**Anesthesia-Pain Management Services**
2345 Murfreesboro Highway, Manchester, TN 37355
Phone (931) 728-5607 *** Fax (931) 728-8354

# *Welcome To Our Practice!*

**Welcome**

Thank you for scheduling an appointment with Anesthesia-Pain Management Services. This letter confirms your appointment and provides valuable information for your visits with us. We are committed to providing you with the best possible medical care in a friendly atmosphere. Please do not hesitate to ask us any questions you may have. Your appointment is scheduled for _____ at _____ with _____.

**Office Hours**

**Office Hours:**

| Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|
| 7:00 - 5:30 | 7:00 - 5:30 | Closed | 7:00 - 5:30 | 7:00 - 5:30 |

**Emergencies: For life-threatening situations, call 911 or go to the nearest Emergency Room. If you have an urgent problem during working hours, please call our office at (931)728-5607 and a message will be given to a nurse. After hours, please leave a message on our answering machine. Your call will be returned on the next business day.**

**First Visit**

Please come 30 minutes before your appointment time and bring with you:

* Insurance card(s)
* Driver's license or photo I.D.
* ALL medicine bottles **(must have with you or appointment will be rescheduled)**
* **Completed** patient information and clinical history forms (included with this letter)
* Co-payment (if required by your plan)

**Appointments**

Please make any follow-up appointments as you leave.

* Call in advance to make or reschedule office visit appointments.
* As a courtesy to other patients and staff, please call the office as soon as possible if you are going to be late or are unable to keep your appointment.
* If you will be more than 15 minutes late, you will need to reschedule your appointment for the next available day and time.
* A $25.00 fee will be assessed for missed appointments which were not cancelled.
* Due to the large time allotment required, RFTC and RACZ appointments require 24 hours notice to cancel; otherwise, a $100.00 fee will be assessed.

**Prescriptions**

All prescriptions and refills should be obtained during your appointment. We do not call in refills. **Please bring all medications and bottles prescribed by us to your appointments or your appointment will be rescheduled.**

**Financial Policy**

* You are financially responsible for all charges incurred.
* Payment of any co-pays, deductibles and co-insurance is expected at time of service.
* We will file your insurance as a courtesy to you. Any remaining balance after 60 days will become your obligation.
* We accept: *Cash, Check, Visa, MasterCard, and Discover*
* Please see our "Policies and Procedures" for our complete financial policy.

**Insurance**

Prior to your appointment, please check your insurance information so you will be informed about referrals, co-payments, and any deductible required at the time of the visit. We accept Medicare as well as most other insurers.

* If your insurance requires a referral from your primary care physician, a written referral or authorization number must be in our office prior to your visit.
* Your health insurance contract is between you and your insurance company. Any concerns regarding your coverage or co-payments should be directed to your carrier.

**What We Need From You**

* To arrive on time for scheduled appointments and cancel the appointment, when necessary, with a phone call.
* To inform the Medical Practice staff of any pertinent changes in insurance, demographic information, employment or other care/service givers.
* To notify the Medical Practice of any change in your health status.
* To follow the recommended treatment plan and inform the Medical Practice of any physical or mental impairment requiring special accommodations.
* To ask questions if directions and procedures are not understood.
* To provide payment for services requested and delivered by the Medical Practice not covered by insurance within 90 days of date of service.

**What You Should Expect From Us**

* To be treated with respect and dignity.
* Professional, timely and appropriate services.
* To be informed of your care needs in order to make appropriate decisions.
* That teaching materials will be provided in a manner you can understand.
* To be informed of the Medical Practice billing process.
* To have your records kept confidential except when consent has been given or to co-ordinate health care services for you.
* To communicate your complaints to the Medical Practice Manager and expect to receive follow-up without negative repercussions or changes in services.
* To receive care without discrimination due to race, religion, age, sex, disability or ethnic origin.

# Patient Information

Name: _____ Date:_____

Date Of Birth: _____ SSN: _____

Current Address: _____

City, State, Zip: _____

Phone #: _____ Cell #: _____

Emergency #: _____ E-mail: _____

Primary Care Physician: _____

Marital status: (circle one) Single Married Divorced Separated Widowed

Spouse's Name: _____

Spouse's DOB: _____

Spouse's SSN: _____

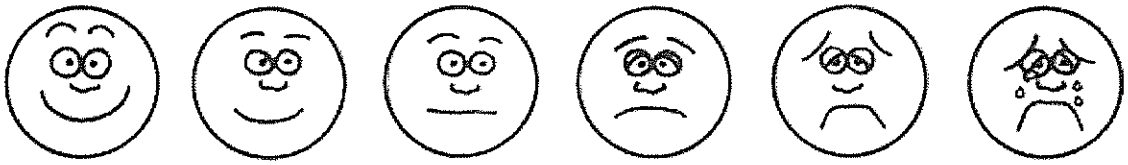
Insurance Co. #1: _____

Insurance Co. #2: _____

# Patient Subjective Pain Assessment

Patient Name _____ Date _____

Wong-Baker FACES Pain Rating Scale



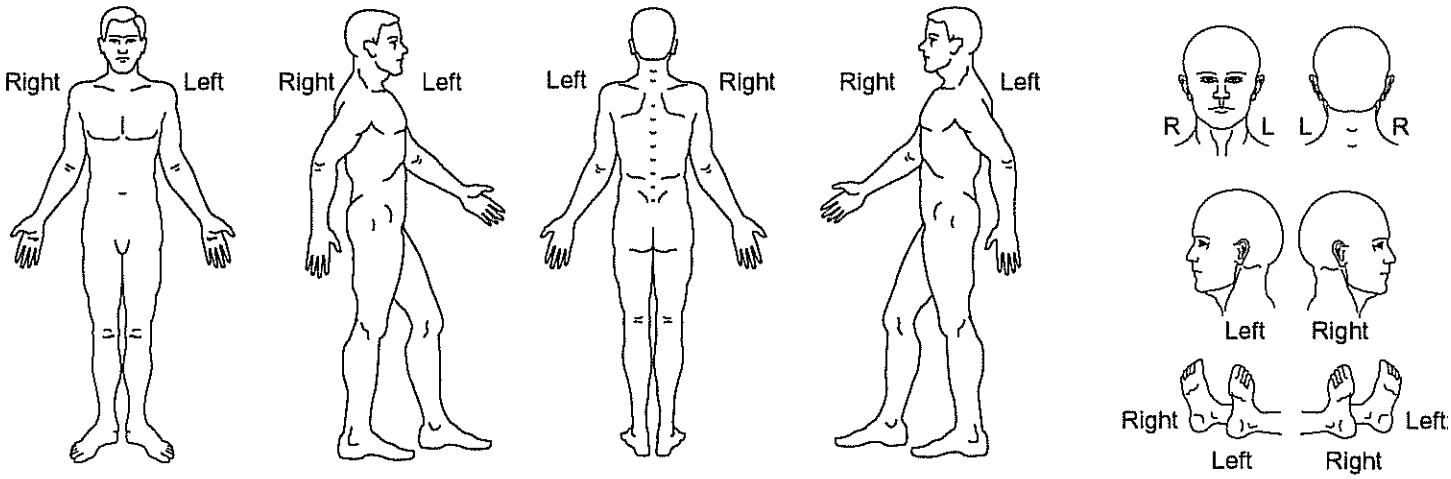
| 0-1 | 2-3 | 4-5 | 6-7 | 8-9 | 10 |
|---|---|---|---|---|---|
| No Pain | Tolerable | Distressing | Intense | Severe | Unbearable |

1. Using the scale above, how bad is your pain?
   Right Now _____ On A Normal Day _____ On Your Worst Day _____

2. Please circle the words that best describe your pain.

| | | | | | |
|---|---|---|---|---|---|
| Numb | Pinching | Sharp | Stabbing | Crushing | Aching |
| Burning | Pricking | Dull | Cold | Cramping | Cutting |
| Tingling | Flickering | Squeezing | Throbbing | Nagging | Stinging |

3. Mark the locations of your pain to the best of your ability




4. How much have these helped with your pain?

**0 = Haven't Tried 1 = Not Effective 2 = Somewhat Effective 3 = Extremely Effective**

| | | | |
|---|---|---|---|
| Biofeedback/Relaxation | | Psychotherapy | |
| Exercise | | Heat/Cold | |
| Bed rest | | Massage/Rubbing | |
| Group Therapy | | Prayer | |
| Medications | | Acupressure | |
| Distraction | | Acupuncture | |
| Tens Unit | | Brace | |
| Other | | | |

# ANESTHESIA-PAIN MANAGEMENT
## REVIEW OF SYSTEMS/SOCIAL HISTORY

Patient:_____ Date: _____

***PLEASE CHECK* if you now have or recently have had ANY of the following:**

**1. Constitutional**

- ☐ fever
- ☐ chills
- ☐ weight loss
- ☐ weight gain
- ☐ weight gain
- ☐ generalized weakness

comments:_____

**2. Cardiovascular**

- ☐ chest pain
- ☐ fast heart beat
- ☐ slow heart beat
- ☐ leg swelling
- ☐ heart murmur
- ☐ rheumatic fever
- ☐ pacemaker
- ☐ heart valve problem
- ☐ heart surgery
- ☐ heart attack
- ☐ awakened by shortness of breathe
- ☐ shortness of breath w/ walking

comments:_____

**3. Respiratory**

- ☐ shortness of breath
- ☐ persistent cough
- ☐ coughing up blood
- ☐ bronchitis
- ☐ asthma
- ☐ chest pain w/ breathing
- ☐ emphysema

comments_____

**4. Gastrointestinal**

- ☐ nausea
- ☐ vomiting
- ☐ diarrhea
- ☐ constipation
- ☐ abdominal pain
- ☐ dark tarry stool
- ☐ rectal bleeding

comments_____

**5. Genito-urinary**

- ☐ painful urination
- ☐ pain w/sexual intercourse
- ☐ blood in urine
- ☐ kidney stone
- ☐ loss of interest in sex
- ☐ frequent urination

comments:_____

**6. Musculoskeletal**

- ☐ muscle pain
- ☐ arthritis
- ☐ rheumatoid arthritis
- ☐ fibromyalgia
- ☐ joint pain
- ☐ osteoarthritis
- ☐ osteoporosis
- ☐ joint swelling

comments:_____

**7. Skin**

- ☐ rash
- ☐ hives
- ☐ easy bruising
- ☐ itching
- ☐ dry skin

comments:_____

**8. Neurological**

- ☐ headache
- ☐ loss of consciousness
- ☐ paralysis
- ☐ numbness
- ☐ memory loss
- ☐ seizures
- ☐ muscle weakness

comments_____

**9. Psychiatric**

- ☐ depressed mood
- ☐ thoughts of suicide
- ☐ weight gain or loss
- ☐ attempt at suicide
- ☐ difficulty concentrating
- ☐ rarely enjoy anything
- ☐ difficulty falling asleep
- ☐ waking in middle of night
- ☐ feelings of doom or dread
- ☐ feelings of hopelessness
- ☐ feelings of nervousness
- ☐ treatment for depression
- ☐ treatment for anxiety

comments:_____

**10. Metabolic/endocrine**

- ☐ change in hair texture
- ☐ fatigue
- ☐ increased thirst
- ☐ heat intolerance
- ☐ cold intolerance

comments:_____

**11. Hematologic/Lymphatic**

- ☐ bleeding tendency
- ☐ swollen lymph nodes
- ☐ liver disease
- ☐ hemophilia
- ☐ anemia
- ☐ hepatitis (type)_____
- ☐ other blood diseases
- ☐ history of cancer

comments:_____

## Family History

Father: ___ Alive _____ Age Any health issues: _____
___ Deceased Cause of death_____
Mother: ___ Alive _____ Age Any health issues: _____
___ Deceased Cause of death_____
Brothers/Sisters: Health issues _____
_____

## Social History

Tobacco (About how much) _____
Alcohol (About how much) _____
History of substance abuse? _____ What Substances: _____
_____
Work history: Past: _____
Present: _____
Retired: _____ On disability: _____ Applying for disability: _____
Lawsuit relating to your pain?_____

If you live alone and need help, is there family/neighbors/friends who can help? _____
If so, please give their name and phone number below.

Name:_____
Phone number:_____

# Anesthesia Pain Management Services
## Oswestry Pain Questionnaire

Name: _____ Date: _____

This questionnaire has been designed to give your physician information as to how your back pain has affected your ability to manage in everyday life. Please answer every question by placing a mark in the **one** box in each section that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but **please mark only the box which most closely describes your current condition.**

**Pain Intensity**
**Point Value**
0☐ I can tolerate the pain I have without having to use pain medication.
1☐ The pain is bad but I can manage without having to take pain medication.
2☐ Pain medication provides me complete relief from pain.
3☐ Pain medication provides me with moderate relief from pain.
4☐ Pain medication provides me with little relief from pain.
5☐ Pain medication has no affect on my pain.

**Personal Care (Washing, Dressing, etc.)**
0☐ I can take care of myself normally without causing increased pain.
1☐ I can take care of myself normally but it increases my pain.
2☐ It is painful to take care of myself and I am slow and careful.
3☐ I need help but I am able to manage most of my person care.
4☐ I need help every day in most aspects of my care
5☐ I do not get dressed, wash with difficulty and stay in bed.

**Lifting**
0☐ I can lift heavy weights without increased pain.
1☐ I can lift heavy weights but it causes increased pain.
2☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (ex. on a table).
3☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4☐ I can lift only very light weights.
5☐ I cannot lift or carry anything at all.

**Walking**
0☐ Pain does not prevent me from walking any distance.
1☐ Pain prevents me from walking more than 1 mile.
2☐ Pain prevents me from walking more than ½ mile.
3☐ Pain prevents me from walking more than ¼ mile.
4☐ I can only walk with crutches or a cane.
5☐ I am in bed most of the time and have to crawl to the toilet.

**Sitting**
0☐ I can sit in any chair as long as I like.
1☐ I can only sit in my favorite chair as long as I like.
2☐ Pain prevents me from sitting for more than 1 hour.
3☐ Pain prevents me from sitting for more than ½ hour.
4☐ Pain prevents me from sitting for more than 10 minutes.
5☐ Pain prevents me from sitting at all.

**Standing**
**Point Value**
0☐ I can stand as long as I want without increased pain.
1☐ I can stand as long as I want but increases my pain.
2☐ Pain prevents me from standing more than 1 hour.
3☐ Pain prevents me from standing more than ½ hour.
4☐ Pain prevents me from standing more than 10 minutes.
5☐ Pain prevents me from standing at all.

**Sleeping**
0☐ Pain does not prevent me from sleeping well.
1☐ I can sleep well only by using pain medication.
2☐ Even when I take pain medication, I sleep less than 6 hours.
3☐ Even when I take pain medication, I sleep less than 4 hours.
4☐ Even when I take pain medication, I sleep less than 2 hours.
5☐ Pain prevents me from sleeping at all.

**Social Life**
0☐ My social life is normal and does not increase my pain.
1☐ My social life is normal, but it increases my level of pain.
2☐ Pain prevents me from participating in more energetic activities (ex. sports, dancing, etc.)
3☐ Pain prevents me from going out very often.
4☐ Pain has restricted my social life to my home.
5☐ I have hardly any social life because of my pain.

**Traveling**
0☐ I can travel anywhere without increased pain.
1☐ I can travel anywhere but it increases my pain.
2☐ My pain restricts travel over 2 hours.
3☐ My pain restricts my travel over 1 hour.
4☐ My pain restricts my travel to short necessary journeys under ½ hour.
5☐ My pain prevents all travel except for visits to the doctor/therapist or hospital.

**Employment/Homemaking**
0☐ My normal homemaking/job activities do not cause pain.
1☐ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
2☐ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (ex. lifting, vacuuming).
3☐ Pain prevents me from doing anything but light duties.
4☐ Pain prevents me from doing even light duties.
5☐ Pain prevents me from performing any job or homemaking chores.

(_____ ÷ _____) X 100 = _____ % of Maximum
(Patient's Total Points) (No. of Sections Completed x 5)

Anesthesia-Pain Management Services

# Policies and Procedures

Thank you for choosing Anesthesia-Pain Management Services for treatment of your pain. Our goal is to help you improve your quality of life and level of function. To accomplish this, it is imperative that you work with your physician and follow the treatment plan he designs for you. In our efforts to provide the highest level of medical care to our patients, it is important for you to be aware of the guidelines of our practice and to adhere to the policies set forth:

***(Please read and initial beside each policy acknowledging your understanding.)***

____ • **Information Updates:** Please keep us informed of any changes to your insurance, name, address, or telephone number.

____ • **Insurance Cards:** Please always bring all current insurance cards. We are eager to help you receive your maximum allowable benefits, but must have current information in order to do this.

____ • **Medications:** Always bring your medicine bottles with medicines (prescribed by us) to every appointment. I give permission to Anesthesia Pain Management to download my medication history from my pharmacies into my electronic chart.

____ • **Medical Changes:** Make sure you report any tests or hospitalizations since your last appointment.

____ • **Co-Pays:** All co-pays are due and expected at the time of your appointment. We accept cash, check, or credit card.

____ • **Financial Policy:** As a service to you, we will gladly submit your claims to your insurance company. However, you are financially responsible for all charges. ∞ Along with your co-pay, if you have any remaining balance after we receive insurance payment from a previous visit, you will be expected to make that payment at the time of your appointment. ∞ As the patient, you are responsible to obtain any pre-cert, authorization, or referral necessary for your appointment. ∞ If your insurance denies your charges, you are responsible to call them for an explanation. We expect payment of all services within 60 days. This may require you to pay your account in full if your insurance company fails to pay. ∞ If you do not have insurance, you will be expected to pay in full at time of service. ∞ Payment options are available by speaking with our billing staff. ∞ There is a $25 charge for all checks returned to us for insufficient funds. ∞ Delinquent accounts of greater than 90 days will result in your discharge from this facility, up to 50% collection fee added to your account, and will be referred to our collection agency. It will also be reported to the credit bureau.

____ • **Appointment times:** All patients will be seen in order by appointment time. Please arrive on time. If you are *more than 15 minutes late* for an appointment you will be re-scheduled.

____ • **Cancellations:** A fee will be charged for any and all missed appointments. Out of consideration for others in pain, *please give 24 hours notice* if you cannot keep your appointment to allow the time to be used by another hurting patient. *If notice is not given, a $25 fee will be charged.* Multiple missed or cancelled appointments will be considered non-compliance and may result in discharge from the clinic. Due to the length of the reserved time slot, *if you miss an RFTC or RACZ appointment without giving 24-hour notice, a $100 fee will be charged.*

____ • **Treatment:** It is your obligation to tell your physician the truth about the nature and duration of your symptoms and medical history. You are also obligated to follow your physician's instructions concerning diet, medication, exercise, personal habits, and follow up appointments.

____ • **Drug tests:** Random laboratory tests will be performed to make your medication regimen as safe as possible. By signing this form, you agree to submit to random blood or urine tests, as is required by your Medication Management Contract. You will be responsible for the charges incurred for these tests. Any Illegal substances (including marijuana, cocaine, etc.) or controlled substances not prescribed by this office detected in these tests may result in termination from this practice.

____ • **Prescription Refills:** All prescriptions *must* be obtained by appointment. *No refills or new prescriptions will be phoned in.*

____ • **Telephone calls:** All telephone calls will be returned within twenty-four hours. If your condition is such that you feel like you can't wait that length of time, please go to the nearest emergency room.

____ • **Medical Records Release:** Medical records will be released only with the patient's signed consent. There will be a charge for reproduction of medical records or completing FMLA or other papers. Requests will be completed within ten business days and payment is due at time of pickup. If records are to be mailed, payment must be made in advance.

• **PHI:** Anesthesia-Pain Management Services uses and discloses patient health information to provide treatment, to obtain payment and for health care operations, including administrative purposes. By signing below, you consent to such use and disclosure of your health information.

By signing below, I understand and agree to abide by the above office policies.

Signature: _____ Date: _____

# *Anesthesia-Pain Management Services*
# *HIPAA NOTICE OF PRIVACY PRACTICES*

## THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED ANS DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operation (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past , present, or future physical or mental health or condition and related health care services.

**1. Uses and Disclosures of Protected Health Information**

**Uses and Disclosures of Protected Health Information**
Your protected health information may be used and disclosed by your physician, our staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. Workers Comp, Adjusters, Nurses, Case Managers , Referral and Pre-cert personnel along with Dr. to Dr. for peer review are some examples of who we may disclose your protected health information to. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you or to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a pain management procedure may require that your relevant protected health information be disclosed to the health plan to obtain approval for the procedure.

**Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of an appointment. We also require a photograph of each patient in order to verify administration of treatment and medications. Refusal of this photograph would impede care of the medication disbursement and you then have the right to another healthcare professional.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements.

**Other Permitted and Required Uses and Disclosures** Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

**You may revoke this authorization,** at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use and disclosure indicated in the authorization.

(over)

**Individual Rights**
Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and obtain a copy of your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action proceeding, and protected health information that is subject to law that prohibits access to protected health information. The doctor will determine whose record will be denied based upon endangerment to the patient or others. You must make the request in writing to obtain access to your medical information. If you request copies, there will be a charge of $.25 per page and postage if you want the copies mailed to you.

**You have the right to request a restriction of your protected health information.** This means that you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to the family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Any agreement to the restrictions on the use and disclosure of your medical information must be in writing and signed by a person authorized to make such an agreement on behalf of the company. The company will not be bound unless the agreement is so memorialized in writing.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to another healthcare professional.

**You have the right to request and receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This accounting will list each disclosure that was made of your medical information for any reason other than treatment, payment, health care operations and certain activities since April 14, 2003.

**This notice was published and becomes effective on/before April 14, 2003.**

**Questions and Complaints.** If you want more information concerning the companies' privacy practices or have questions or concerns, please contact us with the information below.

If you are concerned that the company has violated your privacy rights, or you disagree with a decision made about access to your medical information, or in response to a request you made to amend or restrict the use or disclosure of your medical information or to have us communicate with you by alternative means or at alternative locations, you , may complain to us using the contact information below. You may also submit a written complaint to the U.S. Department of Health and Human Services. The address to file a complaint with the U.S. Department of Human Services will be provided upon request.

The company supports your right to protect the privacy of your medical information. There will be no retaliation in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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**We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.**

**Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:**

**Print Name:**_____ **Signature:**_____ **Date:**_____

**Original 4-14-03 Revised 7-16-08**

# *ANESTHESIA - PAIN MANAGEMENT SERVICES*

James R. Nunley, D.O.
Marshall S. Millman, M.D.
C. Robert Harmuth, M.D.
John Stuart Slaven, M.D.

## Your Protected Health Information (PHI):

Please indicate who we may give your Protected Health Information (PHI) to.

Y N Spouse's Name _____

Y N Children's Name _____

Y N Other's Name _____

Y N Parent's Name (If patient is minor) _____

**Messages:** On your answering machine or voice mail, may we leave messages regarding:

| | | |
|---|---|---|
| Appointments? | Y | N |
| Billing? | Y | N |
| Other PHI? | Y | N |

**Emergency Contacts:** Please list two people that DO NOT live with you and indicate if we may give them your Protected Health Information.

Y N Name: _____ Home Phone #_____

Relationship to patient: _____ Work Phone #_____

Y N Name: _____ Home Phone #_____

Relationship to patient: _____ Work Phone #_____

Patient signature:_____ Date:_____

Anesthesia-Pain Management Services

# Assignment of Benefits

## Primary Insurance:

I hereby assign payment of medical benefits due to me to be paid directly to :

**James R. Nunley, D.O., P.C./Anesthesia-Pain Management Services**

and I authorize the release of any health information needed to determine these benefits or the benefits payable for related services to the insurance company/companies that I have supplied you with. I understand that filing my claims for services rendered is a service to me provided by Anesthesia Pain Management and this assignment does not relieve me of my primary obligation to pay my bill to: James R. Nunley, D.O., P.C./Anesthesia-Pain Management Services.

I stand responsible for payment.

**Signature** _____ **Date** _____

## Medicare (One-Time Authorization):

I request that payment of authorized Medicare benefits be made on my behalf to:

**James R. Nunley, D.O., P.C./Anesthesia-Pain Management Services**

for any services furnished me by that provider. I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services (CMS) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

**Signature** _____ **Date** _____

## MEDIGAP or any Secondary Insurance (Signature on File Statement):

Name of Beneficiary _____ HICN _____

Name of Medigap or Secondary Insurer_____ Policy Number _____

I request that payment of authorized benefits be made on my behalf to:

**James R. Nunley, D.O., P.C./Anesthesia-Pain Management Services**

for any services furnished me by that provider. I authorize any holder of my personal medical information to release any information needed to determine these benefits payable for related services.

**Signature** _____ **Date**_____

## Workers Compensation or Litigation:

I, _____hereby authorize my attorney, _____
to withhold sufficient funds from any judgment, settlement, or recovery which I might have or effect in my pending action against _____to pay any and all medical expenses due and owing to:

**James R. Nunley, D.O., P.C./Anesthesia-Pain Management Services**

and I direct my attorney to pay that sum directly to **James R. Nunley, D.O., P.C./Anesthesia-Pain Management.** I hereby assign to **James R. Nunley, D.O., P.C./Anesthesia-Pain Management** to the extent of my outstanding medical expenses due and owing to him, all amounts received by attorney for my benefit. I understand that this assignment does not relieve me of the primary obligation to pay my bill to **James R. Nunley, D.O., P.C./Anesthesia-Pain Management** and that if a recovery is not made or if the amount of the recovery is not sufficient to pay **James R. Nunley, D.O., P.C./Anesthesia-Pain Management** in full, then they may proceed against me for payment.

**Signature** _____ **Date**_____