COASTAL VIRGINIA SPINE & PAIN CENTER

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Suite нлл
Virginia Beach, VA 234p2
Phone: 757-227-3820
Fax: 757-226-9021

Thank you for choosing Coastal Virginia Spine and Pain Center to provide you with health care services. We appreciate your trust in us, and we pledge to do all that we can to accommodate your needs and expectations.

On the day of your appointment please arrive approximately thirty (30) minutes early, so that we can ensure all necessary paperwork is in order.

Your initial visit will require that you be in our office for approximately ninety (90) minutes. Occasionally, due to unforeseen circumstances, this length of time may be longer.

We also would like to familiarize you with some record-keeping items that will facilitate your visit with us. Enclosed, you will find the following forms. **Please complete each of these forms prior to your scheduled appointment.**

- ☐ Patient Registration Form
- ☐ General Consent/Agreement to Outpatient Services
- ☐ In-Office Visit during Covid-19 Pandemic - Patient Authorization and Consent Form
- ☐ Financial Agreement – Office Visit
- ☐ Informed Consent for Spinal or Joint Injection
- ☐ PQRS Form

The following documents are available for your review in our office or on our website www.CovaSpineandPain.com.

- Our Notice of Privacy Practices (HIPAA)
- Notice of Patient Rights and Responsibilities

On the day of your appointment, please bring your insurance card, a state-issued ID (driver's license, Virginia ID card) and your specialist co-pay in order to be seen.

The doctors and staff of Coastal Virginia Spine and Pain Center are dedicated to excellence in patient care, service and satisfaction. If you have any questions please do not hesitate to ask any staff member in our practice.

Sincerely,

Coastal Virginia Spine and Pain Center

PATIENT REGISTRATION

PLEASE PRINT

LAST NAME: _____ First:_____ MI: _____

Date of Birth: _____ Sex M F Social Security #:_____

Address:_____ City_____ State_____ Zip_____

PHONE: HOME:_____ CELL:_____ WORK:_____ E-MAIL: _____

Referring Physician: _____Patient PCP: _____

Preferred Pharmacy: _____ Phone: _____

Employer: _____ Phone: _____

Marital Status: _____ If married, Spouse's Full Name:_____

EMERGENCY CONTACT: _____ Relationship to Patient: _____ Phone:_____

INSURANCE INFORMATION

(if Worker's Comp, please write W/C under Primary Insurance)

PRIMARY INSURANCE PLAN: _____

ID#_____ GROUP #:_____

Policy Holder: ☐ **SELF** ☐ **OTHER**

If Other: Last Name:_____ First Name_____ MI_____

Relationship to Patient: _____Policy Holder: Date of Birth:_____ Last 4 digits of SSN: _____

Address if different from patient: _____

SECONDARY INSURANCE PLAN: _____ I

ID#_____ GROUP #:_____

Policy Holder: ☐ **SELF** ☐ **OTHER**

If Other: Last Name:_____ First Name_____ MI_____

Relationship to Patient: _____ Policy Holder: Date of Birth:_____ Last 4 digits of SSN: _____

Address if different from patient: _____

The information below will be used to improve the quality of healthcare by granting us the ability to measure and minimize care disparities based on ethnicity, race and preferred language. It gives the practice an accurate estimate of our patient population, and accordingly assesses the need for different services such as interpreter services translated patient forms and cultural competency training for our staff. You have the

RACE: (Please check one) ☐ DECLINED

☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other Race

ETHNICITY: (Please check one) ☐ DECLINED

☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown

ASSIGNMENT and RELEASE

I hereby assign my insurance benefits to be paid directly to the physician.

I understand that I am financially responsible for all non-covered services

I authorize the physician to release any information required to process this claim

SIGNED: _____ **DATE:**_____

GENERAL CONSENT/AGREEMENT TO OUTPATIENT SERVICES

1. **CONSENT TO TREATMENT:** I hereby consent to treatment by Coastal Virginia Spine & Pain Center (COVA), their associates, and/or assistants, and accept responsibility for payment of fees for such medical services. I understand that treatment by include injections, manipulation, medication management, medical appliances, and/or other procedures as deemed necessary and appropriate. I understand that I could be tested for HIV, and have the right to opt out. I understand that my consent will be requested for HIV and other testing in case of an unintended exposure of a healthcare worker..

2. **PAYMENT FOR SERVICES**: I understand that COVA may bill my health plan for the care I receive. I agree that payments from my health plan may go directly to COVA. If I should receive the payments, I understand that I will be responsible for paying COVA. I understand that I must pay any co-payment or other part of the bill that my health plan says I must pay. I know that I may need to pay this before I am treated. I understand and agree that if my plan does not pay the physician or their associates/assistants, I will have to do so. I understand that COVA will hold me responsible in any one of the following situations:

   a. When I choose to have a service that my health plan covers, but I do not obtain the required referral or authorization from my health plan.
   b. When I choose not to use my health plan and agree to pay for services myself. *(Use Do Not Bill Insurance Form)*
   c. When my health plan does not participate with COVA for the services I want or need and I agree to pay for my care myself.
   d. When I receive services that are not covered under my health plan.

3. **ADVANCED DIRECTIVES**: COVA does not honor Advanced Directives. Unexpected complications due to procedures and/or treatment are not natural causes, and therefore will be treated. This means that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative or other stabilizing measures, and transfer you t an acute care hospital for further evaluation. At the acute care hospital, further treatment, or withdrawal of treatment measures already begun, will be ordered in accordance with you wishes, Advanced Directive, or Health Care Power of Attorney. The admitting facility is not affiliated, or in partnership with COVA.

4. **ELECTRONIC PRESCRIBING**: I authorize SureScripts, an electronic prescribing network, to release my medication refill history to COVA for the purpose of continued treatment.

5. **RELEASE OF INFORMATION**: I authorize COVA to release healthcare information for purposes of treatment, payment or healthcare operations. Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under Worker's Compensation.

   If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, laboratory reports, operative reports, physician progress notes, physical therapy notes and consultations.

   Federal and state laws may permit this medical practice to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that my include, but no limited to: improving the accuracy and increasing the availability of my health records; decreasing the

PRE-PROCEDURE CHECK-IN

NAME: * _____ Date of Birth: * _____

Primary Care Physician: * _____ Referring MD Name: * _____

******Please CIRCLE the appropriate answer. Please ask for assistance if you do not understand any questions.******

Y N Is this your first Injection for this problem? If no, how many have you had in the last 12 months? _____

Y N Are you diabetic? If yes, is your blood sugar currently well controlled? Y N

Y N Do you take insulin? Please list your diabetic medications (not doses) _____

Y N Are you taking any blood thinning medications? Plavix, Ticlid, Coumadin/Warfarin, Eliquis, Pradaxa, Xarelto, etc.?

If yes, what date did you last take the medication? _____

Y N Are you currently taking: Aspirin, Motrin, Advil, Aleve, Naprosyn, Feldene, Relafen or other non-Steroidal Anti-inflammatory medications (NSAIDS)?

Please list all of the medication (not doses) you are currently taking: _____

_____

_____

Y N Are you aware of any kidney problems? Explain _____

Y N Do you currently have any active infection or fever? If yes, what? _____

Y N Are you currently taking antibiotics? If yes, what _____

Y N Are you allergic to IV contrast or iodine-based dyes?

If yes, did you take a Prednisone or Benadryl prep before coming today Y N

Y N Do you have any other medication allergies? If yes, please list, _____

_____

Y N Have you ever had a severe allergic reaction (anaphylaxis)?

Y N Are you allergic to latex?

Y N **Female Patients:** Is there any chance that you are pregnant? ***If YES, please notify staff prior to the procedure***.

Y N Are you driving yourself home today? Select "NO" if you brough a driver.

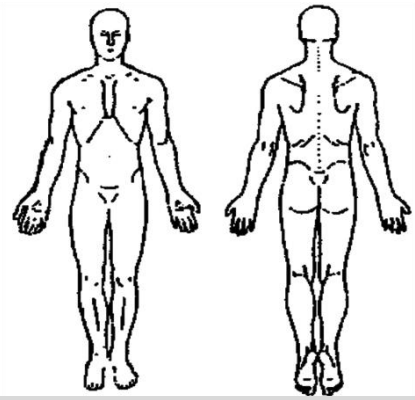
Which physician is currently treating you for this problem? Dr. Spear Dr. Nock Other: _____

Date of follow-up appointment with that physician. _____

Patient Signature: * _____ Date: _____

Please draw the location of your pain on the diagram

Include any radiation into the arms or legs



What is your pain level TODAY? _____/10

(0 = No Pain 10 = Worst pain in your life)

Office Notes	VITALS	PRE	POST	3__	4__
	02 Sat-				
	Pulse				
	BP				

EFFECTIVE: 1/1/2019
REVISED: 10/19/2022

FINANCIAL AGREEMENT
OFFICE VISIT

Please initial any relevant sections. Write N/A if it does not apply to your situation.

_____ I do not have insurance coverage and understand I am fully responsible for payment at time of service for all services rendered at Coastal Virginia Spine and Pain (COVA). Services today may cost between $50 and $1500.

_____ I understand that COVA has not received authorization and or a referral for today's services, and I agree to pay the cost of this visit at the time of service. I understand that the visit may cost between $50 and $1500 and I agree to pay the amount of today's session, should the visit not be covered by my insurance company.

_____ I understand that _____ is NOT a covered service and that I am responsible for payment. Payment arrangements have been made by the COVA Billing Department and approved by Dr. _____, I have been made aware of, and agree to pay this fee _____. I have also agreed NOT to allow my balance to exceed $300 at any time.

_____ I understand that COVA has received insurance authorization for _____, but should insurance decide to deny coverage at any time (i.e. insurance expired prior to procedure date, etc.), I agree to pay for the physical therapy services within 30 days of notification. I agree to pay my co-pay, or 20% of the procedure cost, whichever is the expected payment agreement with the insurance company at the time of service.

_____ I understand that COVA is not required to obtain insurance authorization for _____, but should insurance decide to deny coverage at any time (i.e. insurance expired prior to procedure date, secondary insurance plans that may be out of network, etc.), I agree to pay for services within 30 days of notification. I agree to pay my co-pay, or 20% of the visit cost, whichever is the expected payment agreement with the insurance company at the time of service.

_____ I understand that my insurance requires conservative treatment for three (3) months prior to this procedure. I understand that the visit may cost between $500 and $2000 and I agree to pay the amount of today's session, should the visit not be covered by my insurance company.

_____ I understand that today's services will be covered under my Worker Injury Compensation, and that an authorization from my claims adjuster has been received. I also understand that COVA will file all claims for services for Worker Injury Compensation cases.

_____ I have a personal injury case in litigation. I am aware that I must be prepared to pay for my initial consultation today, and await a final decision by my physician to determine if an attorney lien will be accepted. The cost of today's appointment will range between $50 and $1500.

_____ I, _____, am aware that my insurance is currently listed as "inactive-pending investigation" due to a lapse in payment of my premiums. If for any reason the insurance company does not cover my visit for date of service _____, I understand that I will be responsible for the full cost of the services rendered that day.

* _____ * _____

Patient/Responsible Party Name (Print) Date

* _____

Patient/Responsible Party Signature

EFFECTIVE: 1/1/2019
REVISED: 10/19/2022

PRE-PROCEDURE CHECK-IN

NAME: * _____ Date of Birth: * _____

Primary Care Physician: * _____ Referring MD Name: * _____

******Please CIRCLE the appropriate answer. Please ask for assistance if you do not understand any questions.******

Y N Is this your first Injection for this problem? If no, how many have you had in the last 12 months? _____

Y N Are you diabetic? If yes, is your blood sugar currently well controlled? Y N

Y N Do you take insulin? Please list your diabetic medications (not doses) _____

Y N Are you taking any blood thinning medications? Plavix, Ticlid, Coumadin/Warfarin, Eliquis, Pradaxa, Xarelto, etc.?

If yes, what date did you last take the medication? _____

Y N Are you currently taking: Aspirin, Motrin, Advil, Aleve, Naprosyn, Feldene, Relafen or other non-Steroidal Anti-inflammatory medications (NSAIDS)?

Please list all of the medication (not doses) you are currently taking: _____

_____

_____

Y N Are you aware of any kidney problems? Explain _____

Y N Do you currently have any active infection or fever? If yes, what? _____

Y N Are you currently taking antibiotics? If yes, what _____

Y N Are you allergic to IV contrast or iodine-based dyes?

If yes, did you take a Prednisone or Benadryl prep before coming today Y N

Y N Do you have any other medication allergies? If yes, please list, _____

_____

Y N Have you ever had a severe allergic reaction (anaphylaxis)?

Y N Are you allergic to latex?

Y N **Female Patients:** Is there any chance that you are pregnant? ***If YES, please notify staff prior to the procedure***.

Y N Are you driving yourself home today? Select "NO" if you brough a driver.

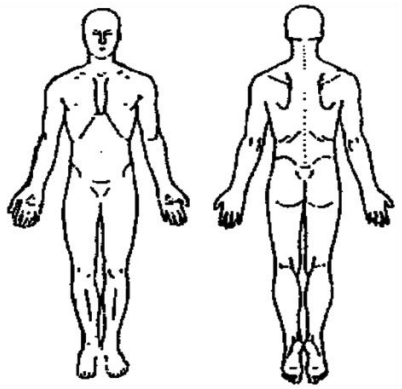
Which physician is currently treating you for this problem? Dr. Spear Dr. Nock Other: _____

Date of follow-up appointment with that physician. _____

Patient Signature: * _____ Date: _____

Please draw the location of your pain on the diagram

Include any radiation into the arms or legs



What is your pain level TODAY? _____/10

(0 = No Pain 10 = Worst pain in your life)

Office Notes	VITALS	PRE	POST	3__	4__
	02 Sat-				
	Pulse				
	BP				

EFFECTIVE: 1/1/2019
REVISED: 10/19/2022

INFORMED CONSENT FOR SPINAL OR JOINT INJECTION

The injection involves placing a small needle in or around the painful area injecting a numbing medication and anti-inflammatory medication (steroid or other type of solution). If the injection is for diagnostic purposes only, anesthetic or contrast dye will be used. This injection will hopefully give you significant pain relief and give us importantinformation that will enable us to diagnose you condition.

Some injection procedures involve the use of radiofrequency energy to interrupt nerve transmission by lesioning or shocking of specific nerves.

Dr. _____ and/or his/her associate has explained the nature and purpose of this procedure and has answered my questions. I do understand that this is considered an elective procedure. I understand my current condition for which I am having the procedure is not life threatening.

Possible side effects associated with this procedure include:

1. Regional numbness, weakness and/or dizziness. You may have increased numbness for one-hour to six hours after the block. We advised you not to operate a vehicle or perform any activities that require coordination for six to ten hours after the block.
2. Vasovagal reactions (fainting) could occur during or after the procedure with possible heart and blood pressure problems.
3. Reactions to medication include minor or temporary allergic reaction and/or a temporary decrease in blood pressure. These problems may require more aggressive treatment including IV or other medications
4. Increased pain. Twenty percent of patients may have increased pain for one to seven days after the injection.
5. Less than one percent of patients may have a headache after the procedure. Treatment of the headache may necessitate additional procedures and/or hospitalization.
6. Infection either around the injection site or deep in the spine is also a potential risk. Other rare complications might include hip (bone) damage caused by steroids, temporary or permanent nerve impairment, bleeding, bruising, seizures, stroke, paralysis, collapsed lung, bowel/bladder/sexual dysfunction and death.

If the block is performed specifically for diagnostic purposed, a steroid may not be used. If this is the case, complications or side effects associated with steroid use will not be a possibility..

I have discussed treatment alternatives with Dr. _____ including no treatment.

I *_____ consent to this procedure to be performed by Dr. _____ and/or his/her associate.

As requested by my physician, I am aware that I am NOT to drive myself home or operate a vehicle for six to ten (6-10) hours.

Name of procedure**: _____(For Provider Use Only)

*_____ *_____

Patient Signature Date

_____ _____

Physician Signature Date

_____ _____

Witness Signature Date

☐ Time out process performed prior to procedure _____

Procedure room Tech/MA Signature

EFFECTIVE: 1/1/2019
REVISED: 10/19/2022

COASTAL VIRGINIA SPINE & PAIN CENTER

Patient Name: _____

Date: _____

Date of Birth: _____

PQRS QUESTIONNAIRE 2022

Coastal Virginia Spine and Pain Center (COVA) participates with the Physician Quality Reporting System. PQRS gives the physicians at COVA the opportunity to assess the quality of care they are providing to their patients, helping to ensure that our patients get the right care at the right time. Please help us further assess your health care needs by completely answering the following questions.

1. Do you have an Advanced Care Directive/Living Will or a Medical Power of Attorney? ☐ YES ☐ NO

   a. If yes, please complete one of the choices below:
      1) Who has your Medical Power of Attorney? _____
      2) Provide a copy of your Advanced Care Directive/Living Will

2. Have you had two or more falls in the past year or any falls with an injury in the past year? ☐ YES ☐ NO

3. Have you had a Pneumococcal Vaccination (Pneumonia Injection)? ☐ YES ☐ NO
   If yes, date of injection: _____

4. Have you had a flu shot? If yes, date of injection: _____ ☐ YES ☐ NO

5. Are you a smoker? If yes, how many packs per day? _____ ☐ YES ☐ NO

6. Have you had a bone density study since turning 60 years of age? ☐ YES ☐ NO

7. Do you sometimes drink beer, wine or other alcoholic beverage? ☐ YES ☐ NO

   How many days per week do you have an alcoholic beverage? _____

   How many alcoholic beverages to you drink weekly? _____

BMI: Height: _____ in Weight _____ lbs BMI _____

Normal ranges for age 65 and older: 23 - 30

Normal ranges for less than 65 year of age: 18.5 - 25

EFFECTIVE: 1/1/2019
REVISED: 10/19/2022