Sussex Pain Relief Center
18229 DuPont Blvd, Georgetown, DE 19947
P: 302.514.7246 F: 302.253.8028 E: contact@sussexpainrelief.com

Pain Questionnaire

*THE FOLLOWING MULTIPAGE QUESTIONNAIRE IS A **VERY** IMPORTANT TOOL THAT IS USED TO ASSESS YOUR PAINCONDITION AS WELL AS THE APPROPRIATE TREATMENTS FOR YOUR PROBLEM.*

*PLEASE READ AND FILL OUT EVERY SINGLE ITEM IN THIS FORM. FAILURE TO COMPLETE OR SIGN THIS FORM COULD RESULT IN A DELAY IN YOUR APPOINTMENT.PLEASE BRING THE COMPLETED FORM ALONG WITH ANY PERTINENT FILMS, REPORTS, DOCTOR NOTES, **COMPLETE MEDICATION LIST**, AND **PRESCRIPTION BOTTLES** FOR YOUR INITIAL CONSULTATION.*

Please bring your COMPLETE MEDICATION LIST with you.

Name: ________________________ Gender: M / F Race: ________________

Social Security: ____________________ Date of Birth: ____________________

Home Address: ____

Primary Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Spouse's Name (If any): ______________________________________

Employer's Name: _____________ Employer's Address: ______________________

EMERGENCY CONTACT (*PERSON living with you*)

Name: ____________________ Phone: ______________ Relationship: __________

INSURANCE INFORMATION

Primary Insurance Name: ______________________________________

ID #: ________________________ Group #: ________________________

Subscriber's Name: _______________ Date of Birth: __________ Relationship: _________

Secondary Insurance Name: ______________________________________

ID #: ________________________ Group #: ________________________

Subscriber's Name: _______________ Date of Birth: __________ Relationship: _________

Referring Doctor: __________________ Phone: ____________ Fax: _____________

Primary Care Doctor: ________________ Phone: ____________ Fax: _____________

Consent for Treatment and Financial Agreement: I hereby request treatment to be performed by physicians or providers of Sussex Pain Relief Center and/or assistants. Such treatments to include: injections, ultrasound, diagnostic procedures, and such other office procedure as they deem necessary. I accept full responsibility for any charges incurred for services rendered to me.

Signature: ______________________________ Date: ____________________

SPECIALISTS

Orthopedic Surgeon: ______________________________ Neurologist: ______________________________

Rheumatologist: __________________________________ Chiropractor: _____________________________

Have you ever been to another Pain Physician? Whom? ___________________ Last seen: ________________

Reason for leaving: ____

PAIN HISTORY (*Please describe your pain*)

Where is your primary pain? Back / Neck / Hip / Other: ____

Who referred you? _______________________________ Why? ____

When did the pain first start? ____________ Was this Work, Auto, or Trauma related? ___________________

How did it first start? ____

Pain Timing: Sudden / Gradual / Spontaneous?

Where does your primary pain radiate to? Hip / Leg / Arm / Head

Please help us **rate** your pain (o = No Pain at ALL & 10 = Worst Pain Imaginable)

Today	0 = No Pain	1	2	3	4	5	6	7	8	9	10 = Worst Pain
On good days	0 = No Pain	1	2	3	4	5	6	7	8	9	10 = Worst Pain
On bad days	0 = No Pain	1	2	3	4	5	6	7	8	9	10 = Worst Pain
Average past week	0 = No Pain	1	2	3	4	5	6	7	8	9	10 = Worst Pain

Describe your pain (*Circle all that apply*)

Sharp	Dull	Annoying	Throbbing
Burning	Aching	Miserable	Piercing
Shooting	Tender	Intense	Tight
Stabbing	Tingling	Unbearable	Numb

Which activities **bring on or worsen** your pain? Walking / Sitting / Standing / Twisting / Other: ____________

Which activities seem to **improve** your pain? Sitting / Lying / Standing / Ice / Heat / Other: ________________

Associated symptoms

- [ ] Weakness of arm(s) - Left / Right / Both
- [ ] Weakness of leg(s) - Left / Right / Both
- [ ] Numbness of arm(s) - Left / Right / Both
- [ ] Numbness of leg(s) - Left / Right / Both
- [ ] Loss of bladder or bowel control
- [ ] Tenderness of affected area
- [ ] Cool, pale skin
- [ ] Discolored or mottled skin
- [ ] Depression
- [ ] Headaches
- [ ] Impotence
- [ ] Decreased sex drive
- [ ] Weight gain (How many lbs. past 6 mos? __)
- [ ] Weight loss (How many lbs. past 6 mos? __)
- [ ] Difficulty sleeping
- [ ] Pain awakens you at night
- [ ] Pain with only light touch
- [ ] Fever

Other: ____

How does pain **affect** your lifestyle? Daily Activity / Household Activities / Physical Activities / Work

How does pain affect your sleep? Not at all / Trouble falling asleep / trouble staying asleep

PAST PAIN TREATMENT

Please describe what you have tried in the past for your pain. Please let us know if any of these things helped.

NSAIDS (anti inflammatory medication): Ibuprofen / Mobic / Diclofenac / Naprosyn / Celebrex /
Other: ______________________________

PAIN MEDICATION: Tramadol / Hydrocodone-Acetaminophen / Percocet / Morphine / Oxycodone /
Oxycontin / Hydromorphone / Fentanyl / Other: ______________________________

PHYSICAL THERAPY: When ______________ Did it help? ______________

CHIROPRATIC THERAPY: When ______________ Did it help? ______________

INJECTIONS: Type ____________ When ____________ Did it help? ______________

SURGERIES: Type ____________ When ____________ Did it help? ______________

Please describe any other treatment you have tried in the past for you specific pain: ______________

____

____

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____

MEDICATIONS

Please list your current medication start with what you take for pain. Please include the name, dose, and frequency.

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PAST MEDICAL & SOCIAL HISTORY

Have you ever been diagnosed with or treated for any of the following health problems?

- [ ] Alcohol Abuse/Addiction
- [ ] Angina/Chest Pain
- [ ] Angioplasty or Stent for blocked artery
- [ ] Anxiety, Depression, or Panic Disorder
- [ ] Arrhythmia/Atrial Fibrillation/Cardiac Arrest
- [ ] Arthritis (Type: Osteo or Rheumatoid)
- [ ] Asthma/Wheezing
- [ ] Bipolar Disorder
- [ ] Cancer (Type: ________________________)
- [ ] Chronic Cough
- [ ] Congestive Heart Failure (Year: : _________)
- [ ] Deep Venous Thrombosis (Blood Clot - Leg)
- [ ] Diabetes(Type I or II)
- [ ] Drug Abuse/Addiction
- [ ] Emphysema, Chronic Bronchitis, or COPD
- [ ] Fibromyalgia
- [ ] Headache (Migraine, Cluster, or Tension)
- [ ] Heart Attack (Year: : ___________________)
- [ ] Hepatitis (Type: A or B or C)
- [ ] High Blood Pressure
- [ ] HIV or AIDS
- [ ] Implantable Defibrillator
- [ ] Kidney Failure/Dialysis
- [ ] Liver Disease/Cirrhosis
- [ ] Neuropathy (Type: ____________________)
- [ ] Obesity
- [ ] Pacemaker
- [ ] Paralysis (Describe: : __________________)
- [ ] Previous Suicide Attempt
- [ ] Pulmonary Embolism (Blood Clot - Lung)
- [ ] Seizure or Epilepsy
- [ ] Sickle Cell Disease
- [ ] Stomach or Duodenal Ulcer (Year: : ______)
- [ ] Stroke or TIA
- [ ] Thyroid Disease (Under or Overactive)

Other: ____

ALLERGIES

Please list your **allergies to medication or other drug**

Name of Medication	Type of Reaction Experienced
____________________________________	____________________________________
____________________________________	____________________________________
____________________________________	____________________________________

Are you allergic to Iodine Contrast Dye (e.g. IVP Dye)? Yes / No

If yes, what type of reaction did you have? ____

Are you allergic to Aspirin or Anti-Inflammatory Medication? Yes / No

Do you have any of the following conditions?

Kidney Disease / CVA / Diabetes / Ischemic Heart Disease / Obstructive Sleep Apnea / Pulmonary Embolism

Taking Blood Thinners / Anxiety / Depression / Bipolar / Schizophrenia / Suicidal History / Sexual Dysfunction

Have you had problems with Conscious Sedation? ____

Have you had problems with Anesthesia? ____

SURGICAL HISTORY

Please list any s**urgery**(s) and **date of surgery** you have had in the past

Surgery	Date of Surgery
______________________________	______________________
______________________________	______________________
______________________________	______________________
______________________________	______________________
______________________________	______________________

Have you been to the hospital in the last 30 days? If so, describe when, where, and why:

____

FAMILY HISTORY

Please list health issues with the following

Mother: ______________________________ Father: ______________________________

In your immediate family (mother, father, sisters, brothers, grandparents) are there any of the following:

Family history of Addiction: Yes / No Family history of Alcoholism: Yes / No

Family history of Cancer: Yes / No Family history of Chronic Pain: Yes / No

FUNCTIONAL HISTORY

Circle any of the following that you are unable to do:

Walk (use cane, walker, or wheel chair) / Bath / Dress / Toileting / Brush teeth / Eat / Cook / Drive / Shop / Manage finance / Manage medications / Use computer / Use phone

What has pain limited your ability to do?____

____

____

SOCIAL HISTORY

Marital Status: Married / Single / Separated / Divorced / Widowed How many Children do you have? _____

Whom do you live with? Alone / Spouse / Significant Other / Child / Family / Friends / Homeless

Do you drink alcohol? Yes / No How much __________ Of what ____________ How often ________________

Do you use illicit drugs? Yes / No Last time __________ Of what ____________ How often ________________

History of sexual abuse? Yes / No Describe: ____

Do use tobacco? Yes / No How many per day __________ Of what _____________How long ______________

Manonmani Antony MD
Managing Member

18229 DuPont Blvd.
Georgetown, DE 19947

Phone: 302-514-PAIN
Phone: 302-253-8026
Fax: 302-253-8028

contact@sussexpainrelief.com
www.sussexpainrelief.com

Sussex Pain Relief Center, LLC

Dear Patient,

The purpose of this letter is to tell you about our general practice policies and position on using controlled substances, such as Opioids (narcotics), to treat pain. We give this letter to all our new patients. If you have any further questions after reading this letter, remember to discuss them with your doctor.

We will explore all medical treatment options within the scope of our medical practice to help you restore function and lead an active, healthy life, using a variety of treatments to accomplish our goals including but not limited to physical therapy, procedures, heat and/or cold therapy, a home exercise program, non-controlled medications and, in some cases, controlled medications. We require all our patients to have a primary care physician and we expect you to help us obtain your medical records from your primary care doctor and any other doctor who has treated you using controlled medications. The faster we receive records, the faster you'll be seen.

If your healthcare practitioner decides to prescribe controlled medications to you as part of your overall treatment plan, he/she *must and will* follow federal and state laws and regulations governing controlled substance prescribing. Here are just a few of the things we may ask you to provide for us in connection with our patient selection and treatment process:

1) Get information from your doctors about your medical history and your past pain treatments, including a list of all medications you take to treat your pain;

2) Ask whether you or your family has had any problems with alcohol, illegal drugs, legal drugs, or tobacco; and

3) Ask you to provide a urine sample for testing as part of the initial patient selection process. If we accept you into our pain management and rehabilitation program, we may ask you to submit additional urine samples as part of your ongoing treatment program. All urine samples are requested at the discretion of your healthcare practitioner and you will be asked to cooperate with us or we have the discretion to not treat you.

We will monitor your medical condition and supervise your use of medication using various tools in addition to urine drug testing, including medication counts, family conferences, psychological consultations, etc. These tools are not meant to be offensive and are used in conjunction with professional and state/federal guidelines. Furthermore, third-parties such as insurance companies, require that we perform these tests to obtain prior authorization for medications and procedures. We want you to know that we are committed to treating you and doing what is medically acceptable and appropriate for you to help you control your pain. We look forward to serving you and empowering you to take control of your pain.

Sincerely,
Dr. Manonmani Antony

Patient

______________________	______________________	______________________
Print Name	Signature	Date

Witness

______________________	______________________	______________________
Print Name	Signature	Date

Global Pain Scale

Instructions: For each question, please indicate your level of pain by circling a number from 0 to 10.

YOUR PAIN:

My **current** pain is	**No pain:**	0	1	2	3	4	5	6	7	8	9	10	**:Extreme pain**
During the *past week,* the **best** my pain has been is	**No pain:**	0	1	2	3	4	5	6	7	8	9	10	**:Extreme pain**
During the *past week*, the **worst** my pain has been is	**No pain:**	0	1	2	3	4	5	6	7	8	9	10	**:Extreme pain**
During the *past week*, my **average** pain has been	**No pain:**	0	1	2	3	4	5	6	7	8	9	10	**:Extreme pain**
During the *past 3 months*, my **average** pain has been	**No pain:**	0	1	2	3	4	5	6	7	8	9	10	**:Extreme pain**

YOUR FEELINGS: During the past week I have felt:

Afraid	**Strongly Disagree:**	0	1	2	3	4	5	6	7	8	9	10	**:Strongly Agree**
Depressed	**Strongly Disagree:**	0	1	2	3	4	5	6	7	8	9	10	**:Strongly Agree**
Tired	**Strongly Disagree:**	0	1	2	3	4	5	6	7	8	9	10	**:Strongly Agree**
Anxious	**Strongly Disagree:**	0	1	2	3	4	5	6	7	8	9	10	**:Strongly Agree**
Stressed	**Strongly Disagree:**	0	1	2	3	4	5	6	7	8	9	10	**:Strongly Agree**

YOUR CLINICAL OUTCOMES: During the past week:

I had trouble sleeping	**Strongly Disagree:**	0	1	2	3	4	5	6	7	8	9	10	**:Strongly Agree**
I had trouble feeling comfortable	**Strongly Disagree:**	0	1	2	3	4	5	6	7	8	9	10	**:Strongly Agree**
I was less independent	**Strongly Disagree:**	0	1	2	3	4	5	6	7	8	9	10	**:Strongly Agree**
I was unable to work (or perform normal tasks)	**Strongly Disagree:**	0	1	2	3	4	5	6	7	8	9	10	**:Strongly Agree**
I needed to take more medication	**Strongly Disagree:**	0	1	2	3	4	5	6	7	8	9	10	**:Strongly Agree**

YOUR ACTIVITIES: During the past week I was **NOT** able to:

Go to the store	**Strongly Disagree:**	0	1	2	3	4	5	6	7	8	9	10	**:Strongly Agree**
Do chores in my home	**Strongly Disagree:**	0	1	2	3	4	5	6	7	8	9	10	**:Strongly Agree**
Enjoy my friends and family	**Strongly Disagree:**	0	1	2	3	4	5	6	7	8	9	10	**:Strongly Agree**
Exercise (including walking)	**Strongly Disagree:**	0	1	2	3	4	5	6	7	8	9	10	**:Strongly Agree**
Participate in my favorite hobbies	**Strongly Disagree:**	0	1	2	3	4	5	6	7	8	9	10	**:Strongly Agree**

Scoring: Add up the total score and divide by 2. Each subset is worth 25 points. The maximum total score is 100.

Name: ______________________________ Date: _________________________

Sussex Pain Relief Center

www.sussexpainrelief.com

Oswestry Disability Questionnaire

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking one box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply, but please just shade out the spot that indicates the statement which most clearly describes your problem.

Section 1: Pain Intensity
- ○ I have no pain at the moment
- ○ The pain is very mild at the moment
- ○ The pain is moderate at the moment
- ○ The pain is fairly severe at the moment
- ○ The pain is very severe at the moment
- ○ The pain is the worst imaginable at the moment

Section 2: Personal Care (eg. washing, dressing)
- ○ I can look after myself normally without causing extra pain
- ○ I can look after myself normally but it causes extra pain
- ○ It is painful to look after myself and I am slow and careful
- ○ I need some help but can manage most of my personal care
- ○ I need help every day in most aspects of self-care
- ○ I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting
- ○ I can lift heavy weights without extra pain
- ○ I can lift heavy weights but it gives me extra pain
- ○ Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed (eg. on a table)
- ○ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- ○ I can only lift very light weights
- ○ I cannot lift or carry anything

Section 4: Walking*
- ○ Pain does not prevent me walking any distance
- ○ Pain prevents me from walking more than 1 mile
- ○ Pain prevents me from walking more than ½ mile
- ○ Pain prevents me from walking more than 100 yards
- ○ I can only walk using a stick or crutches
- ○ I am in bed most of the time

Section 5: Sitting
- ○ I can sit in any chair as long as I like
- ○ I can only sit in my favorite chair as long as I like
- ○ Pain prevents me sitting more than one hour
- ○ Pain prevents me from sitting more than 30 minutes
- ○ Pain prevents me from sitting more than 10 minutes
- ○ Pain prevents me from sitting at all

Section 6: Standing
- ○ I can stand as long as I want without extra pain
- ○ I can stand as long as I want but it gives me extra pain
- ○ Pain prevents me from standing for more than 1 hour
- ○ Pain prevents me from standing for more than 30 minutes
- ○ Pain prevents me from standing for more than 10 minutes
- ○ Pain prevents me from standing at all

Section 7: Sleeping
- ○ My sleep is never disturbed by pain
- ○ My sleep is occasionally disturbed by pain
- ○ Because of pain I have less than 6 hours sleep
- ○ Because of pain I have less than 4 hours sleep
- ○ Because of pain I have less than 2 hours sleep
- ○ Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)
- ○ My sex life is normal and causes no extra pain
- ○ My sex life is normal but causes some extra pain
- ○ My sex life is nearly normal but is very painful
- ○ My sex life is severely restricted by pain
- ○ My sex life is nearly absent because of pain
- ○ Pain prevents any sex life at all

Section 9: Social Life
- ○ My social life is normal and gives me no extra pain
- ○ My social life is normal but increases the degree of pain
- ○ Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sport
- ○ Pain has restricted my social life and I do not go out as often
- ○ Pain has restricted my social life to my home
- ○ I have no social life because of pain

Section 10: Traveling
- ○ I can travel anywhere without pain
- ○ I can travel anywhere but it gives me extra pain
- ○ Pain is bad but I manage journeys over two hours
- ○ Pain restricts me to journeys of less than one hour
- ○ Pain restricts me to short necessary journeys under 30 minutes
- ○ Pain prevents me from travelling except to receive treatment

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

Please include any additional information you wish about the above answers.
Thank you.

PATIENT CONSENT & ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Sussex Pain Relief Center, 18229 DuPont Blvd, Georgetown, DE 19947

I understand that as part of the provision of healthcare services, Sussex Pain Relief Center creates and maintains health records and other information describing among other things, my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their privacy practices and the terms of this notice at any time. Upon my request, I will be provided with any revised Notice of Privacy Practices. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and healthcare operations. I have the right to revoke this consent in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.

2. A photocopy or fax of this consent is as valid as the original.

3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or healthcare operations restricted. I also understand that the Practice and I must agree to any restrictions in writing that I request on the use and disclosure of my Protected Health Information which have been previously agreed upon.

______________________________ ______________________________

PATIENT OR PERSONAL REPRESENTATIVE OR GUARDIAN'S NAME PRINTED **DATE**

______________________________ ______________________________

PATIENT OR PERSONAL REPRESENTATIVE OR GUARDIAN'S SIGNATURE **SOCIAL SECURITY NUMBER (FOR IDENTIFICATION PURPOSES ONLY)**

______________________________ ______________________________

WITNESS **DATE**

Financial Policy   Sussex Pain Relief Center

You are financially responsible for the medical services you receive. Please review our policies below and sign at the end to indicate your agreement to these terms.

APPOINTMENTS

1. **Copayments.** Copayments for clinic visits are due at the time of service. If you are unable to make your copayment at the time of service, Sussex Pain Relief Center reserves the right to reschedule your appointment until a time that you can make your copayment. Payment for any outstanding balance is due at the time of your appointment.

2. **Missed Appointments and Late Arrivals.** If you are more than 15 minutes late, we may reschedule your appointment. If you are more than 60 minutes late, or if you do not show up to your appointment, you will be responsible for a missed appointment fee. Missed office visit appointments are subject to a $35 charge. Missed procedure, is subject to a $100 charge. These charges are your responsibility and will not be billed to any insurance carrier.

INSURANCE PAYMENTS

3. **Financial Responsibility.** Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurer will be your responsibility, except as limited by our contract (if any) with your insurance carrier.

4. **Coverage Changes and Timely Submission.** It is your responsibility to inform us in a timely manner of any changes to your billing or insurance information. There is a time limit within which Sussex Pain Relief Center must submit a claim on your behalf to your insurer. If Sussex Pain Relief Center is unable to submit your claim within this period because we have not been supplied with your correct insurance information, you will be responsible for the charges.

5. **Self-Pay.** If you do not have health insurance, or if your health insurance will not pay for services rendered by Sussex Pain Relief Center, you will be considered a self-pay patient. Your charges will be based on our current self-pay schedule. Self-pay patients are expected to make payment in full at the time of service or at the time they are billed.

BENEFITS AND AUTHORIZATION

6. **Insurance Plan Participation.** We participate in many but not all insurance plans. It is your responsibility to contact your insurance company to verify that your assigned physician participates in your plan. Out-of-network charges may have higher deductibles and copayments.

7. **Referrals.** Referral and prior authorization requirements vary widely among insurance carriers and plans. If your insurance carrier requires a referral for you to be seen by Sussex Pain Relief Center, it is your responsibility to be aware of this fact and to obtain this referral.

8. **Prior Authorization and Non-Covered Services.** Sussex Pain Relief Center may provide services that insurance plans exclude or require prior authorization to pay for. If insured, it is ultimately your responsibility to ensure that services provided to you are covered benefits authorized by your insurer. Sussex Pain Relief Center, as a courtesy to our patients, makes a good faith effort to determine if services we order are covered by your insurance plan, and, if so, whether prior authorization for treatment is required. If we determine that a prior authorization is required, we will attempt to obtain such authorization on your behalf.

9. **Out-of-Network Payments.** If we are not part of your insurance carrier's network (out-of-network) and your insurance carrier pays you directly, you are solely responsible for payment and agree to immediately forward the payment to Sussex Pain Relief Center.

Financial Policy Sussex Pain Relief Center

ACCOUNT BALANCES AND PAYMENTS

10. **Reassignment of Balances.** If your insurance company does not pay within a reasonable time, we may transfer the balance to the patient, so they are your sole responsibility. Please follow up with your insurance carrier to resolve non-payment issues. Balances are due within 30 days of receiving a statement.
11. **Collection of Unpaid Accounts.** If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney, which may result in reporting to credit bureaus and/or legal action. Sussex Pain Relief Center reserves the right to refuse treatment to patients with outstanding balances over 120 days old. You agree to pay Sussex Pain Relief Center for any expenses we incur to collect on your account, including reasonable attorneys' fees and collection costs.
12. **Returned Checks.** Returned checks will be subject to a $38 returned check fee.
13. **Refunds.** Refunds for overpayment are made only after there has been full insurance reimbursement for all medical services on your account. Please submit a written refund request and allow four to six weeks for your request to be processed.
14. **Statements.** Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing dates.

Agreement and Assignment of Benefits

I have read and understand the financial policy of Sussex Pain Relief Center, and I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to Sussex Pain Relief Center. I understand that I am financially responsible for all services I receive from Sussex Pain Relief Center. This financial policy is binding upon you and your estate, executors and/or administrators, if applicable.

Signed:____ Date: ______________________