Today's Date: / /

PATIENT INFORMATION

Last name:	First:	Middle:	Marital status:

Is this your legal name?	If not, what is your legal name?	Birth date:	Age:	Sex:
○ No ○ Yes				○ M ○ F

Address:

Social Security #:	Home phone no.:	Cell phone no.:
Reason for visit (Type of illness or injury):	Date of injury:	Language:

INSURANCE INFORMATION

(Please give your insurance card and photo ID to the receptionist)

The person who comes to our office for medical care is responsible for the charges unless a third-party payer is authorized in advance. There is a $185.00 minimum payment required at the time of the initial visit for our self-pay patients ($60 deposit payable at time of scheduling for self-pay patients) (No Insurance, No MVA, and No WC), and it will be cash or $200 credit card. All co-pays and deductibles are due at the time of service. Patients will be charged a $40 no-show fee for missed appointments that have not been cancelled within 24 hours of said appointment.

Method of Payment:

○ Medicare ○ Insurance ○ Worker's Compensation ○ Letter of Protection (Attorney Case)

○ Self Pay ☐ Cash ☐ Check ☐ Credit Card ☐ Other

Name of PRIMARY insurance:	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:

Name of SECONDARY insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY			
Name of local friend or relative:	Relationship to patient:	Home phone no:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature: _____

Please Help Us By Answering The Following Questions Accurately

Is this appointment related to any type of injury?	☐ **Yes** ☐ **No**	
	If yes: Were you involved in a Motor Vehicle Accident and your case is still active and open?	☐ **Yes** ☐ **No** **If yes**, is this appointment related to your MVA? ☐ **Yes** ☐ **No** **If yes,** Date of Accident: State where the accident happened:
	Were you involved in a work-related accident and your case is still active and open?	☐ **Yes** ☐ **No** **If yes**, is this appointment related to your work injury? ☐ **Yes** ☐ **No** **If yes,** Date of Accident: State where the accident happened: Have you filed a claim with your employer? ☐ **Yes** ☐ **No** **If yes,** Worker's Compensation Claim # Worker's Compensation Adjuster Name, Number and Address
	DO YOU HAVE AN ATTORNEY INVOLVED FOR AN INJURY/MVA/WC? ☐ **Yes** ☐ **No** If you checked yes, please provide us with the attorney's name and phone number. **THIS INFORMATION IS NECESSARY AND A REQUIREMENT TO CONTINUE TREATMENT WITH OUR OFFICE.**	

HIPAA PERMISSIONS

Please keep in mind, we confirm all appointments 2 -3 days in advance, if we cannot contact you or you do not call back to confirm your appointment, it will be cancelled.

What method can we use to contact you about your appointments?

☐ Phone? Preferred Phone Number_____

☐ Email (notice: our email is not encrypted) Preferred Email _____

May we leave messages on your voicemail with your specific appointment information?

☐ Yes ☐ No

May we release your complete medical records to your referring physician and/or your primary care physician?

☐ Yes ☐ No

I, the patient hereby authorizes Charles J. Nivens, M.D. to release my medical information (appointments, lab/x-ray results, diagnoses. Treatments, medications, surgeries, etc.) via postal mail, telephone, fax, or email to the following family members:

Name	Date of Birth	Relationship

I further release my medical information to the following physicians, clinics, and/or hospitals:

Doctor	Phone #	Clinic

Patient Name (Printed): _____ Patient /Guardian Signature: _____ Date: _____

Medical History

Please list all medications you are currently taking

Drug Name	MG	Frequency per day	Prescribed by

Please List any current health conditions (Heart Disease, High Blood Pressure, Diabetes, GERD, etc.)

Please list any allergies to medications, latex and/or x-ray or contrast dye (past or present)

Agent/Substance	Reaction

Please list any surgeries you have had in the past below.

Date (Mo./Yr.)	Reason

Please list any Hospitalizations you have had in the past below.

Date (Mo./Yr.)	Reason

FAMILY MEMBER	Is the Family Member Deceased?	YEAR OF BIRTH	AGE	DIABETES	HYPERTENSION	HEART DISEASE	MENTAL ILLNESS	CANCER	OSTEOARTHRITIS	NEUROPATHY	SCOLIOSIS	LOW BACK PAIN	UNKNOWN
DAUGHTER	○ Deceased												
FATHER	○ Deceased												
SON	○ Deceased												
MOTHER	○ Deceased												
PATERNAL GRAND FATHER	○ Deceased												
PATERNAL GRAND MOTHER	○ Deceased												
MATERNAL GRAND FATHER	○ Deceased												
MATERNAL GRAND MOTHER	○ Deceased												
PATERNAL UNCLE	○ Deceased												
PATERNAL AUNT	○ Deceased												
MATERNAL UNCLE	○ Deceased												
MATERNAL AUNT	○ Deceased												
SIBLING(S)	○ Deceased												

CHILDREN	Deceased												

Do you or any members of your family have a history of the following? (Check all that apply)

Social History

1. Are you currently taking a blood thinner?
   a. ☐ NO ☐ YES Name of Blood Thinner _____

2. Do you smoke cigarettes?
   a. ☐ YES, I smoke daily ☐ Yes, I smoke occasionally/socially ☐ I smoked in the past ☐ NO, I have never been a smoker

3. Do you have a history of abusing prescription medication?
   a. ☐ YES ☐ NO

4. Any past or present illicit drug use or abuse?
   a. ☐ YES ☐ NO

5. Marital Status?
   a. ☐ Single ☐ Separated ☐ Widowed ☐ Divorced ☐ Married

6. Employment Status?
   a. ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Unemployed ☐ Retired ☐ Disability

7. Have you ever tested positive for HIV, Hepatitis (A, B, or C) or Tuberculosis Test/Screening?
   a. ☐ YES ☐ NO

8. Please list all physicians you see on a regular basis;(Cardiologists, Urologists, Primary Care Physician, etc.)

Charles J. Nivens, MD, PA Narcotics Policy

Taking pain pills can sometimes prolong the pain that you are in. If narcotics are blocking pain stimulus to your brain when you have injured yourself, you may be more active than you normally would be. At this time, the painful area may feel okay, but when the pain pills wear off, you may find yourself worse in the long run.

Anti-inflammatory pills such as Ibuprofen, Celebrex, or Relafen are much different. They reduce pain by treating the problem--inflammation. They work similar to putting ice on a painful area.

Your brain also makes its own pain blockers called endorphins. They are natural pain reducing chemicals that help block the pain. If you are taking narcotic pain medicine when you begin to have pain, your brain will not make endorphins. This could make your pain worse once the medicine wears off.

All narcotic pain medicines are in the same family as heroin and morphine. Most people become **dependent** on these medicines after ***2-3 weeks*** of taking them. Breaking such a dependency is very difficult. Many patients have this type of problem when they first present to our office. We try not to add to this problem.

Our philosophy is to help your pain, not block your pain. This is usually done best with anti-inflammatory medicines, injections, and rehabilitative therapy. If there is acute pain or pain after an injection, we will give you short term narcotics. Otherwise, we have a No Narcotic Policy. Please do not expect us to refill your pain medications automatically. There is a 24 to 48 hour turn-around on refill requests.

It is important that there is only one physician giving a patient pain medication. If Dr. Nivens prescribes pain medication, then he is to be the only physician doing so. **If a patient is receiving narcotic prescriptions from another physician, this could result in a discharge from Dr. Nivens practice for failure to comply with this narcotic policy.** The patient is to use the pain medication ONLY as prescribed. Patients are NOT to increase their pain medication without first consulting Dr. Nivens.

After Hours Narcotic Policy

There will be no narcotic medications prescribed after the close of the business day. Our office hours are Monday thru Thursday, 8 am- 5 pm and Friday 8 am – 2 pm. All medication requests will be assessed and dispensed with Dr. Nivens' approval, only during these hours. If for any reason you

anticipate the need of any narcotic medications over the weekend all requests must be done so within the week, as there will be no requests taken over the weekend.

Pain associated with, or extending from, having an injection is encouraged to be reported, as these situations will be taken care of in a direct and responsive manner. For assistance after hours, you may contact our regular business phone; the answering service will in turn contact Dr. Nivens.

I, _____, have read and understand Dr. Nivens' Narcotics policy. Patient /Guardian Signature: _____ Date: _____

Patient Financial Policy and Procedure

Introduction:
Dr. Nivens' practice is a professional business providing non-surgical spine medicine including health related diagnostic and therapeutic services. These services are provided to its patients and clients with the expectation of making the profit needed to financially support its employees, to pay its necessary expenses, and to develop future new services.
A professional relationship requires honest financial accountability. This document states the policy by which Dr. Nivens' office will hold itself and its patients and clients accountable

Appointments:
Please contact our office to schedule time to see your Doctor. You can expect to be in our office for approximately 1-2 hours. Walk INS are accepted, if the schedule is booked, we will make every effort to work you in as soon as possible, however, you may have to wait longer than the normal waiting time for scheduled appointments. Please understand that our staff is working very hard to give the best care and would appreciate your patience in this matter.

Confirmation policy:
Due to the nature of patient's problems and the volume of patients in Dr. Nivens practice, the office staff confirms all upcoming appointments. A member of the office staff will call to confirm your appointment. If you cannot be reached by the day prior to your appointment to confirm, your appointment will be cancelled and will have to be rescheduled. Please inform office staff of any changes to your contact numbers to ensure you can be reached.

Cancellation policy:
If you need to cancel an appointment; a 24- hour notice policy applies. Due to the nature of our patient's problems, this will allow us to schedule someone in severe pain in your spot, if we know about the cancellation far enough in advances. There is a $40.00 fee for missing an appointment without a 24- hour cancellation notice.

Charges for Professional Services:
All services will be charged to the patient according to a fee schedule determined by the office Contractual discounts to third party payers, agreed to by the office, will be honored in good faith. No fee or charge can be reduced or waived without the permission of only the administrator or billing manager. Upon request, these fees can be issued to the client.

Monthly statements of payment transactions and the total amount owed will be sent until the debt is totally satisfied.

Payment:
Payment for services is considered the patient's responsibility. All co-payments, co-insurance, balances and deductibles will be collected at the time of service. Dr. Nivens' reserves the right to request payment of the total negotiated fee on the date due unless directed otherwise by contract. Cash, check, money order, and certain credit cards will be acceptable methods of payment.

Non-urgent professional service may be delayed or terminated within the guidelines of good medical practice for bad-faith patient noncompliance with this financial policy.

Insurance:
Health insurance is primarily a contract between the patient and the insurance company. However, Dr. Nivens' office also has contractual obligations with certain private and government entities. The patient is primarily responsible for holding the insurance company accountable for claims reimbursement. Dr. Nivens' office will make available substantial resources to facilitate insurance payment and will dedicate its resources towards its own contractual obligations with these entities.

Credit:
Credit will be extended for 60 days to patients with valid insurance policies applicable to the charges for services after fulfillment of appropriate co-payments. After 60 days, this credit will be revoked, and all payments will be immediately due. It is a SC State law that insurance companies have 60 days after receiving a medical claim to make payment to the provider.

Collection Agencies:
Dr. Nivens' office will use all reasonable means to collect owed funds. Defaults in payment of agreed amounts will be automatically referred to a collection agency for payment.

Responsibilities of the Patient:
The patient is expected to have knowledge of the benefits provided through their insurance carrier or third-party payer. A telephone number on the back of the insurance card can usually be used to obtain this information.

At each office visit or patient encounter, the patient will provide a current mailing address and telephone number as well as current third-party information necessary for billing purposes. This information must be given to the receptionist upon signing in, or to our medical assistant as the patient is being checked out. The doctor will need to know the identity of the insurance company to make proper referrals under the managed care contract, thus, proper identification is mandatory.

The patient is to contact his or her insurance company if payment is not made within 60 days.
The patient is to immediately make total payment when the debt is due.
The patient is to inform the office if payment arrangements need to be made, due to extenuating circumstances.

Responsibilities of the office:
The office will make a good effort to obtain necessary pre-certifications for requested procedures required by contracted third parties to facilitate approval for payment. Failure to obtain pre-certifications or approval from the insurance company does not necessarily mean that the requested procedure is not medically necessary; in this circumstance, the patient may be financially responsible for services ordered or rendered.

Upon receiving accurate insurance/third party information the clinic will file an appropriate American Medical Association-approved claim to the appropriate entity (for example: insurance company, employer, worker' compensation plan). The office will make a good-faith effort with help from the patient to follow up these claims to

facilitate payment.
The office will fairly enforce this policy and procedure upon all patients.
I state that I have read this financial policy and procedure and have been given an opportunity to ask questions. I accept this policy and procedure and will comply with it as part of my professional relationship with Dr. Nivens' offices.

Patient or Responsible Party Printed Name: _____

Patient /Guardian Signature: _____ Date: _____

Witnessed By: _____