INTERVENTIONAL
SPINE & REHAB
OF LOUISIANA

ISRLouisiana.com
PH 225-263-0600 FAX 225-263-0601
4021 WE Heck Ct. Building M-1 Baton Rouge, LA 70816

MARK JOHN, M.D.
PHYSICAL MEDICINE & REHABILITATION
INTERVENTIONAL PAIN MANAGEMENT

Patient Demographics (Please Print)

Referring Physician: ______________________ PCP: ______________________

Patient Name (Last, First, M.I.): ______________________
Address: ______________________ Apt: __________
City: ______________________ State: ______________ Zip: __________
Contact Numbers: (Primary): ______________ (Secondary): ______________
DOB: __________ SSN: _____-____-_____ Height: __________
Email Address: ______________________
Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed
Student Status: [ ] Full-time [ ] Part-Time [ ] Not a Student
Employment Status: [ ] Full-Time [ ] Part-Time [ ] Not Employed [ ] Retired
Name of Employer: ______________________
Job Description: ______________________

Emergency Contact Name: ______________________
Phone: ______________ Relation: ______________

Pharmacy Name/Location: ______________________

Preferred Imaging Facility: [ ] Bluebonnet Imaging [ ] Imaging Center of LA [ ] Baton Rouge General [ ] OLOL
[ ] Other: ______________________

Is this related to an automobile accident? [ ] Yes [ ] No Is there pending litigation? [ ] Yes [ ] No
If yes: Attorney Name: ______________________
Law Office: ______________________ Date of Accident: __________

Is this a work-related injury? [ ] Yes [ ] No If yes, please answer the following.
Work-Comp Carrier: ______________ Adjustor: ______________
Phone: ______________ Fax: ______________
Date of Injury: __________ Do you have an Attorney? [ ] Yes [ ] No
If yes: Attorney Name: ______________________
Law Office: ______________________

______________________ Signature

__________ Date

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Patient Name: ______________________________ DOB: ____________________

**Medications (Please include all prescriptions, OTC and vitamins including fish oil, any aspirin products or medications taken on an as needed basis)**

| Name | Dosage | Frequency Taken |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Past Medical History** (Please circle **ALL** that apply)
Acid Reflux/GERD ADD/ADHD Anemia Anxiety Arthritis (Degenerative, Rheumatoid) Asthma Atrial Fib/Arrhythmia Bipolar Blood Clots/Clotting Disorders Cancer (Type: ____________________) Degenerative Disc Disease Depression Diabetes (Type 1, Type 2) Headaches/Migraines Hearing Loss Heart Attack Heart Failure High Blood Pressure High Cholesterol Hepatitis HIV/AIDS Hyperlipidemia Immune Disorders (List: ____________________) Kidney Disease Liver Disease Osteoporosis Peptic Ulcer Disease Pre-Diabetes Scoliosis Seizures Sleep Apnea Spinal Stenosis Stroke/TIA Stents/Cardiac Disease Thyroid Disease Other (List: ______________________________)

**Immunizations** Have you had any immunizations within the past year?
[ ] Yes [ ] N If yes, please complete the section below.
[ ] Flu Date: ________________
[ ] Pneumonia Date: ________________
[ ] Shingles Date: ________________
[ ] COVID-19 (Pfizer/Moderna/Johnson & Johnson) (1st) ________________ (2nd) ________________
[ ] Other: ______________________________
**If you have not had the COVID-19 vaccination, do you plan on getting it? [ ] Yes [ ] No [ ] Undecided

**Allergies** (Medications, dyes, adhesive tapes, etc.):
______________________________
______________________________

**Surgical History** (Please list **ALL** spinal **AND** non-spinal surgeries, including but not limited to pacemaker, aneurysm clips and **approximate** year):
______________________________
______________________________

**Hospitalization History** (Please list ALL non-surgical hospitalizations, including **approximate** year):
______________________________
______________________________

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Patient Name: ______________________________ DOB: ____________________

**Family History**

Please list relation to you (**Mother, Father, Maternal Grandmother, Paternal Grandfather, etc.) and if they are alive (A) or deceased (D**).

Cancer (Type): ______________________________

High Blood Pressure: ______________________________

Heart Disease: ______________________________

Diabetes Mellitus: ______________________________

Thyroid Disease: ______________________________

Stroke: ______________________________

Arthritis (Degenerative, Rheumatoid): ______________________________

Immune Disorders (List): ______________________________

Other: ______________________________

**Social History**

CBD Oil: [ ] Yes [ ] No

Tobacco Use:

[ ] Non-smoker [ ] Former smoker – Year quit: ____________________

[ ] Current Smoker – Frequency? ______________________________-Interested in quitting? [ Yes [ ] No

- Product(s) used: [ ] Cigarettes [ ] Cigars [ ] Chewing [ ] Tobacco/Dip [ ] Hookah/Pipe Tobacco [ ] Vape

Alcohol Use:

[ ] I do not consume alcohol.

[ ] I consume alcohol – Frequency? ______________________________

Do you use the following (this does not include prescriptions)? [ ] Yes [ ] No If yes, please select all that apply.

[ ] Cocaine [ ] Opiates/Morphine [ ] Amphetamines [ ] Methamphetamines [ ] Phencyclidine [ ] Benzodiazepine

[ ] Barbiturates [ ] Methadone [ ] Oxycodone [ ] Propoxyphene [ ] MDMA [ ] Buprenorphine [ ] Marijuana

**Current Pain/Problem**

1) How long have you had this problem? (Please write number, do not place a check)

___ Days ___ Weeks ___ Months ___ Years

2) On a scale of 0-10 (0=none, 10=worst): On average, how bad is your pain? ___ At its worst? ___ Today? ___

3) When do your symptoms occur? [ ] Constantly [ ] With activity [ ] Rest [ ] Other: ____________________

4) Which statement best describes your pain? [ ] Always present, always the same intensity [ ] Always present, intensity varies [ ] Usually present, but have short periods without pain [ ] Often, but I am pain free for most of the day

5) What makes your pain feel worse? (Please check ALL that apply) [ ] Bending [ ] Sitting [ ] Standing [ ] Walking

[ ] Other: ______________________________

6) What makes your pain feel better? (Please check ALL that apply) [ ] Medication [ ] Heat [ ] Lying down

[ ] Other: ______________________________

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Patient Name: ______________________________ DOB: ____________________

Review of Symptoms: Please check **yes or no to every symptom** pertaining to what you are **CURRENTLY** experiencing:

COVID-19
___ Y ___ N New change in taste
___ Y ___ N New change in smell
___ Y ___ N Body aches (NOT muscle aches)
___ Y ___ N Sore throat
___ Y ___ N Congestion/runny nose
___ Y ___ N Traveled outside state in last 21 days
___ Y ___ N Diagnosed within last 14 days
___ Y ___ N Exposed within last 14 days
___ Y ___ N Quarantined yourself/household

General/Constitutional
___ Y ___ N Change in appetite
___ Y ___ N Fever
___ Y ___ N Chills
___ Y ___ N Sweats
___ Y ___ N Fatigue
___ Y ___ N Difficulty sleeping
___ Y ___ N Bowel changes
___ Y ___ N Bladder changes

Allergy/Immunology
___ Y ___ N Hives
___ Y ___ N Sneezing
___ Y ___ N Cough

Opthalmologic
___ Y ___ N Blurred vision
___ Y ___ N Double vision
___ Y ___ N Itching/redness

ENT
___ Y ___ N Hearing loss
___ Y ___ N Nasal congestion
___ Y ___ N Nosebleed
___ Y ___ N Difficulty swallowing

Endocrine
___ Y ___ N Excessive sweating
___ Y ___ N Excessive thirst

Respiratory
___ Y ___ N Shortness of breath
___ Y ___ N Wheezing
___ Y ___ N Sputum production

Cardiovascular
___ Y ___ N Chest pain
___ Y ___ N Dizziness
___ Y ___ N Abnormal heartbeat
___ Y ___ N Palpitation

Gastrointestinal
___ Y ___ N Abdominal pain
___ Y ___ N Bowel incontinence
___ Y ___ N Heartburn
___ Y ___ N Nausea
___ Y ___ N Vomiting
___ Y ___ N Diarrhea
___ Y ___ N Constipation
___ Y ___ N Blood in stool

Hematology
___ Y ___ N Easy bruising
___ Y ___ N Prolonged bleeding

Genitourinary
___ Y ___ N Difficulty urinating
___ Y ___ N Painful urination
___ Y ___ N Change in frequency
___ Y ___ N Change in urgency

Musculoskeletal
___ Y ___ N Muscle aches
___ Y ___ N Joint pain
___ Y ___ N Joint stiffness
___ Y ___ N Joint swelling
___ Y ___ N Back pain

Podiatry
___ Y ___ N Ankle pain (L / R)
___ Y ___ N Ankle swelling (L / R)

Skin
___ Y ___ N Rash
___ Y ___ N Itching

Neurologic
___ Y ___ N Seizures
___ Y ___ N Blackouts
___ Y ___ N Fainting
___ Y ___ N Tremors
___ Y ___ N Headaches
___ Y ___ N Migraines
___ Y ___ N Gait abnormality
___ Y ___ N Loss of strength
___ Y ___ N Tingling/numbness
___ Y ___ N Coordination problems
___ Y ___ N Memory loss

Psychiatric
___ Y ___ N Anxiety
___ Y ___ N Depression
___ Y ___ N Suicidal thoughts

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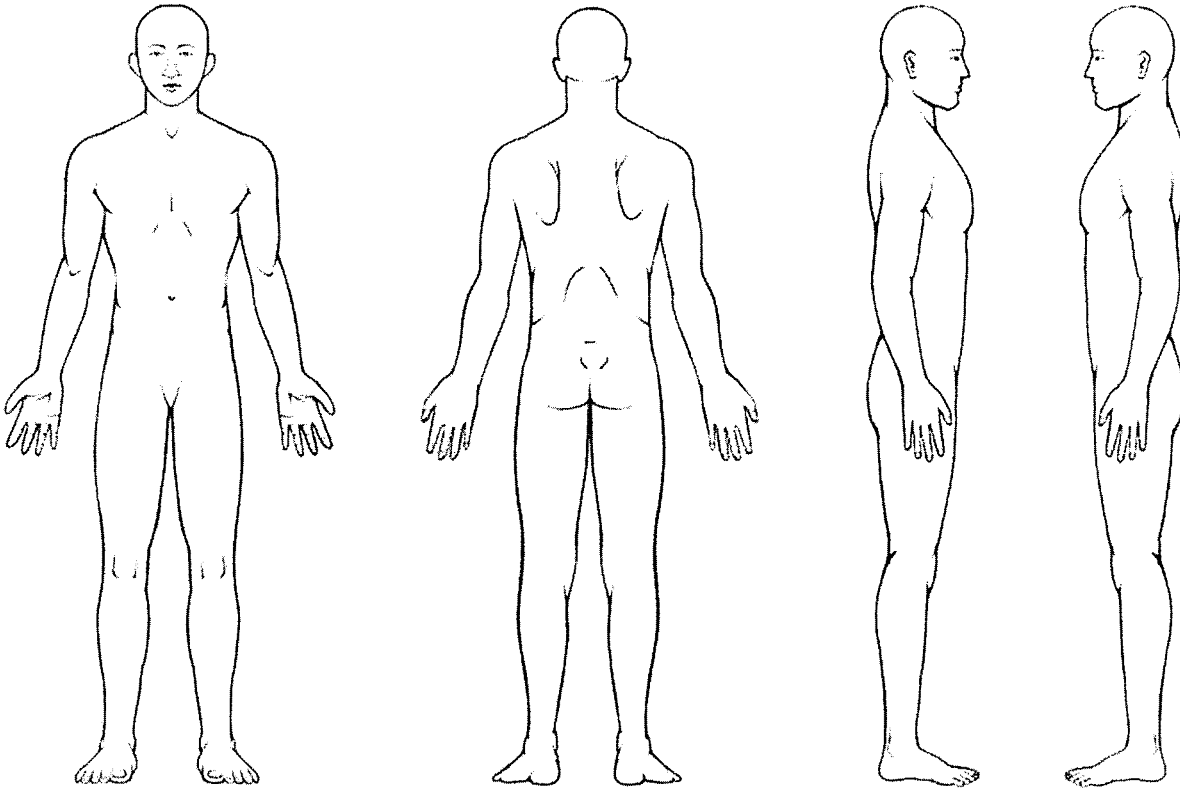
Patient Name: ______________________________ DOB: ____________________

Please describe your pain (Check **ALL** that apply) [ ] Aching [ ] Numbness [ ] Pins/Needles [ ] Burning
[ ] Stabbing/Sharp [ ] Other: ______________________________

Using the diagram below, circle where you are having your pain.



Please use the space below to list anything that you would like the doctor to know.

______________________________
______________________________
______________________________
______________________________
______________________________

## Office Policies

Our goal is to provide and maintain a good physician-patient relationship. Letting you know our office policies in advance allows for a good flow of communication and enables us to achieve our goal. Please understand that payment for services is an important part of the provider-patient relationship. In order to accommodate the needs of our patients, we have enrolled and are contracted with many health plans. If you do not have insurance or proof of insurance, payment for services will be due at the time of service. If you have any questions, please do not hesitate to ask a member of our staff.

## Office Hours & Appointments

Our office is open from 07:00am-04:00pm Monday through Thursday and 07:00am-12:00pm (noon) on Friday, except for weekends and holidays. Patients are seen by appointment only and seen each day in the order of their scheduled appointments. We strive to minimize any wait times; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.

Please arrive promptly to your appointment in order for our staff to better serve the needs to each and every one of our patients. If you are more than 15 minutes late for your appointment, we reserve the right to reschedule your appointment to another day. However, we will do our best to accommodate you if our schedule permits. Appointments may be cancelled if not confirmed (either by our automated system of calling the office).

We understand that patients may have a need to cancel or reschedule their appointment. We are happy to accommodate your scheduling needs. Please call our office at least 24 hours prior to your clinic appointment time and 48 hours prior to your procedure appointments to reschedule so we may offer your appointment time to other patients. There are fees associated with late cancellations and no shows for both clinic appointments (in-person and telehealth) and procedures. There will be $35.00 fee for same day cancellations and no shows for clinic appointments, and this fee must be paid in full by the next clinic appointment. There will be a $100.00 fee for late cancellations and no shows for procedures, and this fee must be paid in full before rescheduling the procedure. *These fees are subject to change. If you fail to show up for three (3) scheduled appointments or consistently cancel your scheduled visits, the office reserves the right to discharge you from the clinic.

## Medical Insurance

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. However, it is the patient's responsibility to provide accurate insurance information and to alert us to change as they occur. If the insurance company you designated cannot be verified, you will be responsible for the payment of the visit. It is the patient's responsibility to understand their benefit plan with regards to covered services, financial responsibilities, and participating facilities (this includes knowing which laboratory is in network (LabCorp, Aegis, Quest) – to send urine drug screens to). It is also the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges.

Referrals and pre-authorizations: Certain health plans (HMO, POS, etc.) require that a referral or prior authorization be obtained from your primary care provider (PCP) before visiting a specialist and/or directly from the carrier when scheduling a procedure. Patients are responsible for obtaining referral authorizations for office visits. Failure to obtain the referral and/or pre-authorization may result in rescheduling of an appointment or a lower payment or denial of your claim by your carrier.

If your insurance policy has provisions such as co-payments, deductibles or co-insurance, please note that these are provisions that have been agreed upon between you and your insurance carrier and must be paid at the time of service.

**Financial Responsibilities**

Copays are due at the time of service. If we do not participate in your insurance plan, payment in full is expected at the time of your visit. Patient balances are billed immediately once an explanation of benefits has been received from your insurance plan (this includes deductibles and co-insurance). Any balance outstanding for more than 90 days may be forwarded to a collection agency. We accept cash, Visa, MasterCard, Discover, American Express, and checks (for balances only).

Should your claim be denied by your insurance carrier, whether it is not considered a covered benefit or related to an accident (motor vehicle, worker compensation, etc.), all charges will be your responsibility.

If you are undergoing medical care as a result of an accident, your must notify our office immediately. Patients who are receiving medical care as a result of an accident and using their own insurance have the same financial expectations as other patients.

Payments for scheduled procedures: We will provide you with an estimate of the cost of procedures when they are scheduled. Prior to your procedure, we ask that all co-pays, deductibles, and co-insurance be paid in full. For a number of reasons, it is not uncommon for our estimate and the amount paid by your carrier to be different as they can only make their final determination of your eligibility and benefits after they receive our claim. We will bill all balances unpaid by the carrier to you as well as return any overpayments to you or your carrier as is appropriate.

Billing of amounts due: We will provide a detailed bill to you for amounts owed. Our preferred method of presenting bills is electronically by email or text as it is the most efficient and cost-effective. When you receive your billing notification, a link will be provided to your account. You may change your preferred delivery method at any time. We appreciate your prompt payment.

Outstanding balance policy: Due to the high cost of sending bills to collect amounts due from patients, it is our policy to send only one bill. It is our preference, in most cases, to send bills electronically via email or text. Your prompt payment helps us to reduce our costs and to continue to provide a high-quality of care for all of our patients. Our payment portal allows our patients to establish payment plans and to elect automatic payment of outstanding amounts monthly via credit card. It is our expectation that you communicate with us about your account and that all accounts are paid timely. If payment is not made on the account, it may be sent to an agency for collection and the patient may be discharged from the practice. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collection costs, including attorney fees and court costs. Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

**Workers Compensation**

We will work directly with the carrier and closely with their case managers in your recovery. If your claim has been accepted or deemed compensable, there will be no charged incurred by you. Should your claim be denied or deemed not compensable by the worker compensation carrier, all charges will be your responsibility.

**Transfer of Medical Records**

If you transfer to another physician, we will as a courtesy to you, gladly provide a copy of your medical records to your new physician, free of charge. You will need to complete a medical release of records and allow ten (10) working days for the request to be completed. If you or any other entity is requesting a copy of your records, they are available for a rate of $1.00 per page for the first 25 pages and $0.50 per page for 26-500. A physician's handling fee of $25.00, plus actual postage will also be included. This fee scale is based on Louisiana Revised Statues 40:1299.96. If your attorney is requesting a copy of your medical records, have them send our office a signed release. Once the request is received and processed, we will then issue an invoice to the attorney for payment. Once payment has been received, medical records will be mailed out promptly. Please allow at least ten (10) working days for all medical records.

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**Forms**

There will be a $50.00 charge for all forms needing to be completed. This includes but is not limited to disability forms, FMLA. This fee does not include any copays or balances due. Forms are only completing during appointment times and will not be completed if patient information is missing.

**Medications**

All prescription refills must be requested by the patient. No pharmacy requests will be accepted or approved by our office. Please contact our office during regular business hours for any prescription refill requests.

Prior authorizations: Allow five (5) working days for all prior authorizations. Once our office receives the authorization information, we will forward it to your pharmacy.

**Assignment/Medical Records Release Authorizations/Consent to Contact**

I request that payment of authorized Medicare and/or other insurance benefits made on my behalf to Mark John MD, LLC for any services furnished to me by these providers. I authorize any holder of medication information about me to release to the Health Care Finance Administration or other insurance company any information need to determine these benefits or the benefits payable for related services. I understand that I am financially responsible for all charges at the times and authorize Mark John MD, LLC and their agents including attorneys and collection agencies acting on their behalf to contact me regarding my outstanding balances through various means of communication including, but not limited to cell phone, landline, text numbers that I provide, an email address that I have provided, auto-dialer systems and pre-recorded voice messages.

I have read and understand the above policy. I agree to assign insurance benefits to Interventional Spine and Rehabilitation of Louisiana whenever applicable. I also agree, in addition to the amount owed, I will be responsible for the fee charged by the collection agency for the costs of collections if such action becomes necessary. Please let us know if there is any way we can be of further assistance. Thank you in advance for your time and consideration.

Signature of Patient: ______________________________ Date: ________________

Printed Name: ______________________________