

Patient Information



**Michael Najjar, MD**  
Board Certified Pain Management  
Board Certified Anesthesiology

Name: \_\_\_\_\_

SS # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Marital Status (S/M/D/W/Sep) \_\_\_\_\_ Sex \_\_\_\_\_ Religion (Optional) \_\_\_\_\_

Street Address \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ How long? \_\_\_\_\_

Employer's Address \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_

Business # \_\_\_\_\_ If unemployed, for how long? \_\_\_\_\_

\*\*\*\*\*

Is patient covered under spouse's insurance plan? \_\_\_\_\_ If yes, please complete the following:

Insurance Carrier \_\_\_\_\_ Group ID \_\_\_\_\_ Policy # \_\_\_\_\_

Spouse's Name \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_

Address (if different) \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Occupation \_\_\_\_\_ How Long? \_\_\_\_\_

Employer's Address \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_

Business # \_\_\_\_\_

\*\*\*\*\*

Person to contact in an emergency:

Name: \_\_\_\_\_ Address \_\_\_\_\_

Home # \_\_\_\_\_ Business # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Pharmacy Name \_\_\_\_\_ Phone # \_\_\_\_\_

Medications Currently Taking: \_\_\_\_\_

Drug Allergies \_\_\_\_\_

Has any member of your family been treated by the doctor before? \_\_\_\_\_

If so, name of family member: \_\_\_\_\_



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**Authorization for Release of Information**

I, \_\_\_\_\_, authorize Advanced Pain Care to RELEASE medical and psychological information pertaining to me to:

- Any referring or consulting physician
- Appropriate Rehabilitation Nurse/Caseworker
- Appropriate Hospital/Clinic
- Appropriate Imaging Center

I further authorize Advanced Pain Care to OBTAIN medical and psychological information pertaining to me from:

- Any referring or consulting physician
- Appropriate Rehabilitation Nurse/Caseworker
- Appropriate Hospital/Clinic
- Appropriate Imaging Facility

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Date

**Assignment of Benefits**

I hereby assign all Medical and/or Surgical benefits. These include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to: Advanced Pain Care, P.C.

This assignment will remain in effect until revoked by me in writing. A photocopy or scanned image of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I hereby authorize Advanced Pain Care, P.C., to release all information necessary to secure payment.

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Date

**Prescription Refill Policy**

Due to the high volume of request, we will only be able to honor future refill request during the office visit. Lost or stolen medications or prescriptions will not be refilled. Our office does not prescribe opioids except in certain instances involving cancer pain patients.

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Date

**Patient Consent for Physician to Use or Disclose Health Care Information for  
Treatment, Payment and Health Care Operations**

Patient's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

SSN: \_\_\_\_\_

I understand that my health information is private and confidential. I understand that **Michael Najjar, M.D.** works very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand the signing of this document means that **Michael Najjar, M.D.** may use and disclose my personal health information to help provide health care to me, to handle billing and payment, and to take care of other health care operations. Failure to sign this consent may result in the physician declining to treat me.

**Michael Najjar, M.D.** has a detailed document called the 'Notice of Privacy Practices'. It contains more information about the policies and practices used to protect the patient's privacy. I understand that I have the right to read the 'Notice' before signing this agreement.

**Michael Najjar, M.D.** may update this 'Notice of Privacy Practices'. If I ask, **Michael Najjar, M.D.** will provide me with the most current 'Notice of Privacy Practices'.

Under the terms of this consent, I can ask **Michael Najjar, M.D.** to restrict how my personal health information is used or disclosed to carry out treatment, payment, or health care operations. I understand that **Michael Najjar, M.D.** does not have to agree to my request. If **Michael Najjar, M.D.** does agree to my request, I understand that **Michael Najjar, M.D.** would follow the agreed limits.

I understand that I have the right to cancel this consent, in writing, at anytime. If I do cancel the consent, I understand that **Michael Najjar, M.D.** may have already used or disclosed information about me and canceling this consent would not affect the information already used or disclosed.

I may cancel this consent at any time by writing, signing, and dating a letter **to Michael Najjar, M.D.** If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of my personal health information for treatment, payment, and health care operations.

I understand if I cancel this consent, **Michael Najjar, M.D.** does not have to provide any further health care services to me.

My signature below indicates that I have been given the chance to review a current copy of **Michael Najjar, M.D.**'s "Notice of Privacy Practices".

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

**If the patient refuses to sign, indicate your attempt to obtain a signature below.**

[ ] Patient refused to sign this Acknowledgement.

Date: \_\_\_\_\_

Time: \_\_\_\_\_

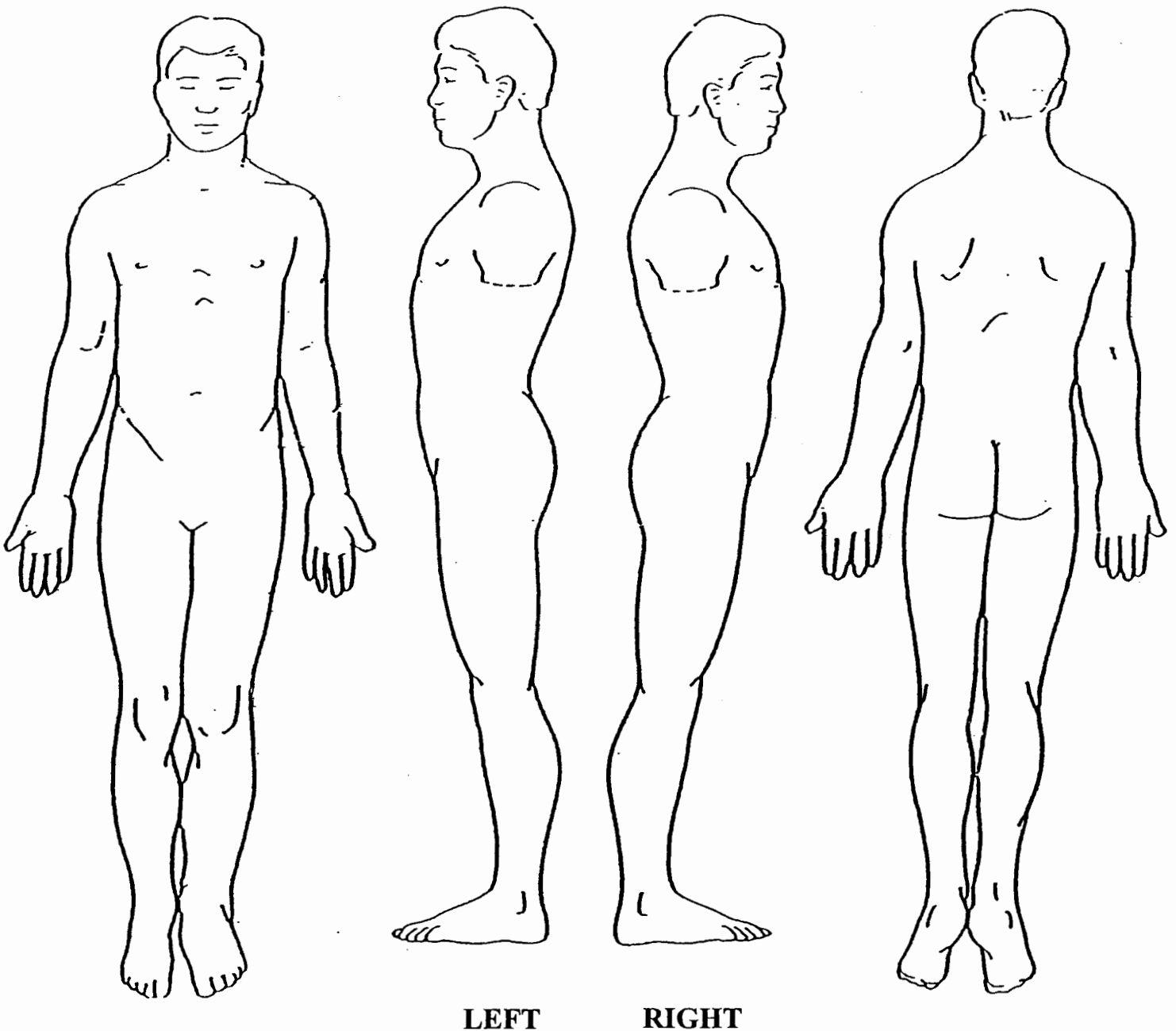
Employee Name: \_\_\_\_\_

NAME \_\_\_\_\_

## PAIN LOCATION

Mark on the drawing the exact spot where your pain is with a solid black dot (●). If the pain starts at that spot and radiates elsewhere (travels to another part of your body), draw a line from the spot where it starts to where it ends. If it is a whole area that hurts, shade in that area with a pencil.

Next to the places on the drawing where you showed pain, put an "E" if the pain is external (on the outside surface). If the pain is internal (inside the body) mark it with an "I". If the pain is both internal and external, mark "EI".





## REVIEW OF SYSTEMS

Are you currently or have you in the past had problems with:

Constitutional			Eyes		
Fever	Yes	No	Injuries	Yes	No
Weight Loss	Yes	No	Glaucoma	Yes	No
Fatigue	Yes	No	Cataracts	Yes	No
Ears, Nose, Throat and Mouth			Heart		
Hearing Loss	Yes	No	Chest Pain	Yes	No
Ear Pain	Yes	No	High Blood Pressure	Yes	No
Ringing in Ear	Yes	No	Leg Pain when walking	Yes	No
Balance Problems	Yes	No			
Nosebleeds	Yes	No	Gastrointestinal		
Inability to smell	Yes	No	Nausea/Vomiting	Yes	No
			Blood in Vomit	Yes	No
Respiratory			Liver disease	Yes	No
Asthma	Yes	No	Jaundice	Yes	No
Emphysema	Yes	No	Abdominal Pain	Yes	No
Shortness of Breath	Yes	No	Ulcers	Yes	No
Bronchitis	Yes	No	Colon cancer	Yes	No
Pneumonia	Yes	No			
Lung cancer	Yes	No	Musculoskeletal		
Last chest x-ray date:			Arm or leg weakness/pain	Yes	No
			Arthritis	Yes	No
Genitourinary			Skin		
Bladder infection	Yes	No	Skin cancer	Yes	No
Blood in urine	Yes	No	Breast disorder	Yes	No
Trouble starting/stopping Urine stream	Yes	No	Last mammogram date:		
Incontinence	Yes	No			
Prostate cancer	Yes	No			
Uterine/cervical cancer	Yes	No	Blood Disorder		
			Anemia	Yes	No
			Currently taking Coumadin Or Plavix	Yes	No
Neurological			Endocrine		
Blackout spells	Yes	No	Diabetes	Yes	No
Seizures	Yes	No	Thyroid problems	Yes	No
Speech difficulty	Yes	No	Excessive thirst/urination	Yes	No
Double/Blurred vision	Yes	No	Hormone problems	Yes	No
Facial weakness	Yes	No			

The above information is accurate to the best of my knowledge.

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_

I have reviewed the information with the patient.

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_



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## Treatment Philosophy

*As a participant in Advanced Pain Care's Program, I agree to the following:*

- 1. I understand that I am not seeking a "cure" for my pain; rather I will be provided with methods to cope more effectively with my pain and to live more productively.*
- 2. I understand that Advanced Pain Care's management team does not take overall responsibility for my health care, not do they substitute for my family doctor except in the case of an emergency.*
- 3. I understand that the main goal of my treatment program is to:*
  - Increase my activity;*
  - Reduce pain and pain behavior;*
  - Emphasize my abilities rather than my disabilities;*
  - Work to be a contributing member of my family and society, (including returning to employment where possible).*
- 4. I understand that part of the program will help me reduce my dependence on medications, health-care professionals, the emergency room, and my family. I will voluntarily and actively work with Advanced Pain Care to accomplish these goals.*
- 5. I agree to perform activities at the rate that will be determined by the Advanced Pain Care management team and myself.*
- 6. I understand that I must take responsibility for the required activities of the program and that I may be discharged from the treatment program if I do not adhere to these guidelines.*
- 7. I understand that my spouse's/significant other's involvement is essential to the success of the program; I will encourage their participation in the program.*
- 8. I agree to have a photograph taken to be kept in my file. This is for identification purposes only and will not be released by Advanced Pain Care except with my written permission.*

## **INSURANCE FACTS AND PAYMENT POLICIES**

To all our patients:

Medical insurance is confusing for all of us. Here are some medical insurance facts to assist you:

- Even with two or more insurance plans, there may be amounts or services not covered for which you may be directly responsible.
- Many insurance plans have patient cost-sharing – they are called deductibles and co-payments.
- Many insurance plans designate 80% coverage. This set amount is usually lower than our current fee. The patient portion of payment will be whatever insurance does not cover.
- “Assignment” simply means the patient requests insurance payments to be made directly to the physician. The patient is still responsible for the balance.

Everyone is trying to hold down health insurance premiums. Accept that insurance plans will contain more limitations and exclusions to coverage – your out-of-pocket costs for medical care will be higher. For example:

- Patient deductibles are higher: \$500 to \$1,000 per year is not unusual.
- Your insurance may limit the number of visits covered or how frequently a service is covered. You may now be paying for services that were covered last year.
- Your insurance could specify that certain medical problems must be present for a service to be covered; if not, there may be no coverage and you may be responsible for payment.
- Your insurance could have “annual maximums,” which are caps on payable amounts per year. Beyond that cap, you may be expected to pay the balance.

Our practice strives to hold down the cost of patient care. Our fees are comparable and often less than others in our specialty in our community. We will always discuss with you the fees for a particular service. If you ever have a question about your bill or need help with your insurance forms, please ask Anne, the office’s financial advisor. If you wish us to file your insurance for you, please assist us by bringing you insurance card(s) with you to your appointment.

### **Medicare**

Our office participates in the Medicare program. If Medicare Part B covers you, you should be prepared to pay your co-pay at the time of service. If you have a secondary policy, there will be no requirement for payment at the time of service unless you have not met your deductible.

### **Medicaid**

Our office participates in the Medicaid program. If you are a GBHC recipient, we must have a referral number from your primary care physician before you can be seen. Georgia law requires you to have a current eligibility slip. If you do not have a current eligibility slip, you will be responsible to pay for your services, in full, or we must reschedule your appointment for a time when you will have your slip. If your slip shows “yes” under co-pay, you will be required to pay \$2.00 at the time of service.

### **Blue Cross/Blue Shield**

Our office is a participant with regular Blue Cross coverage. However, we do not participate with any Blue Cross PPO or HMO plans. You will be required to pay any co-pays or co-insurance at the time of service.

### **State Health Benefits**

Our office is a participating member of State Health Benefits. You will be required to pay the 10% or 20% co-insurance at the time of service.

### **Auto Insurance**

If you have been involved in an automobile accident, you must be prepared to pay for your services in full, even if you feel your insurance will be paying for medical expenses. On the average, it takes auto insurance companies six months to a year to settle medical claims and we are unable to carry an unpaid balance for that length of time. If you are making a medical claim against the policy of another driver, you are still required to pay at the time of service. You will be provided with a receipt that you can use for reimbursement from your auto insurance carrier.

### **Worker's Compensation**

If you are covered by Worker's Compensation, we must have authorization from your employer or insurance adjuster to treat you. It is important for us to have the correct injury date. If your employer or their carrier disputes your claim, you may be responsible for your entire bill.

### **Self Payment**

If you do not have insurance or if we are not able to verify your coverage, you are considered "self-pay." Projected payment is due, in full; at the time service is rendered. You will be billed for any additional charges.

### **Insurance Claim Filing**

We are happy to file your claims for you and will do so within a few days following each visit. Once payment has been received, we will credit your account. If your payment and the payment of your carrier create a credit, we will send you a refund. Due to the problems we have with secondary insurance carriers not paying in a timely fashion and/or requiring multiple filings before paying, we will only file to your secondary carrier once per service. The balance on your account following payment from your primary carrier is due in full from you.

### **Delinquent Accounts**

All accounts over 120 days old will be turned over to a collection agency.

*We do not wish to cause embarrassment or hardship to any patients. Nor do we want patients to face unpleasant financial hardships such as unexpected out-of-pocket costs for medical care. Please let us know immediately if you have a financial questions or problem.*

For additional information, or if you have any questions, please contact Britney Smith, at 706-226-7585.