Coastal Bend Pain Management

Jason B Baney, FNP-C
Family Nurse Practitioner
Board Certified
by the American Academy of
Nurse Practitioners

Michael E. Tschickardt, M.D.
Medical Director
Board Certified in Pain Medicine
by the American Board of Anesthesiology
Fellowship Trained in Pain Medicine

Madeline Benavidez, FNP-C
Family Nurse Practitioner
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Dear _____,

Welcome to Coastal Bend Pain Management! I am pleased you have been referred to my office for your pain management care. My team-members and I look forward to meeting you in the near future!

Pain Management is the understanding of pain sensation, identifying the cause of your pain, and finally providing treatment options and/or lifestyle changes to help control your pain. I use a multidisciplinary approach and an experienced team to assist you in overcoming and controlling your pain. When needed, I can call upon a team of medical doctors, surgeons, physical medicine or rehab physicians, psychologists, anesthesiologists, registered nurses, and medical assistants to treat you, our patient.

Please complete your entire packet prior to your appointment. At the time of your appointment, we will collect your completed packet and will need a copy of your insurance card(s), and photo identification.

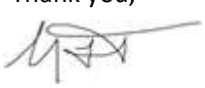
Your initial visit consists of a physical examination, review of symptoms, radiology review, and if applicable, review of referring physician notes and developing a treatment plan specifically for you. Treatment options requiring surgical procedures or invasive diagnostic testing will not be performed at the initial visit, rather scheduled at the earliest availability. If demanded, authorization for surgical procedures will be requested and scheduled in the timeliest fashion possible. All surgical procedures are scheduled to be performed in office.

A physician must notify patients when they have direct financial interest in separate diagnostic, treatment and/or dispensary facilities to which a patient has been referred, or in a separate prescribed treatment, good or service if the facility, dispensary, treatment, food or service is available on a competitive basis. In compliance with the requirements of these laws, I provide a Physician Disclosure that outlines the ancillary healthcare providers in which I have financial interest. Total Medical Management Solutions, LLC (TMMS) is an ancillary healthcare provider that I utilize for anesthesia services for our in-office surgical procedures. If you choose to use intravenous (IV) anesthesia, your insurance will be billed by Total Medical Management Solutions, LLC (TMMS), as an out-of-network service. If, for any reason, you prefer a facility other than the one selected by myself, please notify one of my team members and we will do our best to accommodate you.

If you are unable to make your appointment for any reason, we ask you to please notify our office **24 hours in advance or you will be considered a no show**. Missed procedure appointments will result in a $75.00 no show fee. Missed follow-up appointments will initially result in a $50.00 no show fee. Please note **no show fees need to be paid prior to rescheduling**.

If you have any further questions, my team will be happy to assist you.

Thank you,



Michael E Tschickardt, M.D.

Patient Signature: _____ Date:

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Demographics: Physician Disclosure

As required by Section 102.006 of the Texas Occupations Code

Patient Name: **Provider Name:** **Michael E. Tschickardt, M.D.**
Patient DOB: **Date of Service:**

Texas law requires a physician to disclose to a patient those arrangements permitted under applicable Texas law whereby such physician accepts remuneration to secure or solicit a patient or patronage for a person licensed, certified or registered by a Texas health care regulatory agency. The purpose of this disclosure is to notify you, the patient, that your attending physician may receive remuneration for referring you to any of the following ancillary healthcare providers for certain healthcare services:

- **Total Medical Management Solutions, LLC (TMMS)**

Accordingly, I hereby acknowledge Coastal Bend Pain Management has disclosed to me, at the time of initial contact and at the time of referral (i) his affiliation with the foregoing ancillary healthcare provider(s) for whom, I, the patient, am being referred; and, (ii) he will receive, directly or indirectly, remuneration for the referral to such ancillary healthcare provider. I understand that I, the patient, have the right to choose the providers of my healthcare services and/or products and, as such, I have the option of receiving ancillary healthcare services from any ancillary healthcare provider and/or facility that I choose.

Patient Signature: _____ Date:

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Consent for Treatment | Assignment of Benefits

Patient Name: **Provider Name:** **Michael E. Tschickardt, M.D.**
Date of Birth: **Date of Service:**

I. CONSENT FOR TREATMENT: I hereby consent to the evaluation and management services provided by Dr. Tschickardt of Coastal Bend Pain Management and within this facility. Services may include diagnostic radiology and possibly surgical procedures. I understand that my consent may be revoked, in writing, at any time. However, such revocation does not release any financial obligation for services already rendered.

II. AUTHORIZATION TO RELEASE/OBTAIN INFORMATION: The undersigned hereby authorizes Dr. Tschickardt and associates of Coastal Bend Pain Management to release to any insurance carrier represented as contractually responsible for payment in whole or in part of the patient's health care bill, such as information as is deemed minimally necessary for the proper and accurate processing of such healthcare claims. Further, the undersigned releases Dr. Tschickardt of Coastal Bend Pain Management to provide to outside healthcare providers/services such information as is necessary to facilitate proper healthcare, limited only to that which is deemed minimally necessary to execute referrals, etc. on behalf of the patient. In addition, by copy of this document the patient consents to the release of prior medical records from referring physicians, hospitals, nurses or other entities, which have records necessary for proper evaluation and treatment of the patient.

III. STATEMENT OF FINANCIAL RESPONSIBILITY: In consideration of medical treatment and service provided to the above-named patient, the patient or the undersigned guarantor unconditionally guarantees payment in full to Dr. Tschickardt of Coastal Bend Pain Management. Coastal Bend Pain Management agrees to abide by the terms and conditions set forth in individual managed care contracts with which the patient and physician both participate. Patients covered by insurance that do not have a managed care contract with Dr. Tschickardt of Coastal Bend Pain Management understand that Coastal Bend Pain Management will submit claims for processing. However, the patient/guarantor is ultimately responsible for payment of the entire account balance regardless of insurance coverage on insurance benefit determination. Should an insurance carrier not pay on a claim within the mandatory 45-day state limit, the balance due will be the responsibility of the patient/guarantor. All co-pays are due at the time of service. The patient/guarantor understands he/she is responsible for providing accurate and complete billing information.

IV. ASSIGNMENT OF INSURANCE BENEFITS: The undersigned hereby authorizes any insurance carrier represented as contractually responsible for payment in whole or in part of the patient's healthcare bill, including Personal injury Protection or Medical Payment coverage, to pay directly to Dr. Tschickardt of Coastal Bend Pain Management proceeds and benefits payable to me. Additionally, I agree that any payments shall be applied toward any settlement or judgment I receive under any auto liability or uninsured/underinsured motorists coverage provided by Medical Payments coverage. I acknowledge and accept the terms and conditions set forth in Sections III and IV of this policy statement:

The undersigned, being the patient and/or guaranteeing party to the above named account, hereby acknowledges and agrees to the following:

Patient Signature: _____ **Date:**

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HIPAA | Notice of Privacy Practices Acknowledgement

Patient Name: **Provider Name:** **Michael E. Tschickardt, M.D.**
Date of Birth: **Date of Service:**

I acknowledge that Coastal Bend Pain Management provided me with a written copy of his/her Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, pharmacy benefits and health care operations.

Signature: _____ Date:

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Consent | Patient Portal

Patient Name: **Provider Name:** **Michael E. Tschickardt, M.D.**
Date of Birth: **Date of Service:**

The Patient Portal is a web-based system that is your secure communication link with our office. When you log in to the Patient Portal with your private user name, you can:

- Request a medication refill or contact us for quicker response times than phone calls
- View your medical record and print or save an electronic copy of your Clinical Summary to avoid medical record fees
- View appointments
- View your ledger and statement
- Update your contact information

Patient Portal Consent Form

The patient portal is a secure way to access your medical records including medications, lab results, and medical history through the internet. You can also communicate with our office via secure messaging to ask questions, provide information, request appointments, and request medication refills.

Please read the following policy carefully:

- We are offering the patient portal as a convenience to you at no cost. We will not sell or give away any private information, including email addresses.
- The portal is for **non-emergency** uses only. We will reply to your request/inquiry within two (2) business

days. Please note: the portal is not checked or updated on weekends.

- We are not allowed to refill narcotics or other controlled medications through the internet portal.
- If you do not receive a timely email reply from us, please check your Junk or Spam email folder as messages are sometimes redirected into those folders.

By using this online patient portal, you agree to protect your password from any unauthorized individuals. It is your responsibility to notify us should your password be stolen. You agree to not hold Coastal Bend Pain Management responsible for any network infractions beyond our control.

User Name:

Temporary Password:

After we create your account, visit www.coastalbendpain.com and click on "Patient Portal" to log in.

Patient Signature: _____ Date:

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Consent | Release of Information to Family Members

Patient Name: **Provider Name:** **Michael E. Tschickardt, M.D.**
Date of Birth: **Date of Service:**

Many patients allow family member(s) such as their spouse, parents, and caretakers, etc. to call on patient's behalf and request medical or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without a patient's written consent. If you wish to have your medical or billing information released to family members, you must sign this form. Information will only be discussed and or released to family members or individuals indicated below.

I authorize Coastal Bend Pain Management medical providers and personnel to disclose protected health information to the following:

1. _____ Relation to Patient: _____ Phone: _____
2. _____ Relation to Patient: _____ Phone: _____

I understand that certain information cannot be released without specific authorization as required by state or federal law. By initialing the lines below, I authorize the release of the following protected or sensitive information

_____ **All health & billing information**
_____ Physicians Orders
_____ Billing and Insurance Information
_____ Past/Present Medications
_____ Diagnostic Test Reports
_____ Radiology Reports & Images
_____ Lab Results
_____ **Other:** _____

Right to Revoke: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named listed above. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

Signature Authorization: I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Patient Signature: _____ Date: