Dr. Eric Solomon, DO
1395 South Marietta Parkway Bldg. 100 - Suite 102 - Marietta GA 30067
Phone: (770) 425-8700 | Fax: (770) 425-8740 | www.PRCMD.com

PATIENT DEMOGRAPHICS

PATIENT NAME:_____ DOB:_____ DATE:_____

ADDRESS: _____

EMAIL ADDRESS:_____ CONTACT PHONE# _____

SS#_____ EMPLOYER: _____

ONLY ONE PHARMACY MAY BE USED FOR PRESCRIPTIONS. MY PHARMACY'S NAME & LOCATION IS:

_____

(List Name and address of Pharmacy)

_____

PRIMARY INSURANCE COMPANY:_____INSURANCE ID#_____

INS GROUP #_____POLICY HOLDER NAME:_____

POLICY HOLDERS ADDRESS(If different from above): _____

POLICY HOLDERS DOB:_____POLICY HOLDER'S SS#_____

POLICY HOLDER'S RELATIONSHIP TO PATIENT: SELF___ SPOUSE___ PARENT___ OTHER_____

POLICY HOLDER'S EMPLOYER:_____ EMPLOYER'S PHONE #:_____

SECONDARY INSURANCE COMPANY:_____INSURANCE ID#_____

INSURANCE GROUP #_____ POLICY HOLDER'S NAME:_____

POLICY HOLDERS ADDRESS(If different from above): _____

POLICY HOLDERS DOB:_____POLICY HOLDER'S SS#_____

POLICY HOLDER'S RELATIONSHIP TO PATIENT: SELF___ SPOUSE___ PARENT___ OTHER_____

_____

PLEASE COMPLETE: IN CASE OF AN EMERGENCY OR IF PATIENT IS A MINOR

CONTACT PERSON'S NAME: _____DOB:_____

RELATONSHIP TO PATIENT: _____ SS#_____

ADDRESS:_____ CONTACT #:_____

_____

**WHO MAY WE THANK FOR THE REFERRAL?_____

I authorize the physicians at the chronic Pain Clinic of America, LLC to treat my illness or injury. I hereby authorize the release of any medical information necessary to process my claim and I authorize payment of medical & surgical benefits to said clinic. if my insurance company denies payment for any reason, I will be responsible for the balance of the account. I understand that my co-payment is due at the time of service.

SIGNATURE:_____ DATE: _____

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NEW PATIENT MEDICAL HISTORY

Patient Name:_____Height_____Weight: _____

PCP:_____Referring Physician:_____Off. Ph#_____

Where is your main Pain Located? (One Area Only):_____
Ask for another page for additional areas

When did your pain begin?_____

What caused your pain to begin?_____

Circle any of these that describe your pain: Aching Dull Burning Sharp Shooting Spasm

Other:_____

When you have pain,how long does it last?_____Is it Constant ____or Intermittent____

Circle what aggravates or makes your pain worse: Sitting Standing Walking Bending Lying down

Other:_____

Is your pain associated with any of the following? Weakness?___ Where?_____

Numbness?___Where?_____

Tingling?___ Where?_____

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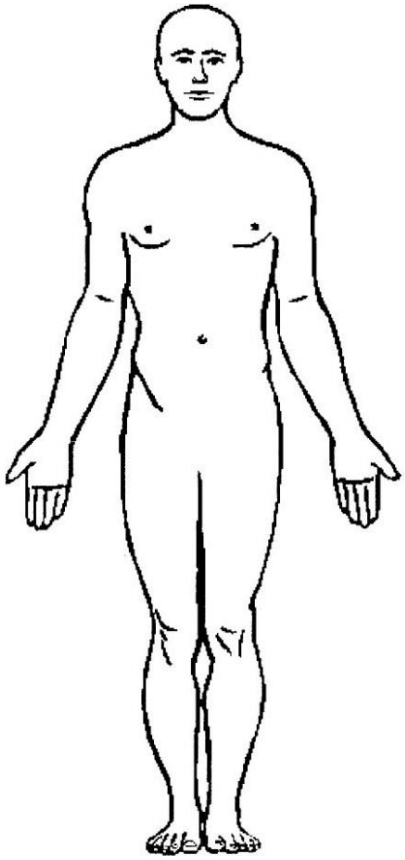
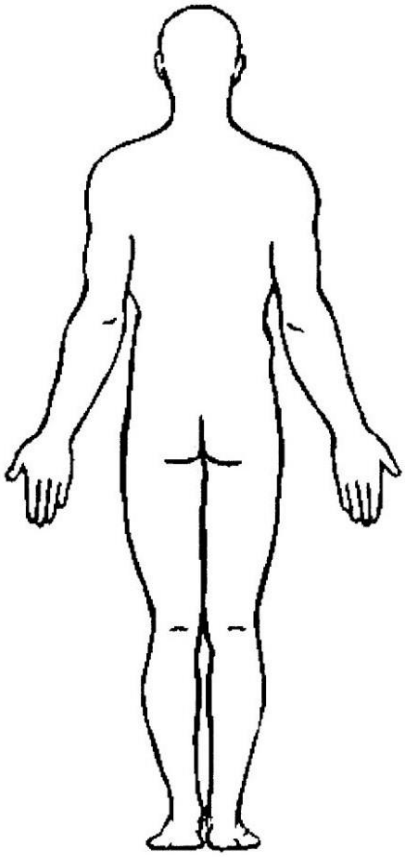
PAIN DRAWING: Mark the drawings according to where you hurt (i.e., if the right side of your neck hurts, mark the drawing on the right side of the neck, etc.). Please indicate which sensations you feel by referring to the key below.

KEY: Stabbing /// Burning XXX Pins & Needles 000 Numbness === Aching +++



Right



Left Right

PAIN LEVEL	KEY
0 1 2 3 4 5 6 7 8 9 10 Circle your current pain level **0 1 2 3 4 5 6 7 8 9 10** Circle your pain at its worst Does the pain affect your sleep? YES _____ NO _____	0 = No pain 1 = Mild pain 2 = Moderate pain tolerated without medication 3 = Moderate pain that requires medication to tolerate 4-5 = More severe pain: you begin to feel antisocial 6 = Severe pain 7-9 = Intensely severe pain 10 = Most severe pain

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Do you ever drink alcohol? Yes___ No___ How much?_____

Have you had a drink in the past 24 hours? Yes___ No___

Have you ever had a problem related to alcohol? (e.g. DUI, Injury, Break Up, etc.) Yes___ No___

Check the Appropriate Boxes:

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol		
Illegal drugs		
Rx drugs		
Personal history of substance abuse		
Alcohol		
Illegal drugs		
Rx drugs		
Age between 16—45 years		
History of preadolescent sexual abuse		
Psychological disease		
ADD, OCD, bipolar, schizophrenia		
Depression		

Medicine that you take now:

Name	Why Taken	How Much	Date Started	Prescribing MD	Does it help?	Any Side Effects?

Allergies to Medications:_____

Any other Allergies you know of?_____

Patient Signature: _____ **Date:** _____

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CONSENT TO TREATMENT AND OTHER ACKNOWLEDGEMENTS

By reading and signing this document, [the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations. medications. anesthesia, medical services, and surgical or diagnostic procedures (including but not limited to the use of lab and radiographic studies). as I acknowledge and consent to the following:

I. **INDEPENDENT CONTRACTORS;** Chronic Pain of America LLC may utilize independent contractors for office, outpatients. or inpatient treatment/procedures. These include, but are not limited to, surgical assistants, physical therapists, and consulting and referral physicians. Healthcare professionals that are independent contractors are not agents or employees of Chronic Pain of America LLC and are responsible for their own actions. I understand that Chronic Pain of America LLC shall not be liable for the acts or omissions of independent contractors. This Consent to Treatment also applies to any independent contractor utilized by my physician(s).

2. VALUABLES; Chronic Pain of America LLC assume no responsibility for, and I hereby release Chronic Pain of America LLC from liability for, loss or damage to any of my personal property while on the premises and/or receiving treatment.

3. AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF THIRD PARTY PAYMENTS; I hereby expressly authorize Chronic Pain of America LLC and all healthcare professionals providing care to release all necessary information to any insurance company, health plan or other entity (third party payer) which may be responsible for paying for my care. I authorize and direct all payers to pay all benefits due for such care directly to Chronic Pain of America LLC and all professionals (including independent contractors) providing for such care and I hereby assign such sums to them. I understand this authorization and assignment shall remain valid unless I provide WRITTEN notice of revocation to Chronic Pain of America LLC and the third party payer signed and dated by me; however, such revocation shall not be effective as to information release and/or charges incurred prior to such revocation.

4. PAYMENT FOR SERVICES; In return for services to be provided by Chronic Pain of America LLC. I promise to pay for services rendered by Chronic Pain of America LLC to me or for my benefit If the services I receive from Chronic Pain of America LLC are covered by a third party payer, Chronic Pain of America LLC are covered by a third party payer, Chronic Pain of America LLC may elect to bill and accept payment from such third party. I will pay the portion of these bills which the third-party payer determines are my responsibility. In the case of services which I agree to receive but which are not covered by the third party, I will pay the amount due upon receipt of services. If no third party is involved in paying for my services, I agree to pay in full for such services at the time the services are received.

A. **SPECIAL REPORTS;** I understand that any special reports/documentation that I request my physician to complete on my behalf will incur a charge of $50.00 that is not covered by my insurance and Is to be paid at the time the request is made.

5. HIPPS; We are required by law to protect the privacy of your information, provide notice about our information practices and follow the information practices that are described in the HIPPA Notice displayed in our waiting area for your review.

6. AUTHORIZATION AND RELEASE FOR PHOTOGRAPHS; I authorize and release Chronic Pain of America LLC and its employees and agents to take photographs, videos. x-rays. and/or other photographs, electronic or other images of me and to use them as medically appropriate. Such images may be used for educational or other purposes as necessary and appropriate. These images may be maintained as a permanent part of my medical record. I understand and acknowledge that Chronic Pain of America LLC may use cameras for security and patient monitoring. and patient confidentiality will be maintained for all such images.

7. NO GUARANTEE OF RESULTS; Chronic Pain of America LLC and healthcare professionals cannot guarantee any specific result(s) of any examination, treatment, procedure; or medical care. I release Chronic Pain of America LLC, its physicians and healthcare professionals from any liability for any accident or injury that Is not directly caused by the negligence of Chronic Pain of America LLC or its employees.

8. PATIENT ACKNOWLEDGEMENT; During the course of my care and treatment, I understand that various types of examinations, tests, diagnostic or treatment procedures ("procedures") may be necessary. These procedures may be performed by physician(s), nurses, technicians, physician assistants, or other healthcare professionals. While routinely performed without incident, there may be material risks associated with these procedures; I will ask my physician(s) to provide me with additional information. 1 also understand my physician may ask met sign additional
Informed Consent documents relating to specific procedures.

9. PATIENT ACKNOWLEDGEMENT; l understand that the healthcare professionals involved In my care will rely on my documented medical history, as well as other information provided by me, my immediate family or others having information about me, in determining whether to perform or recommend the procedure. I agree to provide accurate and thorough information regarding my medical history and any conditions or events which may impact medical decision-making.

By signing this document. I certify that I have read and understand its contents and the information provided by me is accurate and complete (including insurance information and current eligibility for benefits).
A copy of this document may be utilized the same as the original

Patient Signature:_____ **Date:** _____
If not signed by patient, please indicate relationship to patient on the line below:

Signature:_____ **Date:** _____ **Relationship**:_____

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ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS AN ERISA/PPACA REPRESENTATIVE AND A BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible for paying: Chronic Pain Clinics of America, LLC dba Pain Relief Clinic, MD and/or Dr. Eric Solomon D.O as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, and/or medications that *have been* or *will be* rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA plan. PPACA plan, or insurance contract rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(i(;)s). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our representative, ERISA representative, or PPACA representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by ERISA and PPACA and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment and/or designation will remain in effect unless revoked in writing. A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____20_____

x _____
patient signature

x _____
printed patient name

x _____
signature of guardian if applicable

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AGREEMENT FOR THE PRESCRIPTION & USE OF THE NARCOTIC/OPIOID PAIN MEDICATION

In recognition of the potential for side effects, abuse, addiction and illegal trade of pain medications (also referred to as narcotics and opioids), I the undersigned patient of Dr. Solomon, agree to the following provisions in order to receive narcotic/opioid pain medications from Dr. Solomon.

1. I will take the medication as prescribed. I will not exceed the written prescription and/or directions on the bottle unless I am directed to do so by Dr. Solomon. I will not run out of the medication early, if I exceed the amount of medication prescribed by Dr. Solomon and run out early, I realize that I may go into withdrawal, as Dr. Solomon will not normally renew pain medication early.

2. I will not take any other prescription pain medication without Dr. Solomon's permission. This will include any pain medication I have left over from previous prescriptions, pain medications obtained from any other person, including doctors, pharmacists, other health professionals, family, friends, acquaintances or any other person, company or entity. I recognize that to accept pain medication from anyone other than a licensed physician or pharmacist is illegal and may result in criminal penalties.

3. I will not give, sell, loan, trade or otherwise distribute my medication to any other person, or otherwise allow any other person to have access to my medication. This includes family, friends, acquaintances and other persons. I recognize that to do so is also illegal and may result in criminal penalties.

4. I will keep my medication safe and secure from loss, theft, and destruction. I realize that if my medication is lost, stolen or destroyed, Dr. Solomon will not likely replace my medication and that I may go into withdrawal.

5. I will not use alcohol while taking my pain medication. I recognize that alcohol has an additive effect to the sedative properties of pain medication and that taking the two together can result in mental confusion, sedation, loss of consciousness and death.

6. I will not use any illegal substance and/or recreational drug while I am under the care of and/or receiving pain medications from Dr. Solomon, Illegal and recreation drugs include any defined by the US DEA as Schedule 1 of the Controlled Substances Act, including, but not limited to marijuana, cocaine, amphetamines, methamphetamines, ecstasy, heroin, and other drugs of abuse.

7. (Women only) If I am able to get pregnant, I will make every effort to not get pregnant while I am taking pain medication. I recognize that pain medication may have long-term and/or irreversible negative effects on an unborn baby if I become pregnant while taking pain medication and that this damage may occur in the first few weeks of pregnancy before I become aware that I may be pregnant. If I believe that I may be pregnant while taking pain medication, I will immediately contact Dr. Solomon for advice on this issue.

8 I recognize that pain medications may cause drowsiness, confusion, and memory impairment. I recognize that under current Georgia (and likely most states) law, driving a motor vehicle while taking pain medication can be considered as Driving Under the Influence and/or Driving While Intoxicated. I will, therefore, avoid driving or operating dangerous machinery while taking pain medication.

9. I recognize that other side effects of pain medication may include nausea, vomiting, constipation, slowing of breathing (respiratory depression) urinary retention, impaired sexual functioning, itching and abnormal sweating. Some side effects may be treatable.

10. I am aware that if I take pain medications I may become physically dependent on them. This would mean that if I suddenly stopped taking them, I could go into a withdrawal syndrome characterized by increased pain, runny nose, diarrhea, abdominal cramps and feelings of impending doom. I recognize that withdrawal from pain medication is not a life-threatening condition, but is uncomfortable.

11. I recognize that taking pain medications for an extended period of time may result in a condition called tolerance, where the medication no longer has the same effects it previously had, such as pain relief. The development of tolerance does not mean that Dr. Solomon will necessarily raise the dose of the pain medication or prescribe a different medication.

12. I recognize that addiction, while rare in pain patients, does occur in some people taking pain medications. I realize that I may not even be aware if I become addicted to pain medication, Addiction is characterized by intense cravings for a drug, compulsive use of the drug, loss of control of use of a drug (unable to control one's own use), and continued use of a drug despite the harm or negative effects of it. I am aware and agree that if Dr. Solomon believes I may have an addictive disorder, I will be referred to and agree to see an addiction specialist. I further agree to inform Dr. Solomon of any history of drug or alcohol abuse and/or addiction in myself or my family members (first-degree relatives with a history of drug or alcohol abuse impart an increased risk of drug abuse to their family members).

13. I realize and agree that while I am taking pain medication from Dr. Solomon I am subject to unannounced and/or random urine and/or blood drug tests. This is a urine and/or blood sample, given by myself to Dr. Solomon to be tested for various pain medication and drugs of abuse. Failure to provide a urine or blood sample, when requested, may result in my being weaned off of pain medication.

14. Any and all questions I have regarding these terms and this agreement have been answered to my satisfaction before I signed this.

Patient Signature: _____ **Date: _____**

Chronic Pain Clinics of America, LLC
Dr. Eric Solomon, DO
1395 South Marietta Parkway Bldg. 100 - Suite 102 - Marietta GA 30067
Phone: (770) 425-8700 | Fax: (770) 425-8740

A. Notifier: _____

B. Patient Name: _____ C. Identification Number: _____

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
CPT Code **80307: Urinary Drug Screen / Analyzer** **G0483: Conformation of Drug Screen / LCMS**	- **Benefit Maximum Exceeded** - **Not Medically Necessary** - **Not a Covered Service**	**80307: $74** **G0483: $242**

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

SSN: _____ Patient Phone Number: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Pain Relief Clinic, MD
1395 South Marietta Parkway
Bldg 100, Suite 102
Marietta, Ga 30067

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

○ Yes ○ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

○ Yes ○ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS (90) AFTER IT IS SIGNED