NEW PATIENTS POLICIES: Please familiarize yourself with the following policies before your first appointment.

Regarding: Insurance

Please bring all current insurance cards to your office visit; this is required to be scanned into your chart. Also, it is your responsibility to know the amount of your copayment, coinsurance, or deductible which is due at time of service.

Regarding: Copayment, Coinsurance, and Deductible

Office policy requires that all copayment, coinsurance, and deductible be paid at time that services are rendered. If you are unable to make the copayment, coinsurance, or deductible amount required for your office visit, we will be required to reschedule.

Regarding: New Patient Paperwork

Please have all your paperwork completed and ready to be entered by the time you arrive for your appointment. Any incomplete paperwork will result in rescheduling of your appointment. If you have not received your paperwork by the evening before your appointment, please arrive 45 minutes early.

Regarding: No Show/ Same Day Cancelations/ Late Arrivals

Your initial appointment reserves 45 minutes of the doctor's time specifically for you, therefore arriving late may result in the rescheduling of your appointment. Also, if you do not show up for your scheduled office visit or have a same day cancellation or arrive late, a $25.00 fee will be due at your next visit. If you are scheduled for a pain procedure and do not show or have a cancellation of less than 2 business days a $100.00 fee will be due at your next office visit.

Regarding: Rescheduling an appointment

Our office policy allows you to reschedule your initial consult one time, after that one reschedule, we are no longer able to schedule an appointment for you.

Regarding: Pain Procedures

If your doctor is referring you for pain procedures, your initial appointment will be for a consult only. At that time Dr. Gajipara will discuss pain procedures, treatment options, and give any information you require regarding your care.

Pain Care Options
8210 Walnut Hill Ln, Ste 905
Dallas, Tx 75231

PATIENT REGISTRATION INFORMATION
Please fill out the following forms completely.

Demographics

Name: _____
Address:_____ City:_____

State: _____ Zip: _____

Primary Phone: (____) _____-_____ Secondary Phone: (____) ____-_____

SSN: _____-_____-_____ DOB: ____/_____/_____ Sex: ☐ M ☐ F

Emergency Contact:

Name:_____ Relationship:_____

Phone: (___) ____-_____

Are you employed: ☐ Y ☐ N ☐ F/T ☐ P/T ☐ Retired ☐ Self- Employed ☐ Disability

Occupation:_____

Are you a student: ☐ Y ☐ N ☐ F/T ☐ P/T

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner

Primary Insurance Information:

Company Name:_____ Policy Number:_____

Group Number: _____

Secondary Insurance Information:

Company Name:_____ Policy Number:_____

Group Number: _____

Tertiary Insurance Information:

Pain Care Options
8210 Walnut Hill Ln, Ste 905
Dallas, Tx 75231

Company Name:_____ Policy Number:_____

Group Number: _____

Primary Care Physician:

Name: _____

Phone: (____) _____-_____ Fax: (____) _____-_____

Referring Physician:

Name: _____ **(please do not leave this space blank)**

Phone: (____) _____-_____ Fax: (____) _____-_____

Pain Care Options
8210 Walnut Hill Ln, Ste 905
Dallas, Tx 75231

Patient Registration Information
Please fill out the following forms completely.

Assignment of Benefits/ Release of Information/ Notice of Privacy Practices

Appointment of Authorized Representative

☐ Jemin N. Gajipara, MD, and associated physicians are committed to securing the privacy of your health information. We are supplying you with a copy of our Notice of Privacy Practices. You are not required to read this notice. By checking you are acknowledging receipt.

☐ I request that payment of authorized Medicare and other insurance benefits be made on my behalf to Jemin N. Gajipara, MD, for any services furnished to be by any healthcare providers associated with that group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or insurance company for any information needed to determine these benefits or the benefits payable to related services.

☐ I appoint Jemin N. Gajipara, MD, to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

☐ Unless I request to the contrary in writing, I will receive appointment reminders on my home or cell phone answering system and or appointment reminder cards by mail, whichever is the policy of the practice.

Patient Financial Responsibility Statement
To keep our fees at the lowest possible level, it is important that we have a good understanding with our patients regarding financial responsibility. We hope that this summary will be helpful toward that end. We encourage you to discuss it with us and ask questions.

We understand that your health coverage is provided through _____.

- If you have out-of-network benefits, we will happily file claims on your behalf.
- You must pay any co-payment and applicable deductible amounts at the time of service unless other arrangements have been made with our office.
- The remainder of your bill will be sent to your health plan for direct payment to our office.
- If your insurance carrier has not paid out claim within 45 days, we will expect payment from you.
- If, by mistake, your health plan remits payment to you, please send it to us along with all paperwork sent to you at the time.
- You will remain responsible for amounts and any service that are not covered by your insurance plan.

Pain Care Options
8210 Walnut Hill Ln, Ste 905
Dallas, Tx 75231

- Your health plan may refuse payment of a claim for some of the following reasons:
    1. This is a pre-existing illness that is not covered by your plan.
    2. You have not met your full calendar year deductible.
    3. The type of medical service required is not covered by your plan.
    4. The health plan was not in effect at the time of service.
    5. You have other insurance which must be filed first.

Please understand that the financial responsibility for medical services rest between you and your health insurance plan. While we are pleased to be of service by filing your medial insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies that clam for any of these or other reasons, our office cannot be responsible for this bill. It is your responsibility as the patient to pay the denied amounts in full.

Our primary mission is to provide you with quality, cost effective, medical care. Together were trying to adapt to the changing way that healthcare is financed and delivered. Again, we value you as a patient and our first priority is to provide you with the best possible care. With this housekeeping core complete, we are pleased to serve you.

Sincerely,

Jemin N. Gajipara, MD

I have completed this form with accurate information. I have read and understand my obligations and responsibilities. I acknowledge that I am fully responsible for supplying correct insurance information, billing information, and payment of any services not covered or approved by mu insurance carrier.

Patient Signature: _____ Date: _____

Pain Care Options
8210 Walnut Hill Ln, Ste 905
Dallas, Tx 75231

NEW PATIENT QUESTIONARE

Patient Name: _____ Date: _____

1. Where is your pain located?_____

2. How long have you had pain?
   ☐ Less than 6 months ☐ 6-12 Months ☐ More than a year

   ☐ More than two years (please indicate how long) _____

3. How did your pain start?
   ☐ After a work-related injury / date of injury: _____

   ☐ After an auto accident / date of accident: _____

   ☐ After an injury / date of injury: _____

   ☐ Developed slowly over time

   ☐ Other:_____

4. Check the description (s) of your pain:

   ☐ Constant pain, always present ☐ Intermittent pain, not present all the time ☐ A sharp "knife like" pain ☐ Pain that occurs with standing or sitting only ☐ Pain that occurs with activity
   ☐ Other: _____

5. Does anything make your pain worse? _____

6. Does anything make your pain better? _____

7. Please rate your pain according to the following: This is how my pain felt during the past week….

   ☐ Mild ☐ Moderate ☐ Severe

8. What tests have been done to try and diagnose your pain?

Pain Care Options
8210 Walnut Hill Ln, Ste 905
Dallas, Tx 75231

☐ X-rays ☐ MRI Scan ☐ Myelogram ☐ Other: _____

☐ Bone Scan ☐ Blood Work ☐ Ultrasound

9. What other treatments have you tried to help this pain?

☐ Physical Therapy ☐ TENS Unit ☐ Home Exercise ☐ Injections or Nerve Blocks

☐ Biofeedback ☐ Chiropractor ☐ Stress Management ☐ Hypnosis ☐ Acupuncture

☐ Other: _____

10. Please check the box if your mother, father, brothers, or sisters have any of the following illnesses:

☐ Blood Clots: _____ ☐ Breathing Problems: _____

☐ Bleeding Problems: _____ ☐ Drug/Alcohol Problems: _____

☐ Cancer: _____ ☐ Thyroid Problems: _____

☐ High Blood Pressure: _____ ☐ Stroke: _____

☐ Diabetes: _____ ☐ Ulcers: _____

☐ Heart Problems: _____ ☐ GI Bleeding: _____

☐ Kidney Problems: _____ ☐ Others: _____

☐ Liver Problems: _____

11. Mother: ☐ Alive ☐ Deceased Father: ☐ Alive ☐ Deceased

12. Please Check YES or NO to any that apply to you:	YES	NO	
Are you married?	☐	☐	
Do you smoke? (If yes, how often and how much?)	☐	☐	_____
Do you drink alcohol? (If yes, how often and how much?)	☐	☐	_____
Do you have a history of alcohol or drug abuse?	☐	☐	
Have you seen a psychologist or psychiatrist?	☐	☐	

Pain Care Options
8210 Walnut Hill Ln, Ste 905
Dallas, Tx 75231

Are you currently under high stress? ☐ ☐

Do you have family history of alcohol or drug abuse? ☐ ☐

Have you experienced a recent crisis? ☐ ☐

Are you experiencing any current depression? ☐ ☐

Please list your medical problems (i.e. diabetes, hypertension, etc.):

ACTIVE PROBLEMS	DATE OF ONSET

INACTIVE PROBLEMS

Please list your surgical procedure history:

TYPE OF SURGERY	DATE OF ONSET

Pain Care Options
8210 Walnut Hill Ln, Ste 905
Dallas, Tx 75231