SOUTHEASTERN MEDICAL, PA

830 SUNSET BLVD.

SUNSET BEACH, NC 28468

OFFICE POLICY ON MISSED APPOINTMENTS

This office calls to remind you of all appointments with Dr. Lepore the day before to confirm your appointment. Should you need to change your appointment, we require 24-hour advance notification of the change.

If your appointment has been confirmed by phone and no advance notice is given and you miss your appointment, a $40.00 charge for that day's missed appointment will be applied.

This charge will need to be paid prior to making any other future appointments.

POLICY ON PERSONAL INJURY OR MOTOR VEHICLE ACCIDENTS

We agree to file your medical insurance claims.

Any special payment arrangements must be approved by the office manager prior to your appointment.

Southeastern Medical, PA does not accept claims that involve attorneys or legal matters arising from personal injury or motor vehicle accidents.

You agree to notify this office at once if you hire an attorney to represent you in any such claim. You agree that you will be responsible for all fees related to your treatment should you have a legal claim pending.

Southeastern Medical, PA does not agree to accept settlements or payment arising from any legal claims.

By signing below, I am in agreement with both the above office policies.

SIGNATURE OF PATIENT_____

DATE: _____ TIME: _____

10/13/21

Southeastern Medical, PA Financial Policies

PLEASE READ CAREFULLY

Our office and billing department will file insurances that we accept. Please consult with our staff to make sure your insurance is one that we participate with. Should your insurance change, and we are not made aware of the change, you are responsible for any and all balances as result of non-coverage.

You will be responsible for all balances that are not paid or covered by your insurance. Please check with your insurance in advance to make sure the treatment you have will be covered by your insurance.

If treatment or procedures are not covered for any of the above reasons, it will be your responsibility for the balance owed.

All balances are due and payable upon receipt. If non payment occurs, balances will not be carried forward and must be paid at the time they are due.

Unpaid balances will result in no further treatment, and an appointment will not be made until your balance is paid in full.

Thank you.

Signature of patient Witness SEM

---------- ----------

Date: ---------- ----------

COPY GIVEN TO PATIENT

Current Medications: Check here if none ( )

Name of Pain Medication | Dosage

_____ _____

_____ _____

_____ _____

Name of other Medication:

_____ _____

_____ _____

_____ _____

Allergies:	**Yes**	**No**
No Know Drug Allergies	___	___
IV Dye	___	___
Iodine	___	___
Seafood/Shellfish	___	___
Adhesive Tape	___	___
NSAIDS	___	___
Penicillin	___	___

Other _____

Are you taking Blood thinner medication:Plavix/Clopidogrel, Warfarin, Coumadin, or Efficient/Prasurgel or others? Yes / No

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____

Medical History: Check here if none ( )

	Yes	No		Yes	No		Yes	No
High blood pressure	___	___	Hepatitis/liver disease	___	___	Migraine	___	___
Heart Disease	___	___	Kidney problems/Stones	___	___	Stomach GI	___	___
Heart attack	___	___	Shortness OB	___	___	Bleeding disorder	___	___
AFIB	___	___	Diabetes	___	___	Asthma	___	___
Stroke	___	___	Osteoporosis	___	___	Emphysema/COPD	___	___
Seizures	___	___	Arthritis	___	___	Cancer	___	___
Tuberculosis	___	___	Depression	___	___	Vascular disease	___	___
Fibromyalgia	___	___	HIV positive	___	___	High Cholesterol	___	___

Other: _____

Surgical History: Check here if none ( )

( ) Low back surgery Date: _____ Surgeon _____

( ) Neck surgery Date _____ Surgeon _____

Social History: Right Handed ( ) Left Handed ( )

Alcohol: ( ) YES ( ) NO ( ) Daily ( ) Few per week ( ) Once per week ( ) Few per month

Illicit Drug Use: ( ) YES ( ) NO ( ) Type _____

Drug/Alcohol treatment? ( ) YES ( ) NO If yes, name of facility _____ Year ____

Past Suicide Attempt? ( ) YES ( ) NO If yes, when _____

Smoker: ( ) YES ( ) NO # packs per day _____ How many years _____ Current ( ) Past ( )

Family History:

Mother ( ) Alive ( ) Deceased Age: ____ Cause/medical conditions _____

Father ( ) Alive ( ) Deceased Age: ____ Cause/medical conditions _____

Family Medical Problems ( ) Diabetes ( ) Heart Disease ( ) Cancer (type) _____ ( ) Other _____

Review of Systems: (circle all that apply): **Pregnant ( ) Yes ( ) No**

General: Weight changes, fatigue, fever, fainting

Lung: Chronic cough, Shortness of breath asthma

Heart: Chest pain, Palpitations, SOB w/exertion

Abdomen: Heartburn, Nausea, Constipation,Diarrhea

Neurology: Stroke, Seizures, Weakness

Endocrine: Thyroid problems, Diabetes

Skin: Bruising, rashes, sores, moles changing

HEAD/EYES: Headache, Blurry Vision, double vision, floaters

ENT: Ears ringing, Sinusitis, Sore throat, trouble swallowing

Blood: Anemia, Easy brusing, Bleeding, Swelling, Phlebitis

Urinary: Blood in urine, Painful urination

Psych.: Depression, Anxiety, Sleep problems, memory loss

Vascular: Leg cramps, Aneurysms

I certify that the information given on the Initial Visit Intake is correct to the best of my knowledge. I will not hold my doctor or any member of his staff responsible for any errors or omissions that I may have made in the completion of this paperwork.

_____ **Date:** _____

Patient/Family/Legal Guardian Signature

Brief Pain Inventory (Short Form)

Date: _____

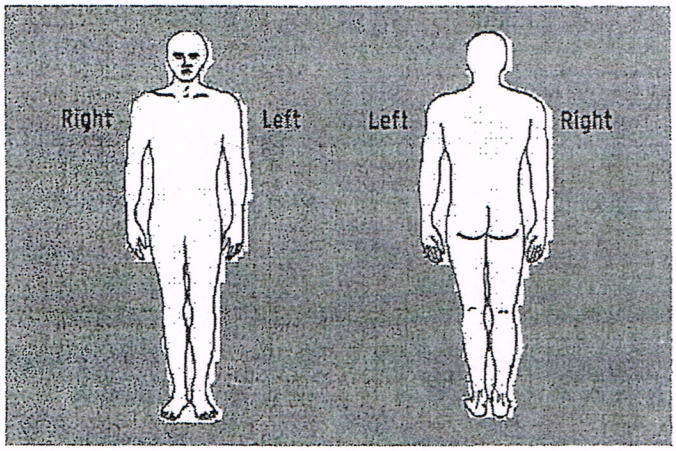
Time: _____

Name: _____
Last First Middle Initial

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

○ 1. yes ○ 2. no

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3) Please rate your pain by circling the one number that best describes your pain at its **WORST** in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No Pain — Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its **LEAST** in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No Pain — Pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the **AVERAGE**.

0 1 2 3 4 5 6 7 8 9 10
No Pain — Pain as bad as you can imagine

6) Please rate your pain by circling the one number that tell how much pain you have **RIGHT NOW**.

0 1 2 3 4 5 6 7 8 9 10
No Pain — Pain as bad as you can imagine

7) What treatments or medications are you receiving for your pain?

_____

8) In the past 24 hours, how much **RELIEF** have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
No Relief — Complete Relief

9) Circle the one number that describes how, during the past 24 hours. **PAIN HAS INTERFERED** with your:

A. General Activity:

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere — Completely interferes

B. Mood

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere — Completely interferes

C. Walking Ability

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere — Completely interferes

D. Normal work (Includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere — Completely interferes

E. Relation with other people

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere — Completely interferes

F. Sleep

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere — Completely interferes

G. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10
Does not Interfere — Completely interferes

SOUTHEASTERN MEDICAL, PA
HISTORY AND PHYSICAL INTAKE FORM

Name: _____ DOB: _____ Age: _____ Today's Date _____

Height: _____ Weight: _____ Occupation: _____ PT ( ) FT ( ) Disabled ( )

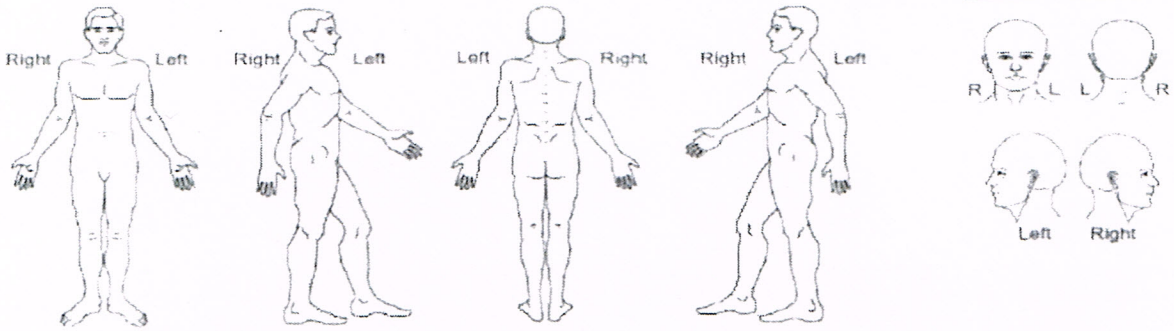
Chief complaints: _____

When and how it started: _____

Does your pain radiate anywhere? _____

Please **circle** the areas where you are experiencing pain & **rate** the area you are having pain from a 1 out of 10 (**1** being minor and **10** being severe):

Pain score: _____ _____



Pain score: ____/ 10 ____ ____/ 10 ____/ 10 ____/ 10 ____/ 10

Describe your pain:

Aching ---- Burning----Cramping----Dull----Electric Shock----Sharp----Shooting----Stabbing----Throbbing

What makes the pain worse?

Standing----Sitting----Walking----Sleep/Rest----Lying Down----Bending forward----Arching backward----Tension/Stress Sneezing----Weather changes----Squatting----Lifting----Reaching----Stair Climbing----Urination----Driving----Twisting Intercourse----Exercise

What makes the pain better?

Standing----Sitting----Walking Weather changes---- Lying Down----Bending forward---- Arching backward ----Sleep/Rest Heat----Cold----Others----Medication

Are you involved in any litigation or lawsuit regarding your pain? Yes----------No---------

Are you seeking Workers Compensation because of your pain? Yes----------No---------

Do you have any of the following symptoms associated with your pain?

Numbess/Tingling No------- Yes ------- where? _____

Weaknesess No------- Yes ------- where? _____

Bowel/Bladder Incontinence No---------- Yes ---------- when it started? _____

List the names of other doctors or specialists you have seen for your pain: _____

_____

Did you have any treatments done by other Pain Doctors? _____

Did you have any test done? X Ray ------- CT Scan ---------- MRI -------- NCS ---------- Other _____

Patient Name: _____ **DOB:** _____

10/13/21

SOUTHEASTERN MEDICAL, PA

Patient Information / Consent to Treat

PATIENT INFORMATION					Date:
Patient name:			Referring doctor:		Referring doctor phone #:
Address:			Primary doctor:		
City/State/Zip:			Employer/School:		
(H) Phone #: Cell phone:		Work phone:	Email address:		
Date of birth:			Age:	Marital status:	Sex:
Race:		Ethnicity:		Religion:	
Emergency contact (name):		Relationship:		(H) Phone #: (C)	
Responsible party:		Relationship:		DOB:	SS#:
Responsible party address:			City/State/Zip:		Phone #:

INSURANCE INFORMATION			
Primary Insurance:	Employer:	Secondary Insurance:	Employer:
Insurance ID #:	Insurance Group #:	Insurance ID #:	Insurance Group #:
Insured Name:		Insured Name:	
Address:		Address:	
City/State/Zip:		City/State/Zip:	
Insured DOB	Insured Social Security #:	**Insured DOB**	Insured Social Security #:

Insured Sex: male female	Insured Sex: male female
What is your deductible? _____ Deductible Met _____	What is your deductible? _____ Deductible Met _____
What is your office Co-pay? _____	What is your office Co-Pay? _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR THE PROMPT PAYMENT OF SERVICES RENDERED TO ME BY SOUTHEASTERN MEDICAL, PA (SEM) AND ITS STAFF. IN THE EVENT THAT I HAVE INSURANCE, I AUTHORIZE SEM TO RELEASE ANY INFORMATION NECESSARY TO PROCESS A CLAIM FOR INSURANCE PURPOSES. I HEREBY AUTHORIZE MY INSURANCE COMPANY TO REMIT PAYMENT DIRECTLY TO SEM. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. I REQUEST AUTHORIZED MEDICARE/MEDICAID BENEFITS BE MADE TO SEM IN MY BEHALF, IN MEDICARE ASSIGNED CASES, THE PHYSICIAN OR SUPPLIER AGREES TO ACCEPT THE CHARGE DETERMINATION OF THE MEDICARE CARRIER AS THE FULL CHARGE, AND THE PATIENT IS RESPONSIBLE ONLY FOR THE DEDUCTIBLE, COINSURANCE AND NONCOVERED SERVICES. COINSURANCE AND THE DEDUCTIBLE ARE BASED UPON THE CHARGE DETERMINATION OF THE MEDICARE CARRIER. I GIVE PERMISSION FOR EVALUATION AND TREATMENT BY SOUTHEASTERN MEDICAL, PA AND ITS STAFF.

DATE_____ SIGNATURE X _____

10/13/21