Pain Specialists of Charleston, P.A.
Get back into life

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www.PainChas.com

# 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, Clinical Trials of South Carolina, 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. A Northwestern University Interventional Pain Fellow, Walter Schuyler is board certified in Anesthesiology and board eligible in Pain Medicine. Supporting our physicians are Brittany Whiteside PA-C and Amanda McFann, MSN, NP-C.

### 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:

- Medical Massage Therapy & Wellness Programs (843) 818-1181
- Clinical Trials of South Carolina (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**

Accredited by the
ACCREDITATION ASSOCIATION for AMBULATORY HEALTH CARE, INC.

Pain Specialists of Charleston, P.A.
*Get back into life*

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: | |
| *Would you like to receive quarterly emails with News & Events from our Practice?* □*Yes* □*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: | |
| ***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: | |
| ***If this is a Workers Compensation case, please include your Adjuster's contact information:*** | | | |
| Adjuster Name: | Adjuster Phone #: | Claim #: | |
| ***If you have an Attorney, please include your Attorney's contact information:*** | | | |
| Attorney Name: | Attorney Phone #: | | |
| **Pharmacy Information:** | | | |
| Pharmacy Name: | Pharmacy Phone #: | Pharmacy Address: | |
| **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: |
|---|---|---|
| • _____<br>• _____<br>• _____<br>• _____<br>• _____<br>• _____<br>• _____<br>• _____ | • _____<br>• _____<br>• _____<br>• _____<br>• _____<br>• _____<br>• _____ | □ ASPIRIN<br>□ PLAVIX (CLOPIDOGREL)<br>□ COUMADIN (WARFARIN)<br>□ PLETAL (CILOSTAZOL)<br>□ TRENTAL<br>□ AGGRENOX<br>□ PRADAXA (DABIGATRAN ETEXILATE)<br>□ XARELTO (RIVARONXABAN) |

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

_____

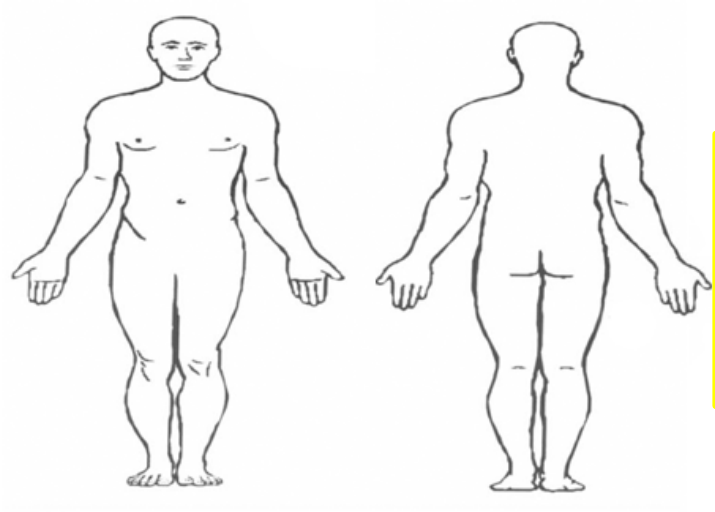
LIST YOUR SURGICAL HISTORY AND DATES OF SURGERIES:

_____

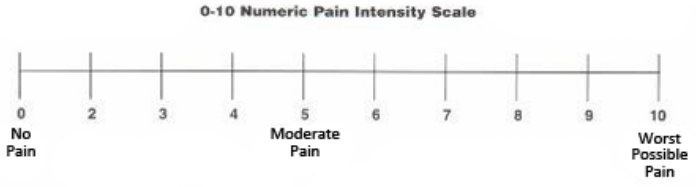
_____

| CHECK ANY CURRENT OR PAST HEALTH PROBLEMS: | | |
|---|---|---|
| □ HIGH BLOOD PRESSURE | □ SEIZURES | □ PROSTATE PROBLEMS |
| □ HIGH CHOLESTEROL | □ OSTEOARTHRITIS | □ KIDNEY PROBLEMS |
| □ HEART DISEASE | □ RHEUMATOID ARTHRITIS | □ FIBROMYALGIA |
| □ BREATHING PROBLEMS | □ GOUT | □ REFLEX DYSTROPHY |
| □ STROKE 0R MINISTROKE | □ SHINGLES | |
| □ HEARTBURN | □ DIABETIC NEUROPATHY | ANY OTHER HEALTH PROBLEMS: |
| □ ULCERS | □ HEADACHES | _____ |
| □ ACID REFLUX | □ DEPRESSION | _____ |
| □ LIVER PROBLEMS | □ ANXIETY | _____ |
| □ HEPATITIS | □ DRUG / ALCOHOL ABUSE | _____ |
| □ DIABETES | □ CANCER | |

**TELL US ABOUT YOUR PAIN:**



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





**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? |
| ☐ SURGERY | _____ | ☐Yes ☐No |
| ☐ PHYSICAL THERAPY | _____ | ☐Yes ☐No |
| ☐ MASSAGE THERAPY | _____ | ☐Yes ☐No |
| ☐ TENS UNIT | _____ | ☐Yes ☐No |
| ☐ BACK BRACE | _____ | ☐Yes ☐No |
| ☐ TRACTION | _____ | ☐Yes ☐No |
| ☐ INJECTIONS | _____ | ☐Yes ☐No |
| ☐ ANTI-INFLAMMATORY MEDS | _____ | ☐Yes ☐No |
| ☐ NARCOTIC MEDS | _____ | ☐Yes ☐No |

**CHECK SYMPTOMS YOU HAVE HAD IN THE LAST MONTH:**

**OVERALL HEALTH:**

- ☐ FEVER
- ☐ LOSS OF APPETITE
- ☐ INSOMNIA
- ☐ WEAKNESS/FATIGUE
- ☐ UNEXPLAINED WEIGHT LOSS
- ☐ UNEXPLAINED WEIGHT GAIN
- ☐ RASH

**MUSCULOSKELETAL:**

- ☐ JOINT PAIN
- ☐ SWELLING
- ☐ STIFFNESS
- ☐ LEG CRAMPS
- ☐ MUSCLE ACHES

**CARDIOVASCULAR:**

- ☐ CHEST PAIN
- ☐ SHORTNESS OF BREATH
- ☐ DIZZINESS
- ☐ SWELLING IN THE ANKLES
- ☐ PALPITATIONS
- ☐ COLD EXTREMITIES

**GASTROINTESTINAL:**

- ☐ NAUSEA/VOMITING
- ☐ DIARRHEA
- ☐ CONSTIPATION
- ☐ BLACK OR TARRY STOOLS
- ☐ DIFFICULTY SWALLOWING
- ☐ HEARTBURN

**NEUROLOGICAL:**

- ☐ NUMBNESS/TINGLING
- ☐ DIZZINESS
- ☐ POOR BALANCE
- ☐ BLURRED VISION
- ☐ WEAKNESS IN ARMS OR LEGS

**RESPIRATORY:**

- ☐ WHEEZING
- ☐ DIFFICULTY BREATHING
- ☐ COUGH
- ☐ USE OF INHALERS

**Clinical Trials of South Carolina:**

Clinical Trials of South Carolina 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 Clinical Trials of South Carolina? Please check the area of diagnosis in which you apply:

- ☐ Arthritis
- ☐ Back Pain
- ☐ Pain After Shingles
- ☐ Diabetes
- ☐ Constipation Caused By Pain Medications
- ☐ Neurology

**WE VALUE YOUR FEEDBACK!**

We know you have a wealth of choices when it comes to health care and we THANK YOU for choosing Pain Specialists of Charleston for your treatment.

If there is anything that our practice can do to better treat or serve you, we invite you to share your feedback!

**Patient Satisfaction Phone Line: 843-818-1181, extension 9**
**Patient Feedback Survey: www.PainChas.com**

Pain Specialists of Charleston, P.A.
Get back into life

# SOAPP® Version 1.0-14Q

Name: _____ Date: _____

*The following are questions given to all patients at Pain Specialists of Charleston P.A. who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.*

Please answer the questions below using the following scale:

**0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often**

| | |
|---|---|
| 1. How often do you have mood swings? | 0 1 2 3 4 |
| 2. How often do you smoke a cigarette within an hour after you wake up? | 0 1 2 3 4 |
| 3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs? | 0 1 2 3 4 |
| 4. How often have any of your close friends had a problem with alcohol or drugs | 0 1 2 3 4 |
| 5. How often have others suggested that you have a drug or alcohol problem? | 0 1 2 3 4 |
| 6. How often have you attended an AA or NA meeting? | 0 1 2 3 4 |
| 7. How often have you taken medication other than the way that it was prescribed? | 0 1 2 3 4 |
| 8. How often have you been treated for an alcohol or drug problem? | 0 1 2 3 4 |
| 9. How often have your medications been lost or stolen? | 0 1 2 3 4 |
| 10. How often have others expressed concern over your use of medication? | 0 1 2 3 4 |
| 11. How often have you felt a craving for medication? | 0 1 2 3 4 |
| 12. How often have you been asked to give a urine screen for substance abuse? | 0 1 2 3 4 |
| 13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years? | 0 1 2 3 4 |
| 14. How often, in your lifetime, have you had legal problems or been arrested? | 0 1 2 3 4 |

*Please include any additional information you wish about the above answers. Thank you.*

_____

_____

_____

# 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 Notice of Privacy Practices

Effective as of April/14/2003
Revised March/26/2013

Pain Specialists of Charleston, P.A
2695 Elms Plantation Blvd – Suite A – North Charleston SC 29406

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY**

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

## USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

## USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (continued)

**Other Permitted and Required Uses and Disclosures** will be made **only with your consent**, **authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

**You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**YOUR RIGHTS:** The following are statements of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information (fees may apply) –** Pursuant to your written request**,** you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

**You have the right to request a restriction of your protected health information –** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

**You have the right to request to receive confidential communications –** You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You have the right to request an amendment to your protected health information –** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures –** You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

**You have the right to receive notice of a breach** – We will notify you if your unsecured protected health information has been breached.

**You have the right to obtain a paper copy of this notice** from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

**COMPLAINTS**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint.
**We will not retaliate against you for filing a complaint.**

*HIPAA COMPLIANCE OFFICER:* Amy Hack: 843-818-1181, extension 5 or ahack@painchas.com

**We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.**

# 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

Pain Specialists of Charleston, P.A.
Get back into life

## PATIENT'S BILL OF RIGHTS FOR PAIN SPECIALISTS OF CHARLESTON, P.A.

**Pain Specialists of Charleston, P.A. endorses a Patient's Bill of Rights. It is an expectation that compliance with the Patient's Bill of Rights can contribute to an effective program for the patient.**

1. The patient has the right to considerate and respectful care.
2. The patient has the right to obtain from their credentialed practitioner complete and current information concerning the diagnosis, proposed treatment, and expected prognosis in terms that the patient may reasonably be expected to understand. When it is not advisable to give to give such information to the patient, the information should be made available to an appropriate person (medical proxy) on the patient's behalf.
3. The patient has the right to receive the necessary information for medical decision making and the granting of informed consent from the treating credentialed practitioner prior to the start of any procedure or treatment. This information shall include at the minimum: the expected procedure or treatment to be used, who will perform the procedure or treatment, what are the likely benefits from the procedure or treatment, what alternatives exist if any, what are the likely risks from the procedure or treatment, what may occur if no treatment is undertaken, and length of probably duration of incapacitation if any is expected.
4. The patient has the right to refuse any and all treatment to the extent permitted by law, and to be informed of any medical consequences of this action.
5. The patient has the right to every consideration of privacy concerning the medical care provided except when there is an imminent risk to the individual or others, or when the practitioner is ordered by a court to breach confidentiality.
6. The patient has the right to examine and receive an explanation of the bill for professional services rendered.
7. The patient has the right to request contact with the Clinical Manager or Chief Operations Officer to express suggestions and complaints and grievances, including those required by state and federal regulations.

**Grievance Information:**

**For any complaints, please contact our office at (843) 818-1181 and speak with our Chief Operating Officer**

You may also contact the State Department of Health at (803)898-DHEC(3432) or the website for the Medicare Ombudsman at www.medicare.gov/claims-and-appels/file-a-complaint/complaints.

All pain management activities are to be provided with an overriding concern for the patient, and above all, with the recognition of the patient's dignity as a human being.

_____ _____

Signature of Patient or Responsible Party Date

Pain Specialists of Charleston, P.A.
Get back into life

# 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. It is an expectation that the patient's compliance with the Patient Guidelines can contribute to an effective program for the patient.**

- **Patient Conduct:** It is the patient's responsibility to be respectful of all the health care providers and staff, as well as other patients.
- **Procedure Appointments:** Patients are required to bring a responsible adult party to procedure appointments when sedation is received. In this circumstance, the responsible party is to remain in the office for the duration of the procedure, act as the patient's driver post-procedure, and must remain with the patient for twelve (12) hours post-procedure.
- **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 for and type of appointment, you WILL need to be rescheduled for a later date.
- **Repeated Missed Appointments and/or Late Appointments:** We will be unable to schedule future appointments for patients having two (2) 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 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 may prescribe long-term narcotics at the provider'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 insurance carrier. If you are unsure of these requirements, please verify your coverage & benefits prior to obtaining medical services. Insurance is considered a method of reimbursing the patient for fees paid to the doctor and not a substitute for payment. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance.

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Signature of Patient or Responsible Party Date

**WE VALUE YOUR FEEDBACK!**

Patient Satisfaction Phone Line: 843-818-1181, extension 9

Patient Feedback Survey: www.PainChas.com