INTEGRITY PAIN & WELLNESS

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ()

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Birth date: / /	Address (if different):	Home phone no.: ()

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance: Workers Compensation Injury | Motor Vehicle Accident

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	IDno.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

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 Integrity Pain & Wellnessor insurance company to release any information required toprocess my claims.

_____ _____

Patient/Guardian signature *Date*

INTEGRITY PAIN & WELLNESS

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) requires healthcare organizations to comply with specific rules regarding:

- Unique identifiers for health plans, providers, individuals and employees
- Healthcare transaction and code set for transmitting data electronically
- Privacy regulation over disclosure and use of health information
- Security regulations over protection of electronic health information

In accordance with HIPPA privacy standards, we will not release confidential and/or unauthorized information over a home telephone answering machine, work or cell phone and/or email. However, in the event that we need to contact you, we would like to have our records reflect your wishes.

PLEASE PROVIDE US WITH NUMBERS WHERE WE MAY CONTACT YOU

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Email:_____

Pharmacy Name, address and phone:_____

Can we leave call back or appointment reminder messages-------(Please check yes or no)

On your home answering machine?	**Yes**_____	**No**_____
On your cell phone voicemail?	Yes_____	No_____
By sending an email?	Yes_____	No_____
On your work voicemail?	Yes_____	No_____

Information will never be left with an unauthorized person. If you have family members or someone other than yourself that you would like to authorize our staff to discuss your medical information with, please fill out the information below.

Spouse:_____ Contact Number:_____

Parent:_____ Contact Number:_____

Other:_____ Contact Number:_____

I hereby authorize INTEGRITY PAIN & WELLNESS staff to fax or email my medical information to referring and consulting physicians, physical therapist, pharmacists, rehab facilities, and/or other medical facilities who are involved in my care. In the event that I wish to change or withdraw the agreement of this release, I accept responsibility of notifying my change(s) in writing to INTEGRITY PAIN & WELLNESS.

Signature of Patient/Guardian:_____ Date:_____

I have been offered an opportunity to review INTEGRITY PAIN & WELLNESS “Notice of Privacy Practice.”

Signature of Patient/Guardian:_____ Date:_____

INTEGRITY PAIN & WELLNESS

FINANICAL POLICIES AND ARRANGEMENTS

We recognize the need for understanding the stress of payment arrangements and insurance filings. This sheet has been put together to address some of these areas for you.

INSURANCE FILING/BENEFITS/PAYMENT

There are numerous insurance plans with which we have contracted to receive payment directly from the insurance company. With these plans, the patient is generally required to meet a deductible or make a copayment. If you are covered by one of these plans, please show us your card. Be prepared to make your co-payment, or pay for your office visit if your deductible has not been met at the time of service. We accept cash, checks, VISA and MasterCard. With plans that we are not contracted with, you will be asked to pay at the time of service is rendered.
If, we are billing your insurance for you, it is extremely important that you furnish us with accurate and updated information so your claim can be filed. It is your responsibility as a consumer to know what benefits are covered by your insurance plan. Most insurance carriers have numerous plans that cover different types of services. Some services may not be covered on your particular plan. Services provided that are not a covered benefit are your responsibility and payment is due at the time services are rendered. If you have questions as to what services are covered, contact member services (the number is listed on your insurance card). We will set aside the portion of the balance estimated to be paid by your insurance carrier for forty five (45) days. If your carrier does not remit payment within forty five (45) days, you will be responsible for the full balance.This office cannot accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed claim. You will continue to receive statements until the account is paid in full.

PAYMENT ARRANGEMENTS

Payment is expected at the time of service. If you do not have your co-pay at the time of service, your visit may be rescheduled.

DELINQUENT ACCOUNTS

Bills that are delinquent for more than ninety (90) days will be transferred to an outside collection agency unless prior arrangements have been made. If you have questions or think an error has been made, please discuss them with us prior to the ninety (90) days in order to help us resolve this.

RETURNED CHECKS

There is a $25.00 service fee for checks returned for insufficient funds. We request a copy of your driver's license or ID card as identification.

CANCELLATION OF APPOINTMENTS/NO-SHOW APPOINTMENTS

If you cancel an appointment, we ask that you give us a forty eight (48) hour notice for routine appointments and a twenty four (24) hour notice for procedures. If you do not cancel an appointment, you can be charged $25.00 as this will be considered a no-show. Three (3) no-show appointments are grounds for dismissal from the office.

ADVANCED BENEFICIARY AGREEMENT

Medicare and other insurance plans will only pay for services that they determine to be reasonable and necessary under section 1882 (a) (1) of Medicare Law. If payment is denied for services or tests, (i.e. routine exam/lab work, vaccinations, contraception, procedures and non-related diagnosis for the services provided), then the patient is personally and fully responsible for payment.

ADDITIONAL HELP

Please feel free to discuss any concerns you may have with our office staff. Our staff is dedicated to making your visits with us as pleasant as possible. It is your responsibility to know what is covered by your insurance plan as well as being financially responsible for any services denied or not covered by insurance.

I have read and agree to the above policy of **INTEGRITY PAIN & WELLNESS**. I understand the contents and by signing below accept the aforementioned financial responsibilities.

Patient/Guardian's Signature:_____ Date:_____

INTEGRITY PAIN & WELLNESS

ALLERGIES / REACTIONS TO MEDICATIONS:

Name of Medication:	**Reaction:**
Name of Medication:	Reaction:
Name of Medication:	Reaction:
Name of Medication:	Reaction:

CURRENT MEDICATION: (Please list any over the counter medication and supplements)

MEDICATION NAME:	STRENGTH:	HOW MANY PRESCRIBED PER DAY:

ADVANCE DIRECTIVES:

Do you have an advanced directive? (Living Will, Power of Attorney, or CPR Directive) Yes_____ No _____

If No, would you like more information about advance directives? Yes_____ No _____

SOCIAL HISTORY:

Tobacco use? Yes_____ No_____	**If yes, how much?**	**How often?**
Alcohol use? Yes_____ No_____	If yes, how much?	How often?
Have you ever abused narcotic medication? Yes_____ No_____	If yes, when?	
Are you Pregnant? Yes_____ No_____		

INTEGRITY PAIN & WELLNESS

PAST MEDICAL HITSORY: (Please check all that apply)**FAMILY HISTORY**: (Please check all that apply)

Arthritis	
Shortness of Breath	
Asthma	
Bleeding Disorder	
Cancer	
Chest Pain	
Coronary Artery Disease	
Stroke/TIA	
Diabetes	
Emphysema	
Fibromyalgia	
Heart Disease	
High Cholesterol	
Thyroid Disease	
Kidney Disease	
Liver Disease/Hepatitis	
HIV/Aids	
Neurological Disease	
Osteoporosis	
Congestive Heart Failure	
COPD	
Heart Attack	
Hypertension	
Rheumatoid Arthritis	
Seizures	

Arthritis	
Shortness of Breath	
Asthma	
Bleeding Disorder	
Cancer	
Chest Pain	
Coronary Artery Disease	
Stroke/TIA	
Diabetes	
Emphysema	
Fibromyalgia	
Heart Disease	
High Cholesterol	
Thyroid Disease	
Kidney Disease	
Liver Disease/Hepatitis	
HIV/Aids	
Neurological Disease	
Osteoporosis	
Congestive Heart Failure	
COPD	
Heart Attack	
Hypertension	
Rheumatoid Arthritis	
Seizures	

SURGICAL HISTORY:

Surgery:	**Date:**
Surgery:	Date:
Surgery:	Date:
Surgery:	Date:
Surgery:	Date:

INTEGRITY PAIN & WELLNESS

CONTROLLED PAIN MEDICATION AGREEMENT

Name: _____ DOB:_____

PLEASE INITIAL ALL

If the provider finds it appropriate to prescribe any controlled substances, we ask that all of our patients adhere to the following policy

_____ **I understand the purpose of this agreement is to prevent misunderstandings about certain medications I will be taking for pain management. This is to help you and your provider to comply with the law regarding controlled pain medication.**

_____ **I understand that if I break the agreement, the provider will stop prescribing me pain medications.**

_____ **I will not use any illegal substances, and I will not increase or decrease the dosage. If I feel that adjustments in the medication dosage are required, I agree to contact the prescribing provider.**

_____ **I will not share my medication with anyone, and I will not take another person's medication.**

_____ **I will not receive any controlled pain medication from other providers, and I will only use one pharmacy (for purposes of verifying controlled pain medications) unless extenuating circumstances require me to fill medications at another pharmacy.**

_____ **I understand that it is my responsibility to safeguard my medication. Should they be lost, stolen, destroyed, or if they are used up early, the medication (s) will under no circumstance be refilled.**

_____ **I agree not to sell, lend, or in any way give my medication to any other person.**

_____ **I agree not to drink alcohol or use other mood altering drugs while I am taking controlled pain medications.**

_____ **I understand that there may be risks associated with the use of controlled pain medication including but not limited to dependence, addiction, changes in personality, sleep pattern disturbance, respiratory depression, bowel and bladder dysfunction, change of appetite, possible weight gain or loss, change of coordination (which may interfere with driving, operating machinery, and fine motor movement), and risk of death.**

_____ **I agree to report any changes in my mental status and any other possible pain medication side effects to my prescribing provider.**

_____ **I agree to submit to testing on an as needed basis to monitor for medication complications and compliance with recommended treatment.**

_____ **I understand that sudden discontinuation of pain medication can lead to rebound pain, withdrawal symptoms, seizures, and other symptoms. I have been informed not to stop any controlled pain medication suddenly unless directed by a pain management provider.**

_____ **I agree to allow my pain management provider to review any of my past medical or psychological records.**

_____ **I have read and understand the above information. I agree and understand that noncompliance with the above will result in formal discharge with notification to my providers.**

Patient Signature:_____ **Date:**_____

Physician Signature:_____**Date:**_____

Witness:_____**Date:**_____

Pharmacy Name / Phone Number:_____

INTEGRITY PAIN & WELLNESS

THE VEIN CLINIC
COMPREHENSIVE VEIN CARE FROM TRUSTED PHYSICIANS

Follow Up Office Visit

Patient Name: _____ Date Of Birth: _____

Today's Date:_____ **PLEASE CIRCLE ALL THAT APPLY TODAY**

Are you on Blood thinners? YES/ NO (if yes which one?)_____

Eliquis Pradaxa Arxtra Heparin Xerelto Warfarin Savysa

For Female patients : Are you Currently Pregnant?_____

Describe Your Pain: 0 1 2 3 4 5 6 7 8 9 10

***Throbbing *Aching *Shooting *Tiring/Exhausting *Stabbing *Pinpoint**

***Sharp *Intermittent *Hot/Burning *Diffuse *Continuous *Numbness**

The Pain Occurs:

***Constantly *Daily *Frequently *Intermittently *Occasionally**

***Often *With Any Movement *Coughing *With Deep Breathing *Weight Bearing**

The Pain Is Located:

***In the Calf *Shoulder *Chest Wall *Lower Back *Knee**

***In the Hand In the Neck *In the Hips *Foot *Ankle**

The Pain Radiates:

***Down The Leg(s) *Down Shoulder(s) *Down Buttock(s) *Down Hip(s) *Down Back**

***To The Chest Wall *Into Fingertips *Into the Toes *Down Neck *Doesn't Radiate**

What Makes It Worse:

***Sitting *Weight Bearing *Standing *Rising From Siitting**

***Bending Forward *Any Movement *Bending Backward *Walking**

***Climbing Stairs *Deep Breathing *Lying on Back *Lying on Stomach**

***Driving *Long Periods of Sitting *Coughing/Sneezing *Lifting Objects**

What Makes It Better:

***Sitting *Weight Bearing *Standing *Rising From Siitting**

***Bending Forward *Any Movement *Bending Backward *Walking**

***Climbing Stairs *Deep Breathing *Lying on Back *Lying on Stomach**

***Driving *Long Periods of Sitting *Coughing/Sneezing *Lifting Objects**

Turn Over-Page 2

CHECKLIST: Review of Systems (Please circle all that apply) **Initial here if no changes since last visit: ___**

General:
***Weight Loss/Gain *Fatigue *Fever/Chills *Weakness *Trouble Sleeping**

Skin:
***Rashes *Lumps *Itching * Dryness *Color Changes *Hair/Nail Changes**

Head:
***Headache *Head Injury *Neck Pain**

Eyes:
***Vision Loss/Change *Glasses/Contacts *Pain *Redness *Blurry/Double Vision**
***Flashing Lights *Specks *Glaucoma *Cataracts *Last Eye Exam:_____**

Nose:
***Stuffiness *Discharge *Itching *Hay Fever *Nosebleeds *Sinus Pain**

Throat:
***Bleeding *Dentures *Sore Tongue *Dry Mouth**
***Sore Throat *Hoarseness *Thrush *Non-Healing**

Neck:
***Lumps *Swollen Glands *Pain *Stiffness**

Breasts:
***Lumps *Pain *Discharge *Self-Exams *Breast-Feeding**

Respiratory:
***Cough *Sputum *Coughing Up Blood *Shortness of Breath *Wheezing *Painful Breathing**

Cardiovascular:
***Chest Pain/Discomfort *Tightness *Palpitations *Shortness of Breath w/Activity**
***Difficulty Breathing Lying Down *Swelling *Sudden Awakening from Sleep w/Shortness of Breath**

Gastrointestinal:
***Swallowing Difficulties Heartburn *Change in Appetite *Nausea**
***Change in Bowel Habits *Rectal Bleeding *Constipation *Diarrhea *Yellow Eyes/Skin**

Vascular:
***Calf pain With Walking *Leg Cramping**

Musculoskeletal:
***Muscle or Joint Pain *Stiffness *Back Pain *Redness of Joints *Swelling of Joints *Trauma**

Neurologic:
***Dizziness *Fainting *Seizures *Weakness *Numbness *Tingling *Tremor**

Hematologic:
***Ease of Bruising *Ease of Bleeding**

Endocrine:

***Heat or Cold Intolerance *Sweating *Frequent Urination *Thirst *Change in Appetite**

Psychiatric:

***Nervousness *Stress *Depression *Memory Loss**

The Effectiveness of The Medication Has Been:

***Helpful *Partially Helpful *Led to Complete Resolution of the Symptoms *Not Been Helpful at Al**

For Office Use Only: **Vitals: Ht: _____ Wt: _____ B/P: _____ Pulse: _____**

INTEGRITY
PAIN & WELLNESS

Opioid Risk Tool

Date: _____

Patient: _____

ONLY MARK EACH ITEM THAT APPLIES

		Item scale If Female	Item Scale If Male
1) Family history of substance abuse:	_____ Alcohol	1	3
	_____ Illegal Drugs	2	3
	_____ Prescription Drugs	4	4
2) Personal history of substance abuse:	_____ Alcohol	3	3
	_____ Illegal Drugs	4	4
	_____ Prescription Drugs	5	5
3) Age (Mark **ONLY** if you are between the ages of 16 – 45) _____		1	1
4) History of pre-adolescent sexual abuse: _____		3	0
5) Psychological disease:	_____ Attention Deficit Disorder	2	2
	_____ Obsessive Compulsive		
	_____ Bipolar		
	_____ Schizophrenia		
	_____ Depression	1	1

Signature: _____

For Office Use Only:
Total: _____
Total score risk category: Low risk 0-3 - Moderate risk 4-7 - High risk >8
(Medicaid/Commercial 99409 and Medicare G0397)