1721 Magnavox Way, Suite B, Fort Wayne IN, 46804
Phone: 260-748-3650 Fax: 260-748-3651

Welcome to Summit Pain Management. It is our pleasure to have the opportunity to serve you. Our goal is to provide you with comprehensive medical care in the most comfortable environment possible.

Below you will find a checklist of information to complete ***prior*** to your appointment. Please fill out the entire new patient packet and bring it in with you on your initial visit. This will help ensure your visit is as successful and efficient as possible.

- ☐ Please bring your completed new patient packet along with your appointment card.
- ☐ Please bring your insurance card(s) and a valid Indiana State ID so we may make copies for your chart.
- ☐ Please bring any films or reports of radiology procedures to your appointment (CT's, PET Scan, MRI's, X-Rays, etc.)
- ☐ Any previous records you may have along with your current medication record.
- ☐ Please know that ***all co-payments are due at the time of service*** and can be paid by money order, cash or credit.
- ☐ Please limit company to one other individual due to seating availability.

Patient Name: _____

Date & Time of Appointment: _____

Physician Name:_____

Located at:_____

Located at: 1721 Magnavox Way, Suite B, Fort Wayne IN, 46804

Should you have any questions and/or concerns, please do not hesitate to call the office. We look forward to seeing you, and again, thank you for allowing us to take part in your care.

Sincerely,

The Summit Pain Management Team

PATIENT INFORMATION

First Name: _____Mid int:____ Last Name: _____ DOB: ___/___/___ SSN:____/___/____

Ethnicity: _____ Address: _____ Phone#: _____

City: _____ State: ___ Zip Code: _____ Alternate Phone#: _____

Email: _____

Emergency Contact: _____ Relationship: _____

Address: _____ Phone #: _____

Employer: _____ Work Phone#: _____

Employer Address:_____

Referring/ Primary Physician: _____

Address: _____Phone#:_____

Primary Insurance Company: _____

Policy Holder's Name: _____ Date of Birth: __ / __ / ___ SSN: __ / __ / __

Policy Number: _____ Group Number: _____

Secondary Insurance Company: _____

Policy Holder's Name: _____ Date of Birth: __ / __ / ___ SSN: __ / __ / __ Policy

Number: _____ Group Number: _____

Financially Responsible Party (if different from patient): _____

Relationship: _____ Phone#: _____ SSN: ____/____/____

Address: _____

CONSENT FOR CARE AND TREATMENT

I, the undersigned do hereby agree and give my consent for Summit Pain Management to furnish medical evaluation, care and/or treatment to me or someone I am authorized to sign, make medical decisions and sign for. This evaluation, care, or treatment is considered medically necessary and proper in the diagnosing or treatment of his/her/my physical condition. I understand that even though I give my consent for evaluation, care, or treatment, I may refuse any of these services at any time.

FINANCIAL POLICY STATEMENT

Summit Pain Management will bill your health insurance company as a courtesy to you. We require that payment of your estimated share (co-pay or deductible) be made to today. If your insurance company does not remit payment for any reason the balance will be due your responsibility. In the event your insurance company requests a refund of payment or denies coverage for your service, you will be responsible for the balance due. Denials based on "Usual and Customary" will be your responsibility pursuant to any managed care contract in place. If payment is made to you for services provided by Summit Pain Management, you are obligated to promptly pay for those services. Any questions regarding your insurance coverage need to be directed to your insurance carrier. You will be responsible for all fees incurred for collections of monies owed including collection agency fees and/or court costs. To request a detailed account of your financial record please see a representative at the front desk.

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby authorize release to my insurance company of all information necessary for the payment of benefits. I hereby assign payment of benefits by my insurance company to Summit Pain Management.

_____ _____

Patient/Guardian/Responsible Party Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY (NP)

A Notice of Privacy (NP) has been made available to me by Summit Pain Management. The NP describes how my health information may be used or disclosed and my rights under the Health Insurance Portability and Accountability Act (HIPAA).

Please initial: **NP accepted** _____ **NP denied** _____

I am giving my consent for release of minimal health information or financial information to the following individuals:

Name:	Relationship:	Date of birth:
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that I have the right to change (in writing) the above named individuals at any time.

_____ _____

Patient/Guardian/Responsible Party Date

□ I further authorize Summit Pain Management to communicate with me electronically through email at the following e-mail address:_____

I understand that this email communication is not secured by encryption therefore is not considered a secured or private communication. Summit Pain Management will not be held responsible for further disclosure of your information sent via unencrypted email.

Patient's signature:_____

For Authorization of E-mail Communications.

REV 04/27/2022

Summary of

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: May 1, 2013

Revised Date: April 18, 2022

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A full version (7 pages) of this Privacy Notice is available to you at the front desk of our locations.

Under the Health Insurance Portability and Accountability Act of 1996 (" HIPAA") we are required to maintain the privacy and security of your protected health information and provide you with notice of our legal duties and privacy standards with respect to such protected health information.

We are required to abide by the terms of the notice currently in effect. We reserve the right to change the terms of our notice at any time and to make the new notice provisions effective for all protected health information that we maintain. In the event that we make a material revision to the terms of our notice, a revised notice will be made available to you within 60-days of such revision. If you have any questions or require further information, please contact our Privacy Officer, Jamie McMillen, at 260-705-6442.

How We May Use or Disclose Your Health Information

The following describes the purposes for which we are permitted or required by law to use or disclose your health information **without your consent or authorization**. Any other uses or disclosures will be made only with your written authorization and you may revoke such authorization in writing at any time.

Treatment: We may use or disclose your health information to provide you with medical treatment, evaluation, or services to coordinate and manage your healthcare. For example, we will record your health information gathered by us in rendering care to you and will maintain that information in your medical record. The medical record we create or gather about you may be shared with other providers involved in coordination or management of your care.

Payment: We may use or disclose your health information in order for services you receive to be billed or collected from your insurance carrier or another third party. For example, we may disclose appropriate information for reimbursement, collection or payment purposes to those involved with processing or coordinating payment. We may also disclose your information for prior authorization.

Health Care Operations: We may use or disclose your health information for Summit Pain Management and associate health care operations. Health care operations include, but are not limited to, quality assessment and improvement activities, underwriting, premium rating, management and general administrative activities. For example, members of our quality improvement team may use information in your health record to assess the quality of care that you receive and determine how to continually improve the quality and effectiveness of the services we provide.

Business Associates: There may be instances where services are provided for our office through contracts with third party "business associates". Whenever a business associate arrangement involves the use or disclosure of your health information, we will have a written contract that requires the business associate to maintain the same high standards of safeguarding and securing your privacy that we require of our own employees and affiliates. Examples of Business Associates are attorneys, consultants, collections agencies, shredding companies and accreditation organizations.

Communication with Family or Friends: Summit Pain Management and associates, using our best judgment, may disclose to a family member, other relative, close personal friend, or any other person **you identify** as involved in your healthcare, health information relevant to that person's involvement in your care or payment of your care. We may also disclose your condition to family or friends who accompany you to our offices. We may leave a message on your phone pertaining to a scheduled appointment or other health related issues. The message will only be left at the phone number you provided us. You may receive information by mail from our office if you have requested it and completed the appropriate paperwork. You may see or overhear protected health information while in our offices, but we make our best attempt to keep our patient information private and confidential as possible.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information or with authorization from you. An example is when you authorize an entity to use you in a research project or we provide de-identified information to a research facility.

Coroners, Medical Examiners and Funeral Directors: We may disclose health information to a coroner or medical examiner. We may also disclose medical information to funeral directors consistent with applicable law to carry out their duties.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Workers' Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

To Avert a Serious Threat to Health or Safety: Consistent with applicable federal and state laws, we may use and disclose health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosure of this nature would only be made to an appropriate agency or individual. In limited circumstances we have a "duty to warn."

Military and Veterans: If you are a member of the armed forces, we may disclose health information about you as required by military command or with authorization. We may also release medical information about foreign military personnel as appropriate to foreign military authorities as required by law or with authorization.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law, including audits, investigations, inspections, and licensure.
Protective Services for the President, National Security and Intelligence Activities: We may disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations, or for intelligence, counterintelligence, and other national security activities authorized by law or with your authorization.
Law Enforcement: We may disclose health information when requested by a law enforcement official as part of law enforcement activities; investigations of criminal conduct; in response to court orders; in emergency circumstances; or when required to do so by law. We are required to report certain types of injuries or wounds such as gunshot wounds and some bums. We may also release information to law enforcement to locate or identify a suspect, fugitive, material witness or missing person. Under certain circumstances we may release information to law enforcement if you are the victim of a crime or of criminal activity at our facility.
Lawsuits/disputes: If you are involved in a lawsuit, we may release medical information that is court ordered, administrative ordered, grand jury subpoenaed or with your authorization.
Inmates: We may disclose health information about an inmate of a correctional institution or under the custody of a law enforcement official to the correctional institution or law enforcement official as required by law or with your authorization.
Marketing/Fund-raising: Marketing without your authorization is prohibited unless the information is about a service or product we offer and that we receive no compensation for the marketing of such said product or service. Occasionally we may use limited information (name, address and dates of service) to let you know about fund-raising events or other charitable events.
Sale of PHI: We are prohibited from selling your health information without your authorization unless the sale is in conjunction with the sale of our practice.

Your Rights Regarding Your Health Information

The following describes your rights regarding the health information we maintain about you. To exercise your rights, you must submit your request in writing to our Privacy Officer at 1721 Magnavox Way, Suite B, Fort Wayne IN, 46804.
Right of Notice of Privacy. You have the right to obtain a paper copy of this Notice of Privacy Practices at any time. You have the right to a full 7 page notice available at any of our offices.
Right to Request Restrictions. You have the right to request that we restrict uses or disclosures of your health information we disclose about you. You may request a restriction on services you pay for out of your own pocket (not paid by insurance) that we would otherwise disclose to your insurance company for payment. We have the right to deny certain requests for restrictions. Requests for restrictions must be made in writing to our Privacy Officer and must list what information you want restricted, whether you are requesting limits on our access or disclosure of the information and to whom you want the restrictions to apply. For example if you restrict disclosures to a spouse or other family member.
Right to Receive Confidential Communications. You have the right to request that we send communications that contain your health information by alternative means or to alternative locations. We must accommodate your request if it is reasonable. For example you may request we only contact you at work. This request must be made in writing to our Privacy Officer.
Right to Inspect and Copy. You have the right to inspect and receive a copy of health information that we maintain about you. If copies are requested or you agree to a summary or explanation of such information, we may charge a reasonable, cost-based fee for the costs of copying, including labor and supply cost of copying; postage; and preparation cost of an explanation or summary, if such is requested. For electronic medical records you may request an electronic version of your records at a reasonable cost for copying. We may deny your request to inspect and copy in certain circumstances as defined by law. If you are denied access to your health information, you may request that the denial be reviewed. All requests for access must be made in writing to our Privacy Officer.
Right to Amend. You have the right to request an amendment to your health information as long as we originated and maintained such information.. Your written request must include the reason or reasons that support your request. We may deny your request for an amendment if we determine that the record that is the subject to the request was not created by us, is not available for inspection as specified by law, or is accurate and complete. All requests for amendments must be made in writing to our Privacy Officer.
Right to Receive all Accounting of Disclosures. You have the right to receive an accounting of disclosures of your health information made by us in the six years prior to the date the accounting is requested (or shorter period as requested). This does not include disclosures made to carry out treatment, payment and health care operations; disclosures made to you; communications with family and friends you authorized; for national security or intelligence purposes; to correctional institutions or law enforcement officials; or disclosures made prior to the HIPAA compliance date of April 14, 2003. Your first request for accounting in any 12-month period shall be provided without charge. A reasonable, cost-based fee shall be imposed for each subsequent request for accounting within the same 12-month period. Your request for an accounting of disclosures must be made in writing to our Privacy Officer.
Right to a Breach Notification. If an unauthorized breach occurs where your healthcare information is involved, we may be obligated to send you a notification of that breach. A risk assessment will be conducted to ensure that the potential risk to you by the breach was investigated and mitigated to the fullest extent possible. In addition to notifying you, if harm is indicated, we may also have to notify the Indiana Attorney General and the Department of Health and Human Services.

How to File a Complaint if You Believe Your Privacy Ridwdwghts Have Been Violated

If you believe that your privacy rights have been violated, please submit your complaint in writing to:

Summit Pain Management
Attn: Privacy Officer
1721 Magnavox Way
Suite B
Fort Wayne IN, 46804

You may also file a complaint with the Office of Civil Rights or the Department of Health and Human Services. You will not be retaliated against for filing a complaint.

Patient Name: _____ **DOB:** _____ **Date:** _____

P.E.G (Pain, Enjoyment, General activity) scale (0-10)

1. What number best describes your Pain on average in the past week?
   (No pain (0) – Pain as bad as you can imagine (10))

   0 1 2 3 4 5 6 7 8 9 10

2. What number best describes how, during the past week, pain has interfered with your Enjoyment of life?
   (Does not interfere (0) – Completely interferes (10))

   0 1 2 3 4 5 6 7 8 9 10

3. What number best describes how, during the past week, pain has interfered with your General activity?
   (Does not interfere (0) – Completely interferes (10))

   0 1 2 3 4 5 6 7 8 9 10

PAIN DIAGRAM

The information you provide on this diagram will assist in your consult. If you are being evaluated for a painful condition please mark the diagram by how you are feeling today. If you are having any of the symptoms indicated below, please mark them on the body with the appropriate letter.

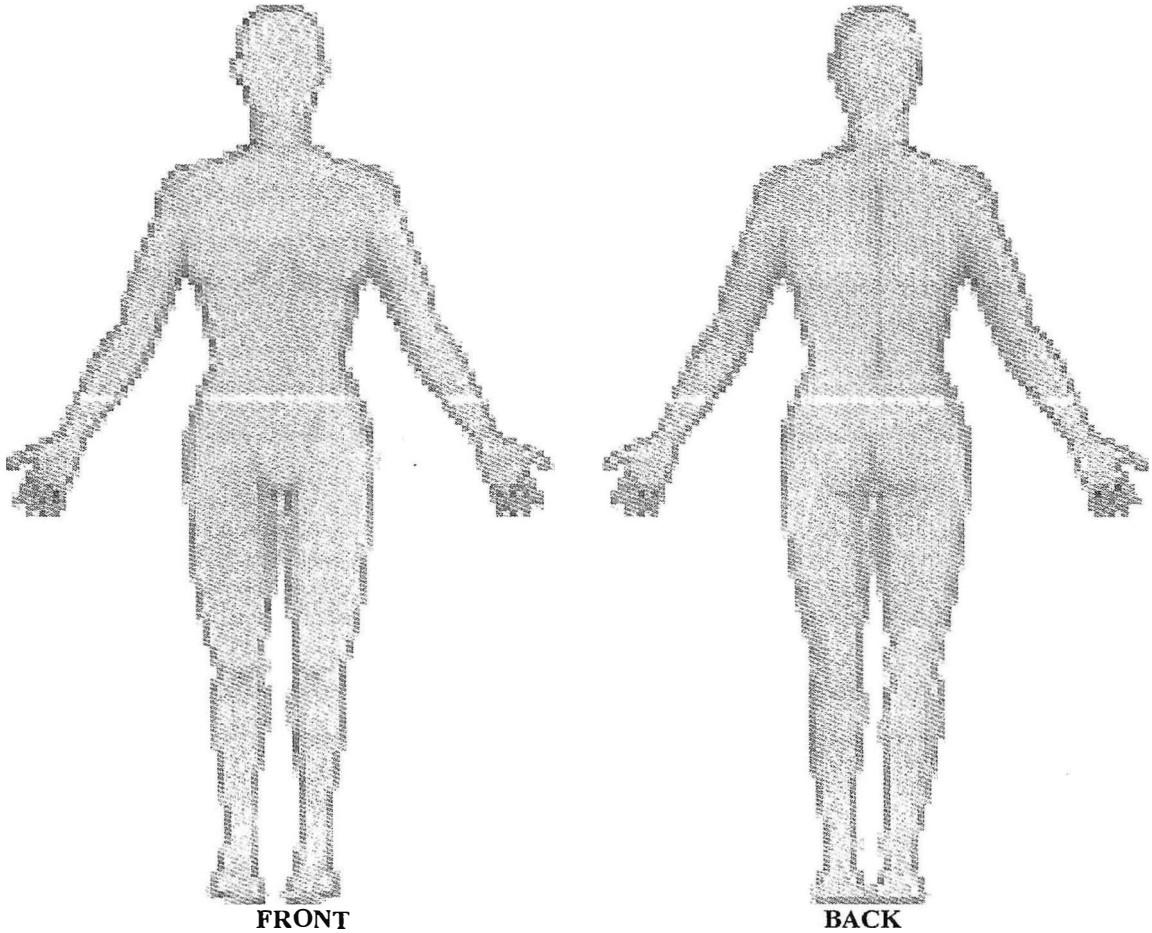
B- Burning

N- Numbness

S- Stabbing

A- Aching

P- Pins and Needles



FRONT **BACK**

Patient Name: _____ **D.O.B:** _____ **Date:** _____

MEDICAL HISTORY QUESTIONAIRE

YOU	FAMILY MEMBER	
		CONSTITUTIONAL SYMPTOMS
Yes / No	Yes / No	Good general health lately
Yes / No	Yes / No	Recent weight change
Yes / No	Yes / No	Fever
Yes / No	Yes / No	Fatigue
Yes / No	Yes / No	Headaches
		CARDIOVASCULAR
Yes / No	Yes / No	Heart disease
Yes / No	Yes / No	Chest pain or Angina
Yes / No	Yes / No	Palpitations
Yes / No	Yes / No	Shortness of breath
Yes / No	Yes / No	Swelling of extremities
Yes / No	Yes / No	High blood pressure
		RESPIRATORY
Yes / No	Yes / No	Chronic or frequent cough
Yes / No	Yes / No	Spitting up blood
Yes / No	Yes / No	Shortness of breath
Yes / No	Yes / No	Asthma or wheezing
Yes / No	Yes / No	Lung disease
		GASTROINTESTINAL
Yes / No	Yes / No	Loss of appetite
Yes / No	Yes / No	Nausea or vomiting
Yes / No	Yes / No	Frequent diarrhea
Yes / No	Yes / No	Constipation/pain
Yes / No	Yes / No	Rectal bleeding/ bloody stool
		MUSCULOSKELETAL
Yes / No	Yes / No	Joint pain
Yes / No	Yes / No	Joint swelling
Yes / No	Yes / No	Weakness of muscle/joint
Yes / No	Yes / No	Muscle pain or cramping
Yes / No	Yes / No	Back pain
Yes / No	Yes / No	Cold hands/feel
Yes / No	Yes / No	Difficulty walking

YOU	FAMILY MEMBER	
		PSYCHIATRIC
Yes / No	Yes / No	Memory loss or confusion
Yes / No	Yes / No	Nervousness/anxiety
Yes / No	Yes / No	Depression
Yes / No	Yes / No	Insomnia
Yes / No	Yes / No	Sleep apnea
		ENDOCRINE
Yes / No	Yes / No	Glandular/hormone problem
Yes / No	Yes / No	Thyroid disease
Yes / No	Yes / No	Diabetes
Yes / No	Yes / No	Excessive thirst/urination
Yes / No	Yes / No	Heat/cold intolerance
Yes / No	Yes / No	Very dry skin
		HEMATOLOGIC/LYMPHATIC
Yes / No	Yes / No	Slow to heal after cuts
Yes / No	Yes / No	Bleeding/bruising tendency
Yes / No	Yes / No	Anemia
Yes / No	Yes / No	Phlebitis
Yes / No	Yes / No	Enlarged glands
		NEUROLOGICAL
Yes / No	Yes / No	Frequent headaches
Yes / No	Yes / No	Light headedness/dizzy
Yes / No	Yes / No	Convulsions/seizures
Yes / No	Yes / No	Numbness/tingling
Yes / No	Yes / No	Tremors
Yes / No	Yes / No	Paralysis
Yes / No	Yes / No	Stroke
Yes / No	Yes / No	Head injury
		ALLERGIC/IMMUNOLOGIC
		-History of skin or other adverse reaction to:
Yes / No	Yes / No	Penicillin or other antibiotics
Yes / No	Yes / No	Morphine, Demerol, Narcotics
Yes / No	Yes / No	Novacaine/anesthetics
Yes / No	Yes / No	Aspirin/other pain meds
Yes / No	Yes / No	Tetanus antitoxins/serums
Yes / No	Yes / No	Iodine/other antiseptics

Other drugs/meds: _____

Food allergies: _____

LIST ANY FAMILY MEMBER, INCLUDING YOURSELF, WITH HISTORY OF HEART, LUNG, LIVER OR KIDNEY DISEASE, ARTHRITIS, GOUT OR GLAUCOMA:

RELATIONSHIP: _____ _____ TYPE: _____ ___

RELATIONSHIP: _____ TYPE: _____

RELATIONSHIP: _____ TYPE: _____

RELATIONSHIP: _____ _____ TYPE: _____ ____

RELATIONSHIP: _____ TYPE: _____

REV 04/27/2022

GENERAL MEDICAL HISTORY QUESTIONAIRE

NAME: _____ _____ DATE: __ _____

DATE OF BIRTH: _____ AGE: FAMILY PHYSICIAN: __ _____

REFERRING PHYSICIAN: __ _____ _____ __

REASON FOR VISIT TODAY: _____ _____ _____

MEDICATION ALLERGIES: _____ _____ _____

OTHER ALLERGIES: _____

PAST OPERATIONS: _____ DATE: _____

_____ DATE: _____

_____ DATE: _____ _____

PAST ILLNESSES: _____ DATE: _____

_____ _____ DATE: _____

_____ DATE: _____

PAST FRACTURES: _____ DATE: _____

_____ DATE: _____

_____ DATE: _____

_____ DATE: _____

PRESENT HISTORY: HEIGHT: _____ WEIGHT: _____

DO YOU SMOKE? YES ( ) NO ( ) If yes, how much? _____

DO YOU USE ALCOHOL? YES ( ) NO ( ) If yes, how much? _____

DO YOU TAKE ASPIRIN? YES ( ) NO ( ) If yes, how much? _____

DO YOU TAKE ANTI-INFLAMMATORIES? YES ( ) NO ( ) If yes, how much? _____

If yes to above medication, for what diagnosis? _____

HAVE YOU HAD COMPLICATIONS WITH PREVIOUS ANESTHETICS? YES ( ) NO ( )

ARE YOU TAKING STEROIDS (CORTISONE)? YES ( ) NO ( )

PRESENT MEDICATIONS:

NAME: _____ DOSE: _____ FREQUENCY: _____

NAME: _____ _____ DOSE: _____ FREQUENCY: _____

NAME: _____ DOSE: _____ FREQUENCY: _____

NAME: _____ DOSE: _____ FREQUENCY: _____

NAME: _____ DOSE: _____ FREQUENCY: _____

NAME: _____ DOSE: _____ FREQUENCY: _____