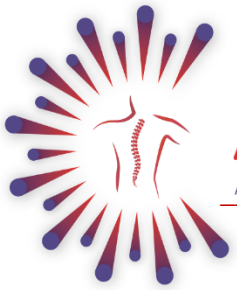


A P M I

Advanced Pain Medicine Institute

Reza Ghorbani, MD, ABIPP, FIPP
President and Medical Director

Welcome and thank you for choosing APMI!

Our mission is to offer you the highest quality of care in a comfortable, efficient and safe manner.

This packet includes medical and insurance forms, as well as some information and guidelines for your review. Kindly fill out the forms completely and accurately, and read the information attached.

Please feel free to contact any member for our team if you have any questions.

You may also visit our website www.APMIpractice.com

Thank you!

7501 Greenway Center Drive | Suite 660 | Greenbelt, MD 20770
5530 Wisconsin Avenue | Suite 1550 | Chevy Chase, MD 20815
Tel : 301-220-1333 | Fax : 301-220-1533

PATIENT INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD AND VALID PHOTO ID

Last name: _____ PCP: _____

First name: _____ DOB: _____/_____/_____

Address: _____ Marital Status: S M D

City: _____ State: _____ Social Security: _____/_____/_____

Zipcode: _____ Emergency Contact:

Primary Phone ( ) _____ Name: _____

Secondary Phone ( ) _____ Phone: ( ) _____

Work Phone ( ) _____ Relationship: _____

Email: _____ Employer: _____FT or PT

Your primary phone number and email will be receiving confirmation notifications

If your appointment is related to an auto accident, please ask for an AUTO ACCIDENT PACKAGE.

If your appointment is related to a work compensation injury:

Name of Insurance Company to be billed: _____

Claim number: _____

Date of injury: _____/_____/_____

Adjuster Name: _____

Phone number: ( ) _____

Primary Insurance: _____ Policy Holder: _____

ID Number: _____

Secondary Insurance: _____ Policy Holder: _____

ID Number: _____

I hereby authorize _____ insurance company to pay by ACH, Mailer check directly to Advance Pain Medicine Institute, LLC. The medical and surgical expense benefits allowable and otherwise payable to me under my current insurance policy. As payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to this assignee, and I agree to pay in current manner and said professional services charges above this insurance payment.

In my current policy prohibits direct payment to physician then I hereby authorize you to make the payment payable to me and mail APMI, LLC. This is a direct assignment of my rights and benefits under this policy.

FINANCIAL POLICY

Thank you for selecting APMI as your healthcare provider. We are committed to providing you the best possible medical care at the lowest possible cost. Please understand that payment on your bill is considered a part of your treatment. For patients who are responsible for their own coverage we expect full payment for professional services. We accept cash or credit. Under certain circumstances we may be willing to arrange a payment plan. Our practice participates with most insurance carriers. As a courtesy, we will contact your carrier to confirm coverage and estimate their payment for services rendered.

We require you to make payment at the time of service so we do not have to send a bill. Prompt payment allow us to control cost which ultimately keeps our fees to a minimum. Patients with standard copayment amount per visit should render that payment at the time of service. This payment will be applied to your policy.

You are responsible to obtain necessary referral from your primary care physician if it is required by your insurance company.

Please be aware that by scheduling an initial consultation with our physicians, you are agreeing to abide by the billing policies of our services. To better serve all our patients, we require a 24-hour notification should you need to cancel or reschedule your appointment. Should you miss, or reschedule your office visit or any procedural appointment less than a 24-hour notice, you will be charged **$35.00 for the office visits and $200.00 for procedural appointments.** Payment will be due at the time of your next appointment. Your insurance company does not cover fees for missed appointments.

Return check fees will be added to your balance.

Our staff is available to answer any question you may have regarding how your claim has been filed with your insurance company.

May we remind you that your insurance policy is a contract between you and your carrier and any case of dispute APMI is not a party to that contract and cannot act as a mediator.

I have read and agree to the above financial policy and to its terms and conditions.

Completed on: _____/_____/_____ Signature: _____

OFFICE POLOCIES

Office Hours/ Appointments

Patients are seen **BY APPOINTMENT ONLY**. Our offices are open generally from 8:00am to 5:00pm, Monday through Friday.
Please see the specific office location for information to confirm the days and hours of operation.
Please come on time for your appointment. There is a 15-minute grace period. If you arrive 15 minutes after your scheduled appointment, you will be rescheduled.

Registration

For initial appointments with our practice, patients should arrive at the office at least 15 minutes prior to their scheduled appointment time. After arriving, please check in with the front desk.
If you are a new patient, we ask that you complete a New Patient Information Packet. This provides valuable information for the physician and will enable us to establish a history and administrative file for you. If you have any questions regarding the information requested, please ask for assistance to complete the form as soon as possible. It is your responsibility to bring in your medical records and images of your MRI or X-rays on your initial visit to avoid unnecessary visits or copays.
If you are an established patient, and information concerning your insurance, address, or phone number has changed, please let us know so that we can update our records accordingly.

Primary Care Referrals

Please obtain all the necessary referral forms (if required by your insurance) from your primary care physician prior to your visit. **Unfortunately, patients cannot be seen without the appropriate referral.**

Copayments

Copayments and/or deductibles, as well as outstanding balances must be paid upon patient's arrival.

Gadget Use

To avoid delays and interruptions, please refrain from talking on your phone or using your hand-held devices inside the treatment/consultation rooms.
Please turn off your cellphones or put your cellphone on silent mode during your consultation with the doctor.
APMI reserves the right to reschedule your visit if such interruptions and distractions occur during the visit.

I have read and understood the policies stated above
I hereby acknowledge that I have read and received a copy of the office policies

Signature of patient or responsible party: _____ Date: ___/___/___

MEDICATION MANAGEMENT

To ensure that your medication needs are met in a timely manner, we request that you call or set up an appointment at least 2 weeks prior to the date your medication is scheduled to run out so we can properly schedule your appointment.

All patients who receive/ will receive narcotic pain medications will be asked to sign a Medication Management Agreement, which outlines the policies regarding medication prescription use, and monitoring. A copy will be made available to the patient and kept in the chart for reference.

If receiving pain medications from another provider prior to becoming our patient be advised that is **NO guarantee that you will get the same medications from our doctors.**

CONFRONTATIONS WITH ANYONE IN THE OFFICE WILL NOT BE TOLORATED.

APMI focuses more on an interdisciplinary approach to pain management to achieve better therapeutic outcomes; prescription management is NOT the man focus of our practice. If your only purpose for coming in is for medication, we will be happy to refer you to another physician that can help with your prescription needs.

MEDICAL FORMS

If you have forms to be filled out, you are responsible for bringing these to the office as soon as possible to avoid delays in completion and submission. The fees for forms and letters will depend on the complexity and time needed for completion of said forms and letters, and range from $50.00 to $400.00. Please ask for an estimate from the front desk.

For transportation, parking placards, work status and FMLA forms, the patient needs to be seen during a follow-up visit for proper completion of the form. The fee for medical records will be $0.75 per page and a retrieval charge of $22.88. The turnaround time for completion depends on the type of form and can take up to 2 weeks for completion.

WAITING ROOM/OFFICE DECORUM

As a courtesy to our other patients and in accordance with privacy laws, **PLEASE REFRAIN FROM DISCUSSING YOUR CONDITIONS AND MEDICATIONS** while in the waiting area.

NO FOOD OR DRINKS are allowed in the office

You are discouraged from bringing family members since waiting space is limited. Only patients are allowed in the consultation rooms unless you need physical assistance. Please refrain from bringing children to the office. Should you bring children with you and their behavior becomes loud and disruptive, APMI reserves the right to RESCHEDULE YOUR APPOINTMENT

NOTICE OF PRIVACY PRACTICES:

I hereby acknowledge that I have received a copy of APMI Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

Signature of patient or responsible party: _____ Date: ___/___/___

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date: ___/___/___ but acknowledgement could not be obtained because:

_____ Patient representative refused to sign

_____ Emergency prevented us from obtaining acknowledgement at the time.

Explain: _____

_____

AUTHORIZATION TO DISCUSS INFORMATION WITH DESIGNATED PERSON

It is often difficult to reach a patient to discuss appointments, medication and other information pertinent to our patient's care. In the event with your signed authorization we would discuss such information to a person you designate. Please complete the section below.

I hereby authorize Advanced Pain Medicine Institute to discuss any information required during my examination or treatment to the following designated person(s)

Name of Designee: _____ Phone number: ( ) _____

Relationship to Patient: _____

Name of Designee: _____ Phone number: ( ) _____

Relationship to Patient: _____

Name of Designee: _____ Phone number: ( ) _____

Relationship to Patient: _____

_____ None

I agree to all the above

Signature of patient or responsible party: _____ Date: ___/___/___

Name: _____

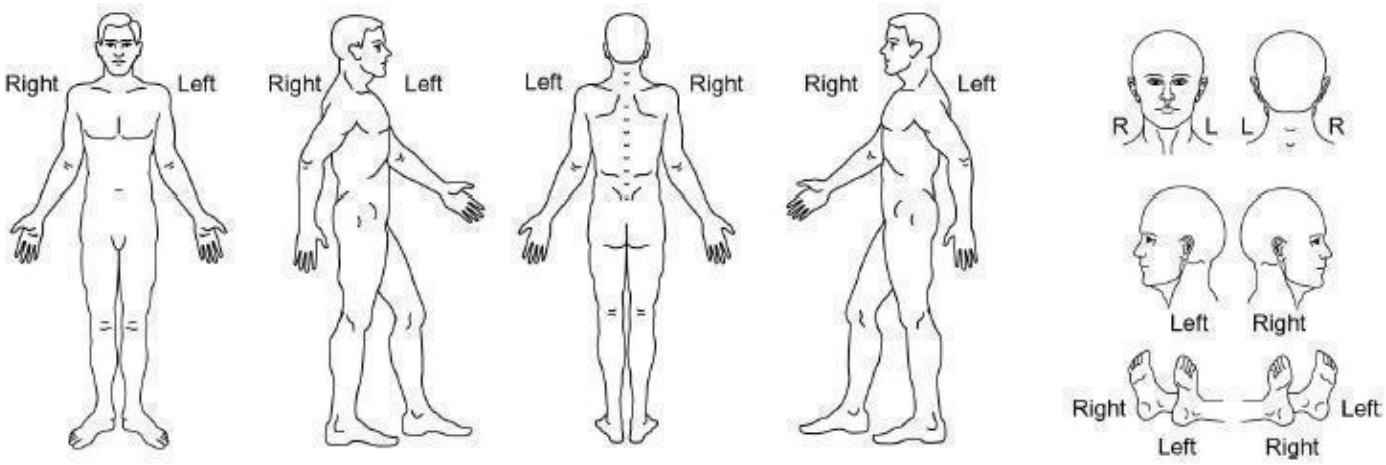
Date: _____

DOB: _____ Age: _____

Height: _____ Weight: _____

Thank you for choosing Advance Pain Medicine Institute. We are very interested in learning more about your pain. Please help us by completing this questionnaire.

- Please use the diagram below to indicate where your MOST areas of pain are located:



- When did you're your pain begin? Month: _____ Day: _____ Year: _____
- Do you know the cause of your pain? (car accident, fall, job related injury, etc.) _____

  _____
- Please circle your AVERAGE daily level of pain
  No pain= 0 1 2 3 4 5 6 7 8 9 10 = Worst pain imaginable

- Please indicate which of the following medications for pain you have tried in the past

__ Acetaminophen (Tylenol)	__ Hydromorphone (Dilaudid)	__ Amitriptyline (Elavil)
__ Ibuprofen (Motrin)	__ Oxycodine (Percocet)	__ Duloxetine (Cymbalta)
__ Naprosyn (Alleve)	__ Morphine (MS Contin)	__ Cyclobenzaprine (Flexeril)
__ Meloxicam (Mobic)	__ Methadone	__ Carisoprodol (Soma)
__Diclofenac (Voltaren)	__ Gabpentin (Neurontin)	__ Tizanidine (Zanaflex)
__ Tramadol (Ultram)	__ Lyrica (Pregabalin)	__ Lioresal (Baclofen)
__ Hydrocodone (Vicodin)	__ Topiramate (Topamax)	__ Methocarbamol (Robaxin)

- Which of the following treatments have you had for your pain?

__ Surgery	__ Physical Therapy	__ Acupuncture
__ Nerve Blocks	__ Pain Psychology	__ Biofeedback
__ Trigger Point Injections	__ TENS Unit	

- Have you ever been treated by another pain specialist? ___ Yes ____ No

  If so, what is the name of the doctor or practice? _____
- Please circle the medical conditions you have been diagnosed with:

High blood pressure	Diabetes	Heart Disease	Kidney Disease
Asthma	COPD	Sleep Apnea	GERD
High Cholesterol	Arthritis	Ulcer	Fibromyalgia
Migraine Headaches	Cancer	Bipolar Disorder	Anxiety
Depression	Other: _____		

- Please list any surgeries you have
  1. _____
  2. _____
  3. _____

- Please list any medications you are currently taking:

Name of Medication	Strength/Dose	How Often	Prescriber

- Do you smoke? ___Yes ___ No
- Do you drink alcohol? ___ Yes ___ No
- Have you ever used illegal drugs? ___ Yes ___ No
- Do you have any allergies to medications or food? _____
- Circle any of the following imaging studies you have had in your area of pain

X-ray CT scan MRI EMG

Patient Name: _____ Date of Birth: _____

At Advance Pain Medicine Institute (APMI) our goal is to test you using a multitude of therapies. Our therapeutic goals include improving the quality of your life without exposing you to long-term health risks associated with the use of chronic high dose narcotics. At APMI we do not prescribe high dose narcotics under any circumstance. We strive to relieve your pain using the latest and most innovative interventional procedures.

If you are a new or self-pay (without insurance) patient, please be aware that APMI is a specialty medical practice, and the purpose of your visit is for a c

onsultation requested by another one of your physicians. This means that you are not entitled to receive prescriptions for narcotic medication. Your payment is for a consultation and NOT a prescription.

Please read this document (PAIN CONTRACT) very carefully as it will become part of your medical records.

I understand that I have the following responsibilities:

- I will only have narcotic pain medication prescribed by the Prescriber at APMI
- I will use only one pharmacy to fill my prescription
- I agree to keep my medication in a safe secure location, and if my medication is stolen, lost, misplaced or damaged, I will not be entitled to a replacement prior to my next appointment
- Narcotic medications are controlled substances that are highly regulated by the Drug Enforcement Agency and I understand sharing, selling and/or borrowing medication is a felony and will not be tolerated at APMI
- I understand that dose adjustment of ANY pain medication prescribed an APMI clinician will be made at the discretion of the prescriber and NOT the patient. Running out of medication is a direct violation of this agreement.
- I agree to submit a urine or saliva sample for drug testing if one is requested. I also understand that this procedure may be random or mandatory at every visit. Failure to provide a urine/salvia sample will result in the discontinuation of treatment with narcotic medication.
- I understand that if my Urine Drug Screen (UDS) is positive for illegal substances such as marijuana, cocaine or methamphetamines I will not be eligible for treatment with narcotic medication regardless of prior treatment plans.
  A. I understand the ONE abnormal UDS may result in mandatory testing at every visit. THREE ARE NO ACCEPTIONS TO THIS AGREEMENT
  B. I understand at 2 consecutive abnormal UDS tests that are positive for illegal substances may render me ineligible for future treatment with narcotics.
- I understand that if prescribed medication is not present in the requested urine or salvia sample you will be provided with a limited supply of medication at the practitioner's discretion and asked to return soon after to repeat the study.
  A. I understand that 2 consecutive UDS tests that are negative for prescribed medication is grounds for discontinuation of narcotic therapy.
- I understand that at ANY time a clinician may request bottles of prescribed medication be presented for tablet count to verify compliance with your treatment plan.

At APMI, treatment plans are determined by licensed physicians or physician assistants. Prescriptions are dispensed based upon their judgement and evaluation, regardless of previous treatment plans from other providers. Signing this document and agreeing with the terms does not guarantee or entitle you to treatment with narcotic medication.

I am signing this contract voluntarily, and I agree to be compliant with all the terms of this document. Refusal to sign this binding contract does not exclude you from receiving non-narcotic medication or interventional therapy.

A copy of this document will be sent to your primary care physician.

_____ _____

Patient signature Today's Date

_____ _____

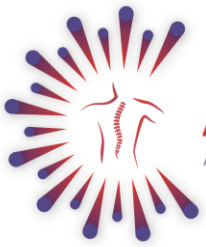
Reza Ghorbani, MD

_____ _____

Name of Primary Care Physician Telephone number

_____

Name of Pharmacy Location-St, City, ST Telephone number



CHEVY CHASE
5530 Wisconsin Avenue #1550
Chevy Chase, MD 20815
Office: (301) 220-1333
Fax (301) 215-4157

GREENBELT
7501 Greenway Center Drive #660
Greenbelt, MD 20770
Office: (301) 220-1333
Fax (301) 220-1533

Date: _____

Authorization for Release of Medical Records

I, _____ authorize_____ to release all medical information (including, but not limited to information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable disease) requested by Advanced Pain Medicine Institute. I authorize you to release all medical information to: Advanced Pain Medicine Institute.

I authorize Advanced Pain Medicine Institute to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning payments under my policy. I direct the insurance company or health plan administrator to release such information to: Advanced Pain Medicine Institute.

I agree to these provisions and will remain in effect until I provide written reactivation to you.

Patient Name: _____

Patient Date of Birthday: _____

Signature of Patient or Representative Party: _____

Witness: _____