



**Welcome to the Crystal Coast Pain Management
division of East Carolina Anesthesia Associates**

Your relief starts here!

Thank you for choosing the Crystal Coast Pain Management division of East Carolina Anesthesia Associates. Our team of board-certified pain specialists is dedicated to providing advanced treatment options in a supportive, compassionate, and patient-centered environment.

To help make your first visit as smooth and efficient as possible, please bring the following with you:

- Completed New Patient paperwork
(mailed to you or emailed via DocuSign)
- Your insurance card(s) and a photo ID (such as a driver's license)
- A current list of all medications you are taking
- Your pharmacy name, address, and phone number

****Please plan to arrive 15 minutes early for your first appointment****

Appointment Information:

Date & Time: _____
Provider: _____
Location: _____

Please be considerate of other patients by providing at least 24 hours' notice if you need to cancel or reschedule an appointment.

A Message from Our Physicians:

"Our goal is to reduce your pain and help restore your highest level of function and independence. You are the most important part of your health care, and we are committed to working with you every step of the way."

Our Office Hours are Monday -Thursday 8:00 a.m. -5:00 p.m.

Together, we are here to help you restore your comfort, function, and quality of life.

CRYSTAL COAST PAIN MANAGEMENT REGISTRATION FORM

Today's Date:		Primary Care Doctor:			
PATIENT INFORMATION					
Patient's Last Name:		First:	Middle:	Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow ☐	
Is this your legal name? Yes ☐ No ☐	Email Address for our Patient Portal:		Birth Date:	Age:	Sex: M ☐ F ☐
Street Address:			Social Security No.	Home Phone:	Cell Phone:
P.O Box:	City:		State:		ZIP Code:
Occupation:	Employer:			Employer Phone No.	
INSURANCE INFORMATION (THIS IS IMPORTANT INFORMATION-PLEASE COMPLETE)					
Please give your insurance card and photo ID to the receptionist					
Please Indicate Primary Insurance:		☐ BCBS ☐ Medicare ☐ Medcost ☐ Cigna ☐ Tricare ☐ Aetna ☐ United Healthcare ☐ AIH ☐ Self Pay ☐ Other: (Please Specify)			
Subscriber's Name:		Subscriber's SSN:		Subscriber's DOB:	
Patient's relationship to Subscriber:		☐ Self ☐ Spouse ☐ Child ☐ Other			
Please Indicate Secondary Insurance:		☐ BCBS ☐ Medicare ☐ Medcost ☐ Cigna ☐ Tricare ☐ Aetna ☐ United Healthcare ☐ AIH ☐ Self Pay ☐ Other: (Please Specify)			
Subscriber's Name:		Subscriber's SSN:		Subscriber's DOB:	
Relationship to Subscriber:		☐ Self ☐ Spouse ☐ Child ☐ Other			
IN CASE OF EMERGENCY					
Name of local friend or relative:		Relationship to patient:		Home/Cell Phone:	Work Phone:
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize CRYSTAL COAST PAIN MANAGEMENT or insurance company to release any information required to process my claims.					
_____ Patient/Guardian Signature			_____ Date		

In-Network companies that we accept:

BCBS * Medicare* Medcost * Cigna *Tricare * AIH * Champ VA* United Healthcare* Heritage Summit*
Sure Choice * Aetna *We do not accept Medicaid. If your insurance is not listed above, we may be
considered an out of network provider.

CRYSTAL COAST PAIN MANAGEMENT

NEW BERN

MOREHEAD CITY

JACKSONVILLE

Name: _____ DOB: _____ Date: _____

How and when did your pain begin?

Is the pain from an accident or injury?
(car accident, trauma, other.) Describe:

Previous treating physicians or providers:

Check the treatments you have had:

Injections Surgery TENS
 Medications Injections Massage
 Acupuncture Other: _____

Have you ever had Physical Therapy?

Yes No If yes, where? _____

Have you ever been to a Chiropractor?

Yes No If yes, where? _____

Have you ever had an MRI?

Yes No If yes, where? _____

List all tests or evaluations you have had:

List all medication allergies:

List all previous pain medications:

What primary pharmacy do you use?

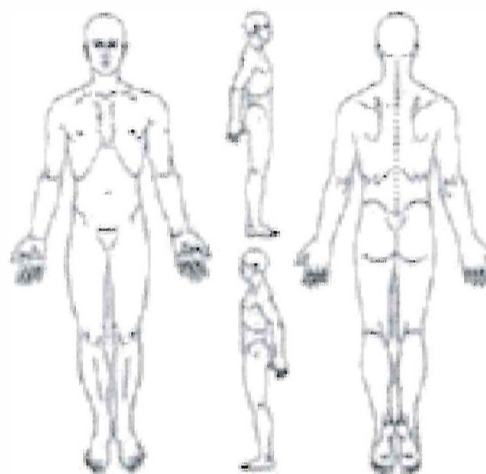
Circle the words that describe your pain:

Burning Aching Sharp
 Electric Throbbing Stabbing
 Prickling Shooting Numbing
 Cramping Stinging Dull
 Constant Frequent Occasional
 Other: _____

Circle your average pain:

None 0 1 2 3 4 5 6 7 8 9 10 Worst

Shade your painful areas:



What makes the pain worse:

What makes the pain better:

List all current medications, dosage, and frequency (prescription, over the counter & herbal):

Review of Systems:

Do you have a history of any of the following?

☐ **Neurologic Disease**

seizures, strokes, headaches, other:

☐ **Cardiac Disease**

heart attack, irregular heartbeat, other:

☐ **Vascular Disease**

high blood pressure, poor circulation, other:

☐ **Pulmonary Disease**

COPD, asthma, sleep apnea, other:

☐ **Kidney Disease**

kidney stones, incontinence, other:

☐ **Liver Disease**

hepatitis, jaundice, other:

☐ **Endocrine Disease**

diabetes, thyroid problems, other:

☐ **Bleeding problems**

take blood thinners, hemophilia, other:

☐ **Gastrointestinal Disease**

ulcers, irritable bowel, Crohn's, other:

☐ **Immune Disease**

recent infection, HIV, other:

☐ **Skin Disease**

psoriasis, rashes, other:

☐ **Rheumatologic Disease**

arthritis, lupus, fibromyalgia, RA, other:

☐ **Mental Illness**

depression, bipolar, PTSD, other:

☐ **Cancer**

Past Medical History:

List all medical problems:

List all surgeries:

Social History:

Marital Status? _____

Children? _____

Are you currently working and at what occupation? _____

What is the highest level of education you achieved? _____

Do you smoke or use tobacco products? _____

How often do you consume alcohol? _____

Do you use any illicit or street drugs? _____

Family History:

Do any relatives suffer from similar pain complaints? _____

Is there a family history of cancer, arthritis, substance abuse or bleeding disorders?



Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED BY THE CRYSTAL COAST PAIN MANAGEMENT DIVISION OF EAST CAROLINA ANESTHESIA ASSOCIATES AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

YOUR RIGHTS: When it comes to your health information you have certain rights. This section explains your rights.

Upon written request:

- Ask to see or get an electronic or paper copy of your health record or other information we have about you. We will also provide a summary of your health information if requested. We will charge a reasonable, cost-based fee. We will provide this information as soon as possible but no later than 30 working days of the request.
- Ask us to correct your health information you think is incorrect or incomplete. We may say “no” but will tell you why in writing within 60 days.
- You can ask us to communicate with you in a certain way (for example, home or office phone) or to send mail to a different address. We will accommodate all reasonable requests.
- Ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree with your request and may say “no” if it would affect your care.
- If you pay for a service or health care item out of pocket in full and you ask us not to share that information for payment or our operations with your health insurer we will agree unless we are required by law to share that information.
- Ask us for a list or an accounting of the times we have shared your health information for reasons other than treatment, payment, healthcare operations, and when you have asked us to share information. We will provide a list for the past six years for the request. One request per year will be provided free of charge. For additional requests we will charge a reasonable, cost-based fee.
- Revoke an authorization to use or disclose PHI at any time except where action has already been taken.

You may also:

- Choose someone to act on your behalf. If you have given someone medical power of attorney or they are your legal guardian, that person can exercise your rights and make choices about your health information. We will ask for proof of this relationship before we take any action.
- Ask for a paper copy of this document even if you have agreed to receive the notice electronically. We will provide that copy promptly.
- File a complaint if you feel your rights have been violated you may contact the designated Privacy Officer, the Practice Administrator, 2111 Neuse Blvd, Suite J, New Bern, NC 28560, 252-636-0300, info@crystalcoastpm.com.
- File a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, D.C. 20201, calling 1.877.696.6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.
- We will not retaliate for filing a complaint.

OUR RESPONSIBILITIES: The law requires us to:

- Maintain the privacy and security of your protected health information.
- Notify you promptly if a breach occurs that may compromise the privacy or security of your information.
- Follow the duties and privacy practices described in this notice and give you a copy.
- Not to use or share your information other than what is described in this notice unless you communicate approval in writing. If you initially provide approval and then change your mind, please let us know in writing.

YOUR CHOICES - For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us.

- In these cases, you have both the right and the choice to tell us to: share information with your family, close friends, or others involved in your care and share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases, we never share your information unless you give us written permission:
 - Marketing purposes
 - Sale of your information
 - Most sharing of psychotherapy notes
 - In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURE – We typically use or share your health information in the following ways:

Treatment: We can use your health information and share it with other professionals who are treating you. Example: we may share your health information with an outside doctor for a referral. We will also provide your health care providers with copies of various reports to assist them with your treatment.

Payment: We can use or share your health information to bill and get payment from health plans or other entities. Example: we give information about you to your health insurance plan so it will pay for your healthcare.

Health Care Operations: We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: we use health information about you to manage your treatment and services.

Other ways we can use or share your health information – We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes.

- **Help with public health and safety issues:** We can share health information about you for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medication, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health and safety.
- **Comply with the law:** We will share information about you whether state or federal laws require it, including with the Department of Health and Human Services if it wants to see if we are complying with federal privacy law.
- **Respond to organ and tissue donation requests:** We will share health information about you with organ procurement organizations.
- **Work with a medical examiner or funeral director:** We can share health information with a coroner, medical examiner, or funeral director when you die.
- **Address workers' compensation, law enforcement, and other government requests:**
 - For workers' compensation claims
 - For law enforcement purposes or with a law enforcement official
 - With health oversight agencies for activities authorized by law
 - For special government functions such as military, national security, and presidential protective services
- **Respond to lawsuits and legal actions:** We can share your health information to respond to a court or administrative order, or in response to a subpoena.
- **Research:** We can use or share your information for health research.

CHANGES TO THIS NOTICE - We can change the terms of this notice, and the changes will apply to all the information we have about you. The new notice will be available on request, in our office and on our website.

Effective date: January 1, 2026



Notice of Privacy Practices Acknowledgment:

I understand that, under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights regarding the privacy of my protected health information (PHI). I acknowledge that I have received, or have been given the opportunity to receive, a copy of The Crystal Coast Pain Management division of East Carolina Anesthesia Associates' Notice of Privacy Practices.

I understand that this practice reserves the right to change its Notice of Privacy Practices and that I may request a current copy at any time.

Patient Name or Legal Guardian: _____

Signature: _____ **Date:** _____

Communication Authorization

I authorize the Crystal Coast Pain Management division of East Carolina Anesthesia Associates to contact me regarding appointments, treatment, and billing information using the following methods (please check all that apply):

- ☐ Leave a message or speak to me on my home phone
- ☐ Leave a message or speak to me on my mobile phone
- ☐ Send a text message to my mobile phone
- ☐ Send an email to: _____

Authorization to Release Information to Others

I authorize CCPM/ECAA to share my health and billing information with the individuals listed below. This may include information related to my diagnosis, test results, treatment, prescriptions, appointments, and financial matters.

This authorization will remain in effect until I notify CCPM in writing that I wish to change or revoke it.

By signing below, I authorize the **Crystal Coast Pain Management division of East Carolina Anesthesia Associate** to use and disclose my protected health information (PHI) to the following person(s):

Name: _____ **Phone:** _____
Relationship: _____

Name: _____ **Phone:** _____
Relationship: _____



2026 Financial Policy

We are pleased to participate in your health care and look forward to establishing a lasting relationship with you. Our goal is to provide clear information so you can make informed decisions regarding your financial responsibility.

While we are happy to assist with insurance information, your medical insurance is a contract between you and your insurance company. For this reason, you are ultimately responsible for payment of all charges incurred for services provided by The Crystal Coast Pain Management division of East Carolina Anesthesia Associates.

Patients with an outstanding balance may be required to pay the balance in full before scheduling future appointments or being seen by a provider.

1. Co-Pays, Deductibles and Non-Covered Services

All co-payments, deductibles, and fees for services not covered by your insurance are due at the time of service.

We accept: Cash, Check, Visa, Mastercard and American Express

Online payments are accepted through the patient portal

Returned checks due to insufficient funds will incur a **\$40.00 fee**.

2. Insurance

Patients (or responsible parties) must complete all required insurance forms and present a current insurance card at each visit. If a valid insurance card is not provided or your insurance cannot be verified, you will be considered self-pay and responsible for the full balance.

Please note:

- Participating with an insurance plan and accepting insurance are not the same.
- Some services may be considered non-covered by your plan, in which case you are responsible for payment in full.
- Per North Carolina Statute 58-22-253, most insurers are required to process a properly submitted claim within 30 days. If your insurance company does not pay a claim within 60 days due to missing or incomplete information that you have not provided, the balance will be transferred to your account and become your responsibility. If payment is later received, you will be reimbursed accordingly.
- The CCPM division of ECAA only accepts Medicaid as a secondary insurance

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3. Authorization / Pre-Certification

We will assist with obtaining insurance authorizations when possible; however, it is your responsibility to ensure that required authorizations are in place prior to your visit.

If services are rendered without authorization and your insurance denies payment, you will be responsible for the full cost of services provided.

4. Third-Party Liability (Auto Accidents, Injury Claims, etc.)

If your visit is related to a third-party liability claim (such as a motor vehicle accident or injury claim), payment is due in full at the time of service.

The Crystal Coast Pain Management division of East Carolina Anesthesia Associates:

- Does not delay or hold charges pending legal settlement
- Does not accept letters of protection
- Does not bill or negotiate with third-party liability insurers

You remain financially responsible for all services rendered, regardless of pending claims or litigation.

5. Appointments and Missed Visits

Please provide **at least 24 hours' notice** if you need to cancel or reschedule.

Missed Appointment Fees:

- Office visit: **\$50.00**
- Procedure visit: **\$150.00**

Patient Initials: _____

Missed appointment fees must be paid prior to your next visit. Repeated missed appointments may result in discharge from the practice.

Late Arrivals: Patients arriving more than 15 minutes late may be required to reschedule their appointment.

Assignment of Benefits & Authorization

I authorize payment of insurance benefits directly to **East Carolina Anesthesia Associates** for services provided. I authorize the release of medical and insurance information necessary to process claims and determine benefits.

I have read, understand, and agree to the Financial Policy.

Signature: _____ **Date:** _____

Printed Name: _____ **Witness:** _____



Authorization to Disclose Protected Health Information

The undersigned authorizes

Name/Facility: _____

Fax: _____

to release my health information as noted below:

All sections must be completed in order for request to be processed

Patient Information

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Former Names? _____

City: _____ State: _____ Zip: _____ Phone #: _____

Release Information To (THIS SECTION MUST BE COMPLETED)

****Please circle which Office or Department FAX number to send FAX too****

☐ Crystal Coast Pain Management 2111 Neuse Blvd Ste. J New Bern, NC 28560 PH: 252-636-0300 FAX: 252-636-0335	☐ Crystal Coast Pain Management 5053 Executive Dr. Unit B Morehead City, NC 28557 PH: 252-726-8480 FAX: 252-726-8638	☐ Crystal Coast Pain Management 57 Office Park Dr. Jacksonville, NC 28546 PH: 910-353-6008 FAX: 910-353-6009
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Separate Department Fax Numbers:

New Patient/Referrals Dept.: FAX: 252-772-9994

Insurance Authorizations Dept.: FAX: 252-649-2977 (Tricare & BCBS only)

Insurance Authorizations Dept.: FAX: 252-565-0948 (Insurances "Except BCBS and Tricare")

Purpose of request: _____

Information to be Released (THIS SECTION MUST BE COMPLETED)

☐ Office Notes ☐ Labs ☐ Operative Notes ☐ Diagnostic Reports ☐ Physical Therapy

Specify "All" or Specific Date(s) of Service: _____

☐ Other (Please Specify): _____

Authorization to Release Protected Health Information

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.* _____ (Please Initial)

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will expire on the following date, event or condition:** _____ If I do not specify expiration this authorization will expire in 1 year.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.



Please confirm that you have filled out this form in its entirety—if form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Signature*: _____ Date: _____

* For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.