2304 Wesvill Court, Suite 320
Raleigh, NC 27607
T 919-825-3902
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Spine & Pain ASSOCIATES
Feel Better, Live Better

1303 Carthage Street
Sanford, NC 27330
T 919-292-2468
F 919-292-2167

www.spineandpainassociates.com

New Patient History Form

Date: _____ Medical Record Number (to be filled in by practice):_____

First Name: _____ Middle: _____ Last: _____

Name you wish to be called in the office: _____

Age: _____ Date of Birth: _____ ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____

Telephone: Home: _____ Work: _____

Cell: _____ Email: _____

Race: ☐ White ☐ Hispanic ☐ African-American ☐ Asian ☐ Native American ☐ Other ☐ Decline

Primary Language (if not English): _____

Referred By: Whom may we thank for referring you to our practice?

☐ Physician: Name: _____

Address: _____

Phone: _____ Email: _____

☐ Friend: Name: _____

☐ Website: (please list which one) _____

☐ Insurance Company Listing: _____

☐ Other: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Advanced Directive: ☐ None ☐ Living Will ☐ Healthcare POA/Proxy: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Education: Highest education level achieved:

☐ Post graduate ☐ College graduate ☐ High school graduate/GED ☐ Other: _____

Employment: ☐ Full-time ☐ Part-time ☐ Retired ☐ Student ☐ Homemaker ☐ Disabled ☐ Unemployed

Work Restrictions: ☐ Yes ☐ No

Occupation: _____

Employer Name: _____

Address: _____

Name of Contact person: First: _____ Last: _____

Phone Number: _____ Fax Number: _____

Reason for Visit

Reason for Visit Today: _____

_____

Pain severity with 0 being no pain and 10 being severe pain:

Current - 0 1 2 3 4 5 6 7 8 9 10

Average pain over the last month: _____ Worst pain: _____ Least pain: _____

Onset

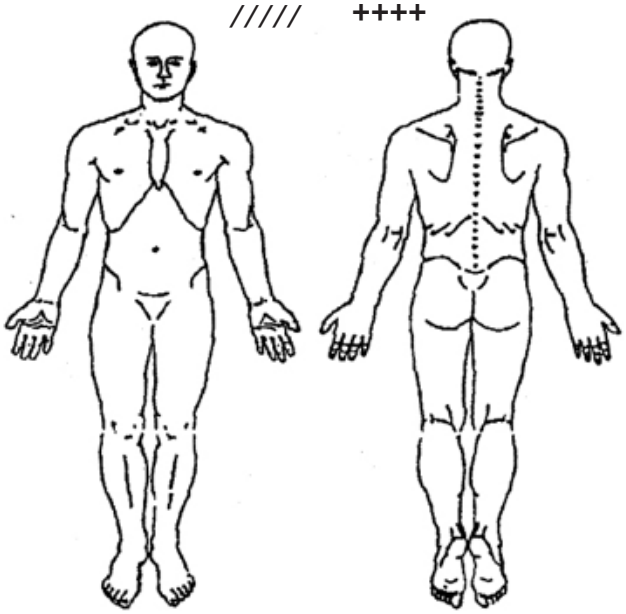
When did symptoms begin? _____

☐ Post-surgery ☐ Medical Illness ☐ Fall ☐ Auto Accident ☐ Work Injury/Date: _____

☐ Other: _____

Using the symbols given below, mark the area on your body where you feel the described sensations. Include all affected areas.

Aching	Numbness	Pins & Needles	Burning	Stabbing	Other
ΔΔΔΔ	−−−−−	ooooo	xxxx	/////	++++



Neck pain % _____
Arm pain % _____
Total % _____

Back pain % _____
Leg pain % _____
Total % _____

Pain Quality – check all that apply
- ☐ Dull/Aching
- ☐ Numbness/Tingling
- ☐ Shooting/Stabbing
- ☐ Stinging/Burning/Hot
- ☐ Throbbing

Do the symptoms radiate? ☐ Yes ☐ No
If so, where? _____
_____

Additional symptoms
- ☐ Spasm
- ☐ Swelling
- ☐ Restless leg
- ☐ Loss of Balance
- ☐ Stiffness
- ☐ Itching
- ☐ Tenderness

Pain Pattern
Current pain began: ☐ Gradually ☐ Suddenly

Pain occurs: ☐ Constantly ☐ Occasionally ☐ Worse in morning ☐ Worse at night ☐ Worse with activity

Since pain began, it has: ☐ Decreased ☐ Increased ☐ Stayed the same

Pain is Worse with:
- ☐ Rest
- ☐ Bending Backward
- ☐ Coughing/Sneezing
- ☐ Twisting
- ☐ Walking
- ☐ Activity
- ☐ Overhead Activity
- ☐ Sit to Stand
- ☐ Turning Head
- ☐ Running
- ☐ Weather Change
- ☐ Climbing Steps
- ☐ Lying Down
- ☐ Sitting/Driving
- ☐ Other: _____
- ☐ Bending Forward
- ☐ Limb Position
- ☐ Lifting
- ☐ Standing

Pain Improves with:
- ☐ Rest
- ☐ Position change
- ☐ Activity
- ☐ TENs
- ☐ Cold
- ☐ Exercise
- ☐ Heat
- ☐ Massage
- ☐ Chiropractic

☐ Injections _____

☐ Medication _____

First Initial: _____ *Last Name:* _____

continued

Treatment History ☐ No prior treatments for current symptoms

Treatment	When, how long	Helped (Yes/No)	Facility/ Provider
Acupuncture			
Brace			
Chiropractor			
Injections			
Massage			
Physical Therapy			
TENs unit			
Other			

Consultations

Type of Consult	Provider	Date/Timeframe
Spine Surgeon		
Orthopedic Surgeon		
Pain Specialist		
Neurologist		
Rheumatologist		
Podiatrist		
Psychiatrist		
Psychologist		

Medications - Check all medications that you have tried for pain control

Over the counter

☐ Acetaminophen (Tylenol) ☐ Aspirin ☐ Ibuprofen ☐ Naprosyn ☐ Patches ☐ Creams/Ointments
☐ Other: _____

Muscle Relaxers

☐ Cyclobenzaprine (Flexeril) ☐ Methocarbamol (Robaxin) ☐ Baclofen ☐ Tizanidine (Zanaflex)
☐ Metaxolone (Skelaxin) ☐ Chlorzoxazone (Lorzone) ☐ Diazepam (Valium) ☐ Carisoprodol (Soma)

Neuromodulating

☐ Gabapentin (Neurontin) ☐ Horizant ☐ Gralise ☐ Amitriptyline (Elavil)
☐ Pregabalin (Lyrica) ☐ Duloxetine (Cymbalta) ☐ Other: _____

Opiates

☐ Codeine (e.g. Tyl #3) ☐ Tramadol (Ultram/Ultracet) ☐ Hydrocodone (Norco, Lortab, etc.)
☐ Oxycodone (Percocet, etc) ☐ Morphine Sulfate ☐ Hydromorphone (Dilaudid)
☐ Oxymorphone (Opana) ☐ Tapentadol (Nucynta)
☐ Long-Acting Opiates: _____ ☐ Other: _____

Diagnostic Tests/Imaging Studies ☐ None

Test	Body Site	Date	Facility
X-ray			
CT Scan			
Myelogram			
MRI			
DEXA Scan			
Bone Scan			
EMG/NCS			
Other			

Medical History

Medical Conditions – Check all conditions that have been diagnosed in the past

General/Medical
- ☐ Cancer – Type: _____
- ☐ Diabetes – Type: _____
- ☐ HIV/AIDS
- ☐ Hypothyroid
- ☐ Hyperthyroid

HEENT
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Headaches
- ☐ Head Injury

Cardiovascular
- ☐ Coronary Artery Disease
- ☐ Congestive Heart Failure
- ☐ Heart Attack (MI)
  When? _____
- ☐ High Blood Pressure (HTN)
- ☐ High Cholesterol
- ☐ Irregular Heart Beat

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema/COPD
- ☐ Sinusitis
- ☐ Sleep Apnea
- ☐ Tuberculosis

Gastrointestinal
- ☐ Acid Reflux/GERD
- ☐ Bowel Incontinence
- ☐ Cirrhosis/Liver Failure
- ☐ Constipation
- ☐ Crohn's Disease/ Ulcerative Colitis
- ☐ GI Bleeding
  When? _____
- ☐ Hepatitis – Type: _____
- ☐ Irritable Bowel Syndrome (IBS)

Genitourinary/Kidney
- ☐ Bladder/Kidney Infections
- ☐ Chronic Kidney Disease
- ☐ Dialysis
- ☐ Kidney Stones
- ☐ Prostate Enlargement
- ☐ Urinary Incontinence

Hematologic
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Blood Clot
- ☐ Peripheral Vascular Disease

Neurologic
- ☐ Dementia/Alzheimer's
- ☐ Multiple Sclerosis
- ☐ Neuropathy
- ☐ Seizure/Epilepsy
- ☐ Spinal Cord Injury
- ☐ Stroke/TIA

Musculoskeletal
- ☐ Amputation/Phantom Limb Pain
- ☐ Carpal Tunnel Syndrome
- ☐ Compression Fracture(s)
- ☐ Connective Tissue Disease
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Joint Disease/Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis

Psychiatric
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Schizophrenia
- ☐ Substance Abuse

Other: _____
_____
_____
_____

Medications

Please list all current medications, including over the counter medications, supplements and vitamins (may use another form if needed)

Medication	Dose	Frequency	Medication	Dose	Frequency

First Initial: _____ *Last Name:* _____

continued

Blood Thinners (Anticoagulants) Check all medications that you are currently taking ☐ Not on any blood thinners

☐ Aggrenox ☐ Coumadin (Warfarin) ☐ Effient ☐ Eliquis
☐ Lovenox ☐ Plavix ☐ Pradaxa ☐ Xarelto
☐ Other: _____

Drug Allergies ☐ No known drug allergies

Medication	Reaction

Are you allergic to any of the following?

☐ Betadine/Iodine ☐ Latex ☐ IV Contrast and/or Dye ☐ Shellfish ☐ Tape

Past Surgical History ☐ I have not had any surgical procedures

Abdominal Surgery:
☐ Appendectomy
☐ Gallbladder Removal
☐ Other: _____

Female Surgeries
☐ Caesarean Section
☐ Hysterectomy
☐ Laparoscopy
☐ Ovarian

Heart Surgery
☐ Aneurysm Repair
☐ Coronary Bypass
☐ Stent Placement
☐ Valve Replacement
☐ Other: _____

Joint Surgery
☐ Hip
☐ Knee
☐ Shoulder
☐ Other: _____

Spine/Back Surgery
☐ Discectomy (levels) _____
☐ Laminectomy _____
☐ Spinal Fusion (levels) _____
☐ Other: _____

Other Common Surgeries
☐ Hemorrhoid Surgery
☐ Hernia Repair
☐ Thyroidectomy
☐ Tonsillectomy
☐ Vascular Surgery

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

_____

Family History ☐ I have no significant family medical history ☐ I am adopted and no medical history is available

☐ Anxiety/Depression ☐ Heart Disease/Stroke ☐ Liver Problems
☐ Arthritis ☐ Headaches ☐ Rheumatoid Arthritis
☐ Cancer ☐ High Blood Pressure ☐ Seizures
☐ Diabetes ☐ Kidney Problems ☐ Substance Abuse

Social History

Alcohol Use: ☐ Never ☐ Social Alcohol Use ☐ Daily ☐ History of Alcoholism

Smoker or Tobacco Use: ☐ Never ☐ Occasional ☐ Current User ☐ Former User

Drug Use: ☐ I have never used any drugs illegally

☐ I am currently using illegal drugs, list: _____

☐ I am currently using someone else's prescription medications, list _____

☐ I formerly used illegal drugs (not currently using), list _____

☐ I have abused narcotic or prescription medications in the past, list _____

_____

☐ I have been treated in a Detox program _____

Review of Systems

Constitutional/Systemic:

☐ Chills/Night Sweats
☐ Difficulty Sleeping
☐ Easy Bruising
☐ Fevers
☐ Weight Loss
☐ Weight Gain

Eyes/Ears/Nose/Throat/Neck:

☐ Allergies/Runny Nose
☐ Difficulty Hearing
☐ Earaches/Ringing
☐ Nosebleeds
☐ Recent Visual Changes
☐ Recurrent Sore Throats
☐ Sinus Problems

Endocrine:

☐ Fatigue/Low Energy
☐ Heat/Cold Intolerance
☐ Increased Thirst
☐ Low Libido

Cardiorespiratory:

☐ Chest Pain
☐ Edema/Swelling in the Feet
☐ High Blood Pressure
☐ Lightheadedness
☐ Palpitations
☐ Shortness of Breath

Gastrointestinal:

☐ Constipation
☐ Diarrhea
☐ Nausea/Vomiting
☐ Reflux

Genitourinary/Nephrology:

☐ Frequent Urination
☐ Incontinence
☐ Painful Urination
☐ Pelvic Pain

Neurological:

☐ Dizziness
☐ Headaches
☐ Imbalance
☐ Loss of Memory
☐ Numbness/Tingling
☐ Seizures
☐ Weakness

Psychiatric:

☐ Anxiety/Stress
☐ Depressed Mood
☐ Hallucinations
☐ Suicidal Planning
☐ Suicidal Thoughts

SPINE & PAIN ASSOCIATES, PLLC.

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION
REVISED 5.14.18

INTRODUCTION
I have had the opportunity to read Spine & Pain Associates, PLLC's HIPAA Notice of Privacy Practices regarding the use and disclosure of protected health information (PHI). I understand that the practice does not need written patient authorization to securely release information related to Treatment, Payment and Operations (TPO). For example, I do not need to provide written permission to release information to a referring physician, insurance carrier or software vendor that is responsible for claims processing.

I also understand that I have choices regarding the authorization of Spine & Pain Associates, PLLC to release private information to designated individuals when necessary, as in the case of an emergency. For example, I may give the practice permission to release specific information to family members or friends. Details are listed below.

- Should I authorize such release of information, I may specify both the names of the individuals and the information that can/cannot be released.
- My signature is required in order to complete the request.
- Spine & Pain Associates, PLLC may use and disclose my PHI only until the expiration date or event relating to me for the specific purpose of the use or disclosure. This authorization is not a blanket permission to use and disclose PHI for an unlimited time period.
- I understand that PHI used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information. At that point, the PHI may no longer be protected under federal or state confidentiality rules.
- At all times, I retain the right to revoke this authorization to use and disclose PHI. Should I wish to exercise this right, I will submit a written request to the Spine & Pain Associates, PLLC Practice Administrator.
- I understand that Spine & Pain Associates, PLLC may charge a fee for copying the medical records for which I have provided authorization for use and disclosure.

If I choose not to authorize Spine & Pain Associates, PLLC to release my PHI to specific individuals and/or I choose not to sign this form, my decision will in no way affect my treatment, payment, enrollment in a health plan or eligibility for benefits.

PATIENT SIGNED AUTHORIZATION TO USE AND DISCLOSE PHI (PROTECTED HEALTH INFORMATION) TO SPECIFIC INDIVIDUALS

I have read and understand the information regarding the use and disclosure of PHI that is provided in the introduction above. I have received a copy of this form and I am the patient or individual authorized to act on behalf of the patient.

Medical Record Number: (to be filled in by practice) _____
Patient Name: _____Date of Birth: _____
Address: _____
Telephone: Home_____ Cell_____ Work _____

PATIENT AUTHORIZATION TO RELEASE INFORMATION

I, (NAME)_____ hereby authorize Spine & Pain Associates, PLLC to release the following information

- Consult Notes
- Office Visits
- Procedure Notes
- Pathology/Lab Reports
- Radiology Reports

to the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

PATIENT RESTRICTION ON RELEASE OF INFORMATION

I, (NAME)_____do ____ do not ____ authorize release of information related to AIDS, HIV infection, sexually transmitted diseases, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

Patient Name or Name of Individual Authorized to Act on Patient's Behalf:
_____
Printed Name: _____
Signature: _____
Date: _____

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Financial Policies

Thank you for choosing Spine & Pain Associates, PLLC. We are committed to compassionate, personalized care in a professional and confidential environment. We ask that you review and accept our financial policies prior to provision of services.

Instructions: Please review each part of our financial policies, initial each one, and sign at the bottom of the form. Complete the form and bring it with you at the time of your visit.

_____ **Payment Required at Time of Service:** We require payment at the time of service. If you have health insurance and we are an in-network provider with your carrier and plan, we will ask for your co-insurance, co-payment and any unmet deductible, if applicable. If we cannot verify your insurance eligibility, if we are non-network provider or if you do not have insurance, we require either full payment at the time of service or the first payment of a payment plan to which we have agreed. We accept cash, VISA, MasterCard, and Discover. We do not accept personal checks.

_____ **Credit Card on File:** You may provide our office with a valid credit card number and authorization so that we can keep the information on file. We may charge this card for one of two reasons: (1) if there is an unpaid balance remaining on your account 90 days after service that neither you nor your insurance company has paid or (2) if you fail to comply with our policies on cancellations, rescheduling and no-shows as explained below.

Insurance: Spine & Pain Associates, PLLC accepts most major private insurance plans as well as Medicare, Medicaid and TriCare. Our participation as an in-network provider may change over time. Please contact us directly at 919-825-3902 (Raleigh) or 919-292-2468 (Sanford) to find out if we are an in-network provider with your carrier and plan.

- If you have insurance coverage, please remember that your health benefit plan is an arrangement between you and your insurance company. Your individual plan determines benefit coverage details, coverage limits and the company need for prior authorizations and referrals. We are willing to help, but we strongly encourage you to contact a representative of your insurance for answers to questions regarding your insurance benefits.

  Prior to your visit, we will seek to verify eligibility. If valid, we will be happy to file a claim on your behalf. Even when your insurance plan verifies your eligibility and benefits, it does not guarantee the accuracy of the confirmation of coverage of benefits. In some cases, your insurance plan may not cover the services we provide or may determine that some of the services are not medically necessary. Your insurance company's rejection of all or part of your medical insurance claim does not relieve you of your financial obligation to Spine & Pain Associates, PLLC.

- If we cannot verify your eligibility for insurance, if we are a non-network provider or if you do not have health insurance coverage, we will be happy to provide care for you as a self-pay patient. Payment will be due in full at the time of service, or the initial payment of a payment plan will be due at the time of service. By signing our Insurance Coverage Waiver form, you will agree to accept full financial responsibility for the care that we provide. If you file a claim, your insurance company will reimburse you directly.

continued

We offer discounted fees for medical services that we provide to self-pay patients. Please contact our practice manager for additional information.

Each time you come to our office, please bring with you a current insurance ID card and a valid government issued photo identification card (e.g. driver's license, passport).

_____ **Pathology Studies and Laboratory Tests:** Our bills for service do not include imaging studies or laboratory tests. If you receive any of these services, you will receive a separate bill from the facility where the services were performed.

_____ **Referrals:** Some insurance plans require a referral from the patient's primary care physician in order to be seen by a specialist. It is the patient's responsibility to: (1) know if his/ her plan requires a referral; and (2) to obtain a referral, if needed, prior to the visit to our office. If you are uncertain about your plan's requirements, please contact your insurance plan prior to your visit. Patients without a valid referral that meets insurance plan requirements will have the option to pay out-of-pocket for the visit on the day of service or to reschedule the appointment.

_____ **Co-Payments and Co-Insurance Co-payments:** co-payments (a fixed dollar amount that is assigned to the patient) are due at the time of the visit and co-insurance (a percentage of total charges that is the patient's responsibility) may be due at the time of visit. Our contracts with insurance companies obligate us to collect these fees; we cannot waive them or bill them.

_____ **Self-Pay Patients:** Payment is due in full at the time of service for self-pay patients, or the initial payment of a payment plan will be due at the time of service. We offer discounts for many of our medical services for people who pay out-of-pocket. We will discuss the cost of any recommended procedures or services in excess of the basic office visit fee prior to the provision of service.

_____ **Credits and Refunds:** We will return any refunds owed to your insurance plan by check. If there are credits or refunds owed to a patient, we will first apply them to any outstanding balance. Remaining patient credits and refunds can be left on the account to be used towards future charges or can be returned to the patient (or to the responsible party who made payment) by check. Please allow 30-45 days for processing.

_____ **Outstanding Balances:** Spine & Pain Associates, PLLC mails billing statements to patients. Payment for any outstanding balance is due upon receipt. Outstanding balances may result from remaining patient balances after we have billed your insurance company. For example, we will bill insured patients for unmet deductibles, additional co-payments, non-covered services or any other charge related to your visit that the insurance carrier assigns to the patient. We also bill patients penalty fees associated with our policy for cancellations, rescheduling and no-shows. In those instances when a patient has a follow-up visit before receiving a statement for prior amounts owed, we will inform the patient of the outstanding balance and request payment at the time of that follow-up visit.

_____ **Cancellations, Rescheduled Appointments and No-Shows:** We understand that plans change and emergencies arise. Please notify us as soon as possible if you need to cancel or reschedule your appointment. Spine & Pain Associates, PLLC has a 24-hour cancellation policy. If you fail to notify us of a cancellation or wish to reschedule an appointment within 24 hours prior to your scheduled appointment or you miss an appointment, we may charge a penalty fee of $25 for office visits and $50 for medical procedures. The penalties may apply regardless of whether or not you receive a courtesy reminder call or text message reminder from our office.

continued

_____ **Responsible Party:** When a patient is less than 18 years of age, the parent or guardian who signs the Spine & Pain Associates, PLLC, Patient Registration Form is responsible for all fees incurred by the minor. When a patient turns 18 or older, he/she becomes responsible for his/her account and financial obligations. If a parent prefers to assume complete financial responsibility for an adult offspring, Spine & Pain Associates, PLLC must receive notification in writing.

_____ **Method of Payment:** Spine & Pain Associates, PLLC accepts cash, VISA, MasterCard, and Discover. Payments may be made in person, by mail, or by phone.

_____ **Collections:** If you have an outstanding balance that requires special arrangements, please contact our Practice Manager at 919-825-3902 (Raleigh) or 919-292-2468 (Sanford) for assistance. It is our sincere desire to help you meet your financial obligations without being sent to collections. Outstanding balances that are not paid within 90 days will be sent to a collections agency. Once a patient's account is sent to collections he/she is responsible for the outstanding balance on the account in addition to a Collections Fee of 35% of the outstanding balance plus any interest, service fees and/or legal fees that accrue while the account is in collections.

Fee Information

Copying Medical Records (in North Carolina)

Pages 1 - 25	$0.75 per page
Pages 26 - 100	$0.50 per page
Pages 100+	$0.25 per page
Minimum charge	$10.00

Electronic Copy of Designated Record Set within Medical Records Requested Under HIPAA: $6.50

Failure to Cancel Appointment within 48 Hours:

Routine office visit	$25.00
Medical procedure	$50.00

Completion of forms unrelated to those required by contracted health insurance: $50

Patient Authorization: My initials above and my signature below signify that I understand and agree to the policies above.

_____ _____

Patient/Guardian Signature Date

_____

Patient/Guardian Printed Name

No-Show Policy

Quality care for our patients is our priority. Please take a few minutes to review our no-show policy and sign at the bottom of the form. If you have any questions please let us know.

Definition of a "No-Show" Appointment

Spine & Pain Associates defines a "No-Show" appointment as any scheduled appointment in which the patient either:

- Does not arrive to the appointment
- Cancels with less than 24 hour's notice
- Arrives more than 15 minutes late and is consequently unable to be seen

Impact of a "No-Show" Appointment

"No-Show" appointments have a significant negative impact on our practice and the healthcare we provide our patients. When a patient "no-shows" a scheduled appointment it:

- Potentially jeopardizes the health of the "no-showing" patient
- Is unfair (and frustrating) to other patients that would have taken the appointment slot
- Disrespects not only the provider's time, but also the time of the entire clinic staff

How to Avoid Getting a "No-Show"

1. **Confirm** your appointment
2. **Arrive** 5-10 minutes early
3. **Give 24 hours'** notice to cancel appointment

1. Appointment Confirmation

Spine & Pain Associates will attempt to contact you two business days before your scheduled appointment to confirm your visit. If we are unable to speak with you and have to leave a message, you will be expected to contact our office to confirm your appointment.

2. Always Arrive 5-10 Minutes Early

When you schedule an office visit with us, we expect you to arrive at our practice 5-10 minutes prior to your scheduled visit. This allows time for you and our staff to address any insurance or billing questions and or to complete any necessary paperwork before the scheduled appointment time.

3. Give 24 Hours' Notice if You Need to Cancel

When you need to cancel or rebook a scheduled visit, we expect you to contact our office at least 24 hours before the scheduled visit. This allows us a reasonable amount of time to determine the most appropriate way to reschedule your care as well as giving us the opportunity to rebook the now vacant appointment slot with another patient. If it is less than 24 hours before your appointment and something comes up, please give us the courtesy of a phone call.

Consequences of "No-Show" Appointments

If you miss 2 or more appointments with Spine & Pain Associates you will be charged a $25.00 "No-Show" fee for office visits and $50.00 "No-Show" fee for procedures.

I have read and understood the Spine & Pain Associates "No-Show" Policy as described above.

_____ _____

Patient Signature Date