**PATIENT INFORMATION: Date of Service:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Sex: M F Marital Status: S M D W Social Security No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Driver’s License No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of person responsible for payment (guarantor): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Race (Question required by the Affordable Care Act):**

 American Indian or Alaskan Native  African American  Asian or Pacific Islander  Caucasian  Refuse to Report

**Ethnicity (Question required by the Affordable Care Act):**  Hispanic  Non- Hispanic  Refuse to Report

**Were you injured on the job**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you filed a claim? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What other specialists have you seen regarding your pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION:**

Name of PrimaryInsurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s Social \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Relationship to Patient:  Self  Spouse  Child  Other Policy Holder Gender:  Male  Female

Insurance ID No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Group No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of SecondaryInsurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s Social \_\_\_\_\_\_\_\_\_\_\_

Policy Holder Relationship to Patient:  Self  Spouse  Child  Other Policy Holder Gender:  Male  Female

Insurance ID No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Group No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is your occupation?** **What is your age?** **When were you in the hospital last? Why?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who is your family doctor?** **Who referred you?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Habits**

Smoke Yes No Chew Tobacco Yes No

Alcohol Yes No How long \_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History & Years Medication Allergies Medications**

Arthritis Yes No \_\_\_\_\_\_\_ \_\_ None Known Name / strength/ how often you take them

Cancer Yes No \_\_\_\_\_\_\_ \_\_ Sulfa \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes Yes No \_\_\_\_\_\_\_ \_\_ Codeine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High Blood Pressure Yes No \_\_\_\_\_\_\_ \_\_ Aspirin \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Disease Yes No \_\_\_\_\_\_\_ \_\_ Penicillin \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Attack Yes No \_\_\_\_\_\_\_ \_\_ Other please list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma Yes No \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emphysema Yes No \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lung Disease Yes No \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hypothyroidism Yes No \_\_\_\_\_\_\_

Stroke Yes No \_\_\_\_\_\_\_ **Social History**

High Cholesterol Yes No \_\_\_\_\_\_\_ \_\_ Single \_\_ Separated Height \_\_\_\_\_\_\_\_\_\_\_\_

Kidney Disease Yes No \_\_\_\_\_\_\_ \_\_ Widowed \_\_ Married, how long? Weight \_\_\_\_\_\_\_\_\_\_\_

Liver Disease Yes No \_\_\_\_\_\_\_ \_\_ Divorced \_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Yes No \_\_\_\_\_\_\_ Do you live alone? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who do you live with? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History (detail)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Surgical History**

Heart Bypass/Valve Yes No \_\_\_\_\_ Pacemaker Yes No \_\_\_\_\_ Carotid Neck Surgery Yes No \_\_\_\_\_

Gall Bladder Yes No \_\_\_\_\_ Hysterectomy Yes No \_\_\_\_\_ Appendectomy Yes No \_\_\_\_\_

**Trauma History**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:** Cancer Diabetes High Blood Pressure Heart Disease Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Family History of Substance Abuse Female Male N/A**

Alcohol [ ] [ ] [ ]

Illegal Drugs [ ] [ ] [ ]

Prescription Drugs [ ] [ ] [ ]

1. **Personal History of Substance Abuse Yes No**

Alcohol [ ] [ ]

Illegal Drugs [ ] [ ]

Prescription Drugs [ ] [ ]

**3) History of Pre-Adolescent Sexual Abuse Yes No**

**4) Psychological Disease Yes No**

Attention Deficit Disorder [ ] [ ]

Obsessive Compulsive Disorder [ ] [ ]

Schizophrenia [ ] [ ]

Depression [ ] [ ]

Anxiety [ ] [ ]

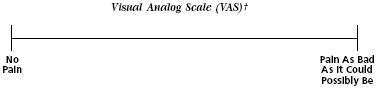
|  |  |  |
| --- | --- | --- |
| Review of Systems | | |
| List any problems you have or have had recently in the following areas | | |
| CIRCLE THE SYMPTOMS YOU ARE CURRENTLY HAVING | | |
|  |  |  |
| General Constitutional (fatigue, fever, unintentional weight gain, unintentional weight loss | Yes | No |
| Head & Face (frequent headaches, frequent face pain, drooping on one side of face) | Yes | No |
| Eyes (blurry vision, red eyes, sensitivity to light) | Yes | No |
| Neck (neck masses, pain in the neck, swollen glands) | Yes | No |
| Heart and Blood Vessels (blacking out or fainting, chest pain, irregular heartbeat) | Yes | No |
| Lungs and Respiratory System (shortness of breath, wheezing and frequent productive cough) | Yes | No |
| Stomach and Digestive (abdominal pain, frequent nausea, frequent vomiting) | Yes | No |
| Bones, Joints or Muscles (cramping, pain in the back, painful joints, stiffness & weakness) | Yes | No |
| Brain and Nervous System (change in alertness, seizures, loss of consciousness, tingling) | Yes | No |
| Mental and Emotional Health (trouble sleeping, anxiety, depression) | Yes | No |
| Endocrine (increased appetite, increased fatigue, increased thirst, enlarged neck) | Yes | No |
| Allergies, Infections, Immune System (frequent infections, severe reaction to insect bite) | Yes | No |

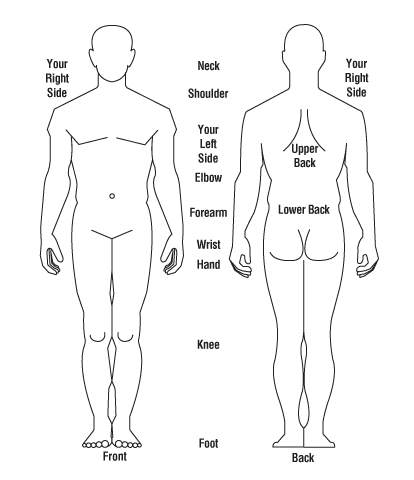
**Name: DOB: Date:**

**Pain Description:**

**Index (Primary): Please use these symbols to VAS: Place a mark (/) on the line below mark your pain on the diagram below. To show the amount of pain you feel today.**  Visual Analog Scale (VAS)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Aching** | **Burning** | **Pins & Needles** | **Stabbing** | **Numbness** |
| **∇∇∇** | **×××** | **•••** | **⊥⊥⊥** | **** |



 **No Pain Pain as bad**

**as it could be**

**{For office use: Index (Primary) Pain Today: \_\_\_\_ / 10}**

**Frequency:** [ ] Constant [ ] Intermittent

**Does this pain radiate? If so, where does it radiate?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Check the column to indicate the level of your pain for**

**Each word, or leave blank if it does not apply to you.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Mild | | Moderate | | Severe |
| 1. Throbbing |  | |  | |  |
| 2. Shooting |  | |  | |  |
| 3. Stabbing |  | |  | |  |
| 4. Sharp |  | |  | |  |
| 5. Cramping |  | |  | |  |
| 6. Gnawing |  | |  | |  |
| 7. Hot-Burning |  | |  | |  |
| 8. Aching |  | |  | |  |
| 9. Heavy |  | |  | |  |
| 10. Tender |  | |  | |  |
| 11. Splitting |  | |  | |  |
| 12. Tiring/Exhausting |  | |  | |  |
| 13. Sickening |  | |  | |  |
| 14. Fearful |  | |  | |  |
| 15. Cruel/Punishing |  | |  | |  |
| S /33 | | A /12 | | VAS /10 | |

**Disability due to pain**: [ ] Enjoyment of life [ ] Normal Work

[ ] Sleep [ ] General Activity [ ] Recreational Activities

[ ] Walking [ ] Mood [ ] Relationships with People

[ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Does your pain wake you up at night? Yes No**

**Are you taking sleep medications? Yes No**

**Do you have trouble controlling your bowels? Yes No**

**Number of healthcare visits in the past 6 months due to pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (BP\_\_\_\_\_\_HR\_\_\_\_\_\_\_RES\_\_\_\_\_\_\_\_WT\_\_\_\_\_\_\_HT\_\_\_\_\_\_\_)**

**Number of ER visits in the past 6 months due to pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name: DOB: Date:**

**Past/current treatments for pain (circle all that apply):**

Opioid medications Muscle relaxants Anti-depressants Anti-inflammatories (Advil, Celebrex, Mobic, etc.)

Anti-Epileptics Epidural injections Facet injections Other injections \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical Therapy Chiropractic treatment

**MRI DATE LOCATION**

**Lumbar \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Neck/Thoracic Spine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Brain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Spine Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please List 4 Activities that you cannot perform due to your pain:**

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Effects of pain (note decreased function or decreased quality of life):**

Accompanying symptoms (e.g. nausea), Appetite, Physical Activity

Relationship with others (e.g. irritability, emotions (e.g. anger, suicidal, crying), concentration

**If pain is a result of *motor vehicle accident*, please describe:**

Date of accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Passenger/Driver Seat-belts/restraints/airbag Vehicle Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Speed/type of other vehicle: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Previous Pain Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Primary care Physician (PCP): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**AUTHORIZATION TO LEAVE MESSAGES CONCERNING YOUR CARE:**

For telephone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ you may leave messages on my answering machine or voice mail for the following: (Please check all that apply)

 Confirming Appointments  Scheduling Procedure Information  Message to Return Call  Billing  All

If you wish us to contact you **via email** for any reason, please provide your email address here: \_\_\_\_

*Please be aware we are not responsible should the email or text get hacked for any reason.*

**NOTICE OF PRIVACY PRACTICES:**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. We will not provide your medical information to your family, friends, or others not directly involved in your medical treatment unless specifically authorized by you in writing. We will not provide your name or other information for the purposes of marketing or fund raising. We strive to protect your health information, but there are situations where your medical information can be disclosed to others as determined by the Federal Government. Your health information may be provided to others for what the government calls “Treatment, Payment, and Operations.” This includes sharing information which other physicians, providers, or pharmacists, reporting to your insurance company or worker’s compensation carrier, legal services, training programs, quality improvement programs, and the like. Your medical bills are sent by mail or by computer to the insurance carriers and may be reviewed by a billing company or clearinghouse before being forwarded to your insurance carrier. Finally, there are exceptions to the privacy agreement; your medical information may be provided to others without your consent in the following situations, as provided by law: (1) State of Texas reporting Public Safety after a seizure, or the duty to prevent a disaster; (2) State of Texas reporting requirements for worker’s compensation claims; (3) State of Texas or local county public health activities; (4) Health oversight activities; (5) Legal proceedings; (6) Police investigations; (7) Any information needed on a deceased patient (i.e. by coroners, etc.); (8) Any information needed for organ donation; (9) Certain types of research such as quality improvement initiatives(identity will be protected); (10) Any information needed by the government and not subject to privacy protection under Federal or State Law. This notice is printed as required by Federal Law.

**EXCHANGE OF INFORMATION:**

I authorize Interventional Pain Associates to disclose to, or obtain from, to the extent allowed by law, my medical and financial record to: (a) any insurance company, attorney, insurance adjuster, employer, or their representatives, agents, or employees that may be responsible for all or part of the payments due for services rendered to the patient; (b) any physician, clinic, hospital, or other healthcare provider who has provided services for me in the past or who may providing future services (e.g. a consulting physician or a facility at which a procedure is to be performed); (c) the Centers for Medicare and Medicaid Services or any other government agency as required by local, state, or federal law; (d) any person or entity to provide quality and/or utilization review. This authorization can be revoked by submitting a request in writing to Interventional Pain Associates, 4613 Bee Caves Rd, Suite 105, Austin, TX 78746.

**FORMS/LETTERS/MEDICAL RECORDS:**

We bill for forms or letters that a provider completes on your behalf. We charge $25 for forms and a copy fee for medical records requested for personal use. There are also additional fees for FMLA, letters to lawyers, etc. Medical records fees are as follows: $35 for the first twenty-five pages (25) and $.25 thereafter for each additional page.

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Print Name of Patient

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Signature of Patient (or responsible party if minor) Date

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Agreement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NARCOTIC AGREEMENT**

We are committed to doing all we can to treat your chronic pain condition. In some cases, controlled substances are used as a therapeutic option in the management of chronic pain, which is strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and the physician by establishing guidelines, within the laws, for proper and controlled substance use. The words “we” and “our” refer to the facility and the words “I,” “you,” “me,” or “my” refer to you, the patient.

**1**. All controlled substances must come from the physician whose signature appears below or, during his/her absence, by the covering physician, unless specific authorization is obtained for an exception.  *I understand that I must tell the physician* whose signature appears below *all drugs that I am taking, have purchased, or have obtained, even over-the-counter medications. Failure to do so may result in drug interactions or overdoses that could result in harm to me, including death.* I will not seek prescriptions for controlled substances from any other physician, healthcare provider, or dentist unless approved by Dr.Saleemi. I understand it is unlawful to be prescribed the same controlled medication by more than one physician at a time without each physician’s knowledge. I also understand that it is unlawful to obtain or to attempt or obtain a prescription for a controlled substance by knowingly misrepresenting facts to a physician, or his/her staff, or knowingly withholding facts from a physician or his/her staff (including failure to inform the physician or his/her staff of all controlled substances that I have been prescribed. ( ).initials

2. I understand that it is unlawful to forge, alter, or modify prescriptions. ( )initials

3. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:

Pharmacy Name:

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4.** You may not share, sell, or otherwise permit others; including spouse or family members, to have access to any controlled substances that you have been prescribed. ( ) initials   
**5.** **Unannounced urine, saliva or serum toxicology** specimens may be requested from you, and your cooperation is required. Presence of unauthorized substances in urine, saliva or serum toxicology screens may result in your discharge from this facility. ( ) initials  
**6.** I will not consume excessive amounts of alcohol in conjunction with controlled substances. I will not use, purchase, or otherwise obtain any other legal drugs except as specifically authorized by the physician whose signature appears below or, during his/her absence by the covering physician, as set forth in Section 1 above. I will not use, purchase or otherwise obtain any illegal drugs, including marijuana, cocaine, etc.

I understand that driving while under the influence of any substance, including a prescribed controlled substance, or any combination of substances (e.g., alcohol and prescription drugs) which impairs my driving ability, may result in *DUI charges*. ( ) initials  
**7.** Medications or written prescriptions may not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen it will not be replaced unless explicit proof is provided with direct evidence from authorities and unless approved by Dr.Saleemi. A report narrating what you told authorities is not enough. ( )initials

**8.** Early refills will not be given except as deemed necessary by Dr.Saleemi. Renewals are based upon keeping scheduled appointments. Please do not phone for prescriptions’ refills after hours or on weekends. ( )initials

**9.** In the event you are arrested or incarcerated related or un-related to legal or illegal drugs (including alcohol), refills on controlled substances will not be given. ( )initials

**10.** I understand that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribed by this physician and ***that law enforcement officials may be contacted***. ( ) initials

**11.** *Reasons for which narcotic therapy will be modified or discontinued with the possibility of a drug taper or non-narcotic withdrawal medication administration* loss or stolen scripts, overuse of medications, *failure of escalating doses of narcotics to provide relief i*n the absence of any demonstrable worsening findings on clinical examination including X-rays/MRI, arrest for driving while impaired, arrest for any alcohol related offence, excessively frequent calls to our clinic regarding chronic pain issues, pre-verification regarding prior. ( ) initials

treatment and substance abuse, canceling appointments for procedures but showing up for office visits, failure to participate in the integrated therapies of our practice, etc.( ) initials

**12** Frequent calls to our clinic for non-urgent issues, *frequent requests of narcotics/controlled substance changes outside appointment times, or histrionic behavior in the* absence of new conditions may make patients non-candidates for continued therapy in our center. Calls made for non-emergent issues or issues which should be handled during office hours may jeopardize continued treatment in our practice. Frequent emergency room visit for pain treatment may result in discharge from this clinic ( ) initials

**13.** I affirm that I have full right and power to sign and be bound by this agreement, and that I have read it and understand and accept all of its terms. By signing this I also agree to be treated with controlled substance should my physician choose to give me one, with the understanding that all controlled drugs have potential of addiction and abuse.

Note: *All refills are subject to Dr. Saleemi‘s discretion, judgment and approval.*

A copy of this document has been given to me.

Print Patient’s /Patient’s representative full Name: Date:

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Patient’s /Patient’s Representative Signature: Date:

**Financial Policy and Assignment of Benefits**

Interventional Pain Associates is committed to providing the best possible care and service to you. We regard your understanding of all your financial responsibilities as an essential element of your treatment.

We have made prior arrangements with many insurers and health plans (PPO & HMO) to accept an assignment of benefits. We will bill those plans and will only require you to pay the authorized copayment, coinsurance and deductible at the time of service. The office policy is to collect this copayment, coinsurance and/or deductible at the time of your appointment. This amount is an **estimate** and is based on the most recent insurance verification obtained by our office staff.

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you, if you assigned the benefits to our doctor. If your insurance company does not pay our office within 90 days, you will be responsible for payment. If we later receive a check from your insurance, we will refund any overpayment.

Not all health plans are the same and do not cover the same services. In the event that your health plan determines a **service to be not covered, you will be responsible for the complete charge**. Payment is due upon receipt of the statement from our office and/or at the time of your office visit.

If your insurance policy requires a referral for Interventional Pain Associates, please understand we will request this referral from your referring practitioner prior to your appointment, but it is ultimately your responsibility to obtain this referral. If your services are denied because the referral was not received, **you will be responsible for the fully charged amount**.

If your insurance requires a pre-authorization we will do our best to obtain this as a courtesy. However, if the pre-authorization is not obtained or otherwise unobtainable with your insurance company, **you will be responsible for the fully charged amount**.

Private pay patients are required to pay in full at the time of service. A quote would be provided for any and all procedures prior to your appointment.

Additionally, if your insurance recoups money in the future, for whatever reason, you are responsible for the balance. We reserve the right to charge your account for any insurance recoupments.

We accept Visa, MasterCard and Discover. We do not accept American Express. Please be advised that there is a $ 50 service charge on returned checks.

If you receive a statement from Interventional Pain Associates the balance needs to be paid in full within 30 days of receipt unless prior arrangements have been made. Any remaining balance due after 90 days would be considered delinquent and will be turned over to an outside collection agency. Future appointments will not be scheduled until the balances have been paid in full and/or a payment plan has been agreed to by our office. Please be sure to update any contact changes with our office staff so you can be reached regarding your balance.

In order to provide the best possible service and availability to our patients, please call us as soon as possible if you know you will need to reschedule your appointment. There will be a $ 25/ cancellation fee charge for all appointments that are missed without advanced notice. This fee must be paid in full or before the missed appointment can be rescheduled.

I hereby assign my medical and surgical benefits, to include major medical benefits, to which I am entitled to Interventional Pain Associates. I hereby authorize and direct my insurance plans, including Medicare, private insurance and other medical/health plan to issue payment checks directly to Interventional Pain Associates for medical services rendered to myself and/or my dependents. In the event that the insurance payment is sent directly to me, I realize that I will be billed personally until the balance is paid.

I have read and understand the financial policy and assignment of benefits of the practice and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

Patient/Responsible Party Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_