Relievus™
Toll Free: (888) 985 - 2727 · Fax: (609) 567 - 8832

Our Commitment to You

- We will provide you with the most appropriate care in the most time efficient fashion.
- We will treat you with respect and professionalism.
- We will always do our best to keep your scheduled appointment and to minimize any wait time you may incur; however, due to circumstances beyond our control, there may be times that we must re-schedule your appointment with short notice.
- In order to give you as much notice as possible we request a phone contact so that we can reach you in person during the day, such as a business number or cell phone.
- We will do our best to move your appointment to an earlier time or date if we have a cancellation in our office schedule.

If you have any questions regarding this information, please do not hesitate to ask us. We are here to help you.

General Information

- Our office hours are very limited. It is very important that you keep your appointment.
- If you have an emergency and cannot keep your appointment, you must contact our office **no later than 48 hours** prior to your scheduled appointment date.
- We may charge a **NO SHOW FEE** if your appointment is not kept or cancelled 48 hours prior to your scheduled time.
- In order to treat you effectively and efficiently and within HIPAA guidelines, we require a Registration Form and several other forms be completed by you.
- We are sorry, but due to high fax volume, we are NOT able to accept any of the following documents via fax. Without the completed documents, films, tests, and referral, if appropriate, you will NOT be seen by the doctor and your appointment will be RESCHEDULED.
    1. Referral; if required by the insurance
    2. Active valid insurance card
    3. Case number or Claim number for Auto insurance or Worker's Comp
    4. Photo ID
    5. MRI films & Reports, CT Scan films & Reports, Bone scan reports
    6. EMG reports
    7. Primary doctor's notes, other specialists' notes (Orthopedic surgeon, neurologist, psychiatrist, rheumatologist, etc.)
    8. List of current medications
    9. Auto Insurance policy Declaration Page (PIP Coverage)

Medication Policy

- It is important to your health that you follow the directions carefully on all medications that we prescribe.
- In addition, we must be informed of all other medications, prescription and over-the-counter.
- We WILL **NOT** refill controlled medications in advance of their refill date.
- We WILL **NOT** mail prescriptions.
- We WILL **NOT** prescribe any opioid (narcotic) medications at the first visit.
- They must be given **IN PERSON** to you at the time of your appointment.
- If there is an unavoidable reason that you cannot make an appointment, we require a 3-day notice for a medication refill.

Financial Policy

- We are committed to providing you with the best possible care.
- We expect that you have an understanding of your responsibilities under your insurance contract in respect to referral and pre-authorization requirements, and your deductible, co-pay, and coverage limits.

- In order to achieve your maximum allowable benefits, we need your assistance and your understanding of our payment policy.
- Payment is due in full at time of service, unless you have made payment arrangements in advance with our business office.
- If you have insurance coverage with one of the plans we participate with, we will bill your insurance company along the guidelines of our contract; however, we require that **ALL COPAYS OR DEDUCTIBLES be paid at the time of service.**
- If you have an insurance with which we do not participate, we ask that payment be made at the time services are rendered and your insurance company will reimburse any amount due to you directly.
- Returned checks will be subject to **an additional $35.00 service fee.**
- We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Please realize; however, that your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
- While filing of insurance claims is a courtesy we extend to our patients, all charges are the responsibility of the patient from the date the services are rendered.
- You will be required to show a copy of your insurance card at the time of service.
- If you do not have your insurance information or we are unable to verify your coverage, you will be required to pay for the services rendered to you that day.
- If your insurance coverage terminates or changes, you are responsible for notifying us of this change immediately so that we can assist you in receiving your maximum reimbursement.

Missed Appointments

- Please help us serve you better by keeping scheduled appointments.
- **Unless cancelled at least 48 hours in advance,** our policy is to charge a **NO SHOW FEE** for missed office appointments.
- **Missed appointments for procedures performed at surgery centers will incur a fee of $100. This includes not following instructions; stopping of medications, food/drink restrictions and having a driver.**

I HAVE READ the Financial Policy. I UNDERSTAND and AGREE to this Financial Policy. I GUARANTEE payment of all charges incurred for the account. I hereby assign benefits to RELIEVUS for all claims submitted to my insurance on my behalf. I further agree to pay any attorney's fee, court cost and related collection fees incurred.

Patient Print Name	Patient Signature	Date

Responsible Party Print Name (if not patient)	Responsible Party Signature (if not patient)	Date

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Important Note Regarding After Hours/Weekend Services

Relievus provides care for chronic problems. As such, our patients are not expected to require urgent care or immediate contact with this practice after hours. If you have an urgent medical problem after regular business hours (8AM to 5PM Monday through Friday) or over the weekend, please do one of the following:

- Contact your primary care physician
- Go to an urgent care center
- Go to the emergency department of the nearest hospital

It is permissible that you obtain medications from these physicians for any acute pain or new injury that you have.

It is your responsibility to contact us within the next two business days to inform us of any changes, additions, or deletions made to your narcotic regimen. All non-narcotic changes should be reported at your next office visit.

Thank you in advance.

By signing below, you agree that you have read the above notice regarding after hours/weekend services and that you understand your responsibilities.

Patient Name	Patient Signature	Date

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Patient Information

Last Name: _____ First Name: _____ Sex: ☐ M ☐ F

If patient is a minor, name of parent or guardian accompanying patient: _____

Relationship to Patient: _____ Phone # (if different): _____

Address: _____

City: _____ State: _____ Zip Code:_____

Home Phone: _____ 2nd Phone: _____ Email: _____

Date of Birth: _____ SS# _____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Referred by: _____Phone: _____ Location: _____

Family Doctor: _____ Phone: _____ Location: _____

INSURANCE

Date of Accident (if applicable): _____ **Type of Accident:** _____
Please briefly describe the accident. If necessary, you may use the back of this page. Please also note whether you were in the course of employment at this time: _____

_____

Primary Insurance Name: _____ ☐ Auto ☐ Health ☐ Workers Comp

Phone #: _____ Adjuster: _____ Ext: _____

Claim or ID #: _____ Group #: _____

Subscriber: _____ Relationship: _____

Subscriber Date of Birth: _____ Subscriber SS #: _____

Secondary Insurance Name: _____ ☐ Auto ☐ Health ☐ Workers Comp

Phone #: _____ Adjuster: _____ Ext: _____

Claim or ID #: _____ Group #: _____

Subscriber: _____ Relationship: _____

Subscriber Date of Birth: _____ Subscriber SS #: _____

Tertiary Insurance Name: _____ ☐ Auto ☐ Health ☐ Workers Comp

Phone #: _____ Adjuster: _____ Ext: _____

Claim or ID #: _____ Group #: _____

Subscriber: _____ Relationship: _____

Subscriber Date of Birth: _____ Subscriber SS #: _____

Attorney Name: _____ Firm: _____

Location: _____ Phone: _____

Employer Name: _____ Phone: _____

Emergency Contact: _____ **Phone:** _____

Are we authorized to release your medical information to the listed Emergency Contact? ☐ Yes ☐ No

Signature: _____ Date: _____

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Patient Name: _____ Date: _____

Date of Birth: _____

HEALTH QUESTIONNAIRE

MEDICAL COMPLAINTS FOR TODAY'S VISIT:

_____

_____

PAST MEDICAL HISTORY:

☐ Diabetes ☐ High Blood Pressure ☐ Asthma ☐ Thyroid Disease ☐ Lung Disease

☐ Heart Disease ☐ Kidney Disease ☐ Other: _____

PAST SURGERIES:

☐ Tonsils ☐ Appendix ☐ Gall Bladder ☐ Tubal Ligation ☐ Hysterectomy ☐ Back Surgery

☐ Neck Surgery ☐ Carpal Tunnel Release ☐ Hernia Repair ☐ Heart Surgery

☐ Other: _____

MEDICATIONS (Please List):

_____

_____

_____

DRUG ALLERGIES:

Are you allergic to any medications? ☐ Yes ☐ No

If yes, list all:

_____

_____

_____

DIAGNOSTIC STUDIES:

Have you had any X-Rays, MRIs, Cat Scans, Bone Scans, EEGs, EMG/NVCs (nerve test), Lab work?

☐ Yes ☐ No If yes, please list all tests completed and where they were done:

_____

_____

_____

SOCIAL HISTORY:

Do you smoke? ☐ Yes ☐ No How much? _____ packs per day

Do you drink alcohol? ☐ Yes ☐ No How much? _____

FAMILY HISTORY:

☐ Diabetes ☐ High Blood Pressure ☐ Cardiac Disease
☐ Adopted ☐ Alcohol/Drug Addiction ☐ Cancer – Type: _____

REVIEW OF SYSTEMS

Do you have any of the following?

General:	☐ Weight Loss/Gain	☐ Fatigue	☐ Sleep Dysfunction	
Head:	☐ Headaches	☐ Dizziness	☐ Confusion	
Skin:	☐ Rash	☐ Color Changes	☐ Abnormal Hair Growth	☐ Nail Changes
Ears:	☐ Decreased Hearing	☐ Right	☐ Left	
	☐ Pain in Ears	☐ Right	☐ Left	
	☐ Ringing in Ears	☐ Right	☐ Left	
	☐ Blood or Drainage	☐ Right	☐ Left	
Eyes:	☐ Decreased Vision	☐ Right	☐ Left	
	☐ Double Vision	☐ Right	☐ Left	
	☐ Pain	☐ Right	☐ Left	
	☐ Redness	☐ Right	☐ Left	
	☐ History of Glaucoma	☐ Right	☐ Left	

Date of last eye examination: _____

Respiratory:	☐ Cough	☐ Difficulty Breathings	☐ Pain over Ribs	
	☐ Other Breathing Pains: _____			
Cardiac:	☐ Chest Pain	☐ Palpitations		
	☐ Passing out (explain): _____			
Gastrointestinal:	☐ Nausea	☐ Difficulty Swallowing	☐ Bleeding	☐ Fecal Incontinence
Genitourinary:	☐ Blood in Urine	☐ Frequency	☐ Burning	☐ Incontinence

Patient Signature: _____ **Date**: _____

Physician Signature: _____ **Date**: _____

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Authorization and Consent

I request that payment of authorized Medicare Benefits be made on my behalf to **Relievus** for any services furnished me by **Relievus.** I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or any information needed to determine these benefits or the benefits payable to related services. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to myself or to the party who accepts assignment.

I request that payment of authorized Medigap Benefits be made on my behalf to **Relievus** for any services furnished to me by **Relievus.** I authorize any holder of medical information about me to release to my insurance carrier or any information needed to determine the benefits payable for related services.

AUTHORIZATION to release information and payment request. I certify that the service(s) covered by this claim have been received and I request that payment for these services be made on my behalf. I authorize any holder of medical or other information about me to release to the Division of Medical Assistance and Health Services or its authorized agents any information needed for this or a related claim.

ASSIGNMENT OF INSURANCE BENEFITS: I irrevocably assign all payments to **Relievus** for medical insurance benefits including any Major Medical Benefits otherwise payable to me under the terms of my policy but not to exceed the balance due to **Relievus** for services performed during this period of treatment. In making this assignment, I understand and agree that I am financially responsible to the above party for charges not paid under this insurance policy. I permit a copy of this authorization to be used in place of the original.

RELEASE OF INFORMATION: **Relievus** may disclose any or all parts of the clinical record to me, my insurance company(s) or employer(s) for purposes of satisfying charges billed by **Relievus**. I further understand that it may be necessary for **Relievus** to contact my past or present employer(s) in regards to this claim. This authorization does not cover 3rd party liability claims.

GUARANTEE OF ACCOUNT: **Relievus,** for and in consideration of services rendered by **Relievus** to the below named patient, the undersigned (jointly and severally, if more than one) guarantees payment of all charges incurred for said patient in accordance with the policy of payment of such bills. There will also be added 35% collection and reasonable attorney fee if your account goes to a collection agency.

THE UNDERSIGNED CERTIFIES THAT EACH HAS READ AND UNDERSTANDS THE ABOVE TERMS AND CONDITIONS.

Patient/Legal Representative Name	Patient/Legal Representative Signature	Date

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Authorization for Release of Information

Name of Patient: _____ **Date:** _____

Relievus is authorized to release protected health information about the above-named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information Check each person/entity below that you approve to receive information.	**Description of Information to be Release** Check each item below that can be given to the person/entity as indicated on the left.
☐ **Voicemail**	☐ **Results of Lab tests/x-rays** ☐ **Other:** _____
☐ **Spouse (Provide Name & Phone Number)** _____	☐ **Financial** ☐ **Medical as follows:** _____
☐ **Parent (Provide Name & Phone Number)** _____	☐ **Financial** ☐ **Medical as follows:** _____
☐ **Other (Provide Name & Phone Number)** _____	☐ **Financial** ☐ **Medical as follows:** _____

Patient Information
I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.

I understand that information used or disclosed as a result of this arbitration may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

Patient/Legal Representative Name	Patient/Legal Representative Signature	Date

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Notice of Privacy Practices
Acknowledgement of Receipt

Patient Name & Address: ____

____

I have received a copy of the Notice of Privacy Practices for the above-named practice.

Signature: ______________________________ Date: ______________

***** You may review our Notice of Privacy Practices under "Notice of Privacy Practices" on our website at: http://www.relievus.com/forms/ or you may request a copy from the front desk. *****

◆◆

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because of the following:

☐ An emergency existed and a signature was not possible at that time.

☐ The individual refused to sign.

☐ A copy was mailed with a request for a signature by return mail.

☐ Unable to communicate with the patient for the following reason:

____

☐ Other:

____

Prepared by: ______________________________

Signature: ______________________________ Date: ______________