The Pain Center of Jonesboro, LLC
505 East Matthews, Suite 103
Jonesboro, AR 72401
Phone: (870) 972-0411 Fax: (870) 933-8011

NEW PATIENT REFERRAL FORM

PATIENT INFO:

Patient: _____ Phone: _____

Address: _____

Social Security: _____ Date of Birth: _____

INSURANCE INFO:

Primary Insurance: _____ ID#: _____ Group#: _____

Subscriber: _____ Subscriber Date of Birth: _____

Secondary Insurance: _____ ID#: _____ Group#: _____

Subscriber: _____ Subscriber Date of Birth: _____

Is this Workers Comp? _____

Workers Comp contact: _____ **Phone:** _____

PAIN INFO:

Diagnosis: _____ Location: _____

ALL IMAGING REQUIRED TO BE SCHEDULED

Diagnostic Test: **Date** **Where**

Myelogram: _____
MRI: _____
CT Scan: _____
EMG/NCV: _____
X-Ray: _____

Has patient had injections before? _____ **Where:** _____

Referring Physician: _____ **Contact Person:** _____

NPI #: _____ **Medicaid #:** _____

Phone: _____ **Fax:** _____

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USE OR DISCLOSURE AUTHORIZATION

I, _____, hereby authorize The Pain Center of Jonesboro, LLC to disclose all of my medical records, including any specially protected records, such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle-cell anemia, or HIV infection for the purpose of medical treatment: *(If you do not want certain portions of your medical records released, please read this section carefully and identify the information you do not want released. Otherwise, your records will be released as specified above).*

_____

_____

The protected health information may be disclosed to:_____

_____

_____

This protected health informantion is being used or disclosed for the following purpose: (Check/List specific purposes here, if you choose not to provide an explanation of the request, please check "Patient Request").

___ Patient Request

_____

This authorization shall be in force and effect until: (check one of the following)

- ☐ Date: _____
- ☐ The happening of the following event:_____

*I understand that, as set forth in the facility's Privacy Notice, I have the right to revoke this authorization at any time prior to the above date or event by sending written notification to: The Pain Center of Jonesboro, LLC, Privacy Officer at 505 E. Matthews, Suite 103 Jonesboro, AR 72401.

*I understand that a revocation will not have any effect on actions taken by The Pain Center of Jonesboro, LLC, its physicians, employees or agents before they received my revocation.

*I understand that I am not required to sign this authorization. The Pain Center of Jonesboro, LLC will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this authorization.

*I understand that my records mey be subject to disclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that this authorization does not limit The Pain Center of Jonesboro's or its physician's, employees' or agents' ability to use or disclose my informatio for treatment, payment, or health care operations, or as otherwise permitted by law.

_____ _____ _____

Signature of Patient or Personal Representative | Date | Witness

_____

Printed Name of Patient or Personal Representative

_____

Relationship to the patient if not signed by patient

Revised 11/29/17