INTEGRITY PAIN CONSULTANTS
CENTER FOR REGENERATIVE MEDICINE
Life with less pain.

NEW PATIENT PAPERWORK

PATIENT NAME: _____ DOB: ____/____/____

APPOINTMENT DATE: _____ ARRIVAL TIME: _____

- Your first appointment has been scheduled at our: Hendersonville / Cookeville / Hermitage / St. Thomas West /Skyline/ Stonecrest practice location. Although your scheduled appointment is at _____, you must arrive by _____ so that all of your information may be entered into the system and you can be seen at your scheduled appointment.

- Please allot 2 hours for your first appointment and have all paperwork filled out before arrival.

- We require a 24 hour notice for canceled or rescheduled appointments. If this notice is not given or if you do not call at all (No Call/No Show), a **$50 fee** will be due at the time of your next appointment. If you have to reschedule this appointment or No-Call/No-Show twice, we will notify your referring Physician and you will have to make arrangements to be referred to another practice.

- Bring your Insurance Card and **PHOTO ID**. Photo ID must be State Issued. If you are a self-pay patient, payments must be made by credit or debit card that is in your name. If you use a pre-paid card, this card must be issued in your name. No checks or money orders will be accepted.

- Please limit guests to one (1) person as our office is not large enough to accommodate multiple guests and we need to ensure our patients have a place to sit. Do not bring children to your appointment. If you are unable to find childcare, please reschedule for another date.

  If you have any questions, please call our office and press Option 1 to speak to the receptionist.

103 Hazel Path Ct. Ste 7
Hendersonville, TN 37075
(p) 615.431.5484
(f) 615.447.5959

406 N Whitney Ave. Ste 2
Cookeville, TN 38501
(p) 931.372.1799
(f) 931.372.1866

5114 Old Hickory Blv Ste 201 Hermitage, TN 37076
(p) 615.850.6960
(f) 615.777.3393

St. Thomas West
4230 Harding Pike Ste 807
Nashville, TN 37205
(p) 615.846.9970
(f) 615.777.3393

Skyline
3443 Dickerson Pike. Ste 590 Nashville, TN 37207
(p) 615.860.3500
(f) 615.860.2420

Stonecrest
300 Stonecrest Blvd. Ste 220
Smyrna, TN 37167
(p) 615.625.5400
(f) 615.777.3393

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Patient Demographic Form

Patient Name_____ Date of Birth____/____/____ Gender: M / F

Employer Name_____ Occupation_____

Marital Status_____ SSN_____-_____-_____ Email: _____

Home Address_____

City/State_____ Zip code_____

Home Phone_____ Cell Phone_____ Work Phone_____

Referring Provider: _____

Primary Care Provider_____

Emergency Contact _____ Relationship_____

Phone Number_____

Insurance Information

Primary Insurance_____ Policy Holder_____

Policy Number_____ Subscriber's Name_____

DOB_____/____/_____ SSN_____-_____-_____

Secondary Insurance_____ Policy Holder_____

Policy Number_____

Payment Policy

Co-payments are to be collected at the time services are rendered. All medical services provided are directly charged to the patient or responsible party. If our physician is contracted with your insurance carrier, we will accept their negotiated rate for the charges billed. However, you will be responsible for any balance deemed patient responsibility/non-payable/non-covered by your insurance and billed accordingly. Payment is expected in full upon receipt of statement or payment arrangements must be made with our billing office. If this account is assigned to an attorney for collections and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collections. I hereby assign all medical benefits to which I am entitled to my physician for services rendered to my dependent or me. This assignment will remain in effect until revoked, by me, in writing.

I have read, understand, and agree by the above payment policies.

Printed Name_____

Signature_____**Date**_____/_____/_____

INTEGRITY PAIN CONSULTANTS
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HIPAA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family or another individual?	YES	NO

If YES, please list the names of these individuals:

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Name:_____ Relationship: _____

In the event that a scheduled appointment needs to be rescheduled or canceled, do you authorize the above individuals to do so on your behalf? YES NO

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature:_____ Date:_____

Witness: _____ Date: _____

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Medical Records Request Authorization

PATIENT INFORMATION (Please Print)

First Name: _____ **Last Name**: _____

DOB: _____/_____/_____ **SSN:** _____-_____-_____

I authorize _____ and its employees to release or disclose to the below-named recipient all of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection. I hereby authorize the release of medical records to:

INTEGRITY PAIN CONSULTANTS AND CENTER FOR REGENERATIVE MEDICINE

Purpose of Disclosure: Medical/Pain Treatment

The authorization will expire on: _____ (One Year from Today)

This request and authorization applies to:

_____ All medical records

_____ Health care information relating to the following treatment, condition, or dates of treatment:

_____

_____

_____ Specific records to be released (Ex. Labs, imaging, reports, other)

If you **DO NOT WANT** certain portions of your medical records released, please initial the box for the information you do not want released.

____ Substance abuse _____ Psychological or psychiatric treatment ____ STD/HIV/AIDS

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, expect to the extent it has acted in reliance thereon before notice of revocation. I understand that nay disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing this authorization.

I have read the above and authorize the disclosure of the protected health information as stated.

Patient Signature: _____**Date:** ____/____/_____

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Cancellation Policy/No Show Policy
For Doctor Appointments and Procedures

1. *Cancellation/ No Show Policy for Doctor Appointment*

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a twenty-five ($25) fee; this will not be covered by your insurance company.

2. *Scheduled Appointments*

We understand that delays can happen however we must try to keep the other patients and doctors on time. We ask that you arrive 15 minutes prior to your appointment time so that all paperwork, insurance verification and vitals can be completed and you are seen at your appointment time.

3.*Cancellation/ No Show Policy for Procedures*

Due to the block of time needed for procedures, last minute cancellations can cause problems and added expenses for the office.

If procedures are not canceled at least 24 hours in advance you will be charged a fifty ($50) fee; this is will not be covered by your insurance company.

4. Account balances

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a representative with our billing department with whom they can review their account and concerns.

Patients with balances over $100 must make payment arrangements prior to future appointments being made. If your balance is under $100 then this must be paid before your next appointment.

_____	_____	____/____/____
Print Name Patient	**Signature Patient/Guardian**	**Date**

Name: _____
Date of Birth: _____
Date of Appointment: _____

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PAIN QUESTIONNAIRE

Where is your pain (locations)?and please indicate below

- ☐ Head
- ☐ Neck
- ☐ Back
- ☐ Limbs
- ☐ Abdomen
- ☐ Other locations

A = ache

B = burning

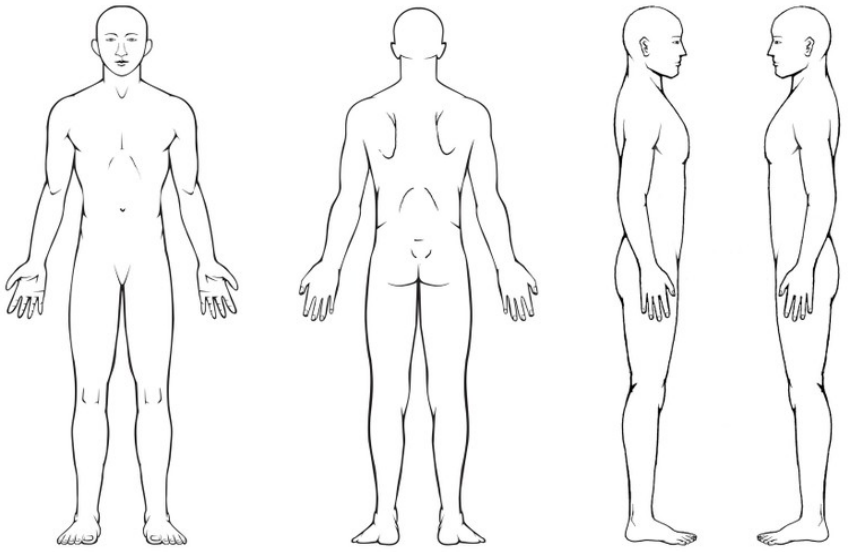
N = numbness

P = pins/needles

S = stabbing

H =shooting

O = other



How long have you had this pain (duration)?

- ☐ Years
- ☐ How many _____
- ☐ Months
- ☐ How many _____
- ☐ Days
- ☐ How many_____

Does your pain travel and where it travel to?

- ☐ Shoulders
- ☐ Upper extremities
- ☐ hands
- ☐ Lower extremities
- ☐ Buttocks
- ☐ Hips
- ☐ Feet
- ☐ None
- ☐ All over

How did your pain start (onset)?

- ☐ Gradually
- ☐ Suddenly
- ☐ Somewhere between
- ☐ Without being noticed

What you think the cause(s) of your pain?

- ☐ Motor vehicle accident(s)
- ☐ Following surgery
- ☐ Fall injury
- ☐ Sports related injury
- ☐ Strenuous labor work
- ☐ Disease related
- ☐ Congenital defects
- ☐ Osteoarthritis
- ☐ Machinery injury
- ☐ Unknown reason

What is your pain pattern?

- ☐ Constant
- ☐ Intermittent
- ☐ Constant with varying intensity
- ☐ Others

Name: _____
Date of Birth: _____
Date of Appointment: _____

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How would you describe your pain?

- ☐ Dull
- ☐ Sharp
- ☐ Stabbing
- ☐ Shooting
- ☐ Aching
- ☐ Throbbing
- ☐ Burning
- ☐ Gnawing

What is your pain score on an average?

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst Pain

What is your pain score while on pain medications?

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst Pain

Do you have any following associated symptoms?

- ☐ Numbness
- ☐ Tingles
- ☐ Pins and needles
- ☐ Weakness
- ☐ Hypersensitivity
- ☐ Allodynia (Centeal pain sensitivity)
- ☐ Paresthesia
- ☐ Photophobia (Sensitivy to light)
- ☐ Phonophobia (Sensitivity to sound)
- ☐ Aura (Intevnsive headaches)
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Temperature changes
- ☐ Paralysis
- ☐ Phantom pain
- ☐ Other symptoms

What makes you pain worse?

- ☐ Standing
- ☐ Walking
- ☐ Walking downhill
- ☐ Walking uphill
- ☐ Sitting
- ☐ Stooping
- ☐ Squatting
- ☐ Lifting
- ☐ Exercise
- ☐ Doing yard work
- ☐ Doing house chores
- ☐ Stress
- ☐ Weather changes
- ☐ Menstruation
- ☐ Medications
- ☐ Any physical activity
- ☐ others

Name: _____
Date of Birth: _____
Date of Appointment: _____

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What alleviates your pain?

- ☐ Sitting
- ☐ Resting
- ☐ Lying down
- ☐ Sleeping
- ☐ Others
- ☐ Exercise
- ☐ TENS unit
- ☐ Hot showers or bath
- ☐ Using heating pads
- ☐ Using cold/ice packs
- ☐ Pain medications
- ☐ Injections
- ☐ Nothing yet

How do you describe quality of your sleep?

- ☐ Sound
- ☐ Difficulty of falling asleep
- ☐ Frequent awakening
- ☐ Can't go back sleep after wake

Please check following all that you have tried to control or help your pain

- ☐ Nerve blocks
- ☐ Trigger point injections
- ☐ Epidural steroid injections
- ☐ Physical and occupational therapy
- ☐ Chiropractor
- ☐ Massage therapy
- ☐ Biofeedback and hypnosis
- ☐ Psychotherapy
- ☐ Psychiatric treatment
- ☐ Spinal cord stimulator
- ☐ Intrathecal (morphine) pump
- ☐ Acupuncture therapy
- ☐ Other remedies

Do you suffer from headaches? ___ Y ___ N If so, on average, how many headache(s) would you say you have each month? _____
If you suffer from more than 15 headaches per month, please fill out our headache questionnaire included to see if Botox for headaches may be an option for you.

Name: _____
Date of Birth: _____
Date of Appointment: _____

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What is your current occupation and how long have you held it?

Occupation: _____
Length of time in this occupation: _____

What test(s) have you had to investigate your pain and where was this performed?

- ☐ Plain x-ray _____
- ☐ EMG _____
- ☐ Nerve conduction studies _____
- ☐ MRI, and where _____
- ☐ CT, and where _____
- ☐ Nyelogram _____
- ☐ Discogram _____
- ☐ Others (please specify) _____

Do you have any of the following medical conditions (please check all that apply)?

- ☐ Heart disease (CAD)
- ☐ Hypertension (high blood pressure)
- ☐ Diabetes (type I or type II)
- ☐ Thyroid disorders (hyper-, hypo-, or cancers)
- ☐ Lungs diseases (COPD, asthma, bronchitis, and emphysema)
- ☐ Sleep apnea (sleep study, CPAP machine and home oxygen use)
- ☐ Gastrointestinal diseases (ulcers, gastritis, colitis, Crohn's disease, hiatal hernia, acid reflux)
- ☐ Liver diseases (hepatitis, cirrhosis, jaundice, ascites)
- ☐ Kidney diseases (kidney stones, infections, UTI, kidney failure, on dialysis)
- ☐ Pelvic diseases (interstitial cycstitis, endometriosis, chronic pelvic pain)
- ☐ Osteoarthritis and degenerative disk diseases
- ☐ Autoimmune diseases (rheumatoid arthritis, MS, lupus, polymyositis)
- ☐ Neurological disorders (stroke, TIA, seizures, epilepsy, neuropathy)
- ☐ Psychiatric disorders (anxiety, major depression, bipolar disease, schizophrenia)
- ☐ Blood disorders (hemophilia, sickle cells disease, lower platelets, on blood thinners)
- ☐ Others (please specify)_____

Please list previous surgery you had and when?

Type of Surgery: _____ **Date/Year:** _____ **Surgeon:** _____
Type of Surgery: _____ **Date/Year:** _____ **Surgeon:** _____
Type of Surgery: _____ **Date/Year:** _____ **Surgeon:** _____
Type of Surgery: _____ **Date/Year:** _____ **Surgeon:** _____

Are you allergic to following medications (please check all that apply)?

- ☐ Antibiotics, which one
- ☐ Steroids
- ☐ Local anesthetics
- ☐ NSAIDs
- ☐ Betadine
- ☐ IVP dye
- ☐ None, NKDA
- ☐ Others (please specify) _____

Name: _____
Date of Birth: _____
Date of Appointment: _____

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Are you depressed because of pain?

- ☐ No
- ☐ Mild
- ☐ Moderate
- ☐ Severe
- ☐ Suicidal ideation or attempts
- ☐ Previous ER or hospital admissions

Do you smoke?

- ☐ No
- ☐ Yes
- ☐ How many a day _____
- ☐ How long _____
- ☐ Have you quit before and how many times? _____

Do you drink alcohol?

- ☐ No
- ☐ Yes
- ☐ How much a day _____
- ☐ How long _____
- ☐ Have you quit before and how many times?_____

Do you use recreational drugs?

- ☐ No
- ☐ Yes
- ☐ What kind(s) _____ _____

What is your marital status?

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Other _____

Please tell us your family medical history

- ☐ Heart disease:
- ☐ Hypertension
- ☐ Diabetes
- ☐ Stroke
- ☐ OA/RA
- ☐ Cancers

Thank you for your time!

_____ Patient Name

_____ Patient Signature

_____ Date

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MEDICATION LIST

PATIENT NAME: _____ DOB: _____ DATE: _____

PREFERRED PHARMACY: _____ PHONE:_____

PHARMACY ADDRESS: _____

Please include prescription, over the counter meds, supplements, vitamins, etc.

Medication Name	**Dosage**	**Directions**

INTEGRITY PAIN CONSULTANTS CENTER FOR REGENERATIVE MEDICINE
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Kenneth Homolya, MD / Brandon Tolman, DO

Rachel Forsythe, ACNP / Angela Allen, ACNP

Ashley Nutt, NP / Dana Hunley, NP

Danielle Molina, PA / Courtney Hatfield, NP

Benjamin Sell, PA-C / Stacey Pappas- NP

Name: _____ DOB:___/___/____ Date:_____

Please answer the questions using the following scale:

0 =NEVER 1 =SELDOM 2 =SOMETIMES 3 =OFTEN 4 =VERY OFTEN

1. How often do you have mood swings? **0 1 2 3 4**

2. How often do you smoke a cigarette within an hour after you wake up? **0 1 2 3 4**

3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs? **0 1 2 3 4**

4. How often have any of your close friends had a problem with alcohol or drugs? **0 1 2 3 4**

5. How often have others suggested that you have a drug or alcohol problem? **0 1 2 3 4**

6. How often have you attended an AA or NA meeting? **0 1 2 3 4**

7. How often have you taken medication other than the way it was prescribed? **0 1 2 3 4**

8. How often have you been treated for an alcohol or drug problem? **0 1 2 3 4**

9. How often have your medications been lost or stolen? **0 1 2 3 4**

10. How often have others expressed concern over your use of medication? **0 1 2 3 4**

11. How often have you had a craving for medication? **0 1 2 3 4**

12. How often have you been asked to give a urine drug screen for substance abuse? **0 1 2 3 4**

13. How often have you used illegal drugs (Marijuana, cocaine, etc.) in the past five years? **0 1 2 3 4**

14. How often, in your lifetime, have you had legal problems or been arrested? **0 1 2 3 4**

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CONSENT FOR CHRONIC OPIOID THERAPY

Integrity Pain Consultants may prescribe Opioid Medicine, sometimes called narcotic analgesics to me for pain management. This decision was made because my condition is serious or other treatments have not helped my pain.

I am aware that the use of such medicine has certain risks associated with it, including but not limited to, sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and possibility that the medicine will not provide complete pain relief.

I am aware about the possible risks and benefits of other types of treatments that do not involve the use of Opioids. I will tell my physician about all other medicines and treatments that I am receiving. I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include, but are not limited to: Using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for his/herself.

I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine is low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has family or personal history of addiction. I agree to tell my physician my complete and honest personal drug history and that of my family to the best of my knowledge.

I understand that physical dependence is a normal, expected result of using these medicines for a long time. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine is markedly decreased, stopped or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling.

I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain; however, it has been seen and may occur to me. If it occurs, increasing doses may not always help, and may cause unacceptable side effects. Tolerance or failure to respond well to Opioids may cause my physician to choose another form of treatment.

MALES ONLY: I am aware that chronic Opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my physician or family physician may check my blood to see if my testosterone level is normal.

FEMALES ONLY: If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric physician and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medications the baby could become physically dependent on opioids and experience withdrawal symptoms, fetal distress, and/or fetal demise. In addition, I understand that there are potential risks of stopping opioid medication on my own during pregnancy which include: risk of relapse, risk of preterm delivery, intrauterine withdrawal, fetal distress, and fetal demise. We highly recommend reliable contraception such as long term reversible contraception. I will notify my provider and an appropriate referral will be made if I am not currently using contraception.

Name (print) _____ Signature: _____ Date: _____

Provider Signature: _____ Date: _____

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Opiate/Pain Management Agreement

The purpose of this Agreement is to prevent misunderstandings about certain medications you will be taking for pain management. This Agreement is to help you and your provider to comply with the law regarding controlled pharmaceuticals.

_____ I will bring unused pain medicine to EVERY OFFICE VISIT in their original bottle for PILL COUNTS. I will NEVER DISPOSE of controlled substances myself. I will dispose of them in this office. If I do not bring my medications in for pill counts I understand I will be rescheduled.

_____ I will not attempt to obtain any other pain medications from any other provider (including Surgeons, ER Physicians, Dentists), family member, or friend.

_____ I will safeguard my pain medication from loss, theft, or unintentional use by others. Lost or stolen medications will not be replaced. I understand if I take more medication than is prescribed to me I will run out of my medication early and it will not be replaced or refilled early. I do also understand this may result in withdrawal from the opioids (nausea, vomiting, chills or sweating). I understand this may result in dismissal from this clinic.

_____I understand I must ensure this office that I have a valid and working telephone number If this office attempts to contact me for a midmonth Pill Count and they are unable to reach me, I understand it may result is dismal from this clinic.

_____ I understand that there is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substances.

_____ I will communicate fully with my provider about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

_____ I will not use any illegal controlled substances, including marijuana, cocaine, etc., nor will I misuse or self-prescribe/medicate with legal controlled substances nor consume alcohol with my prescribed medications.

_____ I will not share my medication with anyone and take my medication as prescribed.

_____ I agree that refills of my prescriptions for pain medications will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

_____ I agree that I will submit to a urine test if requested by my provider to determine my compliance with my program of pain control medications.

____I will keep all my scheduled appointments. If I must reschedule I will provide **24 hour notice** to this NO SHOWS will result in a $25.00 fee. This fee must be paid prior to their next appointment.

_____If I am abusive or belligerent to the staff, I will be discharged from the practice.

_____ I understand that if I break this Agreement, my provider will stop prescribing any pain control medicines and a Discharge Letter will be provided.

_____ I agree to use this pharmacy _____ for filling my pain prescriptions per Tennessee State Law. **In the event that the above stated pharmacy does not have my medication and it is time for a refill I may go to another pharmacy. However, I will call and notify this office of the new pharmacy and reason why I am not going to the above mentioned pharmacy per state guidelines. I will then return to the above mentioned pharmacy the following month per state law.**

This form will expire on: _____

Name (print) _____ Signature: _____ Date: _____

Provider Signature: _____ Date: _____