	Weight change	Thirsty all the time		
Allergy/Immunology:	Hives	Hay fever		
Hematology:	Easy bruising	Bleeding	Edema	Enlarged lymph nodes

CHRONIC PAIN RECOVERY CENTER (CPRC)

NOTICE OF PRIVACY PRACTICES

PLEASE READ THIS NOTICE CAREFULLY. IT DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. AFTER RECEIVING THIS NOTICE YOU WILL BE ASKED TO CONSENT TO THE USE OF YOUR INFORMATION AS DESCRIBED.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF CPRC'S NOTICE OF PRIVACY PRACTICES.

PATIENT NAME: _____

PATIENT SIGNATURE: _____

DATE: _____

FAMILY AND FRIENDS CONTACT FORM

Persons who are involved in you care (family, friends, other doctors, etc.) may inquire about your treatment, lab results, prescriptions, etc. Please let us know what persons we may share information with. (Please note: In emergency situations or other situations outlined in our Notice of Privacy Practice we may share information with others who are not specifically listed on this form.)

Please list those persons (including Family, Friends, Previous Treating Physicians, your Family, Doctor (PCP), and other doctors/specialists) with whom we may share your information:

_____

_____

_____

_____

_____

What is the best phone number for us to contact you?
Phone Number: _____
What is this number (home, work, cell, other)? _____

From time to time we will leave a message for you on an answering machine, voice mail, or with another individual in your absence. Is it okay for such messages to include details (such as diagnosis and medication information) at this number? _____

What other ways may we contact you? Please list any that are acceptable ways to reach you.
Home phone number: _____
Is it okay to leave a detailed message at this number in your absence? _____
Work number: _____
Is it okay to leave a detailed message at this number in your absence? _____
Cell Phone number: _____
Is it okay to leave a detailed message at this number in your absence? _____
Other: _____
Is it okay to leave a detailed message at this number in your absence? _____

_____ _____
Signature of Patient or Legal Representative Date

_____
Print name of Patient or Legal Representative Relationship to Patient

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT
AS REQUIRED BY THE TEXAS MEDICAL BOARD
REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9, CHAPTER 170
3Rd Edition: Developed by the Texas Pain Society, April2008 (www.texaspain.org)

NAME OF PATIENT: _____DATE: _____

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to use the drug(s) recommended to you by me, as your physician. For the purpose of this agreement the use of the word "physician" is defined to include not only my physician but also my physician's authorized associates, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat my condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician (name at bottom of agreement) to treat my condition which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent for my physician to administer or write prescription(s) for dangerous and/or controlled drugs (medications) as an element in the treatment of my chronic pain.

It has been explained to me that these medication(s) include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT HAVE BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT (THIS IS SOMETIMES REFERRED TO AS "OFF-LABEL" PRESCRIBING). MY DOCTOR WILL EXPLAIN HIS TREATMENT PLAN(S) FOR ME AND DOCUMENT IT IN MY MEDICAL CHART.

I HAVE BEEN INFORMED AND understand that I will undergo medical tests and examinations before and during my treatment. Those tests include random unannounced checks for drugs and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances may result in my being discharged from your care.
For female patients only:

To the best of my knowledge **I am NOT pregnant.**
If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment. I accept that it is **MY responsibility** to inform my physician immediately if I become pregnant.

If I am pregnant or am uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY.

All of the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics to assure complete safety to my unborn child (ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo/ fetus / baby.

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension(low blood pressure), arrhythmias(irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medication(s) for the treatment of my chronic pain.

The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and active life. I realize that I may have a chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored specifically for me. I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time and that I will notify my physician of any discontinued use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

I understand that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of medications to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

PAIN MANAGEMENT AGREEMENT:
I UNDERSTAND AND AGREE TO THE FOLLOWING:

That this pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called ‘narcotics, painkillers’, and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). **Therefore, medication(s) will only be provided so long as I follow the rules specified in this Agreement.**

My physician may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior:

My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the **medication(s) may be discontinued**.

I will **disclose** to my physician **all medication(s)** that I take at any time, prescribed by any physician.

I will use the medication(s) **exactly as directed by my physician**.

I agree **not to** share, sell or otherwise permit others, including my family and friends, to have access to these medications.

I will **not allow or assist in the misuse/diversion of my medication**; **nor will I give or sell them** to anyone else.

All medication(s) must be obtained at **one pharmacy, where possible**. Should the need arise to change pharmacies, my physician must be informed. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my physician to release my medical records to my pharmacist as needed.

I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money**. If either are lost or stolen, they may NOT BE REPLACED.**

Refill(s) **will not be ordered before the scheduled refill date**. However, early refill(s) are allowed when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.

I will receive medication(s) **only from ONE physician** unless it is for an emergency **or** the medication(s) that is being prescribed by another physician is approved by my physician. Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.

If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then **my physician may try alternative medication(s) or may taper me off all medication(s**). I will not hold my physician liable for problems caused by the discontinuance of medication(s).

I **agree to submit to urine and/or blood screens** to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), such as marijuana, speed, cocaine, etc., treatment for chronic pain may be terminated. Also, a consult with, or referral to, an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an addictionologist or a physician who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.

I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize **that my active participation** in the management of my pain is extremely important. I agree to **actively participate in all aspects of the pain management program** recommended by my physician to achieve increased function and improved quality of life.

I agree that I **shall inform any doctor** who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.

I hereby give my physician **permission to** discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).

I must take the medication(s) as instructed by my physician. **Any unauthorized increase** in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.

I must **keep all follow-up appointments** as recommended by my physician or my treatment may be discontinued.

I will not consume **alcohol** while I am taking pain medication

I certify and agree to the following:

1) I am **not currently using illegal drugs or abusing prescription medication**(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

2) I have **never been involved** in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.)

3) **No guarantee or assurance has been made** as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life.

4) I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain. **I fully understand the explanations regarding the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.**

_____

Patient Signature

_____

Physician Signature (or Appropriately Authorized Assistant)

_____

_____

Name and contact information for pharmacy

Samuel Alianell, M.D. P.A.

American Board of Physical Medicine and Rehabilitation
American Board of PM&R Subspecialty of Pain Medicine
American Board of Electrodiagnostic Medicine

3117 College Park Dr St 210
Conroe, TX 77384
Phone: 936-321-0214 Fax: 936-271-0219

PATIENT INFORMATION

Thank you for choosing Dr. Samuel Alianell! We welcome you and look forward to a long relationship together. Office hours are Monday through Friday, 8:00AM to 5:00 PM. We are not open on evenings or weekends.

Insurance companies place restrictions on what can and cannot be reimbursed. Patients often ask for services not covered by insurance and when this happens, the financial responsibility is shifted from the insurance company to the patient. No one likes surprises- especially those with a financial impact. Listed below are fees associated with services not covered by insurance. Most of these fees can be avoided with careful planning. Help us help you!

Billing Office Phone numbers
Dale Billing Resources: (281) 419-9669.

Appointment Cancellation

If you are unable to keep your appointment, please call the office 24 hours in advance. If less than 24 hours notice is received, a charge of $50.00 will be incurred. The intent of the fee is to ensure access to Dr. Alianell for patients who need care. This appointment was set aside for you and when you no show or cancel with less than 24 hours notice, another patient who is in pain cannot receive the care they need. With 24 hours notice, we are often able to fit a patient in who might otherwise have to wait.

"Is it covered by my insurance plan?"

If an insurance company limits you to a list of certain drugs or facilities, please tell us. Bring the listing of approved drugs and providers with you to every office visit with Dr. Alianell. Rewriting prescriptions after you leave the office to suit your insurance plan is $14.

Prescription Refills and Prior Authorizations

We want to provide the best and most accurate healthcare possible. Medication is prescribed in person, and in writing, at your appointment. If you pick-up a prescription without an appointment, there is a $14 charge (determined by treatment guidelines).

If your insurance company requires a Prior Authorization, there is a $20 charge. This is a service not included in your office visit. The charge is reduced to $14 if you provide the form to be completed (obtained from your insurance company).

Fee for Service

We file your insurance for office visits as a courtesy. We are required by insurance companies and Medicare to collect co-payments.

However, if your insurance company fails to pay on your behalf after we submit the appropriate paperwork, you are responsible for the fee associated with the service rendered by the doctor. We look to you for payment, not the insurance carrier, unless you are covered by worker's compensation. If there is a problem with your insurance carrier, we need you to resolve the problem directly with them. This is true for Medicare, co-insurance, or other insurance.

Check Returns

A fee of $35 will be charged for each check returned for insufficient funds.

Disability, FMLA and Insurance Forms

There is a fee of $30.00 per form.

Phone Calls

It is the policy of this office that phone calls are returned within 24 hours from the time the message is received, although every effort is made to return call the same day. However, phone messages received after 3:30PM will not be returned until the following business day.

After business hours, non-emergency calls *will* be subject to a $50.00 charge. These charges are not covered by most insurance plans.

Medical Records

There is a $25.00 fee for the first 20 pages and $.50 for each additional page to copy your medical records for your personal use. For patient protection and confidentiality reasons, we require the patient to personally sign an Authorization to Release Medical Records when requesting personal copies. These records may be picked up by the patient. There is no charge to you for sending a copy of your medical record to a referring physician.

Acknowledgement that I have read and understand the patient information packet.

I acknowledge that I have read the information on page 1 and 2 of this packet.

_____
Print Name

_____
Signature

_____
Date