PRESIDIO PAIN RELIEF
ROBERT SAVALA, MD
Board Certified Anesthesiologist,
Fellowship Trained Pain Specialist
Specializing in Diagnosing and Treating Pain Disorders

2000 Van Ness Ave, Suite 208
San Francisco, CA 94109
San Francisco 415.827.3832
F: 415.881.6198

Name: _____ Date of Birth: _____

Address: _____

_____

Phone: _____

Email: _____

Emergency Contact: _____ Phone: _____

_____

Primary Insurance Carrier: _____

Member ID: _____ Group Number: _____

Rx BIN: _____ RX PCN _____ RX Group: _____

Secondary Insurance: _____

Member ID: _____ Group Number: _____

Rx BIN: _____ RX PCN _____ RX Group: _____

_____

Pharmacy: _____

Phone: _____ Fax: _____

Address: _____

_____

We will only send prescriptions to one pharmacy, except for an emergency situation.

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Private Contract

This agreement is between Dr. Robert Savala ("Physician"), whose principal place of business is 2000 Van Ness Ave, suite 208, San Francisco, CA 94109, and the patient, _____, Date of Birth: _____, ("Patient"), who resides at _____ and is a Part B Medicare beneficiary seeking services covered under Medicare Part B pursuant to section 4507 of the Balanced Budget Act of 1997.

The Physician has informed the Patient that the Physician has opted out of the Medicare Program effective March 1, 2024, for a period of at least two years, and is not excluded from participating in Medicare Part B under Section 1128, 1156, or 1892 or any other section of the Social Security Act. Physician agrees to provide the following medical services to patient (the "Services") as described in the patient information material you have received:

Outpatient Pain Management Consultations and Procedures

In exchange for the Services, Patient agrees to make payments to Physician pursuant to his Fee Schedule. Physician agrees to provide Patient with all related Fees prior to Services. Patient agrees, understands, and expressly acknowledges the following:

- Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicare program with respect to the Services, even if covered under Medicare Part B.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for Services.
- Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program and other supplemental insurance plans may likewise deny reimbursement.
- Patient acknowledges that he or she has a right, as a Medicare beneficiary, to obtain Medicare-covered items and Services from physicians and practitioners who have not opted out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.
- Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for Services, and acknowledges that the Physician will not submit a Medicare claim for Services and that no Medicare reimbursement will be provided.

- Patient understands that Medicare payment will not be made for any items or services furnished by the Physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim was submitted.
- We require 24 hours' notice to cancel an appointment. There will be a $100 late cancellation/no show fee for failure to not provide notice.
- There will be a rescheduling fee of $150 for failure to stop any blood thinners, or any other pre-procedural instructions causing a last minute to reschedule within 24 hours of your scheduled procedure.
- Patient acknowledges that they have reviewed and understand this contract.
- Patient acknowledges that a copy of this contract has been made available to them.

_____ _____

Patient, Parent or Guardian Signature Date

A. Notifier: Robert Savala, MD

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D._____below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
New Patient consultations Follow up visits Paim Management Procedures	NOT CONTRACTED WITH MEDICARE	

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

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CREDIT CARD PAYMENT AUTHORIZATION FORM

Date:

I hereby authorize Dr. Robert Savala, MD to charge my credit card for the services provided and any other fees related to my care

Credit Card Number:

Exp: CVV: Billing Zip Code:

Patient Signature:

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PATIENT QUESTIONAIRE

Date: _____

Name: _____ Date of Birth: _____

Who referred you? _____

Who is your primary care doctor? _____

What is the reason for your visit today? _____

What is the cause of your pain? _____

Do you have any allergies? _____

Height: _____ Weight: _____

Have you done any physical therapy for this issue? __ YES __NO

If so, did it help? __ YES __NO

Are you doing any regular home exercises or stretching for this problem? __ YES __NO

In the past few months has your pain: __ Gotten worse __ Improved __ Remained the same

Is your pain worse: __ In the morning __Afternoon __ Evening __ No change throyght the day

Is you pain: __Constant __Occasional

Does your pain interfere with sleep __ YES __NO

What makes you pain worse? _____

What makes your pain better? _____

Please select any of the following that describes your pain:

__ Aching
__ Stabbing
__ Burning
__ Throbbing
__ Cramping
__ Burning
__ Weakness
__ Numbness/tingling
__ Pins and needles

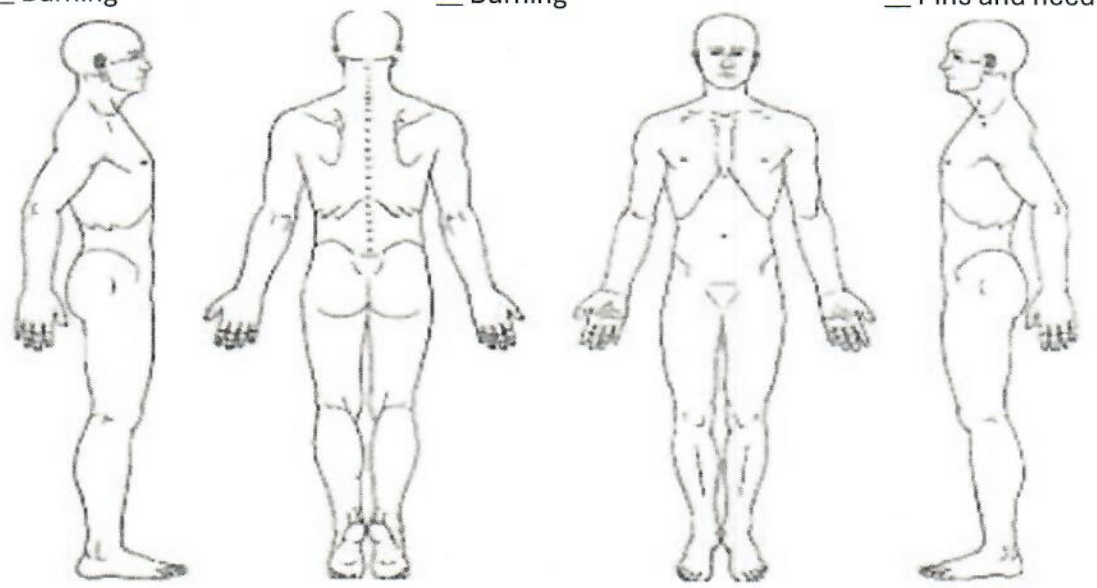
Please rate your pain on the scale below

Please select any of the following that describes your pain:

__ Aching
__ Stabbing
__ Burning

__ Throbbing
__ Cramping
__ Burning

__ Weakness
__ Numbness/tingling
__ Pins and needles



Please indicate any areas of discomfort

Hve you ever been experienced with any of the following:

__ Sedation or drowsiness
__ Insomnia
__ Sucidal thoughts
__ Memory impairment
__ Dizziness
__ Blurred vision
__ Loss of Balance
__ Fainting
__ Hallucinations

__ Stomach pain
__ Constipation
__ Nausea/vomiting
__ Blood in stool
__ Weight loss
__ Headaches
__Black tarry stools
__ Diarrhea
__ Loss of appetite

__ Trouble urinating
__ Severe chest pain
__ Chills/ninght sweats
__ Dramatic increase in pain
__Trouble breathing,
__Fevers
__ Serious rash

Were you ever diagnosed with depression? __ YES __NO

If so, is your pain the source of your depression? __ YES __NO

Do you smoke? __ YES __NO

Have you ever been treated for drug or alcohol addiction? __ YES __NO

Do you belong to any Na/ AA programs? __ YES __NO

Current Medical History:	Yes	No
Diabetes		
Heart Disease		
High Blood Pressure		
Respiratory Disease		
Stomach/GI Problems		
Liver Problems		
Kidney Problems		
Gynecological/Prostate Problems		

Family Medical History:	Yes	No
Diabetes		
Heart Disease		
Cancer		
Bleeding Disorder		
Depression		
Substance/Alcohol abuse		
Auto-immune disorders		
Serious reaction to anesthesia		

Please list any previous surgeries and the approximate date:

Procedure	Date of Procedure

What medications are you currently taking for your pain?

Are you taking any blood thinners? __ YES __NO

Are you __Married __Single __Divorced __Widowed

Is this a Workers Compensation injury: __ YES __NO

Do you have any litigation pending because of this problem? __ YES __NO

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MEDICAL RECORDS REQUEST

Date: _____

To: _____

Fax: _____ Phone: _____

Re: _____ DOB: _____

I hereby authorize _____

To release the following medical records to Dr. Robert Savala, M.D.

_____

_____

_____

_____

Date range: _____

Patient signature: _____