Susquehanna Valley Pain Management, P.C.

Harrisburg Interventional Pain Management Center, Inc (surgery center)

www.harrisburgpaincenter.com

Pre-Procedure Instructions

You have been scheduled to have a procedure performed at Harrisburg Interventional Pain Management Center by your doctor. You are scheduled to see the physician:_________________________

On: ________________________Please arrive at_____________________________

General Information:

- Please bring a list of all medications (prescribed and over the counter) as well as the dosages of the medications that you take.
- Please bring your insurance cards. Co-pays are to be paid at the time of check in**. If your insurance is outside of Pennsylvania, please call your insurance company to check if an authorization is required for your services**.
- Please bring your driver's license or photo identification.
- If a medical emergency occurs while you are at our facility, you may require admission to a hospital.
- We do not allow smoking in our facility.
- All children must be attended to by an adult other than the patient at all times while at our facility; we are unable to provide supervision.
- We request that cell phones be turned off while in the facility.
- We do not allow animals except service animals in our facility.
- Weapons are not permitted in the facility, this includes uniformed officers.
- We request that you do not bring valuables to the facility. If you do, we will ask that you place the valuables in a locker.
- If you are unable to keep the scheduled appointment, please call to reschedule the appointment. If you do not call to reschedule 24 hours prior to the appointment and do not keep the appointment, you will be charged $50.00. This charge will be your responsibility, and your insurance will not cover this cost.
- *If you are taking an anticoagulant or "blood thinner" (listed below), you will need to check with the *physician who prescribed the medication to determine if you can stop the medication for the *appropriate amount of time.

Coumadin/ Warfarin/ Jantoven-3days	Persantine (Dipyradamole)-7 days	Aggrastat (Tirofiban)-7 days
Arixtra (injectable)-24 hours	Plavix (Clopidogrel) -7 days	Pletal (Cilostazol) - 7 days
Aggrenox- 7 days	Ticlid (Ticlopidine) - 7 days	Trental (Pentoxifylline) - 7 days
Heparin- 12 hours	Lovenox (Enozaparin) - 12 hours	Xarelto (Rivaroxaban) - 48 hrs
Pradaxa (Dabigatran)-24 hours	Effient (Prasugrel)-7days	Fragmin- 12 hours
Brilinta (Ticaglelor) – 5days	Eliquis(Apixaban)-48hrs	

Pre-procedure Instructions

- Please continue to drink and eat as you normally would.
- Take all your usual medications except anticoagulants.
- Please allow 2 hours for your first visit to our facility.
- You should not need a driver to accompany you.
- Please bathe or shower with a body soap the day of procedure. Wash hair (for neck procedure)

***We will inform you if your procedure requires sedation**

IF YOUR PROCEDURE REQUIRES THAT YOU HAVE SEDATION:

- Do **not** eat or drink anything 6 hours before your scheduled procedure.
- You must remain at the facility for at least 1 hour after the procedure.
- You **must** have a driver take you home.
- You should not drive for 12 hours after receiving sedation.

Please call (717) 652-8670 if you have any questions.

Susquehanna Valley Pain Management P.C.

Patient Information Today's Date: ____/____/____

Name ________________________________ Date of Birth _________ SS# _______________
(LAST) (FIRST) (MI)

Address ____
(CITY) (STATE) (ZIP CODE)

Home Phone ________________ Work Phone _______________ Cell Phone ______________

Email _____________________________________

Age ______ Marital Status: S M W D Sex: Male/Female Race: _________

Employer ______________ Phone# __________________ Occupation: __________________

Emergency Contact ____________________ Relationship _____________ Phone# __________

Family Physician ________________ Phone# ____________ Referring Physician ___________

Pharmacy name __________________________ Pharmacy phone # _____________________

Insurance Information

PRIMARY INSURANCE ____________________ ID# _____________________ Group# ________

Subscriber Name ______________________ Date of Birth _______ Relationship ____________

Subscriber SS# _______________ Subscriber Address ___________________________________
(IF DIFFERENT FROM PATIENT ADDRESS)

SECONDARY INSURANCE __________________ ID# _____________________ Group#________

Subscriber Name ______________________ Date of Birth _______ Relationship ____________

Subscriber SS# _______________ Subscriber Address ___________________________________
(IF DIFFERENT FROM PATIENT ADDRESS)

Workers Compensation/ Automobile Accident Information Date of Injury ________________
(CIRCLE IF APPLICABLE)

Insurance Carrier Name ________________________ Contact Person ____________________

Policy # ______________________ Claim # _______________________ Group# ___________

Insurance Co Address ____________________________________ Phone# _________________

Attorney Name ____________ Address _____________________ Attorney Phone# _________

Employer Name (IF WC) ______________ Employer Phone# _____________ Contact Name _____

Employer Address ____

Susquehanna Valley Pain Management
Patient Health History
The following information is very important to your treatment. Please take time to fully and completely fill out this important information prior to your appointment. We are counting on you!

Name: ______________________________ Date of Birth: ___________ Age: ____

Chief Complaint

(Reason for today's visit) What kind of symptoms are you having? Include numbness, tingling, weakness

Of arms or legs, etc. ____

How long have you had these symptoms? ____

What caused the symptoms? ____ Are your

symptoms related to work or auto injury? ________________________________

Describe your injuries ____

Please check any of the following treatments you have tried to relieve your symptoms, how long ago and duration.
Example: three months ago for 6 weeks or 2 years ago for 4 weeks.

Dates	Tried	Successful		Dates	Tried	Successful	
____	____	____	Physical Therapy	____	____	____	TENS Unit
____	____	____	Pain Medication	____	____	____	Oral Steroids
____	____	____	Heat	____	____	____	Reduction of Activity
____	____	____	Ice	____	____	____	Epidural Steroid Injections
____	____	____	Anti-inflammatory medications	____	____	____	Bed rest
____	____	____	Chiropractic Care	____	____	____	Exercise program
____	____	____	Massage Therapy	____	____	____	Other:________________
____	____	____	Work Hardening Program				

What makes the pain better? ____

What makes the pain worse? ____

Has anyone in your family ever had the same or similar problem? (Please list who & what type of problem)____

Please name any physicians that you have seen about your pain:

______________________________ ______________________________

______________________________ ______________________________

Occupation: ______________________________ Are you currently working? Yes No

If no, when did you last work? (Please give date)__________________________

Do you have any medical work-related restrictions? Yes No. If yes, please give the name of the physician who put you on restrictions____

How long have you been on restrictions? ____________________

Patient Health History

The following information is very important to your treatment. Please take the time to fully and completely fill out this form prior to your appointment.

Name: ______________________________ Date Of Birth: _______________

PAST MEDICAL HISTORY

1. Please check "yes" or "no" to indicate if you have any of the following illnesses; for "yes", please explain.

	Yes	No			Yes	No	
Diabetes	___	___	________________	Stomach Problems	___	___	________________
High Blood Pressure	___	___	________________	Kidney Problems	___	___	________________
Thyroid Problems	___	___	________________	Neurological Problems	___	___	________________
Heart Problem	___	___	________________	Cancer	___	___	________________
Breathing Problems	___	___	________________	Other Medical Problems	___	___	________________
Bleeding Disorder	___	___	________________				________________

2. Please list family history for the following family members:

Mother:____

Father:____

Siblings:____

Children:____

3.Please list any operations that you have had and the date(s) of the surgery:

____

____

4. Please list current medications (**doses** and number of times the medicine is taken each day). Include over the counter medications, vitamins and herbal supplements.

Name	Milligrams	Dosage& Route

4. Please list **allergies:**

________________ ________________ ________________

________________ ________________ ________________

☐ I give consent to retrieve and use my medication history from electronic pharmacy record.

Social History

Marital Status: Single Married Divorced Widowed Children Yes No How many? ______________

Do you live alone? Yes No Who lives with you? ______________________

Do you use tobacco? List type and amount used per day ______________________________

Do you use alcohol? List type and quantity per day______________________________

Diagnostic Tests

Please list any diagnostic test that you had done related to your pain problem. Please include date & facility.

____

Name: ____________________ **Date Of Birth: _________**

Review of Systems

If yes to any of the following questions, please explain in the space below.

General	Recent weight change	Yes No	Fatigue	Yes No
	Height _________________		Current weight _____________________	
Eyes	Glasses/ Contact	Yes No	Cataracts	Yes No
	Glaucoma	Yes No	Macular Degeneration	Yes No
Ears/Nose	Hearing Loss	Yes No	Wear hearing aids	Yes No
	Nose Bleeds	Yes No		
Neurological	Headaches	Yes No	Lightheaded/dizzy	Yes No
	Seizures	Yes No	Stroke	Yes No
Cardiovascular	Heart attack	Yes No	Palpitations	Yes No
	High Blood pressure	Yes No	Pacemaker	Yes No
	Stents	Yes No	Heart Surgery	Yes No
Respiratory	Asthma	Yes No	Frequent Cough	Yes No
	Short of breath-rest	Yes No	Short of breath with exercise	Yes No
Gastrointestinal	Reflux/GERD	Yes No	Ulcer	Yes No
	Nausea/vomiting	Yes No	Bowel irregularity	Yes No
Genitourinary	Frequent urination	Yes No	Kidney Stones	Yes No
	Incontinence	Yes No		
Musculoskeletal	Joint pain	Yes No	Weakness in muscles	Yes No
	Neck Pain	Yes No	Muscle pain/cramps	Yes No
	Back Pain	Yes No	Difficulty walking	Yes No
Endocrine	Diabetes	Yes No	Thyroid disease	Yes No
Hematologic	Cuts slow to heal	Yes No	Bleeding/bruising tendency	Yes No
Psychological	Anxiety	Yes No	Depression	Yes No
	Bipolar Disorder	Yes No	Panic Disorder	Yes No
	PTSD	Yes No	Insomnia	Yes No
Infections Do you have:			Tuberculosis	Yes No
	Hepatitis	Yes No	AIDS	Yes No
	MRSA	Yes No	HIV	Yes No
Vaccination	Pneumococcal	Yes No		

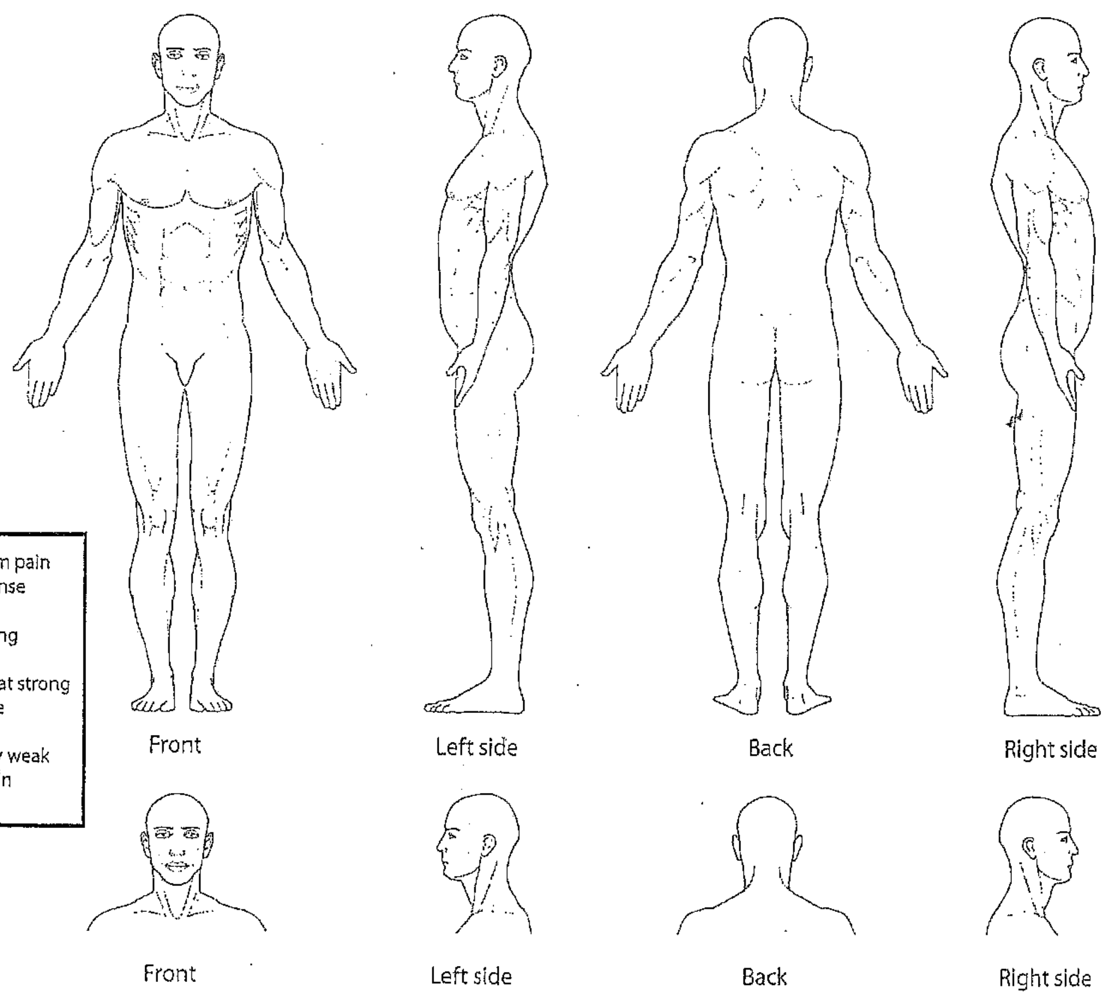
Do you have an Advanced Directive or "Living Will"? Yes No
(If you have an Advanced Directive and would like a copy placed on your chart, please bring a copy to your appointment.)

NAME____________________

DOB___________

Pain level at its lowest (0-10) ____________________
Pain level at its most intense (0-10) _______________
Please indicate your level of pain using a scale of 0-10 (0 is no pain, 10 is the worst pain imaginable.)

USING THE DIAGRAM BELOW, PLEASE INDICATE WHERE YOUR PAIN IS LOCATED.



For Facility Use Only:

BP: ________________ HR: _____________ RR:_____________ Today's Pain Level______
Pt. is accompanied by: Spouse Friend Parent/Legal Guardian None Other: _____________________
Pt. admits to: Hearing: None Hearing Loss Hearing Aids Language: Speaks: English Other: ____________
Pt. admits to: Visual: None Glasses/ Contacts Glaucoma Cataracts Blind Macular Degeneration Other: _______
Blood Thinner: ______________________ Last Dose: ______________ Pregnancy Status: Yes No N/A
Ambulation: Independently W/C With Assistance: Cane Walker Tobacco Use: Y N ___ PPD

Reviewed by: ____Date______________________

CONSENT TO TREATMENT AND FINANCIAL RESPONSIBILITY

I desire to be treated at Harrisburg Interventional Pain Management Center. I understand that I may discontinue treatment at any time.

1. I consent to the rendering of medical care.

2. I hereby authorize all professional staff to release/obtain any medical information/prescription history acquired in the course of the examination and treatment to referring physician, insurance company, pharmacy, workers compensation carrier, the center's attorneys and consultants in accordance with the privacy laws.This information may be shared electronically.

3. As part of the medical procedures or tests, I understand that I may be tested for H.I.V. infection and/or hepatitis, or any other blood- borne infectious disease if the doctor orders the test for diagnostic purposes.

4. Guarantee of Payment: I agree to be responsible to the center for charges resulting from services and supplies rendered at the prevailing rates unless I qualify for discount. I agree all bills are due in full upon demand. Should I fail to honor this agreement I agree to pay any collection cost or attorney fees resulting from the collection of my account.

5. Pre- Certification Requirements: If my insurance company or third –party requires pre-certification, then I understand that it is my responsibility to contact them to obtain such certification. Exception: Medicare.

6. Assignment of Benefits (other than Medicare and Medicaid): I hereby assign all rights and privileges and authorize payment directly to the center for any claim filed on my behalf or on the behalf of the person for whom I am duly authorized to sign for insurance benefits. I also understand that I am financially responsible to the center for co-pays, deductibles, co insurances and charges not covered by this assignment or by my insurance plan.

7. Assignment of Benefits (Medicare and Medicaid): I request that payment of authorized Medicare and/or Medicaid benefits to be made to the center or on my behalf for any services or supplies furnished by the center, including physician services. I authorize any holder of medical or other information about me to release it to the center for Medicare and Medicaid services and its agents, as appropriate, any information needed to determine these benefits for related services. I understand that I am responsible for any coinsurance, unmet deductibles and services not covered by Medicare and/or Medicaid.

8. Grievance Appeal Consent: I hereby authorize Harrisburg Interventional Pain Management Center to act on my behalf in requesting a reconsideration of medical determination made by my managed care plan or utilization review entity regarding my medical care.

9. It is the policy of the physicians and staff of the Facility to honor Advance Directives presented to them by their patients. However, should an untoward event happen to a patient while he or she is in our Facility, it is our policy to stabilize the patient and transport him or her to the hospital of his or her choice with a copy of the Advance Directive (if available).

10. Complaints, concerns, grievances regarding treatment, service, damaged or lost articles or billing should be directed to the Director of Nursing/Administrator for investigation and appropriate response.

_______ PRIVACY NOTICE- I acknowledge that I have received a copy of Harrisburg Interventional Pain Management Center's Privacy Notice.

_________________________________ ________________

Signature of Patient or Legal Representative Date Signed

Susquehanna Valley Pain Management

HIPAA Acknowledgement and Consent

Patient's Name_____________________________________

Date of Birth____________

I have received the "Notice of Privacy Practices" for Susquehanna Valley Pain Management. (The notice of privacy practice is available to view on our website: www.susquehannapaincenter.com and in our office waiting room).

____ Date____________

Signature of Patient (or Patient's Personal Representative) Relationship _____________

Assignment of Insurance Benefits and Billing Policy

I hereby assign all rights and privileges and authorize payment directly to Susquehanna Valley Pain Management for any claim filed on my behalf or on the behalf of the person for whom I am duly authorized to sign for insurance benefits.

Patient Signature or Legal Representative _________________________ Date __________

I understand that my insurance is a contract between my insurance company and me and that I am financially responsible for all charges whether or not the charges are paid by my insurance. Patient Initials here______

I understand that there will be a **$50.00** charge for appointments that I do not show for or call to cancel 24 hours prior to my appointment. This is **not** payable by my insurance and will be my responsibility. Patient Initials here ______

I understand that co- pays and deductibles are to be paid at the time of service. I am aware that co pays and deductibles are determined by my contract with my health insurance plan. Patient Initials here______

I understand that I will receive (two) separate bills for my services, (one) from the physician for the professional services and (one) from the facility (Surgery Center) for the use of operating rooms, supplies and x-ray guidance .
Patient Initials here______

I hereby authorize Susquehanna Valley Pain Management to act on my behalf in requesting a reconsideration of medical determination, to file an appeal or grievance to my insurance company for underpayment or payment related issues.
Patient Initials here______

I understand that if I fail to make timely payment to Susquehanna Valley Pain Management, I agree to pay 40% collection cost or attorney fees resulting from collection of my account. Patient Initials here______

Medicare and Medicaid ONLY

Assignment of Benefits- I request that payment of authorized Medicare and/ or Medicaid benefits to be made to Susquehanna Valley Pain Management. I authorize the release of medical information as may be required to secure payment for the medical services that were rendered. I understand that I am responsible for any coinsurance, unmet deductibles and services not covered by Medicare and/ or Medicaid.

Signature of Patient or Legal Representative ________________________________ Date_________

Patient Bill of Rights

In accordance with the Pennsylvania Provisions for Licensure 553.12

- A patient has the right to expect to respectful care by competent personnel.
- A patient has the right, upon request, to be given the name of his/her attending practioners, the names of all other practioners directly participating in his/her care and the names and functions of other heath care persons having direct contact with the patient.
- A patient has the right to consideration of privacy concerning his/her own medical care program. Case discussion, consultation, examination and treatment is considered confidential and shall be conducted discreetly.
- A patient has the right to have records pertaining to his/her medical care treated as confidential except as otherwise provided by law or third party contractual arrangements.
- A patient has a right to know what facility rules and regulations apply to his/her conduct as a patient.
- The patient has the right to expect emergency procedures to be implemented without unnecessary delay.
- The patient has the right to good quality care and high professional standards that are continually maintained and reviewed.
- The patient has the right to change physicians if other qualified physicians are available.
- The patient has the right to full information in layman's terms, concerning diagnosis, treatment and prognosis including information about alternative treatments and possible complications. When it is not medically advisable to give such information to the patient, the information will be made available to an appropriate person on his behalf.
- Except for emergencies, the practioners shall obtain the necessary Informed Consent prior to the start of a procedure.
- A patient or, if the patient is unable to give informed consent, a responsible person, has the right to be advised when the practioner is considering the patient as part of a medical care research program or doctor program, and the patient or responsible person, shall give informed consent prior to actual participation in the program. A patient, or responsible person, may refuse to continue in a program to which he has previously given informed consent.
- A patient has the right to refuse drugs or procedures to the extent permitted by statue, and a practioners shall inform the patient of the medical consequences of the patient's refusal of drugs or procedures.
- A patient has the right to medical and nursing services without discrimination based upon age, race, color, religion, sex, national origin, handicap, disability or source of payment.
- The patient who does not speak English shall have access, where possible to an interpreter.
- The ASF shall provide the patient, or patient designee, upon request, access to the information contained in his medical records, unless access is specifically restricted by the attending practitioner for medical reasons.
- The patient has the right to expect good management techniques to be implemented within the ASF. These techniques shall make effective use of the time of the patient and avoid the personal discomfort of the patient.
- When an emergency occurs and a patient is transferred to another facility, the responsible person will be notified. The institution to which the patient is to be transferred shall be notified prior to the patient's transfer.
- The patient has a right to examine and receive an explanation of his/her bill.
- A patient has the right to expect that the ASF will provide information for continuing health care requirements following discharge and the means for meeting them.
- A patient has the right to be informed of his/her rights before admission.

To register complaints concerning rights, contact:

- www.cms.hhs.gov/center/ombudsman.asp OR
- Pennsylvania Department of Health 717-787-6267 OR
- Jane Tamanini, R.N., Director of Nursing, 825 Sir Thomas Court, Harrisburg, PA, 17109, **717-901-5008**

Patient Directives – Advance Directives

The 1990 Patient Self-Determination Act is a federal law that says patients must be informed of their rights under state law to make decisions about their medical care, including the right to accept or refuse medical or surgical treatment and the right to have an advance directive. The advance directive is a way for patients to communicate what type of medical care and treatment they do or do not want if they become unable to make the decision on their own.

According to Pennsylvania law, an individual of sound mind who is 18 years of age or older (or who has graduated from high school or is married) may execute a declaration governing the initiation, continuation, withholding, or withdrawal of "life-sustaining treatment." The declaration must be signed by the declarant (or by another person at the request of the declarant if the declarant is unable to sign) and must be witnessed by two individuals over the age of 18. The declaration may include a designation of another person (a "surrogate") to make decisions for the declarant if the declarant later becomes incompetent.

A declaration becomes effective when the attending physician has determined that the declarant is incompetent and in a terminal condition or is in a state of permanent unconsciousness. A declaration can be revoked at any time and in any manner, regardless of the mental or physical condition of the declarant.

Compliance with the 1990 Patient Self-Determination Act is intended for inpatient hospital admissions, not for outpatient surgery centers. West Shore Pain and Spine Institute does not honor Advance Directives. Healthcare providers at WSPSI are bound to do all in their power to assure the safe recovery of every patient, including resuscitation if that becomes necessary. All patients are asked if they have an advance directive at the initial visit and the answers indicated in the EMR. If the patient gives the staff a copy of his/her Advanced Directive, it will be placed in the EMR.