

Referred by:

Name: _____

Phone: _____

Fax: _____

Rehabilitation Physicians of Georgia, P.C.

Patient Information

Name: _____

Social Security #: ____/____/____

Address: _____

Date of Birth: ____/____/____ Age: ____

Sex: M F Marital Status: S M D W

Race: American Indian Alaskan Native Asian Black Hispanic Pacific Islander White

Refused to Answer

Ethnicity: Hispanic Non-Hispanic Refused to Answer

Preferred Language: _____

Home Phone: _____

Spouse's Name: _____

Cell Phone: _____

Spouse's Cell: _____

Emergency Contact: _____

Relationship: _____

Insurance Information

Primary Insurance: _____

Secondary Insurance: _____

Contact number: _____

Contact Number: _____

Claims Address: _____

Claims Address: _____

Policy Number/ID: _____

Policy Number/ID: _____

Group Name: _____

Group Name: _____

Group Number: _____

Group Number: _____

Policy Holder: Self Spouse Mother Father

Policy Holder: Self Spouse Mother Father

Worker's Compensation

Automobile Accident

Date of Accident: _____

Send Claims to: _____

Adjuster: _____

Contact Number: _____

Case Manager: _____

Contact Number: _____

Claim Number: _____

Please read and sign: I consent to treatment by any medical professional associated with Rehabilitation Physicians of Georgia, P.C. I authorize the release of any medical information needed by a physician's office, insurance company, attorney or hospital. I authorize payment for medical benefits directly to the physicians for his/her services. I understand that I am financially responsible for charges not covered by my insurance.

Signature: _____

Date: _____

Patient / Parent / Guardian

Medical History

Date of visit: _____

Patient name: _____ Weight: _____ Height: _____

What is the reason for your visit: _____

What is your pain level on a scale of 0-10: 0 1 2 3 4 5 6 7 8 9 10 Was your pain caused by an injury: Yes No

If yes, when was the injury: _____

Please describe the location of your pain: _____

Your pain is: Sharp Dull Burning Aching Stinging Throbbing Numbness Tingling

When did your pain first begin: _____ Did it start suddenly: Yes No

How often do you have pain: Constantly Frequently Intermittently Occasionally Rarely Daytime Nighttime

Severity of your pain: Mild Moderate Severe Is your pain: Improving Unchanged Worsening

What makes your pain worse: _____ What helps your pain: _____

What does your pain keep you from doing: _____

What tests have you had done regarding your pain: _____

What treatments have you received for your pain: (Medications, injections, therapy, etc) _____

Please list all health problems: _____

List any surgeries: _____

List family medical history: _____

Are you currently working: Yes No If yes, what is your job: _____

If not, why: Retired Student Disabled Are you seeking disability: _____

Do you smoke: Yes No If yes, how long and how many per day: _____

Do you drink alcohol: Yes No If yes, how often: _____

Have you ever used any illegal drugs: Yes No If yes, describe: _____

Do you or your family have any history of addiction: _____

Please list all medications you are currently taking: _____

List any allergies: _____

Review of Systems (Please circle all that apply)

Constitutional	Eyes	Ear/Nose/Throat	Skin
Chills	Eye pain	Difficulty swallowing	Rash
Fever	Eye discharge	Nose bleeds	Skin changes
Weight loss	Vision loss	Hearing loss	Lesions/Incisions
Fatigue	Visual disturbance	Neck swelling	Itching
Difficulty sleeping		Vertigo	Excessive sweating
Weakness			

Cardiovascular	Respiratory	Gastrointestinal	Psychiatric
Chest pain	Cough	Nausea	Depression
Palpitations	Shortness of breath	Vomiting	Anxiety
Pain in legs with walking	Coughing up blood	Diarrhea	Panic attacks
Swelling		Constipation	Suicidal thoughts
		Abdominal pain	Suicidal planning
			Substance abuse
			Insomnia
			Inability to concentrate

Musculoskeletal	Neurological
Neck pain	Elbow pain
Back pain	Wrist pain
Muscle pain	Hand pain
Joint pain	Hip pain
Joint swelling	Leg pain
Joint redness	Knee pain
Joint popping	Foot pain
Shoulder pain	Ankle pain
Arm pain	

Headaches
Weakness
Numbness
Confusion
Memory loss
Seizure
Abnormal walking
Radiating pain to arms or legs
Aura

PATIENT INFORMATION & CONSENT
What You Should Know About EMGs & NCS

Your doctor has ordered an EMG and NCS. Here is some information on what to expect.

What: Electromyography (EMG) and nerve conduction studies (NCS) indicate how well your nerves and muscles are working. EMGs measure the electrical activity of your muscles. Nerve conduction studies indicate whether and how fast the nerves are conducting impulses. In medical terminology, the procedures are different types of "electrodiagnostic testing."

Why: The tests can determine whether ongoing nerve injury or muscle damage is contributing to your current symptoms. They provide objective documentation for many pre-surgical diagnoses such as carpal tunnel syndrome, tardy ulnar palsy, and tarsal tunnel syndrome.

How: In a nerve conduction study, small electrodes send a tiny static-electric impulse through selected nerves in the arm, leg, neck or back region and measure a response. You will feel a mild tingling sensation lasting less than ¼ of a second. During an EMG, one or more tiny electrodes the size of a pin are inserted into the skin of the muscles in the arm, leg, or back area. The electrodes cause a slight prickling sensation as they take readings of the condition of your muscles. The combined tests take between 20 and 40 minutes.

Who: The studies are performed by board certified physician specialists who have received special training in this area of diagnostic medicine.

Where: The tests are performed in an examination room at the doctor's office. If you would like to bring your spouse, a friend or a relative to keep you company during the procedures you are welcome to do so.

When: Your doctor will receive the test results in a formal report.

Preparation: There is no special preparation needed, except that you should not apply any lotions or oils on the day of your test. If you have a pacemaker or have had a mastectomy, please notify the doctor before beginning the tests. The tests can still be done, but modifications must be made. If you wish, you may take pain medication before the tests, and you are encouraged to continue your usual medications because they will not affect the test results. Other than a mild tenderness where the needles are placed, there are no significant complications.

Board certified medical doctors specializing in the diagnosis and treatment of neck & back pain
Rehabilitation Physicians of Georgia, P.C.
404-659-5909
www.attackback.com

CONSENT TO PROCEDURE (S)

Do Not Sign This Form Without Reading & Understanding Its Contents

Patient's Name: _____

SSN: _____

I acknowledge and understand that as a result of the performance of the procedure(s) identified that there is a material risk that I may suffer infection, allergic reaction, and/or skin discoloration.

I have been given ample opportunity to ask questions and any questions I have asked have been answered or explained in a manner satisfactory to me.

By signing below, I acknowledge that I have read or had it read or explained to me and I understand this form and I voluntarily consent to allow Dr. _____ or any physician designated or selected by him/her and all medical personnel under the direct supervision and control of such physician and all other personnel who may otherwise be involved in performing such procedures to perform the procedures described or otherwise referred to herein.

Signature of Patient or Representative

Signature of Witness

Relationship to Patient

_____ AM/PM
Date Time

Patient is unable to sign because: _____

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Financial Policy and Consent Form

Rehabilitation Physicians of Georgia, PC (RPG) recognizes the need for a clear understanding between the patient and medical provider regarding financial arrangements for healthcare and protected health information. The following information is provided to avoid any misunderstanding concerning payment for professional services and protected health information.

Payment: Payments are required at the time of service; this includes any insurance copays. Checks cannot be accepted for payment in the office, only cash or debit/credit card payments will be accepted. For convenience, RPG will file the patient's valid, active insurance. Even though the patient's insurance will be filed, he or she is responsible for any balance after insurance processes the claim. The patient is also responsible for any coinsurances and/or unmet deductible amounts; any overpayment of coinsurances/unmet deductible amounts will not be refunded, but added as a credit to the patient's account. Payment arrangements for billed services must be approved by Kelly O'Neal, RPG billing manager. Checks or debit/credit cards are acceptable forms of payment for billed statements. A \$35 service fee will be charged on all returned checks. If no payment arrangements have been made or payment has not been received within ninety (90) days of the initial billing statement date, the patient's account will be filed under a "collections status," and the patient will not receive any additional treatment (including medications) until payment is made in full.

Secondary Insurance: The state of Georgia requires the patient to provide secondary insurance coverage to providers if applicable. The patient agrees to provide such information. The patient agrees to notify RPG of any additions, deletions, or other changes to the policy coverage: this includes both primary and secondary insurance policies.

Self Pay (private, cash pay): All self pay patients are required to pay fees at the time of service. This may include any additional service fees such as, but not limited to, in-office injections and urine drug screens. If a patient is considered self pay at the time of service and then receives insurance, RPG will not reimburse any previously paid fees at the self pay rate.

Please note, RPG will NOT retroactively file insurance, with the only exception being Medicaid.

Please note the following changes that apply to ALL patients:

Medical Records: In accordance with RPG practice policy, a processing fee of \$25.00 (not payable by insurance) will be charged for sending medical records to the patient. Please allow up to five (5) business days for request processing.

Missed/Late Appointments: A minimum notice of 24-hours is required for cancellation of the office visit or surgery center appointments. A fee of \$25.00 will be charged for all missed appointments without prior sufficient notice.

RPG firmly believes that a good patient/physician relationship is based upon understanding and open communications. It is our hope that the above policies will allow us to provide the highest quality of care to our patients. If you have any questions or need additional information or clarification regarding these policies, please call Kelly at 770-985-6936. By signing below, you agree to the terms and conditions of the RPG financial policy and provide your consent regarding outlined policies.

Patient Name (Please Print)

Patient Date of Birth

Signature (Insured Patient/Guardian)

Date



EXHIBIT 4:

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

Rehabilitation Physicians of Georgia, P.C.

I, _____, have been made available a copy of Rehabilitation Physicians of
Patient Name
Georgia, P.C.'s Notice of Privacy Practices.

Signature of Patient

Date

Late Appointment Policy

Our doctors, medical assistants and staff aim to make your visit a pleasurable one. In our efforts to make your visit more comfortable and to minimize your wait time, our office has implemented a late arrival policy.

If a patient is more than 15 minutes late for an appointment, the appointment will be rescheduled. This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day if one is available. We will try to accommodate late-comers as best as possible, but cannot compromise on the quality and timely care provided to our other patients.

For example: Appointment time 10:00am
Arrival 10:00am-10:15am (SEEN)
Arrival at 10:16am (RESCHEDULE)

New patients are encouraged to print off new patient paperwork from the website and fill it out prior to coming in.

- Incomplete NP Forms: New patients need to arrive at the office at least 30 minutes prior to the scheduled appointment to complete the paperwork or appointment will be rescheduled.

For example: Appointment at 10:00am, paperwork is incomplete
Arrival at 9:30am-9:45am (SEEN)
Arrival at 9:46am (RESCHEDULE)

- Complete NP Forms: If a new patient's paperwork is already completed, patient must arrive before appointment time to avoid rescheduling.

For example: Appointment at 10:00am, paperwork is complete
Arrival at 9:30-10:00am (SEEN)
Arrival at 10:01am (RESCHEDULE)

The doctors and staff at Rehabilitation Physicians of Georgia appreciate your compliance and understanding with this policy so that we can continue to provide excellent medical care as well as excellent customer service.