Integrative Pain Management of Naples
Chaturani Ranasinghe, M.D.
1855 Veterans Park Drive Suite 304
Naples, FL 34109
Phone: (239) 234-2448 Fax: (239) 234-2435

New patient intake

Today's Date: ____/ ____ / _____

Name:_____ D.O.B:___/ ____ /_____ Age: _____ Sex: _____ Email: _____

Address:_____ City:_____ State:_____ Zip:_____

Home phone: _____ Cell phone: _____ Work phone: _____

Name of employer: _____ Occupation: _____ Marital status: _____

Emergency contact name: _____ Phone number: _____

Pharmacy name: _____ Phone number: _____

Primary care physician name: _____ Phone number: _____

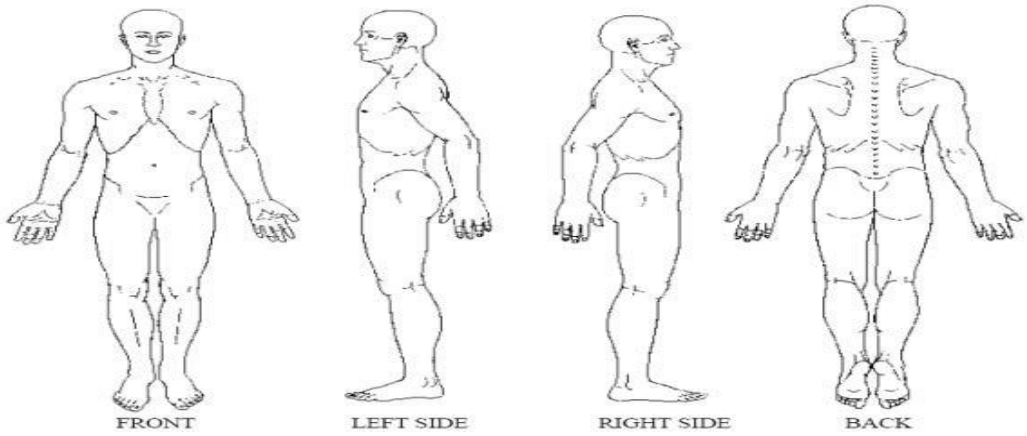
Referring physician name: _____ Phone number: _____

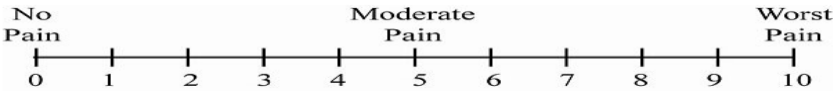
How did you hear about our office?_____

Height:_____Weight:_____lbs

Onset of Symptoms and Reason for Visit Today

Use the diagram below to indicate the location and type of your pain.





What is your current pain level **right now**?_____ What is your **worst** level of pain level? _____

Where is your worst area of pain located? _____ Does the pain radiate? If yes, where? _____

Please list additional areas of pain

_____

When did this pain begin? _____

What caused your current pain or injury?_____

Was the pain or injury due to a motor vehicle accident or personal injury? ❑ Yes ❑ No

How did your current pain episode begin? ❑ Gradually ❑ Suddenly

Since your pain began, has your pain ❑ Increased ❑ Decreased ❑ Stayed the Same

What word best describes the frequency of your pain? ❑ Constant ❑ Intermittent

When is your pain at its worst? ❑ Mornings ❑ During the Day ❑ Evenings ❑ Middle of Night

Check all that describe your pain **today**

❑ Aching	❑ Hot/Burning	❑ Shooting	❑ Stabbing/Sharp	❑ Tiring/Exhausting
❑ Cramping	❑ Numb	❑ Spasming	❑ Throbbing	
❑ Dull	❑ Shock-like	❑ Squeezing	❑ Tingling/Pins and Needles	

FACTORS THAT AFFECT YOUR PAIN

	Increases Pain	Decreases Pain	No Change
❑ Bending Backward	❑	❑	❑
❑ Bending Forward	❑	❑	❑
❑ Changes in Weather	❑	❑	❑
❑ Climbing Stairs	❑	❑	❑
❑ Coughing/Sneezing	❑	❑	❑
❑ Driving	❑	❑	❑
❑ Lifting Objects	❑	❑	❑
❑ Looking Forward	❑	❑	❑
❑ Looking Downward	❑	❑	❑
❑ Looking Side to Side	❑	❑	❑
❑ Rising from a Seated Position	❑	❑	❑
❑ Sitting	❑	❑	❑
❑ Standing	❑	❑	❑
❑ Walking	❑	❑	❑

What other factors worsen or affect your pain that is not listed above? _____

Diagnostic Tests and Imaging- Mark all of the following tests you have had related to your current pain:

❑ MRI of the_____	Date:_____	Facility: _____
❑ X-ray of the_____	Date:_____	Facility: _____
❑ CT scan of the_____	Date:_____	Facility: _____
❑ EMG/NCV study _____	Date:_____	Facility:_____

❑ **I have not had any diagnostic tests performed for my current pain complaints**

PAIN TREATMENT HISTORY- Mark the following pain treatments you have undergone PRIOR to today's visit:

Treatment	No Relief	Moderate Relief	Excellent Relief
❑ Biofeedback	❑	❑	❑
❑ Bracing	❑	❑	❑
❑ Chiropractic	❑	❑	❑
❑ Epidural Steroid Injection, how many	❑	❑	❑
❑ Physical therapy	❑	❑	❑
❑ Home Exercise Program	❑	❑	❑
❑ Medial Branch Blocks or Facet Injections	❑	❑	❑
❑ Medications, please check which ones below			
❑ Topical Cream	❑	❑	❑
❑ Anti-inflammatories	❑	❑	❑
❑ Muscle Relaxants	❑	❑	❑
❑ Nerve Pain Medications	❑	❑	❑
❑ Physical Therapy, how many sessions_____	❑	❑	❑
❑ Radiofrequency Ablation	❑	❑	❑
❑ Spine Surgery	❑	❑	❑
❑ Spinal Column Stimulator	❑	❑	❑
❑ TENS Unit	❑	❑	❑
❑ Trigger Point Injections	❑	❑	❑
❑ Other Treatments:			

❑ **I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS**

OTHER PROVIDERS YOU HAVE SEEN TO TREAT YOUR PAIN

❑ Acupuncturist ❑ Neurosurgeon ❑ Orthopedic Surgeon ❑ Pain Physician ❑ Physical Therapist
❑ Primary Care Provider ☐ Psychiatrist/Psychologist ☐ Rheumatologist ❑ Neurologist
❑ Other

CURRENT MEDICATIONS

Are you taking a **prescribed blood-thinner or aspirin,** if so, which one? Name/Phone number of prescribing Doctor:

_____

Please list **ALL** medications you are currently taking.

1._____ 5._____ 9._____
2._____ 6._____ 10._____
3._____ 7._____ 11._____
4._____ 8._____ 12._____

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Review of systems; Do you have any of the following?

Unintended weight loss	❑ Yes	❑ No
Dry Mouth	❑ Yes	❑ No
Chronic Coughing	❑ Yes	❑ No
Pain in the eyes	❑ Yes	❑ No
Chest pain at rest	❑ Yes	❑ No
Blood in stool	❑ Yes	❑ No
Groin mass	❑ Yes	❑ No
Blood in the urine	❑ Yes	❑ No
History of gout	❑ Yes	❑ No
Substance abuse	❑ Yes	❑ No

ACTIVITY

How many days a week do you exercise?_____

Type of Exercise: ❑ Bicycle ❑ Cardio ☐ Strength ❑ Swimming ☐ Walking ❑ Other

_____

Have you had two or more falls in the past year? ❑ Yes ❑ No

IMMUNIZATIONS

Have you received a pneumonia vaccination? ❑ Yes ❑ No
If yes, when? _____

ALLERGIES

Medication that I'm Allergic to: The Allergic Reaction I have:

_____ _____

_____ _____

_____ _____

Are you allergic to any of the following?

Iodine	❑Yes	❑No
Tape	❑Yes	❑No
Latex	❑Yes	❑No

FAMILY HISTORY- BIOLOGICAL RELATIVES

- ❑ Anxiety/depression
- ❑ Arthritis
- ❑ Cancer
- ❑ Diabetes
- ❑ Headaches
- ❑ Heart Disease/Stroke
- ❑ Kidney Problems
- ❑ Liver Problems
- ❑ Rheumatoid Arthritis
- ❑ Seizures
- ❑ High Blood Pressure
- ❑ Substance Abuse

❑ **I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY**

❑ **I AM ADOPTED (No Medical History Available)**

PAST SURGICAL HISTORY- INDICIATE ALL PROCEDURES YOU HAVE DONE AS WELL AS THE DATE

Abdominal Surgery:
- ❑ Gallbladder removal
- ❑ Appendectomy

Female Surgeries
- ❑ Caesarean section
- ❑ Hysterectomy
- ❑ Laparoscopy
- ❑ Ovarian

Heart Surgery
- ❑ Valve replacement
- ❑ Aneurysm repair
- ❑ Stent placement

Joint Surgery
- ❑ Shoulder
- ❑ Hip
- ❑ Knee

Spine / Back Surgery
- ❑ Discectomy (levels)
- ❑ Laminectomy
- ❑ Spinal fusion (levels)

Other Common Surgeries
- ❑ Hemorrhoid surgery
- ❑ Hernia repair
- ❑ Thyroidectomy
- ❑ Tonsillectomy
- ❑ Vascular surgery

Please list any other surgeries and dates (attach an additional sheet if necessary):

_____

_____

_____

❑ **I HAVE NOT HAD ANY SURGICAL PROCEDURES DONE**

Review of Systems- Mark all of the following symptoms that you CURRENTLY suffer from:

Cardiovascular/Respiratory: ❑ Chest Pain ❑ Cough ❑ Difficulty Breathing ❑ Fainting ❑ High Blood Pressure ❑ Swelling in the Feet **Constitutional:** ❑ Chills ❑ Difficulty Sleeping ❑ Fatigue ❑ Fevers ❑ Night Sweats **Ears/Nose/Throat/Neck:** ❑ Difficulty Hearing ❑ Earaches ❑ Hay fever/Allergies ❑ Nosebleeds ❑ Recurrent Sore Throats ❑ Ringing in the Ears ❑ Sinus Problems	**Eyes:** ❑Recent Visual Changes **Gastrointestinal:** ❑ Constipation ❑ Dark and Tarry Stools ❑ Diarrhea ❑ Nausea/Vomiting **Genitourinary/Nephrology:** ❑ Blood in Urine ❑ Involuntary Urination ❑ Loss of Bowel Control ❑ Painful Urination ❑ Pelvic Pressure **Musculoskeletal:** ❑ Back Pain ❑ Joint Pain ❑ Neck Pain	**Neurological:** ❑ Dizziness ❑ Headaches ❑ Instability When Walking ❑ Numbness/Tingling ❑ Weakness **Psychiatric:** ❑ Anxiety/Stress ❑ Depressed Mood ❑ Suicidal Thoughts ❑ Suicidal Planning

PAST MEDICAL HISTORY/PROBLEM LIST

Cardiovascular

❑ Anemia/Bleeding Disorders
❑ Coronary Artery Disease
❑ Heart Attack
❑ High Blood Pressure
❑ Hypertension
❑ High Cholesterol
❑ Mitral Valve Prolapse
❑ Pacemaker/Defibrillator
❑ Poor Circulation
❑ stroke

Neuropsychological

❑ Alzheimer Disease
❑ Anxiety/Depression
❑ Bipolar Disorder
❑ Depression
❑ Epilepsy
❑ Multiple Sclerosis
❑ Paralysis
❑ Peripheral Neuropathy
❑ Schizophrenia
❑ CRPS/Reflex Sympathetic
❑ Dystrophy

Hepatitis

Hepatitis ❑ A ❑ B ❑ C
❑ active ❑ inactive ❑unsure

Head/Eyes/Ears/Nose/Throat

❑ Glaucoma
❑ Headaches
❑ Head Injury
❑ Hyperthyroidism
❑ Hypothyroidism
❑ Migraine

Musculoskeletal

❑ Amputation/ Phantom Limb Pain
❑ Bursitis
❑ Carpal Tunnel Syndrome
❑ Fibromyalgia
❑ Joint Injury
❑ Osteoarthritis/Osteoporosis
❑ Rheumatoid Arthritis
Vertebral Compression Fracture

Genitourinary/Nephrology

❑ Bladder/Kidney Infection(s)
❑ Dialysis
❑ Kidney stones
❑ Kidney disease
❑ Liver disease
❑ Urinary Incontinence

❑ I HAVE NO SIGNIFICANT MEDICAL HISTORY

SOCIAL HISTORY

Alcohol Use: ❑Current Alcoholism ❑History of Alcoholism ❑Never Drinks Alcohol ❑Social Alcohol Use

Smoker or Tobacco Use: ❑Current User ❑Former User ❑Never

Marijuana Use: ❑Current User ❑Former User ❑Never ❑Medical Marijuana Card Holder

Drug Use:

❑ I Deny Any Illegal Drug Use
❑ I Formerly Used Illegal Drugs (not currently using); list _____
❑ I Have **Abused** Narcotic or Prescription Medications, list _____

General consent and authorization for treatment, evaluation and release of information

GENERAL CONSENT:

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. The consent will remain fully effective until it is revoked in writing. You have the right to discontinue services at any time. I certify that my Medical History is complete and accurate to the best of my knowledge and ability. I consent to reasonable and necessary medical examination, evaluation, testing and treatment which may include diagnostic, radiology and laboratory procedures. If invasive interventional treatment is recommended, I will be informed of the benefits and risk prior to performance of such treatment and will be provided with a separate consent form outlining such benefits and risk.

PROTECTED HEALTH INFORMATION:

The Notice of Privacy Practices for Integrative Pain Management of Naples has been provided to me. I understand I have the right to review Notice of Privacy Practices for Integrative Pain Management of Naples prior to signing this document. The Notice of Privacy Practices for Integrative Pain Management of Naples practice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or the performance of Integrative Pain Management of Naples health care operations. A summary of the Notice of Privacy Practices for Integrative Pain Management of Naples is also posted in the waiting room. This Notice of Privacy Practices for Integrative Pain Management of Naples also describes my rights and the duties of Integrative Pain Management of Naples practice with respect to my protected health information. Integrative Pain Management of Naples reserves the right to change the Privacy Practices that are described in the Notice of Privacy Practices for Integrative Pain Management of Naples. I may obtain a revised Notice of Privacy Practices for Integrative Pain Management of Naples by contacting the office of Integrative Pain Management of Naples at 1855 Veterans Park Drive, Suite 304, Naples FL 34109 by calling (239) 234-2448.

RELEASE OF INFORMATION:

I specifically authorize the uses and disclosures of my health information as described in the Notice of Privacy Practices provided to me. I authorize Integrative Pain Management of Naples, Dr. Ranasinghe, and/or her staff, to obtain my medication history and other relevant health care information, verbally, written or electronically, that is deemed necessary for my treatment. I consent to release of my health information to federal or state health plans, insurance companies, collection agencies, employers or other organizations responsible for payment of services, as appropriate. I understand that this may include information relating to my diagnosis, care, payment for my care, or demographic information.

BY SIGNING BELOW, I AM AGREEING TO THE CONSENTS AND RELEASES DESCRIBED ON THIS FORM. I HAVE READ THIS CONSENT AND HAVE BEEN ABLE TO ASK QUESTIONS.

_____ _____

Printed Name of Patient or Representative Signature of Patient or Representative

_____

Relationship to Patient

Integrative Pain Management of Naples
Chaturani Ranasinghe, M.D.
1855 Veterans Park Drive, Suite 304
Naples, Florida, 34109
Phone: 239-234-2448 | Fax: 239-234-2435
www.ipmnaples.com

PATIENT INFORMATION:

Name: (Last, First, MI) _____

Address: _____

Phone: _____ Date of Birth: _____

AUTHORIZATION:

I hereby authorize (Physician, Clinic, Hospital or other Health Care Provider) to release medical records:

From (Name of Party Releasing Records): Name: _____

Address:

Phone #: _____

_____ Fax#: _____

Date of Services: _____ to _____

To (Name of Requesting Party):

Integrative Pain Management of Naples

Address: **1855 Veterans Park Drive Suite 304, Naples, Florida, 34109**

Fax #: (239) 234-2435 Phone #: (239) 234-2448 Email: relief@ipmnaples.com

PURPOSE OF RELEASE OF MEDICAL RECORDS:

☐ Change in doctor ☐ Specialty appointment ☐ Insurance claim ☐ Other (specify):

☐ Legal claim processing _____

Sensitive Records may require specific patient authorization. Please check the applicable box below to request the following records:

☐ Mental Health Treatment ☐ Sexually Transmitted Diseases ☐ AIDS/HIV Treatment ☐ Alcohol/Drug Abuse Treatment

The undersigned hereby releases Integrative Pain Management of Naples from any and all legal Responsibility or liability that could occur from this Action.

Patient Signature: _____ Date: _____

Integrative Pain Management of Naples
Chaturani Ranasinghe, M.D.

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature:_____ Date: _____

Witness:_____ Date: _____

Integrative Pain Management of Naples
Chaturani Ranasinghe, M.D.

PATIENT FINANCIAL POLICY

As health care providers we are committed to providing our patients with the best medical care possible. As a business, we are committed to providing a streamlined fiscal process that allows our patients to clearly understand their financial responsibility. Our Business Office is committed to providing outstanding customer service for all financial questions, and our professional staff members are experts working with commercial insurance companies, Medicare, and Workers' Compensation.

Proper identification must be presented prior to service being rendered. Current insurance cards must be presented prior to service being rendered.

Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in Medicare. Integrative Pain Management of Naples does not contract with every insurance company. Patients are responsible for asking if IPM of Naples is a participating provider with their insurance company. IPM of Naples will bill non-participating insurances. However, outstanding balances are the responsibility of the patient. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. As a courtesy IPM of Naples will file to your secondary insurance carrier one time.

a) Integrative Pain Management of Naples will submit claims to Medicare, however you may need to sign an ABN for non-covered services.
b) Integrative Pain Management of Naples will submit to Medicare as your secondary insurance carrier one time.

Worker's Compensation- patients are financially responsible for medical services related to Worker's Comp. Patients will supply WC contact information prior to services being rendered.

Motor Vehicle/Third Party Liability

Patients are financially responsible for medical services related to motor vehicle accidents. Patients shall supply auto insurance, third party, and/or attorney information as requested by NASA.
Self-Pay
Self-pay account exist if patient has no insurance coverage.

Full payment is due at the time of service for all self-pay patients

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. New co-insurance or deductible amounts will be billed after the date of service. These amounts can only be calculated after your appointment.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Statements/Payments

Statements

- Statements are sent to patients on a monthly basis and will show outstanding balances.
- After insurance pays, patients are responsible for all outstanding balances.

Payment Methods

- We accept all major credit cards, checks, money orders, and cash.
- Low interest payment plans are available. Patients need to discuss options with the Customer Service Representative.
- Returned Check Fees – a fee of $25.00 will be charged for all returned checks.

9. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

- **No show fee is 50$ for missed procedures and Consultations.**

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I hereby assign, to Integrative Pain Management of Naples, payment of medical reimbursement benefits under my insurance policy. I authorize the release of
any medical information needed to determine my benefits. This authorization shall remain valid until written notice is given by me revoking said
authorization. I understand I am financially responsible for all charges whether or not they are covered by my insurance policy, as well as any copayments
or co-insurance.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

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