



ADVANCED PAINCARE

Compassionate, comprehensive care for your pain.

2501 N. Third Street, Third Floor • Harrisburg, PA 17110

Phone: 717.782.6829 • Fax: 717.782.6831

www.advancedpaincare.org

CONSENT FOR TREATMENT

I consent to the rendering of medical care, which may include diagnostic procedures and such medical treatment as my attending physician considers to be necessary. I also understand that, absent emergency circumstances, no invasive or experimental procedure will be performed upon me unless I have had an opportunity to discuss the procedure with my physician and give informed consent to the procedure. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risk of injury or even death. I acknowledge that no guarantee had been made to me regarding any examination or treatment in this office.

PRE CERTIFICATION REQUIREMENTS

If my insurance company or third party requires pre-certifications, then I understand that it is my responsibility to contact them to obtain such certification.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize my Medicare and /or medical insurance benefits payable to me under the terms of my insurance policies to be paid directly to Advanced PainCare. If my attending physician and /or other physician associated with him/her or whom he/she designates accepts insurance assignment, then I hereby authorize my Medicare and/or medical insurance benefits to be paid directly to those physicians. I assign any and all legal rights that I have to collect benefits to Advanced PainCare. I understand that I am financially responsible for non-covered services, as well as any deductibles, coinsurance or amounts in excess of insurance benefits including costs of collections for unpaid balances. I permit a copy of this consent to be used in place of the original. I also understand that I will be responsible to pay any fees generated to collect any unpaid balance.

GREIVANCE APPEAL CONSENT

I hereby authorize Advanced PainCare to act on my behalf in requesting a reconsideration of medical determination made by my managed care plan or utilization review entity regarding my medical care.

CONSENT MUST BE SIGNED BY THE PATIENT'S LEGAL REPRESENTATIVE IN THE CASE OF A MINOR OR WHEN THE PATIENT IS PHYSICALLY OR MENTALLY INCAPACITATED.

Signature of patient or legal representative.

Date Signed

Printed name of patient representative and relationship to patient

ADVANCED RELIEF

- Back & neck pain • Spinal problems
- Sacroiliitis • Cervicogenic headaches
- Joint pain • Abdominal pain
- Post-laminectomy syndrome • Shingles pain
- Leg pain • Neuropathies

ADVANCED SOLUTIONS

- Advanced diagnostic testing & treatment
- X-ray-guided injection therapy
- Neurostimulators • Botox® therapy • Nerve blocks
- Radiofrequency ablation • Acute & chronic pain treatment
- Discography • Medication management

PATIENT CONVENIENCE

- Most insurance accepted & filed
- Flexible appointments
- MasterCard & Visa welcome
- Caring, professional staff
- Free parking



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NAME: _____ **DATE:** _____

MEDICAL HISTORY

Please list all past and present medical conditions:

Medical Problems

Surgeries

Drug Allergies

Smoke? Yes _____ No _____

If yes ...

Cigarettes _____ pack per day

Cigars _____

Marijuana _____

Drink? Yes _____ No _____

If yes ...

Beer _____ bottles per week

Liquor _____ shots per week

Wine _____ glasses per week

Occupation _____ Full Time _____ Part Time _____ SSDI _____ Retired _____

Patient Initials _____

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NAME: _____ **DATE:** _____

PAIN HISTORY

Approximate date your pain began. _____

Please describe the circumstances surrounding the start of your pain.

Please list previous treatments for your pain condition. (Physical therapy, surgery, etc.)

Please list pain medication that failed to relieve your pain.

Please describe what you do to relieve your pain.

Please describe what makes your pain worse.

Please list any imaging studies you may have had done. (X-ray, MRI, CT scan, etc.)

Study:	Name of Facility:	Approx. date:
_____	_____	_____
_____	_____	_____
_____	_____	_____

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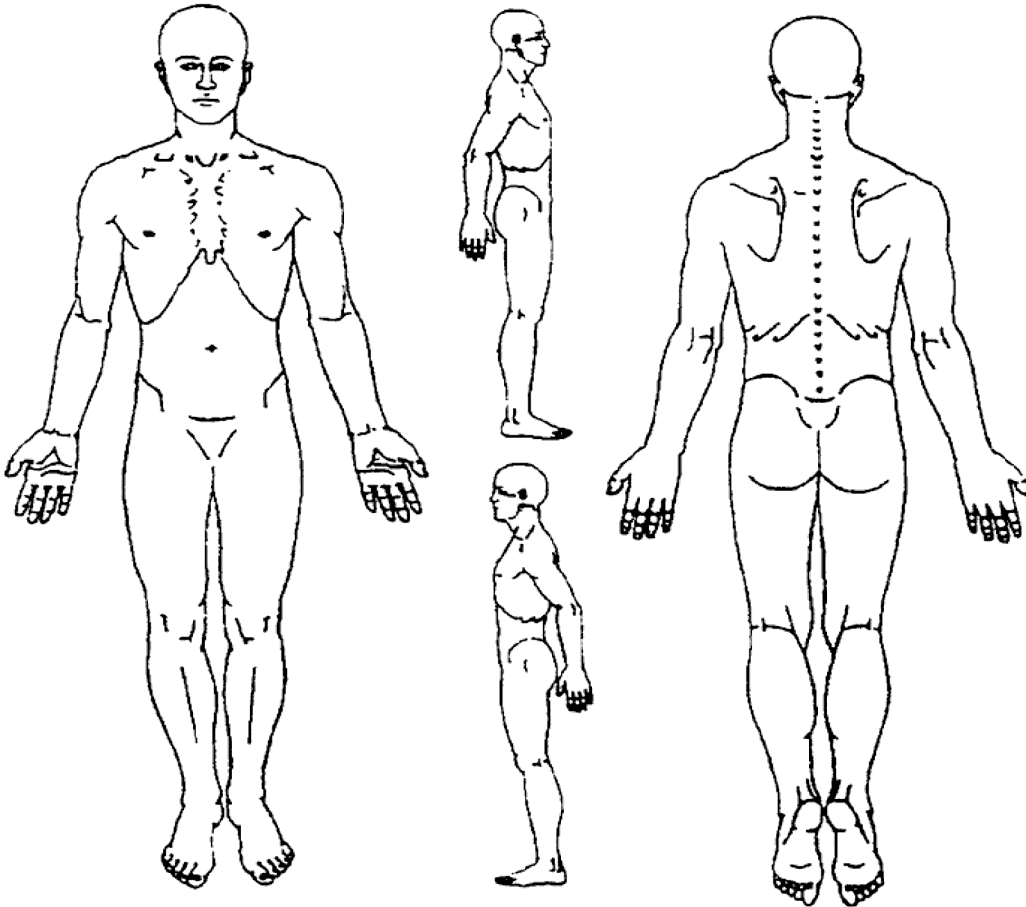
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On the diagram below, please indicate where you are experiencing pain and other symptoms, right now.



A = ACHE

B = BURNING

N = NUMBNESS

P = PINS & NEEDLES

S = STABBING

O = OTHER

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Review of Systems

PLEASE INDICATE BELOW. ARE YOU CURRENTLY EXPERIENCING ANY OF THESE SYMPTOMS:

General, constitutional

Good general health lately Yes _____ No _____
 Recent weight change Yes _____ No _____
 Fever Yes _____ No _____
 Fatigue Yes _____ No _____

Eyes and vision

Eye disease or injury Yes _____ No _____
 Wear glasses/contact lenses Yes _____ No _____
 Blurred or double vision Yes _____ No _____
 Glaucoma Yes _____ No _____

Ears, nose, throat

Hearing loss Yes _____ No _____
 Ringing in the ears Yes _____ No _____
 Earaches or drainage Yes _____ No _____
 Sinus problems Yes _____ No _____
 Nose bleeds Yes _____ No _____
 Mouth sores Yes _____ No _____
 Bleeding gums Yes _____ No _____
 Bad breath or bad taste Yes _____ No _____
 Sore throat or voice change Yes _____ No _____
 Swollen glands in neck Yes _____ No _____

Heart and Cardiovascular

Heart trouble Yes _____ No _____
 Sudden heartbeat changes Yes _____ No _____
 Swelling of feet, ankles, hands Yes _____ No _____

Respiratory

Frequent coughing Yes _____ No _____
 Spitting up blood Yes _____ No _____
 Shortness of breath Yes _____ No _____
 Asthma or wheezing Yes _____ No _____

Gastrointestinal

Loss of appetite Yes _____ No _____
 Change in bowel movements Yes _____ No _____
 Nausea or vomiting Yes _____ No _____
 Frequent diarrhea Yes _____ No _____
 Painful bowel movements or constipation Yes _____ No _____
 Blood in stool Yes _____ No _____
 Stomach pain Yes _____ No _____

Genitourinary

Frequent urination Yes _____ No _____
 Burning or painful urination Yes _____ No _____
 Blood in urine Yes _____ No _____
 Change in force or strain with urination Yes _____ No _____
 Incontinence or dribbling Yes _____ No _____
 Kidney stones Yes _____ No _____
 Sexual difficulty Yes _____ No _____
 Painful periods Yes _____ No _____
 Irregular periods Yes _____ No _____
 Vaginal discharge Yes _____ No _____

Patient initials: _____

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Musculoskeletal

- Joint pain Yes _____ No _____
- Joint stiffness or swelling Yes _____ No _____
- Weakness of muscles/joints Yes _____ No _____
- Muscle pain or cramps Yes _____ No _____
- Back pain Yes _____ No _____
- Cold extremities Yes _____ No _____
- Difficulty in walking Yes _____ No _____

Skin and breasts

- Rash or itching Yes _____ No _____
- Change in skin color Yes _____ No _____
- Change in hair or nails Yes _____ No _____
- Varicose Veins Yes _____ No _____
- Breast pain Yes _____ No _____
- Breast lump Yes _____ No _____
- Breast discharge Yes _____ No _____

Neurological

- Frequent or recurrent headaches Yes _____ No _____
- Light headed or dizzy Yes _____ No _____
- Convulsions or seizures Yes _____ No _____
- Numbness or tingling sensations Yes _____ No _____
- Tremors Yes _____ No _____
- Paralysis Yes _____ No _____
- Stroke Yes _____ No _____
- Head injury Yes _____ No _____

Psychiatric

- Memory loss or confusion Yes _____ No _____
- Nervousness Yes _____ No _____
- Depression Yes _____ No _____
- Sleep problems Yes _____ No _____

Endocrine

- Glandular or hormone problem Yes _____ No _____
- Thyroid disease Yes _____ No _____
- Diabetes Yes _____ No _____
- Excessive thirst or urination Yes _____ No _____
- Heat or cold intolerance Yes _____ No _____
- Dry skin Yes _____ No _____
- Change in hat or glove size Yes _____ No _____

Hematologic/Lymphatic

- Slow to heal after cuts Yes _____ No _____
- Easily bruise or bleed Yes _____ No _____
- Anemia Yes _____ No _____
- Phlebitis Yes _____ No _____
- Transfusion Yes _____ No _____
- Swollen glands Yes _____ No _____

If you have not had a hysterectomy, please give the date of your last menstrual period: _____

Patient initials: _____

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AUTHORIZATION FOR MEDICAL RECORDS RELEASE

I, _____ Date of Birth _____ / _____ / _____
(Patient's Name)

do hereby consent to a authorize: _____
(Office releasing Information)

to disclose to: _____
(Person/Organization to whom Information is to be released)

(Address) (City) (State/Zip) (Phone Number)

Information to be released from said facility's records, including photocopies, relating to my diagnosis, prognosis, and/or treatment unless, otherwise stated below.

(Specify Requested Portions of Records)

This authorization includes the release of information about the following, if included in the medical records: AIDS, HIV-related information or testing, psychiatric disorders, drug treatment and/or alcohol treatment. (Delete those records, if any, which are not to be released.) The specific date of such records to be disclosed include:

(Specific Dates of Treatment)

The information is needed for the following purposes (please check all the apply)

- _____ To provide ongoing treatment
- _____ To obtain insurance, employment or government benefits
- _____ To enable judges, attorneys, caseworkers to support treatment goals or make legal decisions on my behalf
- _____ To coordinate treatment efforts with other professionals

I, the undersigned, have been informed I have the right by law to revoke this consent at any time by oral and/or written request. If not revoked, this consent will remain in force for one year.

Patient's Signature _____ Date: _____ / _____ / _____

Signature of Parent or Guardian _____ Date: _____ / _____ / _____

Signature of Witness _____ Date: _____ / _____ / _____

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