Keystone Pain Consultants
&
Interventional Spine Specialists

Richard Plowey, MD, MPH **Karthik Dwarki, MD**

Professional Building Bower Hill Road
1145 Bower Hill Road, Suite 105, Pittsburgh, PA 15243
Phone: 412-866-7246 Fax:412-866-7240

Washington Health System Building
80 Landings Drive, Suite 202, Washington, PA 15301
Phone: 724-969-0191 Fax: 724-941-9089

Your new patient appointment is scheduled as follows:

Date: _____ Time: _____

Office: Bower Hill Washington Provider: _____

- **We have enclosed several forms for you to fill out. Please bring these completed, along with your insurance card(s), a photo ID and specialist copayment to your appointment. Insurance cards and photo ID are required at every visit.**
- **If you have had any imaging (X-rays, MRI, CT, etc.) pertaining to condition, please bring the reports with you to your appointment.**
- **If your insurance requires a referral, you are responsible for obtaining it prior to your appointment. For more information, you may need to contact your insurance carrier.**
- **Insurance co-pays and payments for any non-covered treatments are due at the time of your visit. We accept cash, checks, and credit cards.**
- **If you are unable to keep your appointment, please notify the office within 24 hours prior to the scheduled appointment. As of January 1, 2015, ALL NO SHOWS will be charged a $35 NO SHOW FEE.**

Thank you for choosing our practice. Please contact our office with any questions or concerns that you may have. We look forward to meeting you.

KEYSTONE PAIN CONSULTANTS & INTERVENTIONAL SPINE SPECIALISTS

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Patient Information

Name: _____

Street Address: _____ **City:** _____

State: _____ **Zip:** _____

Home Phone: _____ **Cell phone:** _____

Date of Birth: _____ **Social Security Number:** _____

Sex: M F Marital status: S M W D

Email address: _____

Primary Care Physician: _____ **Phone:** _____

Referring Physician: _____ **Phone:** _____

Employer Name: _____

Employer Address: _____ **City/State:** _____ **Zip:** _____

Patient Occupation: _____ **Work Phone:** _____

Spouse Name: _____ **Phone:** _____

Emergency Contact: _____ **Phone:** _____

Relationship to patient: _____

AUTHORIZED TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFIT

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I HEREBY AUTHORIZE KEYSTONE PAIN CONSULTANTS TO APPLY FOR BENEFITS ON MY BEHALF OF COVERED SERVICES. I REQUEST THAT PAYMENTS FROM MY INSURANCE COMPANY BE MADE DIRECTLY TO KEYSTONE PAIN CONSULTANTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENTS TO THIS OFFICE WITHIN THE STATED POLICY. A COPY OF THIS AUTHORIZATION CAN BE USED IN PLACE OF THE ORIGINAL.

Signature: _____ **Date:** _____

NON-PAR INSURANCES:

HIGHMARK TOGETHER BLUE

CIGNA MEDICARE

OHIO MEDICAID

THE HEALTH PLAN PEIA

ALL OUT OF STATE MEDICAID PLANS

OUT OF STATE UNITED HEALTH CARE MEDICAID

Please call the office to cancel your appointment if you have one of the above insurances!

If you have AETNA PEBTF HMO, it is the patients responsibility to have their PCP fax to our office the Aetna Referral with Authorization # in order to be seen.

WORKERS COMPENSATION / AUTO COMPENSATION

Name: _____ DOB: _____

All information must be completed in full for Keystone Pain to be able to send your claim out successfully. It is the patient's responsibility to provide the following information. If this information is not provided at the time of your visit, the balance will become the patient's responsibility.

WORKERS COMPENSATION

Company Name: _____

Phone: _____ Fax:_____

Medical Claims Address:

_____

Date of Injury: _____ Claim Number: _____

Case Manager Name: _____ Phone: _____ Fax: _____

Please describe how you were injured: _____

AUTO COMPENSATION

Company Name: _____

Phone: _____ Fax:_____

Medical Claims Address:

_____

Date of Injury: _____ Claim Number: _____

Case Manager Name: _____ Phone: _____ Fax: _____

Please describe how you were injured: _____

Patient History Questionnaire

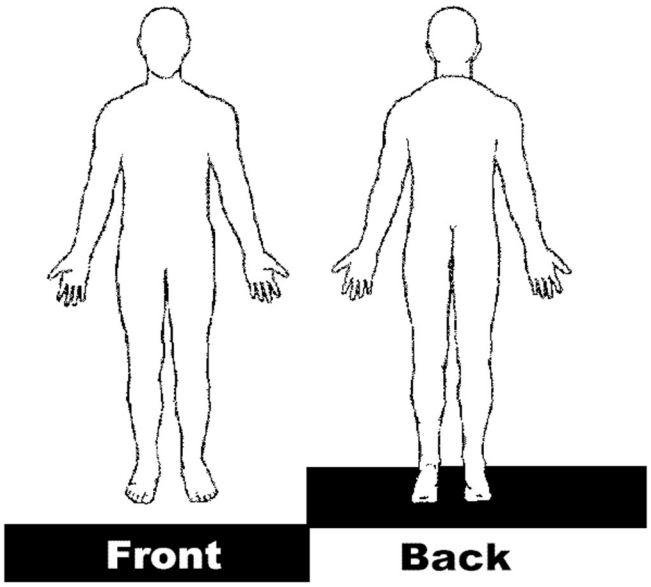
Name: _____ DOB: _____

Briefly describe your main complaint: _____

_____

HEIGHT _____ **WEIGHT _____**

Please mark the areas where you feel pain on your body:



CHECK THE ONE(S) THAT BEST DESCRIBE *YOUR CURRENT PAIN:*

_____SHARP _____SHOOTING _____STABBING _____THROBBING _____CRAMPING _____STINGING _____SQUEEZING

_____HOT _____COLD _____BURNING _____DULL _____PIERCING _____NUMB _____TINGLING

_____GNAWING _____TENDER _____ACHING _____SPLITTING _____OTHER_____

WHICH OF THE FOLLOWING MAKES YOUR PAIN *WORSE?* (CHECK ALL THAT APPLY)

_____SITTING _____LYING _____MEALS _____STANDING _____BRIGHT LIGHTS _____HEAT _____MENSTRUATION

_____POOR SLEEP _____STRESS _____WEATHER CHANGES _____COLD _____LIFTING _____LOUD NOISES _____INACTIVITY

_____EXERCISE _____ALCOHOL _____WALKING _____MEDICATION _____OTHER _____

WHICH OF THE FOLLOWING MAKES YOUR PAIN *BETTER?* (CHECK ALL THAT APPLY)

_____COLD _____HEAT _____EXERCISE _____DISTRACTION _____ACTIVITY _____PRAYER _____WARM SHOWER

_____RELAXATION _____MEDICATION _____OTHER_____

ARE THERE ANY OTHER SYMPTOMS *ASSOCIATED WITH YOUR PAIN?*

_____NUMBNESS _____REDNESS _____SWELLING _____SEXUAL DYSFUNCTION _____ANGER _____WEAKNESS

_____BOWEL INCONTINENCE _____BLURRED VISION _____NAUSEA _____TENDERNESS _____ FATIGUE _____VOMITTING

_____URINARY INCONTINENCE _____NIGHTTIME MOVEMENTS _____SLEEP APNEA _____OTHER_____

DOES YOUR PAIN RADIATE? _____NO _____YES

IF **YES**, WHERE?_____

ANY WEAKNESS IN EXTREMITIES? _____NO _____YES

ANY BOWEL OR BLADDER DYSFUNCTION? _____NO _____YES

RATE YOUR PAIN BY PLACING AN X ON THE LINE TO DESCRIBE YOUR *AVERAGE* PAIN IN THE PAST MONTH:

NONE _____ **EXTREME**

0 1 2 3 4 5 6 7 8 9 10

HOW OFTEN DO YOU HAVE YOUR PAIN? _____**CONSTANT** _____**MOST OF THE TIME** _____**OCCASIONALLY** _____**RARELY**

WHEN DO EXPERIENCE THE WORSE PAIN? _____**MORNING** _____**AFTERNOON** _____**EVENING** _____**BEDTIME**

HAS YOUR PAIN AFFECTED YOUR MOOD? _____**NO** _____**YES (DESCRIBE)** _____

_____

PREVIOUS TREATMENTS

PLEASE CHECK ANY OF THE FOLLOWING TREATMENTS THAT YOU HAVE TRIED TO TREAT YOUR PAIN:

____NONE ____ACUPUNCTURE ____CHIROPRACTOR ____TENS ____TRACTION ____EXERCISE

____PHYSICAL THERAPY ____PAIN CLINIC ____INJECTION THERAPY ____OTHER

TESTING

PLEASE CHECK ANY OF THE FOLLOWING DIAGNOSTIC EXAMS:

____BONE SCAN ____CT SCAN ____DOPPLER ____MRI ____X RAYS ____EMG/NCV

PLEASE CHECK ALL CURRRENT AND PAST MEDICATIONS THAT YOU HAVE TAKEN FOR CURRENT PAIN CONDITION:

ANALGESICS

___Acetaminophen/TYLENOL
___Fentanyl/DURAGESIC PATCH
___Hydrocodone/VICODIN
___Hydromorphone/DILAUDID
___Meperidine/DOLOPHINE
___Morphine/MS CONTIN, KADIAN AVINZA
___Oxycodone/OXYCONTIN, TYLOX PERCOCET
___Propoxyphene/DARVOCET
___Tramadol/ULTRACET, ULTRAM
___Tylenol w/ codeine #2, #3, #4

ANXIOLYTICS /SEDATIVES

___Alprazolam/XANAX
___Buspirone/BUSPAR
___Diazepam/VALIUM
___Eszopiclone/LUNESTA
___Flurazepam/DALMANE
___Haloperidol/HALDOL
___Hydroxyzine/ATARAX
___Lorazepam/ATIVAN
___Ramelteon/ROZEREM
___Temazepam/RESTORIL
___Triazolam/HALCION
___Zaleplon/SONATA
___Zolpidem/AMBIEN

NSAIDS

___Celecoxib/CELEBREX
___Choline Magnesium Salicylate/ TRILSATE
___Diclofenac/VOLTAREN
___Diflunisal/DOLOBID
___Etodolac/LODINE
___Flurbiprofen/ANSAID
___Ibuprofen/MOTRIN
___ Indomethacin/INDOCIN
___Ketoprofen/ORUDIS, ORUVAIL
___Ketorolac/TORADOL
___Meloxicam/MOBIC
___Nabumetone/RELAFEN
___Naproxen/NAPROSYN
___Oxaprozin/DAYPRO
___Piroxicam/FELDENE
___Tolmetin/TOLECTIN

ANTICONVULSANTS

___Topiramate/TOPAMAX
___Gabapentin/NEURONTIN
___Levetiracetam/KEPPRA
___Pregabalin/LYRICA
___Tiagabine/GABITRIL

ANTIDEPRESSANTS

___Amitriptyline/ELAVIL
___Bupropion/WELLBUTRIN
___Citalopram/CELEXA
___Duloxetine/CYMBALTA
___Escitalopram/LEXAPRO
___Fluoxetine/PROZAC
___Nortriptyline/PAMELOR
___Paroxetine/PAXIL
___Sertraline/ZOLOFT
___Venlafaxine/EFFEXOR
___Quetiapine Fumarate/SEROQUEL

MUSCLE RELAXANTS

___Baclofen/LIORESAL
___Carisoprodol/SOMA
___Cyclobenzaprine/FLEXERIL
___Metaxalone/SKELAXIN
___Methocarbamol/ROBAXIN
___Tizanidine/ZANAFLEX

PLEASE LIST ANY OTHER MEDICATIONS THAT YOU CURRENTLY OR HAVE TAKEN FOR YOUR PAIN THAT ARE NOT LISTED ABOVE:

_____

SLEEP

HAS THE PAIN AFFECTED YOUR SLEEP? _____NEVER _____RARELY _____OCCASIONALLY
HOW MANY HOURS DO YOU SLEEP AT NIGHT? _____
DO YOU FEEL RESTED DURING THE DAY? _____YES _____NO
DOES YOUR PAIN AWAKEN YOU DURING THE NIGHT? _____USUALLY ____NEVER _____OCCASSIONALLY

PLACE AN "X" ON THE LINE TO DESCRIBE HOW PAIN HAS INTERFERED WITH YOUR:

NORMAL DAILY ACTIVITY
DOES NOT INTERFERE ----------COMPLETELY INTERFERES
NORMAL WORK (INSIDE AND OUTSIDE OF HOME)
DOES NOT INTERFERE----------COMPLETELY INTERFERES

PAST MEDICAL HISTORY

Please check all that apply: ____NO PROBLEMS

CARDIAC
___High Blood Pressure
___Heart attack
___Abnormal Rhythm
___Murmur
___Pacemaker
___A-Fib

PULMONARY
___Asthma
___COPD
___Emphysema
___Lung Disease

ENDOCRINE
___Diabetes
___Hyperthyroid
___Hypothyroid
___Pituitary

CIRCULATORY
___Stroke
___Aneurysm
___Bleeding disorder

GASTROINTESTINAL
___Stomach ulcer
___GERD
___Bowel Disease
___Celiac
___Crohn's

NEUROLOGICAL
___Peripheral Neuropathy
___Stroke
___Multiple Sclerosis
___Alzheimer Disease
___Parkinson's
___Epilepsy
___Seizure

KIDNEY/UROLOGIC
___Kidney Disease
___Dialysis
___Prostate

LIVER
___Liver Disease
___Hepatitis
___Cirrhosis

OTHER
___Depression
___Anxiety
___OCD
___Fibromyalgia
___Arthritis
___Migraines
___Glaucoma

CANCER: _____NO _____YES TYPE: _____

SURGICAL HISTORY

Have you ever had ANY TYPE of surgery? _____NO _____YES If yes please list below:

PROCEDURE: _____ DATE: _____ SURGEON: _____
PROCEDURE: _____ DATE: _____ SURGEON: _____
PROCEDURE: _____ DATE: _____ SURGEON: _____
PROCEDURE: _____ DATE: _____ SURGEON: _____
PROCEDURE: _____ DATE: _____ SURGEON: _____

FAMILY HISTORY

Does your immediate family have history of: _____BACK DISORDER _____THYROID DISEASE _____HIGH BLOOD PRESSURE
_____HEART ATTACK (UNDER AGE 50) _____HEART DISEASE _____STROKES _____MIGRAINES
_____CANCER (TYPE) _____
_____PAIN PROBLEMS (TYPE) _____
_____ADOPTED _____UNKNOWN.

MEDICATIONS:

PLEASE LIST ***ALL*** MEDICATIONS YOU ARE ***CURRENTLY*** TAKING **INCLUDING OVER THE COUNTER MEDICATIONS AND HERBAL PRODUCTS:**

DATE STARTED	MEDICATION	DOSAGE	FREQUENCY	ORDERING PHYSICIAN

ARE YOU CURRENTLY TAKING A BLOOD THINNER? _____NO _____YES
IF YES, PLEASE LIST _____
ARE YOU CURRENTLY PRESCRIBED MEDICINAL MARIJUANA? _____ NO _____ YES

Pharmacy Name: _____ **Phone:** _____

Pharmacy Address: _____

Do you have separate prescription coverage? YES or NO If yes, please complete below.

Company Name: _____ **Member ID:** _____

**Please provide the front desk with your prescription coverage card so it can be scanned to your chart. **

DRUG ALLERGIES:

ARE YOU ALLERGIC TO ANY MEDICATIONS? ____NO ____YES (IF **YES**, PLEASE LIST BELOW)

YES	NO	MEDICATION /AGENT	TYPE OF REACTION	DATE
		LATEX		
		PENICILLIN		
		SULFA		
		IV DYE/IODINE		
		SHELLFISH		
		STRAWBERRIES		

SOCIAL HISTORY

MARITAL STATUS: ____SINGLE ____MARRIED ____DIVORCED ____SEPARATED ____WIDOWED

ARE YOU PREGNANT OR PLAN ON BECOMING PREGNANT? ____NO ____YES DUE DATE: _____

IF YOU HAVE CHILDREN, PLEASE LIST BELOW:

NAME	AGE	ANY AREAS OF CONCERN REGARDING CHILD

LIVING SITUATION

Who lives in your household? _____

EMPLOYMENT

CURRENT OCCUPATION: _____

PRESENT EMPLOYMENT STATUS: ____FULL TIME ____PART TIME ____HOMEMAKER ____RETIRED ____DISABILITY
____WORKERS COMP ____UNEMPLOYED ____LEAVE OF ABSENCE

PAST MENTAL HISTORY

HAVE YOU EVER HAD MENTAL HEALTH TREATMENT? ____NO ____YES if yes, approximate date: _____
ARE YOU IN CURRENT MENTAL HEALTH TREATMENT? ____NO ____YES if yes, name of doctor/facility: _____
HAVE YOU EVER BEEN HOSPITALIZED FOR PSYCHIATRIC REASONS? ____NO ____YES
IF YES, APPROXIMATE DATE: _____ REASON FOR HOSPITALIZATION: _____

LIFE STYLE HABITS

ARE YOU A CURRENT SMOKER? ____NO ____YES NUMBER OF PACKS A DAY: ____
FORMER SMOKER, DATE QUIT: _____
DO YOU DRINK ALCOHOL? ____NEVER ____OCCASIONALLY (LESSTHAN 1 PER WEEK) ____ DAILY
HOW MUCH CAFFEINE DO YOU CONSUME DAILY? _____ TYPE: _____
HAVE YOU EVER BEEN RECOMMENDED TO A DRUG OR ALCOHOL PROGRAM? ____NO ____YES WHEN: _____
HAVE YOU EVER PARTICIPATED IN A DRUG OR ALCOHOL PROGRAM? ____NO ____YES WHEN: _____

HAVE YOU EVER USED RECREATIONAL DRUGS? ____NO ____YES CURRENTLY? ____NO ____YES
PLEASE LIST BELOW:

YES	NO	NAME OF STREET DRUG	WHEN	HOW TAKEN
		COCAINE		
		"CRACK"		
		HEROIN		
		MARIJUANA		
		LSD		

REVIEW OF SYMPTOMS

CONSTITUTIONAL: ___NO PROBLEMS ___LACK OF ENERGY ___TROUBLE SLEEPING
___POOR APPETITE___CHILLS ___FEVER___NIGHT SWEATS
___WEIGHT GAIN AMOUNT – INTENTIONAL ___YES ___NO
___WEIGHT LOSS AMOUNT – INTENTIONAL ___YES ___NO

EAR, NOSE, THROAT: ___NO PROBLEMS ___HEARING LOSS (___LEFT ___RIGHT) ___DIZZINESS
___SNORING ___FREQUENT SORE THROAT ___HOARSENESS
___RINGING EARS ___DISCHARGE FROM NOSE

VISION: ___NO PROBLEMS ___VISION LOSS IN ONE EYE ___VISION LOSS BOTH EYES
___DOUBLE VISION ___GLASSES/CONTACTS ___BLURRED VISION ___OTHER

RESPIRATORY: ___NO PROBLEMS ___SHORTNESS OF BREATH ___CHRONIC COUGH
___WHEEZING ___OXYGEN: @ ___LITERS (CIRCLE) DAY NIGHT CONTINUOUS
___OTHER_____

GASTROINTESTIONAL: ___NO PROBLEMS ___DIFFICULTY CHEWING OR SWALLOWING
___CONSTIPATION ___ABDOMINAL CRAMPS/BLOATING ___DIARRHEA
___INCONTINENCE OF STOOL ___BLOOD IN STOOL ___ YELLOW SKIN
___CHANGE IN STOOL ___OTHER_____

CARDIOVASCULAR: ___NO PROBLEMS ___CHEST PAIN ___PALPATATIONS ___BLUE/RED COLOR
CHANGES IN HANDS OR FEET ___NARROWING OF THE ARTERIES IN NECK
___OTHER_____

HEMATOLOGIC: ___NO PROBLEMS ___PAINFUL VEINS OR ARTERIES ___EASY BRUISING
___TROUBLE WITH BLOOD CLOTTING ___OTHER_____

ENDOCRINE: ___NO PROBLEMS ___WEIGHT GAIN ___ALWAYS COLD ___ALWAYS HOT
___OTHER_____

MUSCULOSKELETAL: ___NO PROBLEMS ___MUSCLE PAIN ___CRAMPS ___JOINT PAIN
___BONE PAIN ___MUSCLE LOSS ___WEAKNESS ___STIFFNESS
___OTHER_____

NEUROLOGICAL: ___NO PROBLEMS ___HEADACHE ___DIFFICULTY WALKING ___FALLS
___FAINTING ___POOR MEMORY ___POOR CONCENTRATION ___CHANGE IN YOUR
THINKING ___NUMBNESS OR TINGLING IN FACE/ARMS/LEGS
___DIFFICULTY MAKING WORDS WHEN THINKING

PSYCHIATRIC: ___NO PROBLEMS ___FREQUENT SADNESS FEELING UNHAPPY ___PANIC
___ANGER ___UNUSUALLY HIGH ENERGY/EXCITABILITY ___EXCESSIVE WORRY
___ONGOING PROBLEMS IN RELATIONSHIP WITH OTHERS ___OTHER_____

GENITOURINARY: ___NO PROBLEMS ___URINARY FREQUENCY ___PAIN DURING SEX
___BLOOD IN URINE ___INCONTINENCE OF URINE ___PAIN WITH URINATING
___OTHER_____

GYNECOLOGICAL: ___NO PROBLEMS ___PERIOD IRREGULAR ___CURRENTLY LACTATING
___HOT FLASHES ___ABSENCE OF PERIODS ___HEAVY PERIODS
___PAINFUL PERIODS ___PMS SYMPTOMS ___OTHER_____

WAS THIS FORM COMPLETED BY SOMEONE OTHER THAN THE PATIENT? ___NO ___YES
WHOM: _____ RELATIONSHIP TO PATIENT: _____

Keystone Pain Consultants & Interventional Spine Specialists

HIPAA RELEASE FORM AND FINANCIAL POLICY

I, _____(Patient Name)_____(Patient Date of Birth), direct my health care and medical service providers and payers to disclose and release my protected health information described below to:

Please list any family members, friends, and medical providers. I understand I may change this at any time.

NAME	RELATIONSHIP	PHONE NUMBER	LIST ANY RESTRICTIONS

In the event that we need to contact you, are we permitted to leave a message on your answering machine?

____ Yes _____ No

Health Information to be disclosed upon the request of the person(s) named above- Check A or B

____ A Disclose my complete health record (including but not limited to diagnosis, lab tests, prognosis, treatment, and billing)

OR

_____ B List medical records to not be disclosed _____

This authorization shall be effective until (check one):

_____ All past, present, and future dates

_____ This authorization will expire on: __ __/__ __ /__ __ __ __ (DD/MM/YEAR)

_____ _____ _____

Patient Name (Printed) Patient Signature Date

Financial Office Policies

Until staff can verify insurance coverage(s), patients are on a cash basis. If applicable, insurance will be verified and reviewed. Once the coverage and deductible have been verified, {Keystone Pain Consultants} (herein known as "The office") can accept most policies if the insured patient has signed the approved statement of benefits and/or a lien authorizing payment to be sent to the doctor. In some cases, the insurance payment may be withdrawn. It is the responsibility of the patient to provide the patient responsibility portion as well as all non-covered services per month. Payment plans will be discussed following your report of findings.

•The Office cannot guarantee that the insurance company will pay fees charged to them as insurance policies are an agreement between the patient and insurance carrier. Services not covered, or coverage reductions by the insurance carrier, are the responsibility of the patient. The Office will submit insurance claims, but we will not enter into disputes with any insurance company if there are coverage issues. It is the responsibility of the patient and insurance to settle insurance disputes. Denied and disputed claims will be considered uncovered. If the patient account goes to collections, it is the responsibility of the patient to pay attorney fees, court fees, and any collection fees from collecting account balances.

•I authorize the release of medical records and other information pertaining to my health as well as the release of information required to process my claims. Insurance payments are applied to the patient account if a balance is due, despite which company issues the check.

•Refunds can only be made once the balance is paid and approved by The Office. If contact is made for checks from an insurance company, you agree to bring the correspondence into the doctor's office to determine whether action is required. At this time, staff will also check to see if the check is on assignment to the office. If you change insurance companies or employers, you must inform the office and provide the new information. The Office accepts payments using Credit Cards, Personal Checks and Cash.

Thank you for your cooperation. I have read, understand, and agree to abide by the terms of the financial office policy of The Office.

_____

Patient Signature Date

Keystone Pain Consultants & Interventional Spine Specialists

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

In general, any information that is about your health, the healthcare you receive, or payment for that care is considered confidential and protected by our Company. We may need to use your protected health information to carry out treatment, payment, healthcare operations and/or other purposes. Our notice of privacy practices provides a more complete description of permitted uses and disclosures.

I CERTIFY THAT I HAVE READ THE NOTICE OF PRIVACY PRACTICES AND THAT I UNDERSTAND ITS CONTENTS.

_____

Patient Name (printed) & Date of Birth **Date**

_____

Patient Signature **Date**

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Assignment of Benefits & Consent to Care

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, any other health/medical plan, including accident-related compensation to issue payment check(s) directly to Keystone Pain Consultants rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by auto or workers compensation.

Consent to Care

I, the undersigned, do hereby agree and give my consent for Keystone Pain Consultants to furnish medical care and treatment to _____ (Patient Name) that is considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Authorization to Release Information

I hereby authorize Keystone Pain Consultants to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated during examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

By my signature below I acknowledge that I have read, understand, and agree to the terms and conditions contained in the Consent for Care and Treatment, the Authorization to release all information necessary to secure payment and the Consent for Use and Disclosure of Health Information.

_____ _____ _____

Patient/Responsible Party Signature Date of Birth Date