SUN PAIN INSTITUTE
Patient-Centered Care

5354 Reynolds Street, Suite 315
Savannah, Georgia 31405
P: 912.692.0755 F:912.692.0754

NEW PATIENTS

Thank you very much for choosing Sun Pain Institute and Orthopedics, for all of your Pain and Orthopedic needs! We want your first appoint to go as smoothly as possible. For that reason, please remember to bring the following information with you to your appointment.

The enclosed packet completed with your health insurance information. This packet may seem lengthy, but in order to provide you with the best possible care and customer service, it is important that we collect all of the enclosed information:

- Photo ID (must be state or federally issued drivers license, photo ID, or passport)
- Insurance cards
- Recent radiology imaging (reports, films, disks)
- Medical records (Any records from previous treating physicians or pain practice.
- List of all current medications
- Referral (if applicable)
- Co-pay or Co-insurance

If you are unable to complete this packet prior to your appointment, please arrive 45 minutes early to your scheduled appointment time, so that we may assist you and process this paperwork.

Out of respect of for other patients, if you are more that 15 minutes late or not properly prepared for your appointment by bringing all of these items, we reserve the right to reschedule your appointment.

Doris K. Cope MS, MD
Board Certified Anesthesiology
Pain Medicine

John P George MD
Board Certified Orthopedic
Surgeon

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NEW PATIENT INFORMATION

Please answer every question as accurately as possible. This form is especially important to help us understand your pain complaints. This form will help us with providing you with the highest level of care.

PATIENT NAME: ____ DOB: _____/_____/_____

Have you even been seen or are you currently seeing a Pain Management doctor? YES / NO

If Yes, please provide the following:
Pain Doctors name: ____

What is your major pain complaint? ____

Circle the numbers between 0 – 10 that represents the intensity of your pain:

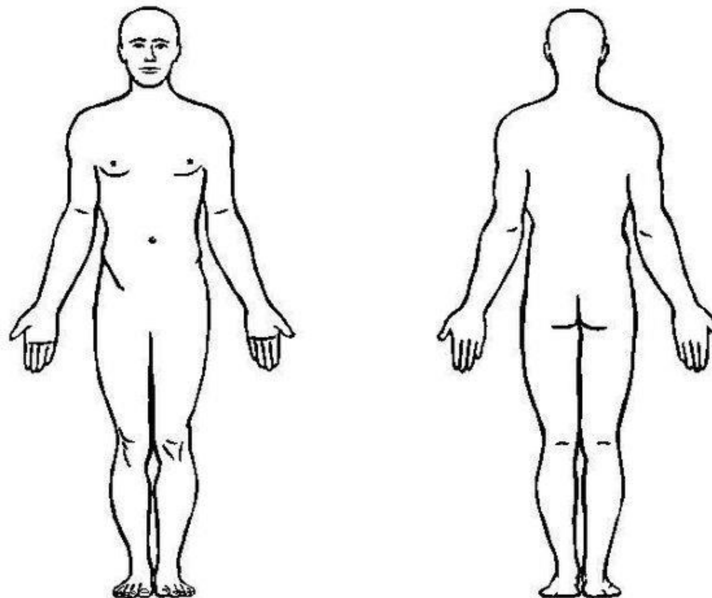
Average Pain = 0 1 2 3 4 5 6 7 8 9 10

Worse Pain = 0 1 2 3 4 5 6 7 8 9 10

What makes your pain worse?
___ Sitting ___ Standing ___ Walking ___ Lifting ___Lying flat Other: ____________

What makes your pain better?
___ Nothing ___ Sitting ___ Standing ___ Walking ___ Rest Other: ___________

Indicate your pain on the diagram below:



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PAIN TREATMENTS: Please check your response to the treatments you have tried.

Treatment	Never tried	No Relief	Moderate Relief	Excellent Relief
Surgery				
Traction				
Injection				
Physical Therapy				
Acupuncture				
Chiropratic				

Are you currently taking blood thinners? YES / NO

Are you allergic to iodine or x-ray contrast? YES / NO

List all CURRENT MEDICATIONS: ____

____

____

____

List all SURGERIES:

Surgery	Date	Doctor

List all MEDICAL PROBLEMS (including any diagnosis of anxiety or depression):

Medical Problem	Treating Doctor	Phone Number

Are you employed? YES / NO
Is yes, what is your job? ____
If no, are you? Disabled / Retired

Patient Signature: ____

Person completing form if different from the patient: ____

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Office and Financial Policies

Appointments:
We believe that our patient's time is valuable and every effort is made to keep your waiting time to a minimum. If you are unable to keep your appointment, please notify the office as soon as possible. This courtesy allows us to give appointments to another patient. If you do not cancel your appointment 24 hours prior to the scheduled appointment time, a No Show fee (25.00) will be charged to your account. If you have 3 or more No Shows within a 12 month period, you could be discharged from the practice.

Financial Policy:
• Your Insurance Card(s) and Driver's License (Picture ID) will need to be presented each time you visit our practice to assure we have the most recent information. If insurance card is not provided, appointment will be handled as self-pay and payment for services will be collected prior to being seen.
• Co-payments must be paid prior to seeing the health care provider on the date service is rendered. Self-pay and uninsured patients will be required to pay a deposit prior to being seen. Patients are responsible for their deductibles or charges not reimbursed by insurance. As a courtesy to you we file your insurance claims, therefore it is your responsibility to provide our office with up to date billing information.
• Please understand that your insurance is a contract between you and your insurance company and you are ultimately responsible for the bill. If you have not received an explanation of benefits within 30 days of seeing your health care provider you are expected to contact your insurance company for an explanation as to why payment has been delayed.
• Self-pay patients are required to pay for services prior to being seen for their visit and will be balance billed for the remainder of the fees at the time of charge posting.
• It is understood that returned checks made payable to this office for insufficient funds, stop payments or other reason for non-payment will be assessed a $50.00 NSF fee for which the patient will be held responsible.
• Patients with no financial ability to pay Sun Pain Institute charges will be screened for eligibility under Medicaid and other state programs and/or evaluated against established guidelines for financial assistance. Please notify the Front Desk staff if you would like more information about how to apply for financial assistance.

Medical Records:
Please note that requests for any health information cannot be processed without a signed medical record release from the patient or legal representative. This service is outsourced and processed weekly. Please allow up to 30 business days for your request to be processed. A fee ($35.00) may be charged for this service.

Other:
Patient is responsible for the protection and safety of patient's property, Sun Pain Institute shall not be responsible or liable to patient for any damage or loss of property in the Building or Premises at any time. Sun Pain Institute is not responsible should patient leave premises against the advice of medical personnel. The use of video recording devices is strictly prohibited on our property.

Patient Signature: ______________________________________ Date: ________________

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Consent and Treatment

Consent:
I hereby authorize SUN Pain Institute (SPI) to provide medical treatments, release information pertaining to treatment deemed necessary by my insurance companies, attorney or referring physician, and to receive direct payment for service rendered. I hereby authorize direct payment of medical benefits provided by my insurance policies to the above named practice. I understand and agree to be responsible for any portion of this claim that for any reason is not covered by my insurance, otherwise provided by law. I further understand that any legal fees incurred to collect this claim are my responsibility.

Waiver:
If I am a member of an HMO insurance plan and SPI clinicians are not participating members or the facility where my procedure is performed in non-par or I choose to be treated without a referral or authorization, I acknowledge that I am fully responsible for any and all charges incurred as a result of my decision to be treated by SPI.

Patient Signature: ____ Date: ________________

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