



PAIN MANAGEMENT SERVICES REFERRAL FORM

4515 Southlake Pkwy, Suite 200, Hoover, AL 35244 Phone 205.313.7246 Fax 205.939.1911

Date: _____

Referring Physician: _____ Contact Person: _____

Address _____ Phone: _____ Fax: _____

Address _____ Email: _____

Does the referring physician plan to continue medical pain management care for this patient? Yes No

Patient Name: _____ DOB: _____ SSN _____

Home Phone: _____ Work/Cell Phone: _____ Diagnosis: _____

Relevant Medical Records required: Check each box as you attach copies to fax or email:

Ins Co: _____ Last 2-3 Office Visit Notes (Treatment for pain)
Name of Insured: _____ Demographic Information
Policy #: _____ MRI and/or X-Ray reports if available
Group #: _____ Insurance Card

Pain Management Services: (Note: All Interventional Procedures are image guided.)

- 1 [] 1st Available [] R. Daniel Chang, M.D. [] Nitin Chhabra, M.D. [] Michael Gibson, MD
2 [] Pain Management Consult Only or [] Complete Transfer of Pain Management Care
3 [] Procedure Only Which procedure? _____ or [] TBD by the BPC M.D.

Psychological Services: Jay Heisler, Ph.D.

[] Counseling/Psychotherapy: [] Screening/Clearance for: _____
[] General/Comprehensive Psychological Evaluation: [] Other (specify): _____

Patient Sections: (Signature at bottom validates the Medical Records Consent, to process referral more quickly.)

Answer each question honestly, explain "yes" answers. ("Yes" does NOT rule out approval, but dishonesty will.)

- 1 Have you ever experienced injury from an accident, while at work, or personal? If yes, date of injury: _____
2 Are you now or have you ever been involved in litigation (law suit) about a medical condition? [] Yes [] No
3 Do you plan to be involved in litigation about a current or past medical condition? [] Yes [] No
4 Are you being treated for a Work Related Injury, whether case has settled or not, or if there is open medical coverage? [] Yes [] No
5 Are you, or have you ever been, a patient in a Methadone or Suboxone Clinic? [] Yes [] No
6 Have you ever been diagnosed with Fibromyalgia? [] Yes [] No
7 Have you ever been dismissed by another Pain Clinic or Pain Doctor? [] Yes [] No
Which clinic or pain doctor? _____
8 Are you being treated for, or do you have a history of substance abuse or addiction? [] Yes [] No
9 Are you currently in a TASC program? [] Yes [] No

Financial Policies: We want to make you aware of the following policies. Please initial each box after reading.

[] NO-KNOW FEES: The BPC will charge me for missed appointments unless I call MORE than 24 hours in advance to reschedule my appointment. Office Visits = \$35 Procedure Apts = \$100. These fees are not covered by insurance but will be billed directly to me.
[] Non-covered Services Statement: I understand that services I receive from The BPC are performed when felt necessary for maintenance of my good health and that some services may not be covered by my insurance. I will be responsible for payment in full of all such non-covered services. The BPC will tell me the service and the charges when possible at or before the time of service, but I am still responsible to pay even if not alerted, except when covered by Medicare where an ABN is required.
[] Medical Records Consent: I authorize The BPC to collect health records pertaining to my past or current health-care, including any and all health record(s), discharge summary, results and reports, images in any format, etc., from any source associated with my care, and I give permission to all sources to release information pertaining to my care to The BPC.

Signature: _____ Date: _____