COASTAL BEND PAIN MANAGEMENT

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

Darin McCann, PA-C
Physician Assistant and Licensed through the
Texas Physicians Assistant Board

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. At Coastal Bend Pain Management, 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, my team-members will collect your completed packet and will need a copy of your insurance card(s) and photo identification. If you are unable to fill these forms out before coming to your appointment, I ask that you show up 15 minutes prior to your first appointment in order for my staff to assist you.

Your initial visit will consist of a physical examination, review of symptoms, X-Ray reports/MRI review, and review of referring physician notes and developing a treatment plan specifically for you.

Treatment options requiring injections or invasive diagnostic testing are not performed at the initial visit but will be scheduled at the earliest availability. If demanded, authorization for procedures will be requested and scheduled in the timeliest fashion possible. All 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, good or service is available on a competitive basis. In compliance with the requirements of these laws, you are being advised I have financial interest in Woodlands CFT management LLC. and Coastal Imaging. There are other facilities that may be available to you as well. 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.

Coastal Bend Pain Management is located at 7101 Williams Dr. Corpus Christi. If you are unable to make your appointment for any reason, we ask that you notify our office 24 hours in advance or you will be considered a No Show. Missed initial appointments will result in a $50.00 no show fee, missed procedure appointments will result in a $ 75.00 no show fee. Missed follow-up appointments will initially result in a $ 25.00 no show fee, any missed follow up appointments after will results in a $ 50.00 no show fee. If you have any further questions, my team will be happy to assist you.

Thank you,

Michael Tschickardt, M.D.

Appointment Date and Time:

Date of Birth:

_____

Patients Signature

Consent for Treatment/Assignment of Benefits

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

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 pain management 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.

Signed: _____ **Date:**

Patient Name: **Date:**

DOB: **SSN:**

_____

II. AUTHORIZATION TO RELEASE/OBTAIN INFORMATION: The undersigned hereby authorizes Dr. Tschickardt 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 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:

Signed: _____ **Date:**

_____

Relationship to Patient: ☐**Self** ☐**Spouse** ☐**Parent** ☐**Guardian**

NEW PATIENT INFORMATION

Patient Name: _____ **SSN:** _____
(Parent/guardian if patient is a minor): _____ **Phone*:*** _____

Sex: _____ **Date of Birth:** _____

Race: _____ **Ethnicity:** _____ **Language Spoken:** _____ **Dominant Hand:** ____ **Right**____ **Left**
Address: _____
Cell Phone: _____ **Home Phone:** _____ **Work Phone:** _____
E-Mail Address: _____ **Please advise preferred method of contact:** _____

Marital Status: _____ **Married** _____**Single** _____**Separated** _____ **Divorced** _____ **Widowed**

Employment Status: _____**Full-Time** _____ **Retired** _____**Disabled** _____**Home-maker/Other**
Place of employment: _____ **Employer Address:** _____
Job Position: _____
Student: _____**Full-Time:** _____ **Part-Time:** _____ **School Attending:** _____

Spouse Name: _____ **Phone:** _____

Emergency Contact: _____ **Relationship to Patient:** _____ **Phone:** _____
Please advise if OK to release or discuss medical issues with your emergency contact: ☐**Yes** ☐**No**

Primary Care Physician: _____ **Other Treating Physician:** _____
Who may we thank for referring you? : _____
Pharmacy: _____ **Address & Phone:** _____

***PLEASE INDICATE IF YOU HAVE EVER HAD A SPINAL CORD STIMULATOR OR PAIN PUMP IMPLANTED-** _____

Is this a work related injury? ☐**Yes** ☐**No** **If yes, please provide DOI and adjuster contact:** _____

Is this a Motor Vehicle accident injury? ☐**Yes** ☐**No** **If yes, please provide date of accident:** _____

INSURANCE COVERAGE INFORMATION

If you are NOT the insured, please fill out the requested information below.
Insurance companies require the below information for billing purposes.

PRIMARY INSURANCE:
Name of Insured: _____ **Relation to patient:** _____
Insured's SSN: _____-_____-_____ **Insured's DOB:** _____/_____/_____
Insurance Co. Name: _____ **Phone:** _____

SECONDARY INSURANCE:

Name of Insured: _____ **Relation to patient: _____**
Insured's SSN: _____-_____-_____ **Insured's DOB: _____/_____/_____**
Insurance Co. Name: _____ **Phone: _____**

TERTIARY INSURANCE:

Name of Insured: _____ **Relation to patient: _____**
Insured's SSN: _____-_____-_____ **Insured's DOB: _____/_____/_____**
Insurance Co. Name: _____ **Phone: _____**

The information provided above is true and correct to the best of my knowledge. I understand that no guarantees have been made to me as to the result of such treatment of examinations. I understand that I am responsible for any services not covered by my insurance.

Patient Signature: _____ Date: _____
(Parent/guardian if patient is a minor)