

AppPain Management

Thank you for choosing AppPain Management as your healthcare provider. We look forward to seeing you at your appointment.

This new patient information packet includes directions to our office and contact information for your records. Also enclosed is the paperwork that you will need for your upcoming appointment. Please complete the paperwork enclosed and bring it to your appointment. Our Billing & Insurance Information, Notice of Privacy Practices and Patient Bill of Rights & Responsibilities are available online at unchealthappalachian.org.

AppPain Management provides comprehensive care for individuals experiencing acute or chronic pain through a wide range of interventional and non-interventional treatment options. AppPain Management is committed to delivering personalized pain management consultations and innovative treatments to help patients regain comfort and quality of life. A referral is preferred.

Services Include:

Injections-Based Procedure

- Epidural steroid injections (ESIs)
- Facet Joint injections
- Trigger Point Injections
- Nerve Blocks
- Radiofrequency Ablation (RFA)
- Intradiscal Injections
- Peripheral Joint/Bursa Injections
- Sacroiliac Joint Injections
- Botox Injections
- Cryoneurolysis (Cryoablation)
- Platelet-Rich Plasma (PRP) Therapy

Minimally Invasive Spine Procedures

- Kyphoplasty
- Spinal Cord Stimulation
- Peripheral Nerve Stimulation
- Basivertebral Nerve Ablation
- Sacroiliac Joint Fusion
- Multifidus Restorative Neurostimulation

Acupuncture/Electroacupuncture Osteopathic Manipulative Treatment (OMT) Pain Management Consultations

Contact Us

Phone & Fax

Phone: (828) 265-5493

Fax: (828) 266-1176

Hours

Monday - Thursday: 8:00 a.m. - 5:00 p.m.

Friday: 8:00 a.m. - 12:00 p.m.

Location

261 Longvue Drive

Boone, NC 28607



New Patient Checklist

For your first appointment, please arrive 15 minutes early and bring the following:

- Insurance Card
- Pharmacy Information
- Medical Records
- Payment
- Current Medications/Prescription Bottles
- Questions for doctor
- Photo ID
- Completed forms from this packet

_____ has an appointment with

Mon. Tues. Wed. Thurs. Fri.

_____ date _____ a.m./p.m.

To reschedule your appointment, please call (828) 265-5493.

UNC
HEALTH®
Appalachian

unchealthappalachian.org

08/19/25



Patient Name	_____
Date of Birth	_____
MRN	_____
CSN	_____
Please Fill in or Affix a Patient Label	

Patient Registration Form (ARMA)

Form #11332

Patient Name: First _____ M/I _____ Last _____

Date of Birth: ___/___/___ **Gender:** Male Female **Social Security #:** ___-___-___

Marital Status: Married Single Divorced Separated Widowed Life Partner

Mailing Address: Street- _____

City- _____ State- _____ Zip Code- _____

Primary Phone #: _____ Cell Home

Secondary Phone #: _____ Cell Home

Work Phone #: _____ **Employer/Occupation:** _____

E-mail: _____

Emergency Contact: _____ **Relationship to patient:** _____ **Ph #:** _____

I consent to Appalachian Regional Medical Associates (“ARMA”) or its representatives: calling my phone and leaving a message texting me (message and data rates may apply) e-mailing me about balances due, financial assistance, appointments, pre-registration, lab results, and other healthcare information. Methods of contact may include pre-recorded voice messages and the use of automatic dialing services.

What is your ethnicity? Hispanic or Latino Not Hispanic or Latino

Select one or more races to indicate what you consider yourself to be: Asian White

American Indian or Alaskan Native Black or African American

Native Hawaiian or other Pacific Islander Other: _____

Preferred language? English Spanish Other: _____

How did you hear about us?

Billboards Doctor Friends/Family Magazine Newspaper Social Media Radio TV

ARHS Website Other _____

If patient is a minor please print Guardian Name:

First: _____ M/I: _____ Last: _____

If patient has a guarantor (someone else responsible for the bill) please provide information below:

Patient’s relationship to Guarantor: _____

Guarantor’s Name: First: _____ M/I: _____ Last: _____

Mailing Address: Street- _____

City- _____ State- _____ Zip- _____

Date of Birth: ___/___/___ Social Security #: ___-___-___ Phone #: _____

Employer: _____ Employer Phone #: _____

Signature of Patient/ Legal Representative ▶		Date: Time:
Name of Patient/ Legal Representative (Please Print) ▶	Relationship of Legal Representative ▶	

Patient Name	_____
Date of Birth	_____
MRN	_____
CSN	_____
Please Fill in or Affix a Patient Label	

Patient Information (Adult)-ARMA
Form #11580

Date: _____ Male Female Date of Birth: ____/____/____
Name: First _____ Middle _____ Last _____
Address: _____ City/State/Zip: _____
Home Phone: _____ Work Phone: _____
Marital Status: Single Married Widowed Separated Divorced
Education Level: _____ Occupation: _____
Employer: _____

Reason for Today's Visit: _____

Medical History

Medications:
1. Non-Prescription - any taken regularly
 Vitamins Aspirin
 Laxatives Antacids
 Decongestants Tylenol
 Other: _____

2. Prescription – (including Birth Control Pills)

<u>Medication</u>	<u>Dosage</u>	<u># Times/Day</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Immunizations: (Any Recived)
 Measles German Measles
 Mumps Smallpox
 Hemophilus Pneumonia
 Hepatitis Influenza
 TB Skin Test: _____ Pos: _____ Neg: _____
 Tetanus Series (Dates): _____
Allergies: (Any You Are Allergic To)
 Animals Demerol Penicillin
 Aspirin Grasses Pollens
 Codeine Insect Bites Sulfa
Based on answer above:
Which Antibiotics? _____
Which Foods? _____
 Other: _____
What reaction? _____
 No Known Allergies

Habits:
Do you use tobacco? Yes No
 Chew Smoke
If yes, what kind? _____
If yes. How much? _____
Do you drink alcohol? Yes No
Do you use drugs? Yes No
Do you drink caffeinated beverages? Yes No
Do you wear your seat belt? Yes No
Do you wear a helmet when biking? Yes No
Do you wear sunscreen/sunglasses? Yes No
Do you sleep well? Yes No
Do you eat well? Yes No
Do you exercise regularly? Yes No
Do you examine breasts/ testes monthly? Yes No
Have you used Narcotics or additive drugs? Yes No
Types: _____
In your home do you have:
Smoke detectors? Yes No
Carbon monoxide detectors? Yes No
Have you been exposed to chemicals, toxins, poisons, fumes, smoke or radioactive materials at home or work?
 Yes No How often? _____
Types: _____
Have you experienced any of the following?
 Marriage difficulties Job difficulties
 Sexual difficulties Sexual attack
 Nervous breakdown Sleep difficulties
 Emotional problems Depressions
How many people live in your Home? _____

Patient Name	_____
Date of Birth	_____
MRN	_____
CSN	_____
Please Fill in or Affix a Patient Label	

Medical History-ARMA
Form #11577

Please list any hospital stays, surgical operations, or serious illnesses, starting with the most recent.

Hospital stays, surgical operations, serious illnesses	Date	Hospital
1.		
2.		
3.		
4.		
5.		

Have you ever received any blood transfusions? Yes No When? _____

Drug Allergies: (Please include type of reaction) Yes No

Drug Name _____ Reaction _____

Drug Name _____ Reaction _____

Latex Allergy

Contrast/ IV Dye/ Shellfish Allergy

Medication List: None

(list names, dosages and frequency of all medications, aspirin, OTC meds and vitamins)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Social History:

Tobacco Use: Yes No Never used

Cigarettes Other tobacco _____ Year(s) Smoked _____ Pack(s)/day

Former tobacco use _____ Year(s) Smoked _____ Pack(s)/day

Alcohol Use? Yes No Never used

If yes, how much? _____

Illicit Drug Use? Yes No Never used

If yes, please specify: _____

Caffeine Use? Yes No Never used (coffee, soda, tea)

If yes, how much? _____

Patient Name	_____
Date of Birth	_____
MRN	_____
CSN	_____
Please Fill in or Affix a Patient Label	

Check if you have or family member has ever had, any of the following conditions:

	You	Family		You	Family
Unexpected weight change of more than 10 lbs In the past year			Asthma		
Serious problems with eyes or ears			Birth defects		
Persistent swollen glands/unusual lumps			Bleeding problems		
Breast lumps or unusual discharge			Cancer		
Irregular or fast heartbeat			Lung diseases		
Chest pains or tightness			Depression		
Frequent swelling of ankles or legs			Sickle cell		
Unusual skin problems or persistent sores			Diabetes		
Redness, severe pain or swelling of joints			Heart attack		
Frequent or severe back pain			Heart disease		
Change in appetite			High blood pressure		
Difficulty swallowing			High cholesterol		
Frequent or severe abdominal pain			Mental retardation		
Frequent nausea or vomiting			Nervous breakdown		
Frequent or severe constipation/diarrhea			Seizures		
Blood in a bowel movement			Stroke		
Black or tarry stools			Thyroid problems		
Pain or burning with urination					
Genital problems					
Problems with pregnancy					

What questions do you wish to ask the doctor?

1 _____

2 _____

3 _____

Do you have a living will or Health Care Power of Attorney? Yes No
 (If Yes please bring a copy with you to your appointment.)

I certify that the above information is correct to the best of my knowledge:

Signature of Patient/Legal Representative	Date: Time:
Printed Name of Legal Representative	Relationship of Legal Representative
Signature of Reviewer (<i>OFFICE USE ONLY</i>) ▶	Date: Time:

GENERAL CONSENT FOR TREATMENT (PAGE 1 of 2)

HIM #129s

I understand that the University of North Carolina Health Care System (UNC Health) is an integrated health system made up of various entities as reflected at www.unchealthcare.org/documentapplicability (each referred to in this form as a “UNC Health affiliate” or collectively as “UNC Health affiliates”). **This consent will be effective for 1 year after the date I sign it at any UNC Health affiliate of which I am a patient; however, this consent will not expire for services, claims processing or collection activities for admissions or visits occurring while this consent was in effect.**

Consent for Treatment/Care

I consent to treatment and care by UNC Health affiliates and by their physicians and health care providers, including those who are located at sites other than the one at which I am present and who provide treatment and care through electronic communications/telemedicine. I also consent to treatment and care by physicians and health care providers who are not employees or agents of UNC Health affiliates (including but not limited to physicians and providers in the specialties of emergency medicine, anesthesia, surgery, pathology, psychiatry, obstetrics and gynecology, radiology, oncology, cardiology, neurology, pediatrics and internal medicine) but are authorized by UNC Health affiliates to provide treatment and care to me as a patient of the UNC Health affiliate, and who provide services to the UNC Health affiliates’ patients in accordance with their professional judgment (collectively, “Independent Providers”). I understand that my treatment and care may include routine care, such as immunizations, and a variety of other medical services depending on my condition, such as laboratory testing. I can receive a list of services and care that I have received from UNC Health affiliates. I understand that my care team at UNC Health affiliates may include resident physicians and students or other trainees. I am aware that the practice of medicine (including surgery) is not an exact science, and no one has made any guarantees about the results of my treatments, examinations, or procedures.

Consent for Use and Release of Information

I give permission to UNC Health affiliates – including their treating and referring providers and other staff members – to release any information about me, my health, the health services provided to me, or payment for my health services as permitted by law. For more detailed information about the way my information may be used or released, I can read UNC Health’s *Notice of Privacy Practices*.

I give permission to UNC Health affiliates and their employees, agents, and contractors to take photographs or make videos of me for permissible treatment, payment, health care operations, education and for research purposes where either I have given consent or an Institutional Review Board has approved as long as such recordings are consistent with policies and laws that protect my rights.

Consent for Use Within UNC Health

I further give permission to UNC Health affiliates and their treating providers and other staff members to disclose to each other any of my sensitive information necessary for my treatment, including information related to behavioral and/or mental health (including records of my treatment by a facility whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, developmentally disabled, or substance abusers, as defined by N.C.G.S. Chapter 122C, Articles 1 and 3), drugs and alcohol (including records of a provider that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 C.F.R. Part 2), HIV/AIDS and other communicable diseases, and genetic testing.

Financial Responsibility

I understand and agree that physician charges for medical and related professional services performed or supervised by a physician will be billed separately from hospital charges. I understand that my actual charges may be different from charge estimates given to me. I also understand that an insurance company may not pay the full amount of my charges, and I may be responsible (as a patient, spouse, guardian, or the parent of a minor child) for the amount not paid. If I do not have health insurance or have not provided current or accurate insurance information, I am responsible for payment of all charges. If I have overpaid any of my accounts with a particular UNC Health affiliate, I agree that the overpayment may be applied to pay any outstanding charges on any of my accounts with other UNC Health affiliates. I designate UNC Health as my authorized representative with respect to any health or liability insurance policy or any group health plan, fund or program applicable to me, and I authorize UNC Health to exercise on my behalf any grievance, claim or appeal rights, including external review rights, I may have under any such health or liability insurance policy or group health plan, fund or program.

Medicare/Medicaid/Insurance Certification, Assignment & Payment Request

I have been informed that Medicare will only pay for services that it determines to be reasonable and necessary under section 1862(a)(1) of the Medicare Law. I certify that the information given by me or by my authorized representative in applying for payment for my health care under the Medicare or Medicaid programs is correct. I request that payment of authorized benefits be made to the appropriate UNC Health affiliate on my behalf. I authorize UNC Health affiliates to bill directly and assign the right to



* S D C O N A U T *

all health and liability insurance benefits otherwise payable to me, and I authorize direct payment to the appropriate UNC Health affiliate.

Social Security Number

I have given my social security number voluntarily. UNC Health affiliates may use it for accurate identification, filing insurance claims, billing and collections, and compliance with federal and state laws.

Wireless Telephone Number and Electronic Mail

UNC Health affiliates, Independent Providers (as defined above), and/or any of their respective agents, representatives, or business associates (including their billing service providers or debt collectors), may contact me by electronic mail or telephone (including phone calls, prerecorded messages using automated technology, or text messages) at any electronic mail address or number contained in my UNC Health affiliate's or my Independent Provider's records, including wireless telephone numbers, for the purposes of communicating with me about my health care, requesting information about patient satisfaction, servicing my account, and/or collecting amounts due. I also understand that UNC physician researchers or members of their research team may also contact me via phone or electronic mail to determine my interest in participating in human subjects research. I consent to receive electronic mail, text messages, phone calls, and prerecorded messages using automated technology from UNC Health Care affiliates, Independent Providers, and/or any of their respective agents, representatives or business associates, including their billing service providers or debt collectors. I understand that consent to receive electronic mail, text messages, phone calls, and prerecorded messages using automated technology is not required to receive health care services. I understand that if I wish to revoke consent to receive communications from UNC Health affiliates via phone calls, text messages, prerecorded messages using automated technology, or electronic mail, I may do so by following the instructions in the communication regarding opt-out, if any, or by calling UNC Health Customer Service at (888) 996-2767. If I wish to revoke consent to receive communications from an Independent Provider via phone calls, text messages, prerecorded messages using automated technology, or electronic mail, I may do so by following the instructions in the communication regarding opt-out, if any, or by contacting the Independent Provider directly.

Personal Property

Unless I am a resident of a skilled nursing facility, I understand that UNC Health affiliates do not assume responsibility for my personal belongings that I keep in my possession, and I release UNC Health affiliates from all liability for the loss or theft of, or damage to, such belongings.

I UNDERSTAND THAT I MAY WITHDRAW THIS CONSENT IN WRITING. MY WITHDRAWAL WILL NOT BE EFFECTIVE FOR ACTIONS ALREADY TAKEN BY ANY UNC HEALTH CARE AFFILIATE, OR IN PROGRESS.

I AUTHORIZE UNC HEALTH CARE AFFILIATES TO RELEASE ALL RECORDS REQUIRED TO ACT ON THESE REQUESTS. I HAVE READ AND UNDERSTAND THIS FORM, BEEN OFFERED A COPY, AND I AM THE PATIENT OR I AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS FORM.

DATE: _____ TIME: _____
PATIENT SIGNATURE (or Authorized Representative)

PRINTED NAME

RELATIONSHIP, if not patient: _____

GUARANTOR OF PAYMENT: This line may be signed by someone who wishes to agree to be responsible for payment *other than*: 1) the patient, 2) the patient's spouse, or 3) a minor patient's parent.

By signing as guarantor below, I agree to pay all charges of any UNC Health Care affiliate not paid, **even if I am otherwise not legally obligated to pay.**

DATE: _____ TIME: _____
GUARANTOR OF PAYMENT SIGNATURE

PRINTED NAME



Patient Name _____
Date of Birth _____

Limited Release of Information to Family/Friends for Physician Clinics
HIM# 1315s

I give my permission to my physician practice that is part of the UNC Health Care System to share certain personal health information about me with the individuals listed below. These individuals will only be given information about me that is related to their involvement in my care or payment for my care.¹ I understand that I am not required to complete this form in order to obtain health care.

Name: _____ Phone Number: _____

Relationship: _____ Talk to this person about (*check each box that applies*):

Any non-sensitive² information regarding my health care or payment for my health care.

OR

Only these things:

My appointments – scheduling & reminders	My test results
My after visit summary (AVS)	My bills
Other:	

Name: _____ Phone Number: _____

Relationship: _____ Talk to this person about (*check each box that applies*):

Any non-sensitive² information regarding my health care or payment for my health care.

OR

Only these things:

My appointments – scheduling & reminders	My test results
My after visit summary (AVS)	My bills
Other:	

If I change my mind about the people or the contact information I have listed in this form, I will complete a new form with such changes.

DATE: _____ TIME: _____

PATIENT SIGNATURE (or Authorized Representative)

PRINTED NAME & RELATIONSHIP (if not patient): _____

¹ This form is not a substitute for a health care power of attorney or other formal designation of an individual authorized to make health care decisions for you if you are not able. If an individual listed above is your guardian or agent (under a power of attorney), or is otherwise authorized by law to act on your behalf, your health care provider may share as much of your personal health information with that person as the law permits.

This form is not a substitute for a valid HIPAA compliant written authorization when it is required to release copies of medical and billing records or information.

² Non-sensitive information excludes mental health, alcohol and substance abuse, HIV and other communicable diseases, and genetic testing. **This form is not considered sufficient authorization to release sensitive information.**

