

**Pain Treatment Centers of America "PTCOA" & Interventional Surgery Institute "ISI"**

**Patient Information**

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SEX: \_\_\_\_\_ DATE: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

DRIVER LICENSE #: \_\_\_\_\_ STATE: \_\_\_\_\_ EXP DATE: \_\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

PHONE #1: \_\_\_\_\_ PHONE #2: \_\_\_\_\_

**MEDICATIONS REQUEST**

I HAVE READ AND UNDERSTAND THAT ALL MRI, X-RAYS AND ANY DOCUMENTS PROVIDED TO APTA / ISI WILL BE VERIFIED PRIOR TO SEEING THE PHYSICIAN. THERE WILL BE NO REFILLS ON MEDICATIONS UNLESS YOU ARE FOLLOWED UP WITH THE PHYSICIAN / NURSE PRACTITIONER MONTHLY. YOU ARE REQUIRED TO BRING YOUR MEDICATION BOTTLES EACH VISIT, THIS IS FOR YOUR PROTECTION AS A PATIENT. WE HAVE A **STRICT POLICY** AGAINST "DOCTOR SHOPPING"; PERSONS FOUND DOCTOR SHOPPING WILL BE DISCHARGED. PRESCRIPTIONS, ONCE WRITTEN ARE THE RESPONSIBILITY OF THE PATIENT. THERE ARE NO EXCEPTIONS IN PRESCRIPTIONS BEING REWRITTEN.

**PATIENT PRIVACY QUESTIONNAIRE**

PLEASE LIST ANYONE WHOM WE MAY INFORM OF YOUR MEDICAL CONDITION AND DIAGNOSIS (INCLUDING TREATMENT, PAYMENT AND HEALTH CARE CONCERNS). IF NAME IS NOT LISTED WE ARE LEGALLY UNABLE TO GIVE OUT ANY INFORMATION REGARDLESS OF RELATIONSHIP WITH PATIENT.

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**ADVANCED DIRECTIVES**

ALL ADULTS IN HEALTH CARE SETTINGS HAVE THE RIGHT IN THE STATE OF ARKANSAS TO AN "ADVANCED DIRECTIVE". THIS IS A WRITTEN OR ORAL STATEMENT MADE AND WITNESSED IN ADVANCE OF A SERIOUS INJURY OR ILLNESS, STATING HOW MEDICAL DECISIONS WILL BE MADE. AN ADVANCED DIRECTIVE ENABLES YOU TO STATE YOUR CHOICE, OR MAY NAME SOMEONE TO MAKE YOUR CHOICE FOR YOU, IF YOU SHOULD BECOME UNABLE TO MAKE DECISIONS ABOUT YOUR MEDICAL CARE. A COPY OF THE ADVANCE DIRECTIVE LAW IS AVAILABLE UPON REQUEST. **I HAVE READ THE ABOVE AND RECEIVED FURTHER INFORMATION IF REQUESTED ON ADVANCE DIRECTIVES.**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**PRIVACY POLICY**

THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US. WE UNDERSTAND THAT YOUR MEDICAL INFORMATION IS PERSONAL AND WE ARE COMMITTED TO PROTECTING IT. WE CREATE A RECORD OF THE CARE AND SERVICES YOU RECEIVE AT OUR ORGANIZATION. WE NEED THIS RECORD TO PROVIDE YOU WITH QUALITY CARE AND TO COMPLY WITH CERTAIN LEGAL REQUIREMENTS, THIS NOTICE WILL TELL YOU ABOUT THE WAYS WE MAY USE AND SHARE MEDICAL INFORMATION ABOUT YOU. WE ALSO DESCRIBE YOUR RIGHTS AND CERTAIN DUTIES WE HAVE REGARDING THE USE AND DISCLOSURE OF MEDICAL INFORMATION. A COPY OF THE PRIVACY POLICY IS AVAILABLE UPON REQUEST. **I HAVE READ THE ABOVE AND RECEIVED FURTHER INFORMATION IF REQUESTED ON THE PRIVACY POLICY.**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**FINANCIAL POLICY**

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO PTCOA / ISI FOR PROFESSIONAL SERVICES PROVIDED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES PROVIDED TO ME BY PTCOA / ISI INCLUDING ALL REMAINING BALANCES. **PATIENTS THAT DO NOT SHOW OR CANCEL LESS THAN 24 HOURS BEFORE THEIR APPOINTMENT WILL BE CHARGED \$20.** I ALSO UNDERSTAND THAT PTCOA/ ISI CONTRACTS PROFESSIONAL CONSULTING SERVICES FOR BILLING. IF YOU HAVE ANY QUESTIONS PERTAINING TO A BILL PLEASE CONTACT THEM DIRECTLY AT (501) 771-4693. PHYSICIAN OWNERSHIP DISCLOSURE: MERAJ N. SIDDIQUI, MD. 1215 SIDNEY ST., STE 200 BATESVILLE, AR 722501 (501) 262-6155 and RONALD E. TILLEY, MD, 525 BURNETT DRIVE, MOUNTAIN HOME, AR 72653 (501) 425-6235.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_