PAIN MANAGEMENT SERVICES REFERRAL FORM

THE BIRMINGHAM PAIN CENTER

7500 Hugh Daniel Drive, Suite 300, Birmingham, AL 35242 Phone 205-313-PAIN (7246) Fax 205/939-1911

Date: _____

Referring Physician: _____ Contact Person: _____

Address _____ Phone: _____ Fax: _____

Address _____ Email: _____

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

Patient Name: _____ DOB: _____ SSN#: _____

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

Relevant Medical Records required:

Ins Co: _____

Name of Insured: _____

Policy #: _____

Group #: _____

Check each box as you attach copies to fax or email:

☐ Last 4-5 Office Visit Notes (Treatment for pain)

☐ Demographic Information

☐ MRI and/or X-ray reports if available

☐ Insurance Card

Pain Management Services:

(Note: All Interventional Procedures are fluoroscopically guided.)

1 ☐ **1st Available** ☐ **Michael Gibson, M.D.** ☐ **Nitin Chhabra, M.D.**

2 ☐ Pain Management Consult Only **OR** ☐ Complete Transfer of Pain Mgmt Care

3 ☐ Procedure Only: What kind of 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 paperwork 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 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? Which clinic or pain doctor?	☐ Yes	☐ No
8	Are you being treated for, or do you have a history of **substance abuse or addiction**?	☐ Yes	☐ No

Financial Policies:

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

☐ **No-Show 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 Appts = $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:** _____