

**Susquehanna Valley Pain Management, P.C.**  
**West Shore Pain and Spine Institute, LLC (surgery center)**

[www.harrisburgpaincenter.com](http://www.harrisburgpaincenter.com)

**Pre-Procedure Instructions**

You have been scheduled to have a procedure performed at West Shore Pain and Spine Institute, LLC 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 (Enoxaparin) - 12 hours    Xarelto (Rivaroxaban) - 48 hrs  
Pradaxa (Dabigatran)-24 hours    Effient (Prasugrel)-7days    Fragmin- 12 hours  
Brilinta (Ticagrelor) – 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 bath or shower with body soap the day of the 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.

*A brochure about the planned procedure is enclosed. Please call (717) 652-8670 if you have any questions.*

Susquehanna Valley Pain Management P.C.

Patient Information Today's Date: / /

Name (LAST) (FIRST) (MI) Date of Birth SS#

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





Name: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_

**Review of Systems**

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

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

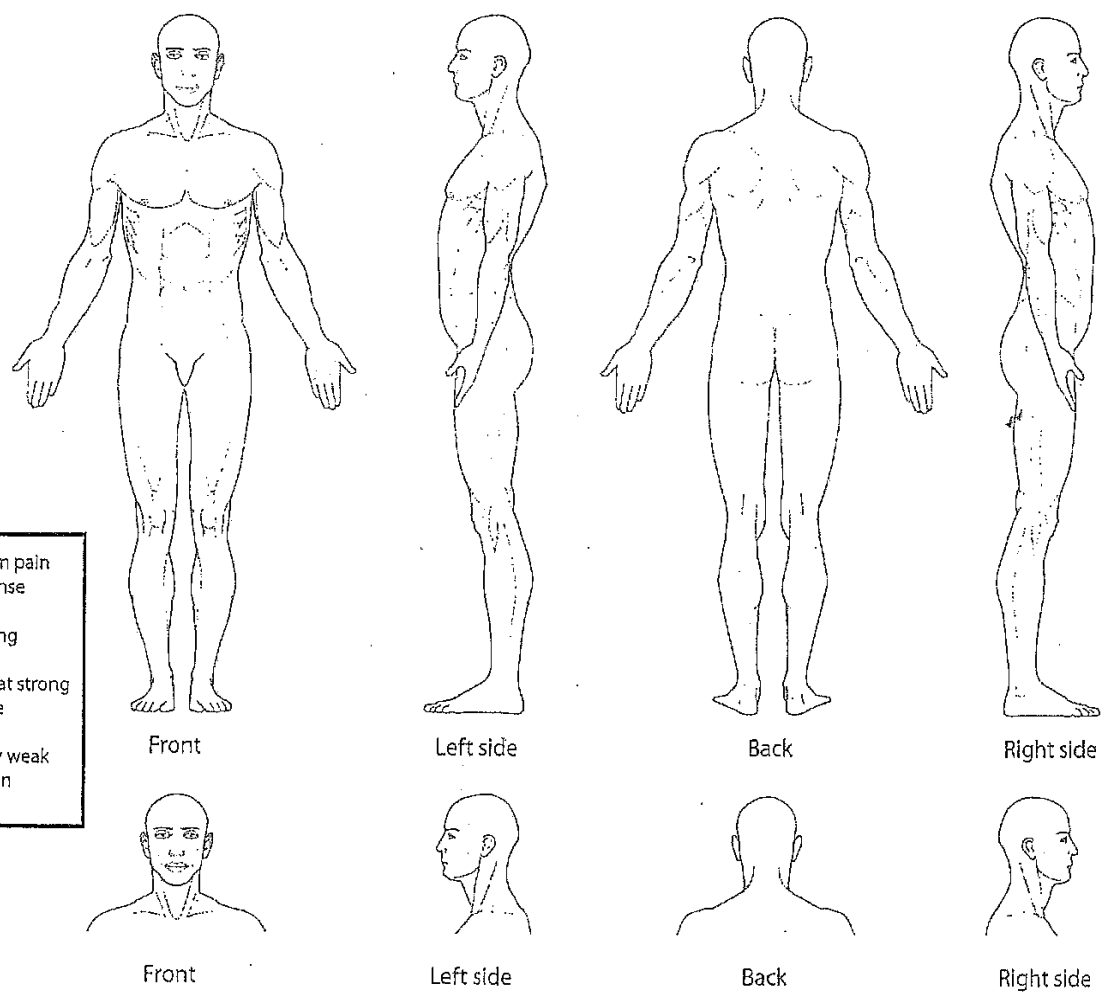
Pain level at its lowest (0-10) \_\_\_\_\_

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.

- 10 - Maximum pain
- 9 - Very Intense
- 8 - Intense
- 7 - Very strong
- 6 - Strong
- 5 - Somewhat strong
- 4 - Moderate
- 3 - Weak
- 2 - Very, very weak
- 1 - Slight pain
- 0 - No pain



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 \_\_\_\_\_

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](http://www.susquehannapaincenter.com) and in our office waiting room).

\_\_\_\_\_

Signature of Patient (or Patient's Personal Representative)

Date \_\_\_\_\_

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 \_\_\_\_\_

West Shore Pain and Spine Institute, LLC  
*Billing Information*

**ITEM I:** You were seen by a physician of **Susquehanna Valley Pain Management** for evaluation of your medical condition. Your physician has recommended a surgical procedure at **West Shore Pain and Spine Institute**. Please be advised that Dr. Momin owns interest in **West Shore Pain and Spine Institute**.

**West Shore Pain and Spine Institute** is a Medicare-approved facility and is licensed by the Commonwealth of Pennsylvania to provide ambulatory/outpatient surgery in its location at 5124 E Trindle Road, Mechanicsburg, PA. **West Shore Pain and Spine Institute** is accredited by the American Association for Ambulatory Health Care, Inc. (AAAHC), the renowned Chicago-based accrediting organization that operates in this capacity.

Both entities, **Susquehanna Valley Pain Management** and **West Shore Pain and Spine Institute** are located in the same building at 5124 E Trindle Road, Mechanisburg, PA. Each of the aforementioned entities is a separate and distinct business.

**ITEM II:** If you have decided to have your surgical procedure at **West Shore Pain and Spine Institute**, there will be two separate charges:

1. A charge from **Susquehanna Valley Pain Management** for your surgeon's fee. This charge is what your physician charges for performing a surgical procedure.
2. A charge from **West Shore Pain and Spine Institute** for a facility fee. This charge covers the use of the operating and recovery rooms, sedation/analgesia (if used), equipment, supplies and medications necessary to perform your surgical procedure. It also covers the services of the clinical staff.

Both you and your insurance carrier will receive a separate bill for each of these services. Your surgeon and the facility are two separate entities and are required to bill separately for these services. **Regardless of where you have your surgical procedure performed, you will receive two separate bills. (This billing method is standard and required by all insurance carriers.)**

My signature acknowledges that the information in Item II was given to me and that I understand the billing method for service(s) which I have chosen to have performed at West Shore Pain and Spine Institute.

My signature also acknowledges that the information in both Item I and Item II was explained to me, and that I understand and agree to the statement made in both Items.

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date



## Patient Bill of Rights<sup>1</sup>

- \* 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](http://www.cms.hhs.gov/center/ombudsman.asp) OR ♦ Pennsylvania Department of Health 717-787-6267 OR ♦ Vivian Wisniewski, R.N., Director of Nursing, 5124 E Trindle Road, Mechanicsburg, PA 17050 **717-920-3277** 1 In accordance with the Pennsylvania Provisions for Licensure 553.12

## 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.

## CONSENT TO TREATMENT AND FINANCIAL RESPONSIBILITY

I desire to be treated at West Shore Pain and Spine Institute, LLC. 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 West Shore Pain and Spine Institute 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 West Shore Pain and Spine Institute's Privacy Notice.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date Signed