Appalachian Regional Pain Management Center

336 Deerfield Road | Boone, NC
Located inside Watauga Medical Center
(828) 265-5493 | Fax (828) 266-1176
apprhs.org

Welcome to the Appalachian Regional Pain Management Center! Thank you for choosing Appalachian Regional Pain Management Center at Appalachian Regional Healthcare System for your pain management needs. We are dedicated to providing excellent clinical care, exceptional customer service and a patient centered approach which will help you to reach the best outcomes possible.

When pain interferes with your quality of life, Appalachian Regional Pain Management Center can help. We will create a comprehensive treatment plan for each patient. When appropriate, referrals will be made for clinical specialties such as physical rehabilitation and behavioral health. Throughout the entire treatment process, we will communicate your progress to the referring provider. As you near the end of your treatment plan, we will ensure that each patient has the information and instructions necessary to manage their condition.

Appalachian Regional Pain Management Center offers the following services:

- Diagnostic pain
- Epidural steroid injections
  - Cervical interlaminar
  - Lumbar, both interlaminar and transforaminal as well as caudal
  - Thoracic
- Lumbar, thoracic, and cervical medial branch or facet joint blocks
- Occipital nerve injections
- Pain medication management
- Peripheral nerve blocks
- Radiofrequency ablation of medial branches for facet joint pain
- Sacroiliac injections
- Spinal Cord Stimulator trials
- Sympathetic chain blocks
- Trigger point injections

Accepting new patients by referral only from all health care providers. Please take a moment to acquaint yourself with our center's policies and contact information for you to keep for your records. Additionally, we've enclosed forms you will need to complete and bring with you to your first visit. For your first appointment, please arrive 15 minutes early.

Our office is available to you by phone from 8:00 a.m. - 4:00 p.m. Monday - Friday at (828) 265-5493. If you have any questions, please contact our office. Our staff is committed to helping you reach your goals and providing you with the best experience possible! We look forward to getting to know you.

Please note: Patients at Appalachian Regional Pain Management Center may receive one or two separate bills depending on which provider they see. Regarding any billing questions from Watauga Anesthesia Associates providers, please contact their office at 828 264-4691.

New Patient Checklist:

- ☐ Insurance Card
- ☐ Pharmacy Information
- ☐ Payment / Co-Pay
- ☐ Current Medications
- ☐ Questions for provider
- ☐ Completed Forms
- ☐ Photo ID
- ☐ Medical Records

_____
has an appointment with

_____

☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri.

_____date _____a.m./p.m.

To reschedule your appointment, please call (828) 265-5493.

Financial Information

Thank you for choosing an Appalachian Regional Healthcare System (ARHS) Facility for your care. Our mission is to support the provision of high quality, compassionate healthcare for the mountain region of northwest North Carolina and northeast Tennessee with a spirit of teamwork based on a set of operating values.

We understand medical bills are often unplanned and can be difficult to understand or pay. ARHS has Patient Financial Advocates who can help. Our Patient Financial Advocates are professionally trained to assist with your financial questions. Please do not hesitate to ask for them while you are here or, if you prefer, you can call them at (828)-262-4413.

ARHS offers several options to help you resolve your account balances. We accept Visa, Mastercard, Discover, cash or checks.

- Set up a payment plan: 0% interest for 12-24 months, with approval
- Apply for a healthcare credit card: for long-term loans
- Apply for financial assistance: contact us 828-262-4413
- Government and community programs: our Patient Financial Advocates can help you determine if you qualify.

As a courtesy to you, ARHS will bill all your insurance providers, as long as you give us all the necessary information.

You are responsible for any portion of your charges remaining unpaid by your insurance company, this includes non-covered services, co-insurance, co payments and deductibles. If your insurance does not pay within 90 days, you will be billed for the full balance. If you feel that your insurance company should have paid your bill, you should contact your insurance company or our customer service center at (828)262-4111.

Before getting care from ARHS, you should find out if your carrier is in- or out-of-network with us and if they have any exclusions, benefits, co-insurance, co-payment and deductibles outlined in your plan.

According to our policy, you may have to pay the full patient responsibility or a deposit representing an estimate of 30% of patient responsibility before leaving the hospital or practice or upon scheduling of services.

You may also be responsible for services rendered by other providers. These may include physicians, anesthesiologists, radiologists and pathologists. We will share your billing information with those providers so that they can file with your insurance company directly.

Financial Assistance is available to those patients who are in need of help to pay their account. Assistance is based on the responsible party's financial status. In order to determine this, the responsible party will need to complete a Financial Assistance application that includes, but is not limited to, proof of income and assets. Please contact a Patient Financial Advocate to complete a Financial Assistance Application, 828-262-4413 or 828-262-4110.

Notice of Privacy Practices

How We May Use Your Health Information:

For Treatment: We may use your health information to provide, coordinate or manage your medical treatment or related services. Information obtained by a nurse, physician, or other member of your health care team will be recorded in your medical record and used to determine the course of treatment for you.

For Payment: We may use and disclose your health information to bill and collect payment for treatment and services that you receive from us or from other health care providers.

For Health Care Operations: We may use and disclose health information about you for health care operations.

To the Hospital Directory: Unless you tell us otherwise, we may include limited information about you in the hospital directory while you are a patient there. The directory information (name, location, and general condition as fair, stable, etc.) will only be released to people who ask for you by name.

To Individuals Involved in Your Care or Payment for Your Care: We may share information about your care or condition with an authorized representative, a family member, or another person identified by you or who is involved in your care or payment for your care, but we will only share information relevant to their involvement.

For Activities: We may share certain health information with the Appalachian Regional Healthcare Foundation so that the Foundation may contact you about ARHS's fundraising efforts. We will only release limited information.

Other Disclosures: Incidental disclosures of your health information may take place in the health care setting and are allowed by law.

Request to inspect and obtain a copy of your health record:
Your health information is contained in records that are the physical property of ARHS. You have the right to request to inspect and obtain a copy of your health information and billing records by submitting a request in writing to the Health Information Management Department.

The above information is an abbreviated version of the Appalachian Regional Healthcare System's Notice of Privacy Practices and Billing & Insurance information. For the complete information or the Patient Bill of Rights & Responsibilities please ask the receptionist or visit apprhs.org.

APPALACHIAN REGIONAL
PAIN MANAGEMENT CENTER
Watauga Medical Center

Patient Name_____
Date of Birth_____
Account Number_____
Please Fill in or Affix a Patient Label

NAME: _____
Last First Middle Initial

PHONE: _____
Home Work Cell

REFERRED BY:
_____ _____
Name of Referring Physician Specialty

_____ _____
Phone Location

_____ _____
Name of Family Physician Location

Your Signature: _____ Date / Time: _____

Reviewed: _____ MD Date/ Time: _____

HISTORY OF PRESENT ILLNESS

1. **When did you first notice your pain?** _____

2. **Under what circumstances did your pain begin (Check one)**
   - ☐ Accident at work
   - ☐ Accident at home
   - ☐ At work, but not an accident
   - ☐ Pain just began, no reason
   - ☐ Motor vehicle crash
   - ☐ Following surgery
   - ☐ Following injury
   - ☐ Other (describe)

3. **If pain began at work, please list.**
   Place of employment when injury began: _____ Date: _____
   How long had you been employed there? _____ Type of work _____

4. **Are you now bringing a lawsuit because of your pain?** ☐ YES ☐ NO

5. **When did you first see a doctor for the pain you now have?** _____
   Doctor _____ Location _____
   Have you been hospitalized or had surgery for your pain? ☐ YES ☐ NO

6. **Have you been to any other pain clinic?** ☐ YES ☐ NO
   If so, when & where: _____

7. **Have you had nerve blocks or injections for pain relief?** ☐ YES ☐ NO
   If yes, did they relieve pain? ☐ YES ☐ NO
   If yes, how long did you get relief:
   ☐ less than one day ☐ A few days ☐ A few weeks ☐ More than one month

8. **Have you had these treatments for pain?-please check**
   ☐ Chiropractic Manipulation ☐ Physical Therapy

9. **Since your pain began, has it:** ☐ Increased ☐ Decreased ☐ Stayed the same

10. **Would you describe your pain as:** ☐ Burning ☐ Shooting ☐ Comes & goes ☐ Sharp ☐ Stabbing
    ☐ Aching ☐ Electric ☐ Dull Ache ☐ Throbbing ☐ Constant

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Revised Date: 03/13/2020
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11. **Do you have:** ☐ Numbness ☐ Tingling, pins and needles ☐ Weakness ☐ Coldness ☐ Increased Sweating ☐ Muscle Spasm, Tightness ☐ Skin Discoloration ☐ Bowel or Bladder

12. **Do you sleep well?** ☐ YES ☐ NO

13. **Is your pain better in the:** ☐ Morning ☐ Afternoon ☐ Evening/ Night

14. **What can you do that makes your pain better?** _____

15. **What activity makes your pain worse?** _____

PAST MEDICAL HISTORY

1. **Please list major illnesses and operations**

_____

_____

_____

_____

_____

_____

2. **Review of Systems**

Have you had any recent problem with your:

Brain: _____

Heart: _____

Lungs: _____

Stomach: _____

Kidneys: _____

Bones: _____

Skin: _____

Eyes: _____

Ears: _____

Mouth/ Throat: _____

Muscles: _____

PERSONAL HISTORY

1. Occupation: _____
2. Place of Employment: _____
3. If not working, how long since you have been able to work? _____
4. Whom should we contact in the event you develop a medical emergency (name, phone number, and relation to you): _____

_____

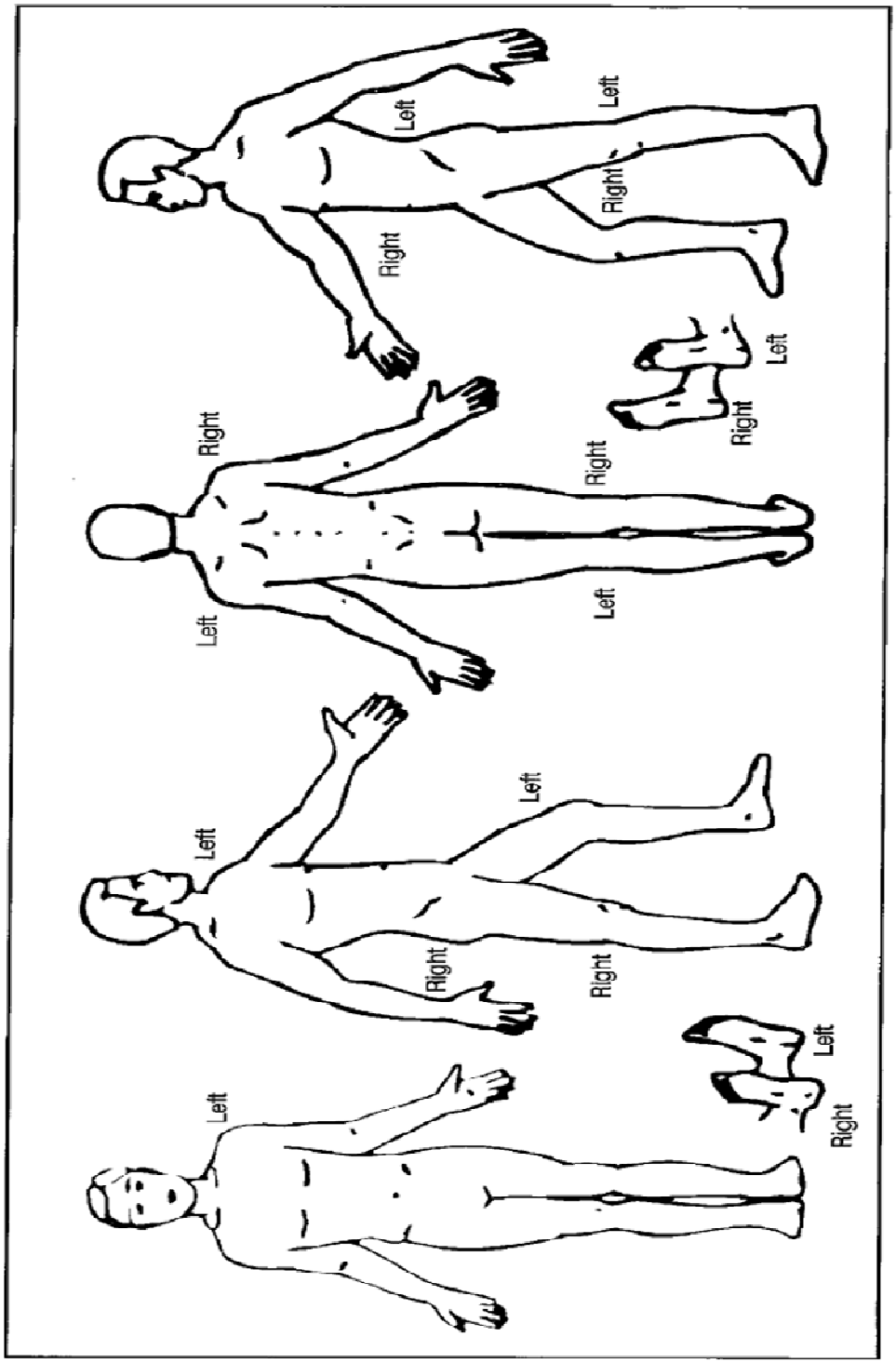
APPALACHIAN REGIONAL
PAIN MANAGEMENT CENTER
Watauga Medical Center

Patient Name_____
Date of Birth_____
Account Number_____
Please Fill in or Affix a Patient Label

Patient information (cont.)

Height_____ Weight_____

Mark the areas of your body where you currently feel pain



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APPALACHIAN REGIONAL PAIN MANAGEMENT CENTER of WATAUGA MEDICAL CENTER	Patient Name_____ Date of Birth_____ Account Number_____ Please Fill in or Affix a Patient Label

Medication List

Date: _____

Allergies: _____

_____

_____

Medications	Dosage

Signature of Patient/ Legal Representative ▶	Date: Time:
Name of Patient/ Legal Representative *(Please Print)* ▶	Relationship of Legal Representative ▶
Signature of Witness ▶	Date: Time:

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