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2791 Tricom Street
Charleston, SC 29406
Office: 843-818-1181

Welcome and Thank You For Choosing *Pain Specialists of Charleston, P.A.*

Our mission is to further advance and promote the development and innovative practice of interventional pain management, research development, and therapeutic techniques while ensuring dependable, high-quality and cost-effective healthcare treatments to both our community and existing patients.

When you choose Pain Specialists of Charleston, P.A., you benefit from:

Specialized Expertise:

At Pain Specialists of Charleston, P.A., we understand the complexities of pain. From your unique pain diagnosis to determining the most successful non-surgical treatments, we specialize in relieving pain and restoring your quality of life.

Advanced Treatments and Therapies:

Pain Specialists of Charleston, P.A. is an AAAHC accredited facility and offers our community quality healthcare through the latest, most up-to-date interventional treatments of musculoskeletal injuries and pain. Our affiliate practice, Pain Research of Charleston (PRC), is an independent clinical research site that focuses on interventional pain procedures and supporting medications as well as researching the most advanced therapies available today.

Superior Staff:

Trained in some of the region's most prestigious medical facilities, our providers are among the most talented pain specialists in the area. With 20 years of pain management experience, Dr. Tavel is a Board Certified Anesthesiologist and Board Certified in Pain Medicine. Crystal Gutierrez is a Board Certified Physician's Assistant specializing in Pain Management. Amanda McFann is a nationally certified Family Nurse Practitioner specializing in Pain Management.

Long-Term Results:

At Pain Specialists of Charleston, P.A., we understand the physical, psychological and emotional toll pain can have on your life. We personalize our care to your unique case and customize your treatment plan to deliver the best possible outcome. Using this approach, we have helped countless individuals get back into life and return to healthy, active lifestyles.

Alternative Therapies:

Pain Specialists of Charleston, P.A. also offers a full range treatment solutions including neuromuscular massage with our certified therapists of Massage Specialists of Charleston, chiropractic treatment, and a Research Department specializing in pain clinical trials. To learn more about Massage Specialists of Charleston or Pain Research of Charleston, contact:

- Neuromuscular Massage and Chiropractic Therapy: (843)818-1181
- Pain Research of Charleston: (843) 637-4010

Pain Specialists of Charleston is committed to quality healthcare.
If you are interested in learning more about our practice or treatment solutions,
please visit www.PainChas.com



This form must be completed every **SIX** months or at any time your **PERSONAL** or **INSURANCE** information changes. This requirement meets with Federal Guidelines.

General Patient Information

Patient Last Name:	Patient First Name:	Patient Middle Name:	Sex: M F
Street Address:	Mailing Address:	City, State, Zip Code:	
Date of Birth:	Marital Status:	Social Security #:	
Home Phone #:	Cell Phone #:	Email Address:	
<i>Would you like to receive quarterly emails with News & Events from our Practice?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No			
Employer Name:	Name of Primary Care Physician:	Where did you have your last MRI?	
Work Phone #:	Name of Referring Physician:	Date of your last MRI:	

Insurance Information:

Primary Insurance Provider Name:	Secondary Insurance Provider Name:	Tertiary Insurance Provider Name:
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***Is your insurance in someone else's name – such as a spouse, parent or family member?
If so, please complete that person's information below:***

Insured Name:	Insured Social Security #:	Insured Date of Birth:
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If this is a Workers Compensation case, please include your Adjuster's contact information:

Adjuster Name:	Adjuster Phone #:	Claim #:
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If you have an Attorney, please include your Attorney's contact information:

Attorney Name:	Attorney Phone #:	
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Pharmacy Information:

Pharmacy Name:	Pharmacy Phone #:	Pharmacy Address:
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Person to Notify In Case of Emergency:

Name:	Telephone #:	Relationship
Address, City, State, Zip Code:		

Patient Name:		
Patient Date of Birth:	Patient Height:	Patient Weight:
Please list all of your allergies:		

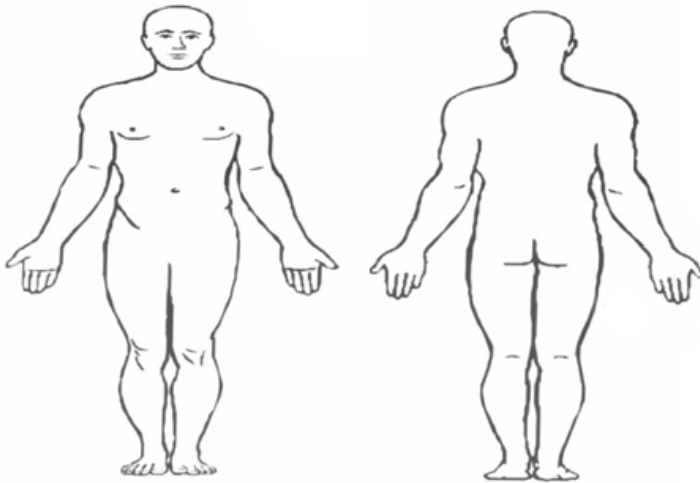
LIST ALL OF YOUR MEDICATIONS & DOSAGES:		CHECK ANY BLOODTHINNERS YOU ARE CURRENTLY TAKING:
<ul style="list-style-type: none"> • _____ • _____ • _____ • _____ • _____ • _____ • _____ • _____ 	<ul style="list-style-type: none"> • _____ • _____ • _____ • _____ • _____ • _____ • _____ • _____ 	<input type="checkbox"/> ASPIRIN <input type="checkbox"/> PLAVIX (CLOPIDOGREL) <input type="checkbox"/> COUMADIN (WARFARIN) <input type="checkbox"/> PLETAL (CILOSTAZOL) <input type="checkbox"/> TRENAL <input type="checkbox"/> AGGRENOL <input type="checkbox"/> PRADAXA (DABIGATRAN ETEXILATE) <input type="checkbox"/> XARELTO (RIVARONXABAN)

ARE YOU TAKING ANY OVER-THE-COUNTER MEDICINE NOT LISTED ABOVE?

LIST YOUR SURGICAL HISTORY AND DATES OF SURGERIES:

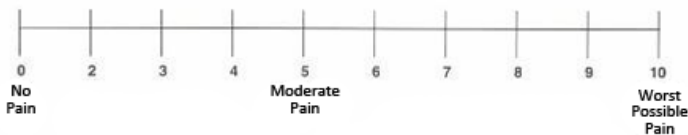
CHECK ANY CURRENT OR PAST HEALTH PROBLEMS:		
<input type="checkbox"/> HIGH BLOOD PRESSURE <input type="checkbox"/> HIGH CHOLESTEROL <input type="checkbox"/> HEART DISEASE <input type="checkbox"/> BREATHING PROBLEMS <input type="checkbox"/> STROKE OR MINISTROKE <input type="checkbox"/> HEARTBURN <input type="checkbox"/> ULCERS <input type="checkbox"/> ACID REFLUX <input type="checkbox"/> LIVER PROBLEMS <input type="checkbox"/> HEPATITIS <input type="checkbox"/> DIABETES	<input type="checkbox"/> SEIZURES <input type="checkbox"/> OSTEOARTHRITIS <input type="checkbox"/> RHEUMATOID ARTHRITIS <input type="checkbox"/> GOUT <input type="checkbox"/> SHINGLES <input type="checkbox"/> DIABETIC NEUROPATHY <input type="checkbox"/> HEADACHES <input type="checkbox"/> DEPRESSION <input type="checkbox"/> ANXIETY <input type="checkbox"/> DRUG / ALCOHOL ABUSE <input type="checkbox"/> CANCER	<input type="checkbox"/> PROSTATE PROBLEMS <input type="checkbox"/> KIDNEY PROBLEMS <input type="checkbox"/> FIBROMYALGIA <input type="checkbox"/> REFLEX DYSTROPHY ANY OTHER HEALTH PROBLEMS: _____ _____ _____ _____

TELL US ABOUT YOUR PAIN:



Shade areas of your body where your pain is the most severe.

0-10 Numeric Pain Intensity Scale



Please rate your pain using these scales:

- 1: Rate pain on your **best** day: _____
- 2: Rate pain on your **worst** day: _____
- 3: What is your **average** level of pain? _____
- 4: What is a level of pain you can live with? _____

CIRCLE WORDS THAT DESCRIBE YOUR PAIN:

SHARP SHOOTING DULL STABBING ACHEY BURNING NUMBNESS/TINGLING

WHEN DID THE PAIN START? _____

WAS IT THE RESULT OF A WORK INJURY? _____ **IF YES, WHAT WAS THE DATE OF THE INJURY:** _____

HAVE YOU HAD XRAYS OR MRI? _____ **IF YES, WHEN AND WHERE WERE THEY DONE?** _____

PLEASE CHECK THE TREATMENTS YOU HAVE HAD FOR PAIN:

TREATMENT	WHEN?	DID IT HELP?
<input type="checkbox"/> SURGERY	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> PHYSICAL THERAPY	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> MASSAGE THERAPY	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> TENS UNIT	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> BACK BRACE	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> TRACTION	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> INJECTIONS	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> ANTI-INFLAMMATORY MEDS	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> NARCOTIC MEDS	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

PATIENT NAME: _____

DATE OF BIRTH: _____

CHECK SYMPTOMS YOU HAVE HAD IN THE LAST MONTH:

<p>OVERALL HEALTH:</p> <ul style="list-style-type: none"><input type="checkbox"/> FEVER<input type="checkbox"/> LOSS OF APPETITE<input type="checkbox"/> INSOMNIA<input type="checkbox"/> WEAKNESS/FATIGUE<input type="checkbox"/> UNEXPLAINED WEIGHT LOSS<input type="checkbox"/> UNEXPLAINED WEIGHT GAIN<input type="checkbox"/> RASH <p>RESPIRATORY:</p> <ul style="list-style-type: none"><input type="checkbox"/> WHEEZING<input type="checkbox"/> DIFFICULTY BREATHING<input type="checkbox"/> COUGH<input type="checkbox"/> USE OF INHALERS <p>MUSCULOSKELETAL:</p> <ul style="list-style-type: none"><input type="checkbox"/> JOINT PAIN<input type="checkbox"/> SWELLING<input type="checkbox"/> STIFFNESS<input type="checkbox"/> LEG CRAMPS<input type="checkbox"/> MUSCLE ACHES	<p>CARDIOVASCULAR:</p> <ul style="list-style-type: none"><input type="checkbox"/> CHEST PAIN<input type="checkbox"/> SHORTNESS OF BREATH<input type="checkbox"/> DIZZINESS<input type="checkbox"/> SWELLING IN THE ANKLES<input type="checkbox"/> PALPITATIONS<input type="checkbox"/> COLD EXTREMITIES <p>GASTROINTESTINAL:</p> <ul style="list-style-type: none"><input type="checkbox"/> NAUSEA/VOMITING<input type="checkbox"/> DIARRHEA<input type="checkbox"/> CONSTIPATION<input type="checkbox"/> BLACK OR TARRY STOOLS<input type="checkbox"/> DIFFICULTY SWALLOWING<input type="checkbox"/> HEARTBURN <p>NEUROLOGICAL:</p> <ul style="list-style-type: none"><input type="checkbox"/> NUMBNESS/TINGLING<input type="checkbox"/> DIZZINESS<input type="checkbox"/> POOR BALANCE<input type="checkbox"/> BLURRED VISION<input type="checkbox"/> WEAKNESS IN ARMS OR LEGS
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PAIN RESEARCH OF CHARLESTON:

Pain Research of Charleston (PRC) is an independent, multi-therapeutic outpatient clinical research site, which conducts Phase II, III and IV clinical trials. Are you interested in learning about and/or participating in Clinical Trials with Pain Research of Charleston? Please check the area of diagnosis in which you apply:

- Arthritis
- Back Pain
- Pain After Shingles
- Constipation Caused By Narcotics
- Pain Medications
- Low Testosterone

Visit www.PainResearchChas.com to learn more about Pain Research of Charleston trials and opportunities.

Financial Policy Agreement

Thank you for choosing Pain Specialists of Charleston P.A. for your health care needs. Our primary concern is that you receive the most appropriate treatment to restore and maintain your good health; as with any type of medical care, understanding the financial impact and responsibilities associated with that treatment is also important. **It is important that you read this financial policy agreement before receiving treatment**

Pain Specialists of Charleston, P.A. accepts cash, check, VISA and MasterCard. We will also bill your insurance carrier as a courtesy to you.

To be treated by Pain Specialists of Charleston, P.A. you must understand, agree to and initial the provisions set forth below:

I understand that if I need to reschedule my appointment, I must call Pain Specialists of Charleston to reschedule at least 24 hours before said appointment. I understand that a \$25 fee will be applied to all office visit consultation appointments and a \$75 fee will be applied to all office visit procedure appointments not cancelled within a 24 hour period.

I understand that my healthcare policy is an agreement between myself and the insurance company. If the insurance company has not paid my bill in full within 60 days of treatment, I agree to contact them to facilitate payment.

I understand that insurance copayments and deductibles are due prior to receiving treatment.

I agree that any payments sent directly to me are the property of the Provider. I agree to immediately forward to Provider all payments, explanation of benefits and correspondence sent directly to me from all Third Party Payors related to the care rendered by the Provider. I agree that failure to do so will make me responsible for the entire billed charge (unless there are contractual obligations between Provider and Third Party Payor disallowing balance billing).

I understand that all treatment charges are my responsibility whether the insurance company pays or not. I understand that not all services are a covered benefit and that I am financially responsible for and agree to pay all charges not paid by my insurance or Third Party Payor within 60 days from time of service. This includes, but is not limited to, deductibles and co-insurance unless there are contractual obligations between Provider and Third Party Payor disallowing balance billing.

I understand that I am financially responsible for any increased co-pays, deductibles and non-covered services provided on an out-of-network basis. As a courtesy to our patients, Pain Specialists of Charleston P.A. will obtain any pre-authorization and/or pre-certification required prior to services performed; HOWEVER, I understand that it is my responsibility to ensure these pre-authorization and/or pre-certifications are obtained. This is not the responsibility of my Provider. I also acknowledge that no guarantees have been made by any employee of the Provider, physician or other party about my treatment including whether it will be paid for by any Third Party Payors and/or whether Provider is in or out of my network with my Third Party Payors.

I agree to fully cooperate with Providers to assist in their efforts to get claims paid on my behalf. It is my sole responsibility to verify the status of my healthcare benefits directly from my Third Party Payors. It is my sole responsibility to determine what portion of the care rendered by the Provider will be covered by my Third Party Payors and that by receiving said care; I agree to pay any and all charges not paid for by my Third Party Payor within 60 days of receiving said care. I unconditionally guarantee payment of these charges.

I agree to promptly notify Provider of any changes in my health insurance plan and/or coverage including changes to my address and/or phone number. I understand that my failure to do so will make me fully responsible for the entire bill as this is not the responsibility of the Provider. In consideration of the services furnished to me, I hereby agree to pay any balance due within thirty (30) days from presentation of my bill and that Providers are not required to honor any limiting notations I make on a payment.

We appreciate your trust in us and thank you for the opportunity to serve your health care needs. If you have any questions or concerns about our payment policies, please ask to speak with a financial counselor either by phone or in person.

ASSIGNMENT AND RELEASE: I authorize payment to be made directly to Pain Specialists of Charleston and fully understand that I am the responsible party for all charges incurred by me or my dependents at this facility. I also authorize the release of any and all information required to collect and process my claims. If legal action becomes necessary, I agree to pay all collection fees.

Responsible Party (Please Print)

Date

Responsible Party Signature

Witness Initials

HIPAA RELEASE & NOTICE OF DISCLOSURE

Pain Specialists of Charleston, P.A. is authorized to release protected health information about the above named patient to the entities named below.

May we leave appointment reminders, prescription information, and messages to call our office back on your answering machine or voicemail?

Yes No

May we share information with your Attorney?

Yes Attorney's Name: _____ No N/A

May we share information with your spouse, caretaker, or child(ren)?

Yes No

If yes, please list their name(s): _____

May we share information with your employer? Yes No

If yes, please list the contact person at your employer: _____

Rights of the patient: 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 in this document by sending a written notification to Pain Specialists of Charleston, P.A. I understand that a revocation is not effective in cases where information has already been disclosed but will be effective going forward.

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

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

Acknowledgement of Receipt of Notice of Privacy Practice: I hereby acknowledge that I received a copy of the Pain Specialists of Charleston, P.A. Notice of Privacy Practices. Copies follow this form.

Patient or Patient Representative Signature

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payors.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient or Patient Representative Signature

PATIENT GUIDELINES FOR PAIN SPECIALISTS OF CHARLESTON, P.A.

Our mission is to offer you the highest quality care in a comfortable, efficient and safe manner. Listed below are some guidelines for your review. Throughout the time you receive services from our organization, please feel welcome to contact any member of our team with questions or need for any information.

Wishing you good health,

The Physicians and Staff of Pain Specialists of Charleston, P.A.

- **Cancellations:** If you are unable to keep an appointment, kindly call our office at least 24 hours prior to your appointment. We can then reschedule your appointment to a more convenient time. A \$25 fee will be applied to all Office Visit appointments not canceled within the 24 hour period or if you fail to keep your appointment. A \$75 fee will be applied to all Procedure appointments not canceled within the 24 hour period or if you fail to keep your appointment.
- **Tardiness:** Please arrive 15 minutes prior to your appointment time. It is important to have your New Patient forms completed prior to your appointment. If the forms are not completed, or you are more than 15 minutes late, you may need to be rescheduled for a later date.
- **Repeated Missed Appointments:** We will be unable to schedule future appointments for patients having three (3) missed appointments and/or cancellations without appropriate notice; particularly if we feel that these missed appointments are adversely affecting our intervention/treatment plan.
- **Co-Payments:** Co-payments and deductibles must be paid at the time of check-in. We accept cash, checks and debit cards Visa, MasterCard and Discover.
- **Medication Prescribing Policy:** We can prescribe medications to our patients for chronic pain. **We do not write for the following medications: Soma or Benzodiazepines (Xanax, Valium). Prescribing responsibilities of these classes of drugs will remain with your primary care physician.** We do prescribe long-term narcotics at the physician's discretion.
- **Medication Refill Policy:** To ensure your medication needs are met in a timely manner, we request a 48-hour notice for refill requests, and no refill requests can be taken after 12 PM on Fridays.
- **Patient Phone Calls:** All patient phone calls or requests will be addressed by a nurse within 24 hours. We regularly check the Nurse's voicemail throughout the day and will contact the patient as quickly as possible.
- **Patient Information Changes:** If you have a change to your insurance, claims adjustor, attorney, primary treating physician, or any other changes to your personal information, please supply us with the new information within 10 days of the change so we can keep your records up-to-date.
- **Insurance:** You are responsible for knowing the coverage & benefits of your particular insurance company. If you are not sure of the requirements of your insurance company, please check with them prior to obtaining medical services. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

Signature of Patient or Responsible Party

Date