



SUNSHINE SPINE & PAIN, P.A.

WWW.SUNSHINESPINE.COM

Arkam Rehman, M.D.

PATIENT REGISTRATION FORM

Today's Date: _____

Patient Information

Name :

Sex: Male Female

Social Security #:

Date of Birth:

Home Address:

City, State:

Zip Code:

Home Phone:

Cell Phone:

Email Address:

Employer:

Mailing Address (If Different):

Marital Status

Please Check One:

Single Married Divorced Widow

If Married Spouse Name:

Spouses Phone #:

Spouse Social Security #:

Date of Birth:

Employer

Health Information

Are you currently here as a result of an **AUTO** accident?

Yes No

Do you have an **OPEN CLAIM OR CASE** for an auto accident? If yes, please fill out the page titled **AUTO**.

Yes No

Are you currently here as a result of an accident that happened on the job and is connected to a **WORKERS**

COMPENSATION case? If yes, please fill out page titled **WORKERS COMPENSATION**.

Yes No

Patient Information Continued

Race: (please check one)

White Black Hispanic

Asian/Pacific Islander Indian

Other: _____

Language: English Spanish

Other: _____

Ethnicity: Latino or Hispanic

Not Latino or Hispanic

Declined to answer

Emergency Contact:

Emergency Contact Number:

Referring Physician:

Primary Care Physician:

Health Insurance

What is your Primary **Health** Insurance?

Policy/ID #:

Group #:

Policy Holders Name:

Date of Birth:

What is your Secondary **Health** Insurance?

Policy/ID #:

Group #:

Policy Holders Name:

Date of Birth:

It is your responsibility as a patient of Sunshine Spine & Pain, PA to provide us with your accurate insurance information at the time of service. If another party (auto, w/c, legal attorney) is responsible for paying for your treatment, you must give us that information. Otherwise, you will be financially responsible. (Please Note: we only have 30 days in which to file your claim and get reimbursed from auto insurance.)



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CONSENT FOR TREATMENT

I hereby consent and authorize the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment at **SUNSHINE SPINE AND PAIN, P.A.**

PRIVACY NOTICE ACKNOWLEDGEMENT

During the course of your treatment it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared:

- During treatment, we may find it necessary to acquire a laboratory analysis.
- During your treatment, a referral to other services may be necessary.
- During health care operations, we may need a second opinion.
- During the payment process, we may need to release notes and other laboratory results.
- Release information to legal authorities or case workers.

I acknowledge that I have had the opportunity to review a copy of the **SUNSHINE SPINE & PAIN, P.A NOTICE OF PRIVACY PRACTICES**. I understand that I am responsible for reading this notice and for notifying Sunshine Spine and Pain, P.A. in writing of any request for restrictions in the use or disclosure of my individually identifiable health information. I understand that the notice includes electronic access to my medication history. Sunshine Spine and Pain, P.A. has the right to revise this notice at anytime and will post a copy of the current notice in the office in a visible location at all times. Sunshine Spine and Pain, P.A. may also provide me with a copy of its most recent notice upon my request.

CONSENT FOR DISCLOSURES

We understand that at times you may need members of your family or friends to contact the office to make inquiries about your health status, diagnosis, treatment options, schedule, reschedule, cancel appointments or to be contacted in the event of an emergency. To do so, please list the person, or persons you are authorizing to make such inquires or changes. Please be advised that we may require them to confirm personal information to verify their authorization, such as your date of birth.

Our commitment here at Sunshine Spine and Pain, PA is to serve our patients in a professional, courteous, and caring manner. Therefore we ask that all members of your party conduct themselves in that same manner while in the office or on the phone. Any inappropriate behavior and/or rudeness to the staff for any reason, is not tolerated and are grounds for discharge

Name: _____ Relationship: _____ Contact #: _____

Name: _____ Relationship: _____ Contact #: _____

I DO NOT give authorization for medical information, lab work results and any other information regarding my appointments or treatment to be released to anyone _____.
(Your Initials)



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FINANCIAL POLICY AND AGREEMENT

I understand that in consideration of the services provided to me, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered by Sunshine Spine & Pain, PA. I am responsible for any applicable deductible, co-payments and coinsurance prior to the provision of services. Sunshine Spine & Pain, PA may file ALL claims for payment with my insurance company as a courtesy to me. If the insurance company fails to pay in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts due. Payments may be made in the form of check, Visa, Mastercard, and Discover. Should my account be referred to a collection agency and/or attorney for collection, the undersigned agrees to pay all collection fees and/or attorney fees associated with the collection of this debt.

I hereby authorize and assign all payments, insurance or Medicare benefits for medical services and/or procedures rendered to the me, directly to Sunshine Spine & Pain, PA. I hereby authorize Sunshine Spine & Pain, PA to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by my insurance company or Medicare.

If my insurance company requires me to obtain referrals/authorizations, it is my responsibility to obtain such and if not, then I will be responsible for any unpaid balance.

By signing this agreement, I acknowledge that I have carefully read, understand and agree to the above terms and conditions. I also understand that it is mandatory to tell Sunshine Spine & Pain, PA if another party is responsible for paying for my treatment (i.e. Automobile Insurance, Workers' Compensation, slip and fall). Section 1128B of Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

MEDICAID INSURANCE WAIVER

This notice is to inform all patients that we are **NOT MEDICAID PROVIDERS**. If you decide to seek treatment at Sunshine Spine and Pain, P.A., **you are required to sign this waiver in acknowledgment that you have received this waiver (even if you do not have Medicaid insurance)**, and that you will be responsible for any portion of your bill that is not covered by any other insurance.

FEE POLICY

Appointment Cancellation/No Show Fees:

If you do not call within **24hrs of your scheduled appointment** to cancel, reschedule, or if you “no show” for a scheduled appointment, the following fees will apply:

- Follow up = \$50.00
- Injections = \$100.00
- Stim Adjustment = \$50.00
- EMG/Nerve Conduction Study = \$100.00
- Medical Botox = \$150.00
- Stim Trial/Radiofrequency = \$300.00
- Hospital Procedures = \$300.00

Medical Records Fees:

If you are requesting a copy of your medical records, a signed authorization to release your records is required before we can process any requests. As a courtesy we will release a copy of your records to a physician of your choice with a signed release form and appropriate forwarding information for that physician free of charge. Any additional requests will be charged a fee (see below) and must be paid in full prior to pick up. Please note the final charge will include postage if you are requesting your records to be mailed. All records are processed out of our Baptist South location and must be picked up at that location. Fees for copies of medical records are as follows:

\$1.00 per page for the first 20 pages, \$0.25 per page thereafter

Paperwork Fees:

(Disability FMLA, etc.)

It is the patients responsibility to ensure all disability paperwork is provided during their office visit in a timely fashion.

Physician Progress Report \$25.00 FEE	2 PAGES \$25.00 FEE	3 PAGES OR MORE \$40.00 FEE
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One page paperwork will be completed at **NO ADDITIONAL CHARGE**. Payment must be collected prior to any forms being completed by your provider. You will need to allow 7-10 business days for the provider to complete these forms. Once the forms are completed, our office will call you to arrange for pick up. You are responsible to ensure that your forms are sent to the appropriate place within the time frame required.

By signing this agreement, I acknowledge that I have carefully read, understand, and agree to the terms and conditions of the Consent for Treatment Agreement, the Privacy Notice Acknowledgment, the Consent for Disclosure, the Financial Policy and Agreement, the Medicaid Insurance Waiver, and the Fee Policy. I have completed these forms accurately and to the best of my knowledge and will be financially responsible if I have failed to provide Sunshine Spine and Pain, P.A. with all of my applicable insurance information.

Patient/Legal Guardian Name (print): _____

Patient/Legal Guardian Signature: _____

Date: _____



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NARCOTIC MEDICATION POLICY/CONTRACT

You **MAY** be given narcotic medication for the treatment of your pain. **If you choose to receive medications from our practice, then you are to abide by the terms of this narcotic contract. If you are choosing NOT to receive medication from our practice, you are still required to complete this form in its entirety in acknowledgment of receiving this policy.** Please **read each statement and sign** this contract below. If you have any questions regarding this, please request clarification from the medical staff.

Any medical treatment is initially a trial and continued prescription/s are based on evidence of benefit. I understand that the goal of using narcotics is to decrease my pain, increase my functional level and to improve the overall quality of my life.

I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, lightheaded, dizziness, confusion, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, kidney or liver disease, sexual dysfunction, physical dependence, tolerance to analgesia, addiction, withdrawal and the possibility that the medicine will not provide complete relief. The overuse of narcotic medication can result in serious health risks including respiratory depression or even death. This medication will be strictly monitored and all of my medications should preferably be filled at the same pharmacy.

Patient must initial each statement below and by initialing, the patient acknowledges what is expected of him/her by the physician. With any violation of this contract, the physician has the right to discharge you as a patient from the clinic.

(Initial)

- **PATIENT WILL NOT USE ANY ILLEGAL SUBSTANCE** _____
- **ABSOLUTELY NO ALCOHOL USE** _____
(Including but not limited to beer, wine, liquor etc.) _____
- **I agree to use good judgment regarding my ability to drive while taking controlled substances** _____
- **Patient will not obtain scheduled substances from another provider without notifying physician.**
- **Patient will not change their dose without prior discussion with physician.**
- **Patient will not be given early refills on medications that are being overused/lost/stolen.**
- **Patient will give a RANDOM urine specimen for drug testing when asked.**
- **Patient will not take old prescribed medications as well as take other people's prescribed medications.**
- **I understand that I am required to bring in medications for counting anytime my Provider requests it due to reasons such as suspecting overuse.**
- **I agree to bring in any left over medications for proper disposal if a medication change is to be made.**

Please continue to read each statement below that is also expected of you by the physician.

- I agree to always conduct myself in a courteous manner with staff while in the office or on the phone. It is my responsibility to ensure that all members of my party also conduct themselves in the same manner. I understand that any inappropriate behavior and/or rudeness by me or anyone accompanying me at my appointment is grounds for my discharge from the clinic.

- I will inform Sunshine Spine and Pain, P.A. of any changes in my medical condition, any changes in any prescription and/or over the counter medication that I take and of any adverse affects or problems that I may experiencing from any of the medications that I have been prescribed to me by this clinic or any other clinic.
- I agree to tell Sunshine Spine and Pain, P.A. my complete and honest personal drug / medication usage and history and if I have been in any drug or alcohol rehabilitation programs in order for the physician to make the best clinical decisions for my care.
- “Random” drug screening will be performed to monitor my adherence to/compliance of my treatment plan. I agree to have the random drug screen performed on the day the physician/clinical staff requests it.
- **A “random” drug screen ordered by the physician can consists of either a urine drug test, oral drug screen test that is done on site or a requisition form to a specific lab that must be done within 24 hours of my office visit in order to be compliant. Not completing a random drug screen is a violation of this contract and is grounds for discharge by the physician.**

I will also inform the physician/provider at Sunshine Spine and Pain, P.A., if I have had or begin to have suicidal/homicidal thoughts at any time during my treatment with this clinic. In the event I begin to have these thoughts, I will contact the office immediately.

I agree to advise the physician if there is a confirmed pregnancy by a physician/lab or if I suspect that I may be pregnant. If applicable.

I also understand that in the event I am given a medication warning for violating this narcotic contract that financial hardships and/or previous payment arrangements may be considered null and void and any balances would be due in full.

If, in the sole opinion of the physician, I violate any of the above, I understand that Sunshine Spine and Pain, P.A. will include any and all such violations in my file and shall immediately discharge me as a patient. Sunshine Spine and Pain, P.A., will forward my files and records to a new physician of my choice at my request.

I give my consent to Sunshine Spine and Pain, P.A., and all its employees to make report to or otherwise cooperate with any law enforcement officials or regulatory agencies in any investigation which may arise as a result of my receiving prescriptions as a patient of Sunshine Spine and Pain, P.A. I waive any and all rights of privacy and privilege in this regard and these authorities may be given full access to my records upon written request to Sunshine Spine and Pain, P.A. without order of clerk or court.

By signing this agreement I affirm that I have read, understand and accept all of the terms of this Narcotic Medication Contract.

Patient/Legal Guardian Name (print): _____

Patient/Legal Guardian Signature: _____

Date: _____

(updated 07/08/16 ac)

Orange Park Hospital Clinic
2021 Kingsley Ave, Suite 109
Orange Park, FL 32073

Baptist South Hospital Clinic
14540 Old St. Augustine Rd, Suite 2397
Jacksonville, FL 32258



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AUTO & WORKER'S COMPENSATION FORM

Patient Name: _____ Date of Birth: _____

AUTO INFORMATION

If you are requesting treatment for injuries sustained in an auto accident, and have an open auto claim or case, please complete this form. Individuals seeking PIP medical benefits **must receive initial services and care within 14 days** after the motor vehicle accident. Initial services and care are only reimbursable if lawfully provided, supervised, ordered, or prescribed by a licensed physician, licensed chiropractic physician, licensed dentist, or must be rendered in a hospital, a facility that owns or is owned by a hospital, or a licensed emergency transportation and treatment provider. **Follow up services and care requires a referral from such providers and must be consistent with the underlying medical diagnosis rendered when the individual received initial services and care.**

Name of Auto Insurance Carrier: _____ Auto Policy # _____
Name of Insured: _____ Claim # _____
Date of Accident: _____ **Date of First Treatment:** _____
Body Parts Injured: _____ Doctor/Facility Name: _____
Adjuster's Name: _____ Phone#/Ext: _____ Fax: _____
Auto Insurance Billing Address: _____
What State Did This Occur In? _____ Do you have an Open Legal Case? Yes No
Attorney Firm: _____ Attorney Name: _____
Phone #: _____ Fax #: _____ Legal Case #: _____
Date Legal Case was Opened: _____

I _____, hereby authorize and direct _____ to send to Sunshine Spine & Pain, P.A. An accounting of payouts made under **all claims** submitted for payment under the above referenced policy relating to the auto accident occurring on the above referenced date **as those payouts occurred.**

WORKERS' COMPENSATION INFORMATION

If you are requesting treatments for injuries sustained while at work, have an open workers' compensation claim or case, please complete this form. Please note: We must have authorization from your workers' compensation adjuster before any treatment can be provided.

Employer: _____ Date of Injury: _____
Body Parts Injured: _____ Claim #: _____
Workers' Comp. Insurance Name: _____
Adjuster's Name: _____ Phone#/Ext: _____ Fax: _____
Claims Mailing Address: _____
Attorney Firm: _____ Attorney Name: _____
Phone #: _____ Fax #: _____ Legal Case #: _____
Date Legal Case was Opened: _____

I have completed this form with accurate and truthful information about the above mentioned incident.

Patient/Legal Guardian Signature: _____ **Date:** _____