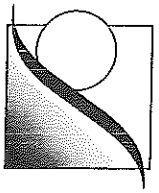


ATLANTIC PAIN MANAGEMENT & REHABILITATION, P.C.

Dear _____ ,

We would like to take this opportunity to welcome you to Atlantic Pain Management & Rehabilitation, the office of Dr. Theodore W. Nicholas. Thank you for choosing our practice!

You have an appointment scheduled with Dr. Nicholas at the Kill Devil Hills office on_____at_____.

PLEASE ARRIVE 20 MINUTES EARLY.

It is our philosophy to provide our patients with the most thorough, quality care available. Your initial visit will require you to be in our office approximately 1-1½ hours.

We appreciate your taking the time to fill out the enclosed forms, and ask that you bring the completed forms to your appointment. If you arrive without all forms fully completed, we have the right to reschedule your visit. In addition, please remember to bring your insurance cards, a valid driver's license or picture I.D. and all medications in their current containers.

The doctor will need copies of all medical records regarding your condition, including MRI, CT and x-ray reports. Please contact any other physicians you have seen for this condition and have them provide these records. They can either be mailed to us in advance of your appointment, or faxed to us at 252-441-7793. If we are unable to obtain your records prior to your appointment, we may have to reschedule your visit.

Our office will gladly provide any medical facility a copy of our office notes promptly, and at no charge with proper written consent of the patient. If you request copies of your records for personal use, or for a non-medical designate, a medical release must be signed. A processing fee of $10.00 and a charge of 50¢ per page will be billed.

In the event that we have a check returned due to insufficient funds, you will be notified immediately. A $30.00 fee will be assessed for any returned check.

Please be aware that our normal business hours are Monday through Thursday, 8:30am to 5:00pm and Friday 8:30am to 12:00pm. We are closed for lunch from 12:00pm to 1:00pm Monday through Thursday.

Dr. Nicholas and the staff of Atlantic Pain Management & Rehabilitation look forward to meeting you. Please feel free to call us if you have any questions, or if we can be of assistance.

Atlantic Pain Management & Rehabilitation, P.C.

– PATIENT REGISTRATION FORM –

Patient's Name: _____ ☐ Male ☐ Female

Street Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Work Telephone: _____ Cell Telephone: _____

Social Security Number: _____ Date Of Birth: _____

Patient's Employer: _____

Contact In Case Of Emergency: _____ Contact Telephone: _____

Primary Insurance Carrier: _____

Policy Number: _____ Group Number: _____ Effective Date: _____

Insured's Name: _____ Relationship To Patient: _____

Date Of Birth Of Subscriber *(If different from self)*: _____

Social Security Number Of Subscriber *(If different from self)*: _____

Subscriber's Employer *(If different from self)*: _____

Secondary Insurance Carrier: _____

Policy Number: _____ Group Number: _____ Effective Date: _____

Insured's Name: _____ Relationship To Patient: _____

Date Of Birth Of Subscriber *(If different from self)*: _____

Social Security Number Of Subscriber *(If different from self)*: _____

Who referred you to this practice: _____

I, _____ hereby authorize Atlantic Pain Management & Rehabilitation, P.C., to apply for benefits on my behalf for services rendered. I request that payment be made directly to Atlantic Pain Management & Rehabilitation, P.C., I certify that the information regarding insurance coverage is true and accurate. I further authorize the release of any necessary medical or other information for this or any related claim to my insurance companies. I permit a copy of this authorization and assignment to be used in place of original. I understand that I am ultimately responsible for all charges whether or not paid by said insurance. I agree to assume responsibility for attorney fees associated with collections, and all other costs of collections (including court costs) in the event of a default.

Signature: _____ Date: _____

Witness: _____ Date: _____

ATLANTIC PAIN MANAGEMENT
& REHABILITATION, P.C.

INITIAL PAIN ASSESSMENT & MEDICAL HISTORY QUESTIONNAIRE

Thank you in advance for taking the time to complete this confidential questionnaire!
Please bring it with you to your first appointment.

Patient Name: _____ DOB: _____ Age: _____

List the body site(s) where you are experiencing pain: _____

_____

Does your pain radiate anywhere? (For example, into arms, legs, chest, abdomen, etc.): _____

_____

Check the words that best describe your pain:

☐ Aching	☐ Sharp	☐ Pins and Needles
☐ Throbbing	☐ Tender	☐ Numbing
☐ Shooting	☐ Burning	☐ Miserable
☐ Stabbing	☐ Nagging	☐ Unbearable

Is your pain: ☐ Intermittent ☐ Constant

Circle the number that best describes your pain at its worst during the last month:
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Imaginable)

Circle the number that best describes your pain at its best during the last month:
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Imaginable)

Circle the number that best describes your pain as it is right now:
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Imaginable)

Please check the things that make your pain better:

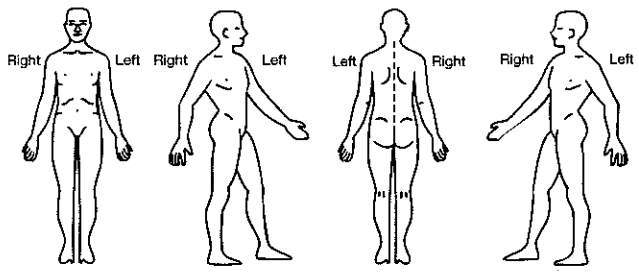
☐ Rest	☐ Standing	☐ Heat	☐ Exercise
☐ Sitting	☐ Activity	☐ Cold	☐ Other: _____
☐ Walking	☐ Position Change	☐ Sneezing/Coughing	_____

Please check the things that make your pain worse:

☐ Rest	☐ Standing	☐ Heat	☐ Exercise
☐ Sitting	☐ Activity	☐ Cold	☐ Other: _____
☐ Walking	☐ Position Change	☐ Sneezing/Coughing	_____

Please mark the areas of your pain, using the key to indicate your pain sensations:

Shooting: →
Stabbing: ///
Aching: x
Throbbing: o
Numbness: =



Is this a work related injury or injury related to an auto accident? ☐ Yes ☐ No

If yes, what was the date of the injury or auto accident? _____

Please indicate which of the following tests you have had:

☐ X-rays ☐ MRI ☐ CT Scan/Myelogram ☐ EMG ☐ Other: _____

Have you ever had surgery for your complaint? ☐ Yes ☐ No

If yes, when, where and who was your physician? _____

_____

_____

Has surgery been recommended to you for your complaint? ☐ Yes ☐ No

If yes, who recommended surgery? _____

Have you ever been to a pain management clinic in the past for your complaint? ☐ Yes ☐ No

If yes, when, where and who was your physician? _____

_____

Please check all of the previous treatments that you have had for your compliant:

Treatment/Procedure	Temporary Relief	Lasting Relief
☐ Physical Therapy	☐ Yes ☐ No	☐ Yes ☐ No
☐ Occupational Therapy	☐ Yes ☐ No	☐ Yes ☐ No
☐ TENS Unit	☐ Yes ☐ No	☐ Yes ☐ No
☐ Osteopathic Manipulation	☐ Yes ☐ No	☐ Yes ☐ No
☐ Epidural Injection	☐ Yes ☐ No	☐ Yes ☐ No
☐ Facet Block	☐ Yes ☐ No	☐ Yes ☐ No
☐ Nerve Block	☐ Yes ☐ No	☐ Yes ☐ No
☐ Sacroiliac Joint Injection	☐ Yes ☐ No	☐ Yes ☐ No
☐ Trigger Point Injection	☐ Yes ☐ No	☐ Yes ☐ No
☐ Joint Injection	☐ Yes ☐ No	☐ Yes ☐ No
☐ Herbal Medication	☐ Yes ☐ No	☐ Yes ☐ No
☐ Acupuncture	☐ Yes ☐ No	☐ Yes ☐ No
☐ Chiropractor	☐ Yes ☐ No	☐ Yes ☐ No
☐ Stimulator/Pump	☐ Yes ☐ No	☐ Yes ☐ No

Please check all of the previous medications that you have tried in an attempt to control pain:

Medication	Reason for Stopping Medication	Medication	Reason for Stopping Medication
☐ Ibuprofen (Motrin/Advil)	_____	☐ Cymbalta	_____
☐ Naprosyn (Aleve)	_____	☐ Effexor	_____
☐ Aspirin	_____	☐ Lexapro	_____
☐ Tylenol	_____	☐ Zoloft	_____
☐ Celebrex	_____	☐ Paxil	_____
☐ Bextra/Vioxx	_____	☐ Prozac	_____
☐ Mobic	_____	☐ Lidoderm Patch	_____
☐ Arthrotec	_____	☐ Ultram/Ultracet	_____
☐ Relafen	_____	☐ Tylenol #3/Tylenol #4	_____
☐ Skelaxin	_____	☐ Darvocet/Darvon	_____
☐ Flexeril	_____	☐ Percocet/Percodan	_____
☐ Soma	_____	☐ Lortab/Lorcet/Vicodin/Vicoprofen	_____
☐ Zanaflex	_____	☐ Morphine (Including MS Contin, Oramorph, MSIR, Kadian, Avinza)	_____
☐ Robaxin	_____	☐ Dilaudid	_____
☐ Valium	_____	☐ Duragesic Patch	_____
☐ Xanax	_____	☐ OxyContin	_____
☐ Neurontin	_____	☐ Demerol	_____
☐ Tegretol	_____	☐ Actiq	_____
☐ Zonegran	_____	☐ Fentora	_____
☐ Lyrica	_____	☐ Opana	_____
☐ Amitriptyline (Elavil)	_____	☐ Other_____	_____
☐ Nortriptyline (Pamelor)	_____		

Please list all medications you are currently taking to control pain:

	Medication	Dose	Frequency
1.			
2.			
3.			
4.			
5.			

Please list all the other medications you are currently taking:

	Medication	Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Please list all allergies or intolerances to medications:

	Medication	Reaction to Medication
1.		
2.		
3.		
4.		
5.		

Please check all current or past medical problems:

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Pacemaker/Defibrillator
- ☐ Anxiety
- ☐ Kidney Disease
- ☐ Stroke
- ☐ Heart Disease
- ☐ Lung Disease
- ☐ Depression
- ☐ Liver Disease
- ☐ Thyroid Disease
- ☐ Seizures
- ☐ Cancer
- ☐ Headaches
- ☐ Other:_____
- ☐ Stomach/Intestinal Problems
- ☐ Blood Clots
- ☐ HIV Positive
- ☐ Urinary/Sexual Problems

Please list all previous surgeries:

	Surgery	Month/Year
1.		
2.		
3.		
4.		
5.		

Who is your family physician or primary care provider? _____

Please tell us about yourself:

Are you: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Do you have children? ☐ Yes ☐ No If yes, how old are they? _____

Do you live in: ☐ House ☐ Apartment ☐ Mobile Home ☐ Condominium

What is your occupation? _____ Employer: _____

Do you currently smoke or use smokeless tobacco? ☐ Yes ☐ No If yes, how much? _____

Do you currently drink alcohol? ☐ Yes ☐ No If yes, how much? _____

If no to any of the above, have you ever smoked cigarettes, used smokeless tobacco, or consumed alcohol? ☐ Yes ☐ No

If yes, please describe: _____

Do you currently use recreational drugs? ☐ Yes ☐ No

If yes, what type and how much? _____

Have you had abuse problems with recreational drugs in the past? ☐ Yes ☐ No

If yes, please describe: _____

Have you had abuse problems with prescription medications in the past? ☐ Yes ☐ No

If yes, please describe: _____

Are there any recreational drug problems, or problems with prescription medications in your household at the present time?

☐ Yes ☐ No If yes, please describe: _____

Please check the appropriate diseases with regards to your family history:

	High Blood Pressure	Diabetes	Heart Disease	Cancer	Arthritis	Stroke
Mother	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐
Siblings	☐	☐	☐	☐	☐	☐
Sons	☐	☐	☐	☐	☐	☐
Daughters	☐	☐	☐	☐	☐	☐
Aunts/Uncles	☐	☐	☐	☐	☐	☐
Grandparents	☐	☐	☐	☐	☐	☐

Please check any problem(s) that you may have from the list below:

Abdomen
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloody Stools
- ☐ Heartburn

Ear/Nose/Throat
- ☐ Ringing in Ears
- ☐ Loss of Hearing
- ☐ Nose Bleeds
- ☐ Sore Throat
- ☐ Hoarseness

Genitourinary
- ☐ Pain with Urination
- ☐ Inability to Urinate
- ☐ Incontinence
- ☐ Bloody Urination
- ☐ Decreased Desire for Sex

Neurological
- ☐ Fainting Spells
- ☐ Weakness
- ☐ Dizziness
- ☐ Headaches
- ☐ Tremors

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Memory Loss
- ☐ Suicidal Ideation
- ☐ Inability to Sleep

Endocrine
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Excessive Thirst
- ☐ Cold Intolerance
- ☐ Heat Intolerance

General
- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Sweats

Eyes
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Irritation
- ☐ Discharge

Lungs
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Cough Up Blood
- ☐ Sleep Apnea

Skin
- ☐ Rashes
- ☐ Coldness of Hands/Feet
- ☐ Dry Skin
- ☐ Easy Bruising

Heart
- ☐ Chest Pain
- ☐ Irregular Heart Beat
- ☐ Heart Murmur

Musculoskeletal
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Cramps

ATLANTIC PAIN MANAGEMENT & REHABILITATION, P.C.

NO SHOW/CANCELLATION POLICY

Atlantic Pain Management & Rehabilitation, P.C. has established a no show/cancellation policy in order to assure all patients have timely access and availability to our physician.

1. **Initial Visit/New Patient:** For optimum care, Atlantic Pain Management & Rehabilitation, P.C. has devoted a large block of time for your first visit. You will be responsible for a $75.00 charge for failure to keep your scheduled appointment without notifying our office at least 24 hours in advance.

2. **Follow-up Visit/Established Patient:** You will be responsible for a $50.00 charge for failure to keep your scheduled appointment without notifying our office at least 24 hours in advance. If you should fail to show for two follow-up visits, our office has the right to dismiss you from the practice.

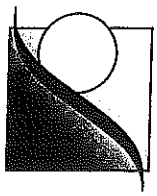
3. **EMG/NCS Patient:** As with new patients, Pain Management & Rehabilitation, P.C. has devoted a large block of time for this diagnostic study. If you do not show, or fail to cancel your EMG/NCS appointment at least 24 hours in advance, you will be responsible for a $100.00 charge and will not be rescheduled for an EMG/NCS until the charge is paid.

4. **Your insurance carrier will not be responsible for any no show or cancellation charges.**

5. **All no show charges must be paid in full prior to rescheduling any future appointments.**

I have read and understand the above policy.

Patient Signature: _____ Date: _____



ATLANTIC PAIN MANAGEMENT & REHABILITATION, P.C.

AUTHORIZATION & CONSENT

Patient's Name_____

Date of Birth _____ MR# _____

1. Consent for Care: The undersigned patient or undersigned responsible party (hereinafter referred to as "I") grant permission to Atlantic Pain Management & Rehabilitation, P.C. to render medical treatment or diagnostic procedures as deemed necessary during care.

2. Authorization for Release of Information: I give consent for Atlantic Pain Management & Rehabilitation, P.C. to release to any insurance company with which the patient has insurance in force as well as any intermediary claims processing agency, such information which may be requested either on paper or via electronic transmission. I agree others, including physicians and hospitals involved in the medical care and treatment may have access to information at the time the patient is registered. I certify that the information given in applying for payment under TITLE XVIII and TITLE XIX of the Social Security Act, or Champus/Champus VA is correct. I authorize any holder of medical or other information to release all information needed to determine these benefits for related services. I further authorize Atlantic Pain Management & Rehabilitation, P.C. to seek funding on the patient's behalf for medical or other state funds and to make the necessary referrals, applications and requests on the patient's behalf. I authorize the Department of Social Services to release to Atlantic Pain Management & Rehabilitation, P.C. the status of any applications made by the patient or on the patient's behalf or the fact that no application was made effective today and from one year from this date. I provide the patient's social security number voluntarily and authorize its use by Atlantic Pain Management & Rehabilitation, P.C. and others providing healthcare for the purposes of identification, filing insurance claims, billing and collections, and compliance with federal and state laws. I additionally authorize any agency or person having the patient's social security number, Medicare claim number, and/or benefit information including effective date, etc. to release same to Atlantic Pain Management & Rehabilitation, P.C.

3. Authorization for Release of Pain Management Medication Information: I give consent for Atlantic Pain Management & Rehabilitation, P.C. to release and receive information regarding any pain management medication that the patient may be taking or prescribed to include pharmacies, doctors, nurses, attorneys, workman's compensation, insurance companies, and law enforcement agencies.

4. Assignment of Insurance Benefits: I hereby assign the right to all health and liability insurance benefits otherwise payable to me and authorize direct payment to Atlantic Pain Management & Rehabilitation, P.C.

5. Financial Responsibility: I understand and agree that, as the patient, or spouse of the patient, or parent of a minor child, I am responsible for payment of all charges not covered or paid within a reasonable time by any medical insurance/coverage. I also understand that what an insurance company pays is established without regard to Atlantic Pain Management & Rehabilitation, P.C.'s costs and charges. I understand that obtaining pre-certification from my medical insurance/coverage does not relieve me of my financial obligation to pay all charges if the patient's medical insurance coverage should deny coverage, fully or partially, for the treatment. I further understand that any price quotations given are based on averages and may vary significantly from actual charges, based on the physician practice patterns, secondary or tertiary medical conditions, and professional interpretations of a physician's order(s).

The undersigned, by signing this sealed document, verifies his/her understanding, agreement with, and/or consent to the above stated terms. Each of the undersigned acknowledges receipt of a copy of this document on the date he or she signed the same.

Patient's Signature: _____ Date:_____

Witness:_____ Date:_____

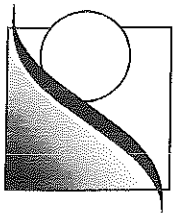
ATLANTIC PAIN MANAGEMENT & REHABILITATION, P.C.

FINANCIAL POLICY

1. Atlantic Pain Management & Rehabilitation, P.C. provides health care services on a fee-for-service basis. Commercial insurance is filed as a courtesy to you. If no payment is received within 60 days, a tracer will be sent to your carrier, and you will be asked to pay your balance in full. Please note that your insurance carrier has a contract with you, and although we file for your convenience, we will hold you ultimately responsible for all charges.
2. All copays and deductibles, as well as fees for non-covered services, are due at the time of your visit.
3. Payment of any outstanding balance is due at the time of your visit.
4. If you receive a bill from our office, payment is due within 30 days, unless you call to make payment arrangements.
5. If your insurance carrier makes a partial payment, or denies your claim, payment is due within 30 days, unless you call to make payment arrangements.
6. For HMO patients: You are responsible for keeping up with your referrals and authorizations for treatment. If you show for an appointment without an authorization or referral, you will have the option of rescheduling your appointment, or keeping it and being 100% responsible for payment of the bill that day.
7. For patients involved in legal cases: If your attorney requests services for which there is a fee, this charge will be billed to your account (through your attorney), but it is your responsibility to ensure that these charges are paid by the attorney or yourself.
8. For uninsured patients: Please be aware that payment is expected at the time services are rendered. Please feel free to inquire about our fees for services.
9. For workers' compensation patients: Our office will obtain authorization for your visit prior to your scheduled appointment. Should your case be controverted or denied for any reason, you will be responsible for any unpaid claims.
10. In the event that we have a check returned due to insufficient funds, you will be notified immediately. The balance must be paid immediately, as well as any associated fees.
11. Please see the reverse side for a schedule of our non-medical fees.

I have read and understand the above policy.

Patient Signature: _____ Date: _____



ATLANTIC PAIN MANAGEMENT
& REHABILITATION, P.C.

TRUTH OF DISCLOSURE STATEMENT

Any information* provided to Atlantic Pain Management, written or verbal, that is intentionally false or deceitful or considered lying by omission in an attempt to obtain medication, **in particular controlled medications**, will be verified to determine authenticity.

***Information such as:**

- What medication you are currently taking
- When and where your medication has been filled
- How much medication was dispensed
- Name(s) of treating physician or health care provider

This verification will be done **prior** to our providers writing any prescriptions. Depending upon how hard it is for us to determine this information, prescriptions may not be written on the first visit. This will be determined by the provider you are seeing. We work closely with all pharmacists (local and out of state), local law enforcement, SBI, and the DEA to identify drug seekers. **If it is discovered that any of the above information was falsified in order to obtain medications, we will prosecute you to the fullest extent of the law.** Also, please be aware that any alteration of a written prescription for a controlled substance is an act of felony and is also punishable by law. You will also automatically be discharged from this practice.

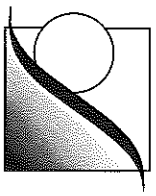
I verify that the information I have written out on my Initial Pain Assessment and Medical History Questonnaire for Atlantic Pain Management is true to the best of my knowledge.

_____ _____

Signature of Patient Date

_____

Print Name



ATLANTIC PAIN MANAGEMENT & REHABILITATION, P.C.

OFFICE POLICIES

Our Goal: The primary treatment goal of our physicians and staff is to help the patient minimize pain and attain maximum function not only medically, but also psychologically, vocationally, and socially.

Our Obligation: Patient trust is fundamental to the patient-physican relationship. This requires adequate communication between the physician and the patient, and that both parties are open and honest. As physicians, we will learn intimate details of the patient's life and promise to hold this information in confidence. We pledge to be an advocate for the required medical care needs of those we treat. Additionally, we will promise to provide neither more, nor less, care than the medical problem requires and administer care in a compassionate manner.

Appointment Policy: We understand that your time is valuable and we strive to see all patients in a timely manner. There are times when our schedule is delayed due to emergencies or unforeseen circumstances. Please accept our apology in advance should this occur during your appointment.

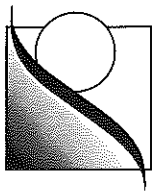
Please plan to arrive 20 minutes before your scheduled appointment. This will allow time for completion of any additional necessary paperwork and room placement prior to your scheduled visit. If you arrive more than 10 minutes late for your scheduled appointment, we reserve the right to reschedule your visit for another date. This is typically necessary so that we can maintain our schedule, minimize waiting time and not inconvenience our punctual patients.

Your scheduled appointment time is reserved specifically for you. Any change in this appointment will impact many people. If a cancellation is unavoidable, please contact our office at least 24 hours in advance so that we may give your appointment time to another patient. If two (2) missed appointments or two (2) cancellations occur without 24 hours notice you will be released from our care. Our charges for no show patients are outlined in our No Show/ Cancellation policy that you sign.

Patient Notes: It is the position of this office that notes made by a physician in the course of diagnosing and treating patients are primarily for the physician's use and are therefore the property of that physician. As medical specialists, we do provide ongoing copies of notes to patients' primary care physician to enhance continuity of care. Our office will happily provide any medical facility a copy of our office notes promptly, and at no charge with proper written consent of patient. If the patient requests a copy of their notes personally, or for a non-medical designate, a medical release must be personally signed in our office and a $10.00 processing fee and $0.50 per page fee paid prior to our office initiating the duplication of notes. The notes will then be ready for the patient to personally acquire in our office 48 hours after the request is initiated.

Telephone Calls: If you ever experience a medical emergency, **Call 911.** If you have a non-emergent medical question or prescription refill, kindly call our office and relay your question to the office staff. The question will be directed to the appropriate physician and the office staff will be instructed to return your phone call with an answer prior to the end of that business day. Some questions may require an appointment. If you are unwilling to leave a message, we will happily schedule an appointment for you. Refills on medications require a 48-hour advance notice to process the refill request.

Continued Other Side



ATLANTIC PAIN MANAGEMENT & REHABILITATION, P.C.

Fees: All medical fees charged are due the day of service. For patients with insurance, your co-payment or deductible amounts are due the day service is provided. We will bill your insurance company for the balance. In the event your insurance company does not pay, the patient is ultimately responsible for his or her own bill prior to any other appointments. Statements for balance due will be mailed monthly. Please pay promptly! This allows us to keep our costs as low as possible.

Forms: Our physicians will happily complete necessary forms which may be needed by any patient currently receiving care through this office. Once received in our office, all forms will be completed within a timely manner. We kindly request that all forms be left with our office staff at the front desk. Please refer to our financial policy form for specific charges.

Returned Checks: In the event that we have a check returned there will be a $25.00 charge assessed to your account. In the event a bad check is not covered within 30 days, future medical payments will only be accepted in cash.

Abuse To The Staff: Abuse of our staff cannot and will not be tolerated. Physical and/or verbal threats, harassment, aggravation, or excessive annoyance of our staff (including multiple phone calls, i.e. more than two (2) on the same day), regarding the same question or request, will unfortunately necessitate discharging the guilty patient from our practice. If physical threats, verbal threats, or harassment occur, then you will be fully prosecuted by the law. We take this very seriously.

Drug Seekers: If one of our physicians decides or determines a patient is seeking, or acquiring, medications for the purposes of abuse, misuse, and/or diversion, that patient will be discharged from our practice.

We thank you for taking the time to read and understand our policies. This helps us provide the best medical treatment possible to our patients.

– The Staff of Atlantic Pain Management & Rehabilitation, P.C.

ATLANTIC PAIN MANAGEMENT & REHABILITATION, P.C.

Theodore W. Nicholas, MD, FAAPMR
- *Board Certified - Physical Medicine & Rehabilitation*
- *Fellow - American Academy of Physical Medicine & Rehabilitation*

January 1, 2013

Dear Patient,

I would like to take this opportunity to welcome you to our practice!

In an effort to assist in financing patient treatments and procedures, we have partnered with CareCredit. We can guide patients through a simple application process from our office. If approved, CareCredit can offer financing at little or no cost to the patient, if paid off in a timely manner.

You may call (800) 677-0718 to apply for a CareCredit card or for more information. You can use the easy, automated system anytime or you can apply with a live agent Monday through Friday from 9:00am – 9:00pm (EST).

Applications may also be submitted at:
http://www.carecredit.com/apply/?dtc=DS6V

Non-Surgical Spine Medicine

Musculoskeletal Medicine

Electrodiagnosis (EMG/NCS)

Chronic Pain Management

Rehabilitation Services

Sincerely,

TWNMD

Theodore W. Nicholas, MD, FAAPMR

CareCredit℠

3210 North Croatan Highway, Suite 3 • Kill Devil Hills, NC 27948
Phone: 252/261-5868 • *Fax:* 252/441-7793

Release of Information

I _____, give permission to Atlantic Pain Management to **discuss my healthcare** with the following persons. I understand that to remove anyone from this list I must do so in writing.

Name	Relationship	Telephone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I _____, give permission to Atlantic Pain Management to **release my prescriptions to the following persons.** I will make them aware that anytime they come to pick up said prescriptions they are to bring photo ID that will be copied and they will need to sign for my prescriptions.

Names

_____ _____

_____ _____

_____

Patient Signature and Date

_____

Witness Signature and Date