Southern Idaho Pain Institute

CLINTON L. DILLE M.D
BOARD CERTIFIED ANESTHESIOLOGIST

176 Falls Avenue
Twin Falls ID 83301
Phone (208)733.3181
Fax (208)733.3168

THANK YOU FOR CHOOSING US!

Our pain management facility offers state of the art technology and equipment that allows our board certified physician to treat your pain in the Idaho's first ambulatory surgery center devoted to the specialty of diagnosing and treating chronic, acute and cancer pain. The types of treatments we offer vary from interventional procedures such as epidural injections and spinal cord stimulators to medication management.

Our healthcare team along with you and your family will decide together, the treatment option that is best for you. Our staff strives to aggressively treat your pain in a timely fashion. Prompt attention to your pain improves the chance that your pain will resolve, allowing you to resume a productive lifestyle.

We are glad to have you as a patient here. We want your experience to be pleasant and educational and we would like to assure you that our devoted healthcare team is dedicated to restoring function and reducing your pain so that you may return to the activities that you enjoy and improve quality of life.

If you ever have any questions regarding your treatment at our facility, please feel free to contact our office @ (208) 733.3181. We look forward to serving your needs.

"WELCOME TO OUR PRACTICE"

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FINANCIAL POLICY

You are financially responsible for the medical services you receive at Southern Idaho Pain Institute (SIPI).

Please review our policies below and sign at the end to indicate your agreement to these terms.

APPOINTMENTS

1. **Copayments.** Copayments for clinic visits are due at the time of service. If you are unable to make your copayment at the time of service, SIPI reserves the right to reschedule your appointment until a time that you are able to make your copayment. Payment for any outstanding balance is due at your appointment.
2. **Procedure Prepayment.** SIPI collects your payment for a procedure at the time when the procedure is scheduled. Your prepayment is based on an estimate of your expected financial responsibility. This is an estimate only. You are responsible for any unpaid balance after your insurance (if applicable) has been billed. In the event of overpayment you may request a refund according to our refund policy, below. We reserve the right to reschedule your procedure until prepayment has been made.
1. **Missed Appointment or Cancelations Made Without 24 hr. Notice & Late Arrivals.** If you are late by 15 minutes or more, we may reschedule your appointment. If you are more than 60 minutes late, or if you do not show up to your appointment, you will be responsible for a missed appointment fee. Missed office visit appointments are subject to a $20 charge. Missed procedure (surgery) appointments are subject to a $50 charge. These fees are also applicable to cancelations made without 24 hr. notice.
   These charges are your responsibility and will not be billed to any insurance carrier.

INSURANCE PAYMENTS

2. **Financial Responsibility.** Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurer will be your responsibility, except as limited by our contract (if any) with your insurance carrier.
3. **Coverage Charges and Timely Submission.** It is your responsibility to inform us in a timely manner of any changes to your billing or insurance information. There is a time limit within which SIPI must submit a claim on your behalf to your insurer. If SIPI is unable to submit your claim within this period because we have not been supplied with your correct insurance information, you will be responsible for the charges.
4. **Self-Pay.** If you do not have health insurance, or if your health insurance will not pay for services rendered by SIPI, you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule (available from our front desks). Self-pay patients are required to make payment in full at the time of service.

BENEFITS AND AUTHORIZATION

5. **Insurance Plan Participation.** We participate in many but not all insurance plans. It is your responsibility to contact your insurance company to verify that your assigned physician participates in your plan. Out of network charges may have higher deductibles and copayments.
6. **Referrals.** Referral and prior authorization requirements vary widely among insurance carriers and plans. If your insurance carrier requires a referral for you to be seen by SIPI, it is your responsibility to be aware of this fact, and to obtain this referral.
7. **Prior Authorization and Non-Covered.** SIPI may provide services that insurance plans exclude or require prior authorization. If insured, it is ultimately your responsibility to ensure that services provided to you are covered benefits and authorized by your insurer. SIPI, as a courtesy to our patients, makes a good faith effort to determine if services we organized are covered by your insurance plan, and, if so, whether or not prior authorization for treatment is required. If we determine that a prior authorization is required, we will attempt to obtain such authorization on your behalf.
8. **Out of Network Payments.** If we are not part of your insurance carrier's network (out-of-network) and your insurance carrier pays you directly, you are solely responsible for payment and agree to forward payment to SIPI, immediately.

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ACCOUNT BALANCES AND PAYMENTS

9. **Reassignment of Balances.** If your insurance company does not pay within a reasonable time, we may transfer the balance to your sole responsibility. Please follow up with your insurance carrier to resolve non-payment issues. Balance is due within 30 days of receiving a statement.
10. **Collection of Unpaid Accounts.** If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney, which may result in reporting to credit bureaus and/or legal action. SIPI reserves the right to refuse treatment to patients with outstanding balances over 120 days old. You agree to pay SIPI for any expenses we incur to collect on your account, including reasonable attorneys' fees and collection costs.
11. **Returned Checks.** Returned checks will be subject to a $25 returned check fee.
12. **Refunds.** Refunds for overpayment or prepayment on cancelled procedures are made only after there has been full insurance reimbursement for all medical services on your account. Please submit a written refund request, allow four to six weeks for your request to be processed. Send requests to: SIPI, Attn: Billing Department, 176 Falls Ave, Twin Falls ID 83301-3115.
13. **Statements.** Charges shown on statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing dates.

Agreement and Assignment of Benefits

I have read and understand the financial policy of SIPI, and I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to SIPI. I understand that I am financially responsible for all services I receive from SIPI. This financial policy is binding upon you and your estate, executors and/or administrators, if applicable.

Patient Signature: _____ Date: _____

Printed Name: _____

IIHI ACKNOWLEDGEMENT

This is to certify that on ___/___/_____ I received a copy of the Southern Idaho Pain Institute's privacy policy and Patient Rights in accordance with SIPI's IIHI (Individually Identifiable Health Information) compliance manual and Federal Law. I understand that SIPI may change their privacy policy without notice and I will be made aware of any updates as they occur. I understand that at any time I may request a copy of the current policy. A copy of this signed document verifying receipt of the policies will be kept in my permanent medical record.

Safe Harbor ASC Patient Disclosure

You have been referred to Southern Idaho Pain Institute, PC. This ambulatory surgery center is owned by Dr. Clinton L Dillé. Although Dr. Dillé is the sole owner of Southern Idaho Pain Institute, PC you have the right to undergo surgery at another facility if you so desire. Please inform us if you do not wish to be treated at Southern Idaho Pain Institute.

Signature valid only when document received/reviewed in the SIPI office.

Patient Signature: _____

Printed Name: _____

Witness: _____

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PLEASE HAVE INSURANCE CARD & IDENTIFICATION CARD AVAILABLE TO BE COPIED FOR OUR RECORDS

TODAY'S DATE: _____/_____/_____ ☐ UPDATE ☐ NEW PATIENT AGE TODAY:_____

PATIENT'S NAME:			GENDER: ☐ F ☐ M
FIRST	MIDDLE	LAST	
DATE OF BIRTH:	S.S#	MARITAL STATUS: S M D W	
HOME#:	CELL#:	WORK#:	
MAILING ADDRESS:	PHYSICAL ADDRESS:		
CITY:	STATE:	ZIP CODE:	

DO YOU CURRENTLY RESIDE IN A NURSING CARE FACILITY? ☐ YES ☐ NO IF YES, WHERE?_____

PREFERRED LANGUAGE: _____ **EMAIL**: _____

PATIENT'S EMPLOYER: _____ OCCUPATION: _____

EMPLOYMENT STATUS: ☐ FULL TIME ☐ PART TIME ☐ UNEMPLOYED ☐ RETIRED ☐ DISABLED ☐ STUDENT

WHO REFERRED YOU TO OUR PRACTICE: _____ PRIMARY PHYSICIAN_____

EMERGENCY CONTACT_____ PHONE#:_____ RELATION:_____

HOW DID YOU HEAR ABOUT OUR OFFICE? ☐ WEBSITE ☐ PROVIDER ☐ FRIEND ☐ OTHER

AUTHORIZATION TO LEAVE INFORMATION ON VOICEMAIL OR ANSWERING MACHINE ☐ **YES** ☐ **NO**

DO YOU HAVE A MEDICAL POWER OF ATTORNEY: YES OR NO WHO: _____
DO YOU HAVE AN ADVANCED DIRECTIVE: YES OR NO **RACE**: _____
ETHNICITY: _____

SPOUSE'S NAME: _____

SPOUSE'S EMPLOYER: _____ SPOUSE'S PHONE #:_____

SPOUSE'S S.S_____ SPOUSE'S BIRTH DATE: _____

INSURANCE INFORMATION:

IS YOUR VISIT ACCIDENT RELATED? YES OR NO IF YES, DO YOU HAVE AN ATTORNEY? YES OR NO
IF YOU HAVE AN ATTORNEY, WHO IS YOUR ATTORNEY? _____ PHONE #: _____
WHO WAS YOUR EMPLOYER AT THE TIME OF YOUR WORK RELATED ACCIDENT? _____

PRIMARY INSURANCE:	ID#:	GROUP#:
POLICY HOLDER'S NAME:		
SECONDARY INSURANCE :	ID#:	GROUP#:
POLICY HOLDER'S NAME:		

PHARMACY: _____ PHONE: _____

AUTHORIZATION TO DOWNLOAD MEDICATION HISTORY: YES OR NO

TODAY I WILL BE PAYING BY: ☐ VISA ☐ MC ☐ DISCOVER ☐ AMERICAN EXPRESS ☐ CASH ☐ CHECK

AUTHORIZATION AND CONSENT TO TREAT/FINANCIAL AGREEMENT

I HEREBY AUTHORIZE THE PHYSICIANS OF THIS OFFICE AND THEIR DESIGNATES TO PROVIDE MEDICAL TREATMENT RELEASE OF INFORMATION PERTAINING TO MY TREATMENT FOR INSURANCES PURPOSES. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL PROFESSIONAL SERVICES RENDERED. I AUTHORIZE THE INSURANCE COMPANY TO PAY BENEFITS DIRECTLY TO THE PHYSICIAN. I UNDERSTAND THAT I AM RESPONSIBLE TO SUPPLY ALL NECESSARY INFORMATION, SUCH AS INSURANCE INFORMATION, AUTHORIZATIONS, AND REFERRALS, SO THAT MY INSURANCE CAN BE PROPERLY FILED. I FURTHER AGREE TO PAY ALL COLLECTIONS COSTS, REASONABLE ATTORNEY FEES, AND OTHER COLLECTIONS COSTS THAT MAY BE INCURRED TO ENFORCE COLLECTION OF ANY AMOUNTS OUTSTANDING.

SIGNATURE:_____ DATE: _____/_____/_____

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PAIN QUESTIONNAIRE

Name _____ **Age** _____ **Date** _____

Referring Physician _____

Chief Complaint (problem you were referred for) _____

_____

Is this a Work Comp Injury? YES NO If yes, Date of Injury _____

Brief History of Problem and description including onset of pain: _____

_____

_____

Circle the words that describe your pain:

constant	burning	stays in one place	coldness
intermittent	heavy	moves around	hotness
unpredictable	sharp	throbbing	annoying
only at night	tingling	pins/needles	
only during day	electrical shock	shooting	
day & night			

Is your pain worsened by any of the following? (Circle all that apply.)

standing lying sitting
bending twisting coughing

Activities that increase your pain: _____

_____

Activities that decrease your pain: _____

_____

Does pain keep you awake at night? YES NO

What time of day is pain the worst? _____

What activities have you quit doing because of your pain?

housework exercise work hobbies sports

Are you currently disabled because of your pain? YES NO

Are you currently involved in litigation or have an attorney? YES NO

Explain _____

_____

_____

_____

_____

_____

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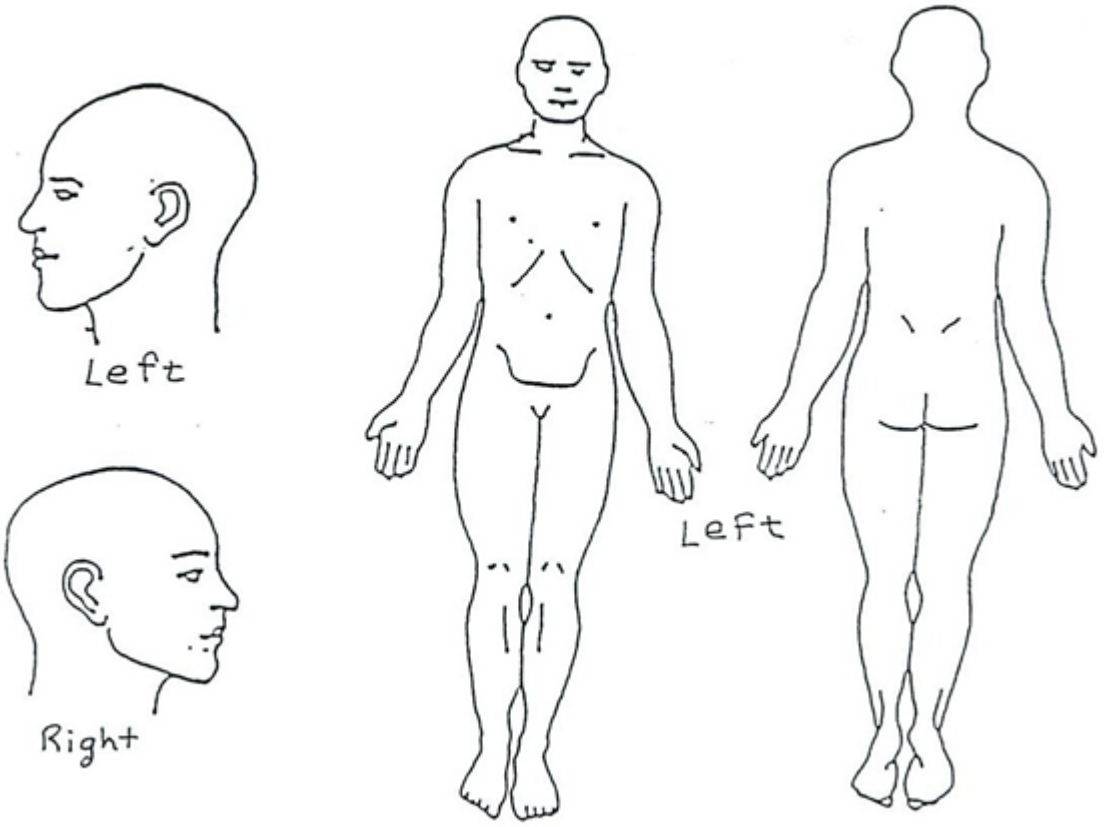
Please shade the figures where your pain starts and mark where it goes with an arrow.



Level of pain (circle one) 1 2 3 4 5 6 7 8 9 10 **(1 minimal to 10 max.)**

Which tests have you had done? (Give dates and locations)

MRI _____

CT Scan _____

X-Rays _____

Circle Treatments:

Physical Therapy Chiropractor Acupuncture
Surgery Homeopath TENS Unit
Hypnosis Biofeedback Psychologist/Psychiatrist

Medication List (current)

Non-Pain Medications	**Pain Medications**
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____

Please list any known allergies with reaction you have: _____

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Past Medical History

Medical illnesses and date of onset:

1. _____
2. _____
3. _____
4. _____

Surgical History and date:

1. _____
2. _____
3. _____
4. _____

Are you currently taking anticoagulants/blood thinners/aspirin/persantine? (Circle if applies)

Do you have problems with bleeding/nosebleed? YES NO

Date of your most recent flu shot: _____/_____
(Month / Year)

If you are 65 years or older, have you ever had a Pneumococcal vaccine? _____/_____
(Month / Year)

If you are 51 years or older, have you had a colonoscopy? _____/_____
(Month / Year)

If you are a female between the ages of 42 and 69, date of your last mammogram? _____/_____
(Month / Year)

If you are a female between the ages of 24 and 62, date of your PAP smear/Pelvic exam? _____/_____
(Month / Year)

Past Family Medical History

Please state if a family member has been diagnosed with an autoimmune disease. (Ex. Mother, Father, Children, Paternal/Maternal Grandmother/father, Sister, Brother, Aunt, Uncle (Blood relation ONLY))

Fibromyalgia: YES NO If so, WHO: _____

Lupus: YES NO If so, WHO: _____

Multiple Sclerosis: YES NO If so, WHO: _____

Rheumatoid Arthritis: YES NO If so, WHO: _____

Other Pain Conditions: YES NO If so, WHO: _____

Social History

Married Single Divorced Widowed Separated

Number of Children _____

Occupation _____

Hobbies _____

Do you smoke? YES NO How Much? _____

Do you drink? YES NO How Much? _____

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Please review the list below and check all that are applicable. You may use the space to the right for any explanations.

( ) Severe Headaches _____

( ) Paralysis of the face _____

( ) Emotional Problems _____

( ) Dizziness _____

( ) Chronic Sinus problems or nasal blockage _____

( ) Asthma or emphysema _____

( ) Chronic hoarseness _____

( ) Shortness of breath _____

( ) Blood in stool _____

( ) Blood in urine or trouble urinating _____

( ) Bleeding disorders _____

( ) Easy bruising or nosebleeds _____

( ) Menstrual disorder _____

( ) Complication after surgery _____

( ) Bad surgical result or unsatisfactory medical care _____

( ) Chest pain _____

( ) Heart disease _____

( ) High Blood Pressure _____

( ) Chronic Skin Condition _____

( ) Recurrent fever blisters _____

( ) Abnormal lump or node _____

( ) Unexplained weight loss _____

( ) Cancer _____

( ) Abdominal Pain _____

( ) Kidney or bladder problems _____

( ) Problems with bones or joints _____

( ) Broken bones _____

( ) Pregnancy (currently) _____

( ) Other _____

Signature of Patient _____ Date _____

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Date: ___/___/_____

Patient Name: _____

Patient DOB: ___/___/_____

Opiate Risk Assessment

		Mark each box that applies
1. Family History of Substance Abuse	Alcohol	[ ]
	Illegal Drugs	[ ]
	Prescription Drugs	[ ]
2. Personal History of Substance Abuse	Alcohol	[ ]
	Illegal Drugs	[ ]
	Prescription Drugs	[ ]
3. Age (Mark box if 16-45)		[ ]
4. History of Preadolescent Sexual Abuse		[ ]
5. Psychological Disease	Attention Deficit Disorder	[ ]
	Obsessive Compulsive Disorder	[ ]
	Bipolar	[ ]
	Schizophrenia	[ ]
	Depression	[ ]

Patient Signature: _____