TENNESSEE PAIN ASSOCIATES

David Delatte, MD

Patient Registration Form

Please fill in the following information to register as a patient with Tennessee Pain Associates.

Full Name: _____

Date of Birth: _____

Social Security Number (SSN): _____

Address: _____

City: _____State: _____ ZIP: _____

Phone Number: _____

Email: _____

Emergency Contact (Name and Phone): _____

Primary Insurance Provider: _____

Secondary Insurance Provider (if any): _____

Previous Primary Care Physician (Name and Contact): _____

Preferred Pharmacy: _____

Employment Status: _____

Marital Status: _____

Race: White, Asian, Hispanic, African American, Pacific islander, Other_____

Decline answer

Primary Language:_____

Ethnicity: Hispanic/ Non Hispanic

Tennessee Pain Associates
Address: 1608 Williams Drive STE 202, Murfreesboro, TN 37129
Phone: 615-849-4006 Fax: 615-895-0975 Website: www.tennpain.com

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Medical History Form

Please complete your medical history form with as much detail as possible to assist in your care.

Current Conditions (check all that apply):

Cardiovascular: - High Blood Pressure [ ] - Heart Disease [ ] - High Cholesterol [ ]

Respiratory: - Asthma [ ] - COPD [ ] - Chronic Bronchitis [ ]

Gastrointestinal: - Acid Reflux [ ] - IBS [ ] - Ulcers [ ]

Neurological: - Stroke [ ] - Epilepsy/Seizures [ ] - Migraines [ ]

Diabetes [ ] - Thyroid Issues [ ] - Cancer [ ]

Other Conditions:

_____

_____

_____

Current Medications (include name, dosage, frequency, and purpose): (disregard if you have a list to give us)

Name: _____ Dosage: _____ Frequency: _____ Purpose:_____

Name: _____ Dosage: _____ Frequency: _____ Purpose:_____

Name: _____ Dosage: _____ Frequency: _____ Purpose: _____

Name: _____ Dosage: _____ Frequency: _____ Purpose:_____

Name: _____ Dosage: _____ Frequency: _____ Purpose:_____

Name: _____ Dosage: _____ Frequency: _____ Purpose:_____

Name: _____ Dosage: _____ Frequency: _____ Purpose: _____

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Name: _____ Dosage: _____ Frequency: _____ Purpose:_____

Allergies:

- Medications: _____ Reaction: _____

- Foods: _____ Reaction: _____

- Environmental: _____ Reaction: _____

Surgical History (Date, Type of Surgery, and Complications):

1. Date: _____ Type: _____ Complications: _____

2. Date: _____ Type: _____ Complications: _____

3. Date: _____ Type: _____ Complications: _____

Family Health History (Check and specify family member e.g., mother, father):

- Diabetes [ ] _____
- Heart Disease [ ] _____

- Cancer [ ] _____
- High Blood Pressure [ ] _____

- Stroke [ ] _____
- Kidney Disease [ ] _____

Lifestyle and Social History:

Smoking Status: - Never Smoked [ ] - Current Smoker [ ] - Former Smoker [ ]

How long did you smoke_____

Alcohol Use (frequency and amount): _____

Drug Use (current, past, or none): _____

Exercise Frequency (times per week): _____

Diet (e.g., low salt, vegetarian): _____

Review of Systems (check any current symptoms):

- Weight Changes [ ] - Fatigue [ ] - Headaches [ ]

- Chest Pain [ ] - Shortness of Breath [ ] - Cough [ ]

- Nausea [ ] - Abdominal Pain [ ] - Diarrhea/Constipation [ ]

- Urinary Issues [ ] - Joint Pain [ ] - Rashes [ ]

Consent for Treatment

By signing this form, I consent to receive medical care at Tennessee Pain Associates. I understand and acknowledge the following:

Scope of Treatment

I authorize the healthcare providers at Tennessee Pain Associates to perform medical examinations, diagnostic tests, and minor procedures as deemed necessary for my care. I understand that treatment may involve inherent risks, benefits, and possible complications, which will be explained to me before proceeding.

Right to Refuse or Withdraw Consent

I understand that I have the right to refuse any recommended treatment or withdraw my consent at any time, even after treatment has begun. This decision will not affect my right to future care or my

relationship with Tennessee Pain Associates.

Telehealth and Electronic Communication Consent

If I choose to participate in telehealth services, I consent to treatment through electronic communication, where my provider will evaluate, diagnose, and/or treat me. I understand that there are potential benefits and limitations to telehealth services, and I may opt out at any time.

Acknowledgment of Understanding

By signing below, I acknowledge that I have read and understand this Consent for Treatment form. I have had the opportunity to ask questions regarding my care and this consent form, and my questions have been answered to my satisfaction.

Signature: _____

Date: _____

HIPAA Privacy Acknowledgment and Consent

This form provides consent for Tennessee Pain Associates to use and disclose your health information as needed for your care, in compliance with HIPAA regulations. Please review the following terms carefully.

Acknowledgment of Privacy Practices

I acknowledge that I have received or been provided with the opportunity to review Tennessee Pain Associates' Notice of Privacy Practices. I understand that this notice describes how my medical information may be used and disclosed, and how I may access this information.

Consent to Share Health Information

I consent to Tennessee Pain Associates sharing my health information with other healthcare providers, insurance companies, and authorized family members for the purposes of treatment,

payment, and healthcare operations as outlined in the Notice of Privacy Practices.

Consent to Access Pharmacy Prescription Records

I consent to Tennessee Pain Associates accessing my prescription records directly from my pharmacy. I understand that this allows my healthcare providers to review my medication history for accurate treatment and care coordination.

Electronic and Secure Communication Consent

I authorize Tennessee Pain Associates to contact me by secure text, email, or other electronic means for appointment reminders, billing inquiries, and other communications. I understand that I may withdraw this consent at any time by notifying the office.

By signing below, I acknowledge that I have read and understand this HIPAA Privacy Acknowledgment and Consent form.

Signature: _____
Date: _____

Financial Policy and Payment Agreement

Thank you for choosing Tennessee Pain Associates. Our goal is to provide you with the highest quality medical care. To help prevent any misunderstandings regarding billing and payment, please review our financial policy carefully and ask any questions you may have before signing.

Insurance Billing and Responsibility

As a courtesy, we will bill your insurance company on your behalf. However, you are ultimately responsible for any charges not covered by your insurance. This includes, but is not limited to, deductibles, co-pays, coinsurance, and charges for services deemed non-covered or out-of-network.

Please notify our office immediately of any changes to your insurance plan. If your insurance provider denies coverage or does not pay within 90 days, you will be responsible for the remaining balance.

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Payment Options and Due Dates

Payment is due at the time of service unless prior arrangements have been made. We accept the following payment methods:

- Cash
- Debit and Credit Cards
- Personal Checks (a fee will apply for returned checks)

Balances remaining after insurance payments are due within 30 days of the billing statement date. If payment is not received by the due date, a late fee may be applied. For returned checks, a service fee of $30 will be charged in addition to the original amount due.

Missed Appointments and Cancellations

We ask that you provide at least 24 hours' notice if you need to cancel or reschedule your appointment. A fee of $50 may be charged for missed appointments or cancellations made with less than 24 hours' notice. This fee is not billable to insurance and must be paid before your next appointment.

Repeated missed appointments may result in discharge from our practice.

Financial Assistance or Payment Plans

If you are experiencing financial difficulties, please speak with our billing office. We offer payment plans and may be able to work with you to develop a plan that fits your budget. Payment plans must be set up prior to the due date of any outstanding balances.

Agreement

By signing below, I acknowledge that I have read, understand, and agree to the financial policy outlined above. I understand that I am financially responsible for any charges incurred at Tennessee Pain Associates.

Signature: _____

Date: _____

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Authorization to Release Medical Information

This form authorizes Tennessee Pain Associates to release your medical information to designated individuals or organizations, as specified below. Please review and complete all sections carefully.

Scope of Authorization

I authorize Tennessee Pain Associates to release the following medical information:

- Medical History
- Lab Results
- Imaging Reports
- Treatment Notes

Other (please specify): _____

Recipients of Information

I authorize the release of my medical information to the following individuals or organizations:

1. Name: _____ Relationship: _____
2. Name: _____ Relationship: _____
3. Organization: _____ Contact Info: _____

Purpose of Release

The purpose of this release is (check all that apply):

- Continuity of Care [ ]
- Insurance Processing [ ]
- Legal or Personal Reasons [ ]

Other (please specify): _____

Expiration of Authorization

This authorization will expire on (choose one):

- Date: _____
- Upon the following event: _____

If no date or event is specified, this authorization will remain valid until revoked by the patient.

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Revocation Rights

I understand that I have the right to revoke this authorization at any time by submitting a written request to Tennessee Pain Associates. I understand that revocation will not affect any disclosures already made in reliance on this authorization.

By signing below, I acknowledge that I have read and understand this Authorization to Release Medical Information form.

Signature: _____

Date: _____

Advance Beneficiary Notice of Noncoverage (ABN)

Patient Name: _____

Date: _____

Tennessee Pain and Pain Associates

Address: 1608 Williams Dr, Suite #202, Murfreesboro, TN 37129

Phone: (615) 849-4006

Notice to ALL Patients:

You Insurance may not pay for all services you receive. This form is to notify you of items or services that we believe your insurance may not cover in certain situations, and that you may be personally responsible for payment.

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Commonly Non-Covered Service(s)/Item(s):

1. Routine Physical Exams – Insurances typically only covers a one-time "Welcome to your insurance" visit and annual wellness visits, but does not cover general physical exams.

2. Pain Management Procedures - Specific pain procedures, such as trigger point injections, joint injections, and epidural steroid injections, may be denied if not deemed medically necessary by your insurance.

3. Laboratory Tests - Some diagnostic tests, such as **Hemoglobin A1C, Lipid panels**, vitamin D testing, hormone panels, or routine screening panels not related to a specific diagnosis, may not be covered.

4. Certain Prescription Medications – Your insurance may not cover medications administered in-office or those that are not part of a covered treatment plan.

5. Preventive Services Beyond Medicare's Scope - This includes some screenings, therapies, and wellness counseling sessions that exceed your insurance's allowed frequency or are not covered for a specific diagnosis.

Reason Your Insurance May Not Pay:

- Your insurance may consider the service or item not medically necessary based on your condition.
- Your insurance may not cover this service/item in your situation or may limit coverage to certain conditions or diagnoses.

Estimated Cost:

Routine Physical Exams: $_____

Pain Management Procedures: $_____

Laboratory Tests: $_____

Prescription Medications: $_____

Preventive Services: $_____

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Options: (please circle one)

1. Option 1: I want the items or services listed above. I understand that my insurance may not pay for them, and I agree to be personally responsible for payment.

2. Option 2: I want the items or services, but do not bill my insurance. I will pay for them myself.

3. Option 3: I do not want the items or services. I understand I will not be billed.

Signature: _____

Date: _____

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