Patient History

Name: _____ SS # ____-___-_____ D.O.B _____

Age: _____ Sex: _____ Height: _____ Weight: _____

Where is your MAIN pain located: _____
OTHER pain sites _____

PAIN doctors seen in the past: 1. _____
2. _____
3. _____

FAMILY doctor: _____ Phone: _____
Referring doctor: _____ Phone: _____
PHARMACY: _____ Phone: _____

PAIN started: ☐ Suddenly ☐ Gradually Approximate duration: (in years) _____
Exact date of onset (if known) _____

PAIN is DUE to: ☐ Work Injury ----- Is there a BWC claim - Yes / No
☐ Auto accident --- Is there a lawsuit - Yes / No
☐ OTHER injury (specify) _____
☐ Other reasons like disc, sciatica, surgery, etc. _____
_____
☐ Not sure why I have pain – No diagnosis has been made

PAIN is ☐ Constant ☐ Comes and goes ☐ Brought on by _____

Worst pain level: [0 to 10] _____ Best pain level [0 to 10] _____ Usual pain level [0 to 10] _____

What makes your pain worse: _____

What makes your pain better: _____

How many hours a day you have little / none or tolerable pain (0 to 3) _____

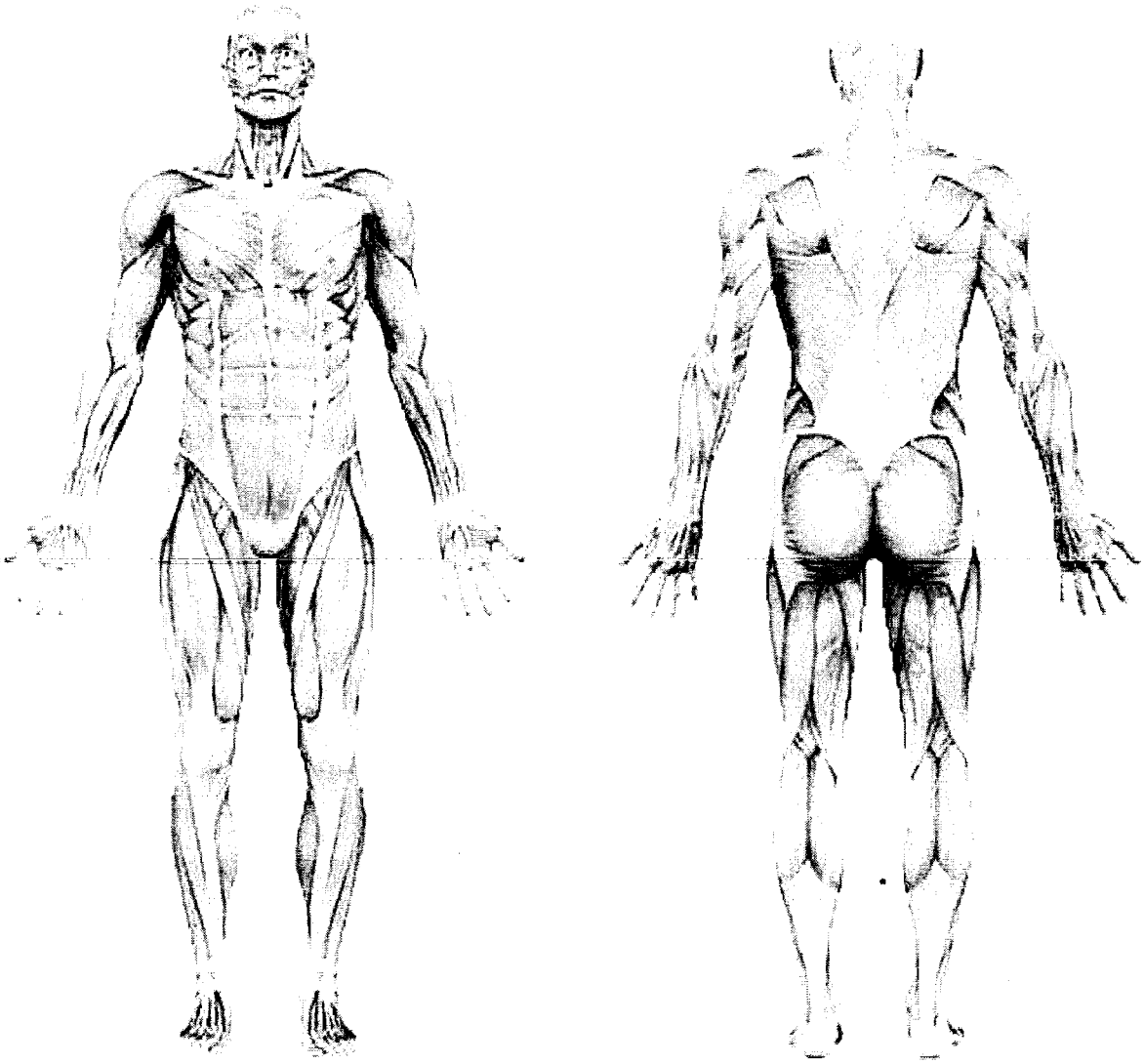
How many hours a day you have unbearable pain (8 to 9) _____

My pain affects my ☐ Sleep ☐ Social life ☐ Sexual life ☐ Work ☐ Financial ☐ Mood

Quality of your pain is best described as - ☐ sharp, ☐ shooting, ☐ stabbing, ☐ burning, ☐ cramping, ☐ aching,
☐ throbbing, ☐ aching (Check all that apply)

Describe your pain in your own words: _____
_____
_____
_____
_____
_____

PLEASE MAKE SURE YOU FILL THIS PICTURE ACCURATELY



Where does the pain start: _____

Does it move ? If so, where ? _____

What activities do you want to do, but cannot do, due to your pain:

- _____
- _____
- _____

CURRENT PAIN Medicines that you take: _____ dose: _____
_____ dose: _____
_____ dose: _____
_____ dose: _____

Pain medicines tried in the past but NOT taking now: _____

_____

_____

_____

Other medicines you take for anything: _____

_____

_____

BLOOD Thinners: ☐ NO ☐ YES - which (circle) Coumadin / warfarin, Lovenox, Aspirin, Pletal, aggrenox, other_____

ALLERGY: ☐ NONE ☐ _____

Medical history (circle): High blood pressure, Angina, Congestive heart failure, Heart attack, Pacemaker, Bypass

Angioplasty, COPD, Bronchitis, Emphysema, Sleep Apnea, On oxygen/CPAP, Asthma

Seizure, Stroke, Paralysis, Neuralgia, Fibromyalgia, Arthritis, Lupus, Rheumatoid

Acid Reflux, Ulcers, Irritable Bowel Syndrome, constipation, Diabetes, Thyroid, Hepatitis

Psychological: Depression, Anxiety, Bipolar, Panic Attacks, Claustrophobia, Other:_____

Family History: Drugs/ Alcohol/ Imprisonment

Medical History of family, do any of your family members suffer from the problems listed above?

_____

_____

Surgical History: _____

_____

Social History: Married, Separated, Divorced, Widowed, Single Smoking: YES/NO Alcohol: YES/NO

Exercise: Occasional, Regular, None Drugs: YES/NO If yes, Current/Past

Currently working: YES/NO

Name & relationship of people living in your household: _____

Treatment history: Trigger Point Injection/ Epidural Cortisone Injection/ Facet or facet nerve injection/ Sacroiliac injection

Radiofrequency ablation/ Lysis of adhesions/ IDET/ Laser discectomy/ Microdiscectomy/

Spinal cord stimulator/ Pain Pump/ Other_____

Physical Therapy: YES/NO When_____ Behavioral/ Psychological counseling YES/NO

Tests: Xrays/ MRI/ CT scan/ EMG/NCV/ Bone scan/ Discogram/ Other_____

Signature of Patient (required) : _____ **Date:** _____

Interventional Pain Center

DEMOGRAPHICS

*** Indicates required fields.*

Patient Information:

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

**Date of Birth: _____ **Social Security #: _____ Sex: _____Male _____Female

**Address: _____ City: _____ State: _____ Zip: _____

**Best phone number for contact: _____ Alternate Phone Number: _____

**Email: _____

**Marital Status: ____Married ____ Single ____Widowed ____ Divorced ____Separated

Employed: _____ Yes _____ No Employer: _____ Address: _____

Primary Care Physician: _____ Phone Number: _____

Do you have an advance directive (living will)? ____Yes ____No If yes, at which hospital is it filed? _____

How did you hear about our office: _____

Guarantor (if different from above):

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ Social Security #: _____ Sex: _____Male _____Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contact:

**Name: _____ Relationship: _____ Phone: _____

Alternate Emergency Contact: _____ Phone: _____

Insurance Information:

** Primary Insurance: _____ Policy Holder: _____ ID#:_____

** Secondary Insurance: _____ Policy Holder: _____ ID#:_____

Is this a work related injury filed with the Bureau of Worker's Compensation? ____Yes ____ No

If yes, Claim #: _____ Date of Injury: _____

*** Signature:* _____ *Date:* _____

INTERVENTIONAL PAIN CENTER
OFFICE POLICIES

Please read and initial the following policies.

____ **CANCELLATION AND NO SHOW POLICY:**

We at Interventional Pain Center are concerned about your health care. Not keeping scheduled appointments hinders our ability to provide quality care. We ask that you provide our office with a minimum of **48 hour notice** for all cancellations. If you do not provide advanced notice, **you will be charged a $50 fee for missing a follow up and a $75 fee for missing a procedure**. Last minute cancellations and a no call no show deprives other patients from being scheduled and receiving treatment. We understand that a situation may occur that will keep you from attending your scheduled appointment; however official documents are required for review in such cases. For example- if you miss an appointment due to a previously scheduled appointment, we would require a document stating you were at that appointment. Failure to provide notice or documentation will result in the above listed fees. ***Please note: If you miss a scheduled appointment, you must pay the appropriate fee in order to be seen and in order to receive your prescription. ALSO, THREE OR MORE NO SHOWS MIGHT RESULT IN DISCHARGE FROM THE PRACTICE***

____ **FINANCIAL AGREEMENT:**

Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. **Please remember that some or perhaps all of the services provided MAY NOT be covered by your insurance plan. In this case, you as the patient will be responsible for any balance remaining on your account.** If you are unsure about your contractual agreement with the insurance company, it is your responsibility to contact them to assure that the services to be received are covered and do not require any authorization.

_____ **CO-PAYMENTS:**

All copayments and deductibles are due at the time of service. **Appointments will be rescheduled if the patient is unable to make the appropriate co-payment on the day of service.**

I understand the bill is my responsibility. I assign and authorize payments to be made directly to Interventional Pain Center. I understand that I am responsible for any balance due that is not covered by insurance. I understand that I will be directly responsible to pay for: Returned Checks, Missed Appointments, Medical Records, and any additional services such as letters of Medical Necessity or paperwork to be filled by the physician.

_____ Please initial if you have read and understood the financial agreement above.

_____ **AUTHORIZATIONS:**

I understand that as part of my healthcare provider, Interventional Pain Center originates and maintains health records and/or radiology records describing my symptoms, diagnoses, current or past treatment plans, medication list and health history. These records will be retained by Interventional Pain Practice even if my provider(s) leave the practice. I authorize the release of any medical information necessary to process insurance claims and to request payments of benefits.

I affirm that I have the full right and power to sign and be bound by this agreement. I have read, understood and accepted all of its terms.

SIGNATURE: _____ **Date:** _____

If you wish to receive a copy of these policies, ask one of the staff members and we would be happy to provide you with a copy.

INTERVENTIONAL PAIN CENTER
PATIENT HIPAA CONSENT FORM

Please read carefully and sign when directed.

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment from third party payers (example: insurance company)
- Any medical records requests made by healthcare providers and/or insurance companies in order to process prior authorization requests.

I have also been informed of, and given the option to review and secure a copy of your Notice of Privacy practices, which contains a more complete description of the uses and disclosures of my potential health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand I have the right to request restrictions on the disclosure of my medical and/or billing records; however, your establishment has the right to deny these restrictions. If the restrictions are allowed then you are bound to comply with these restrictions.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent will not be affected.

I allow the following listed persons to inquire about my account and personal records.

_____ _____

_____ _____

Printed Patient Name: _____

Signature: _____ **Date:** _____

If you wish to receive a copy of this document, ask one of the staff members and we would be happy to provide you with a copy.

Interventional Pain Center
Sachit Manocha M.D., FIPP

____ 85 E. Wilson Bridge Road
Worthington, Ohio 43085

____ 78 Messimer Drive
Newark, Ohio 43055

Phone: 614-262-7246 / 740-522-8755
Fax: 614-262-4699

Authorization for Release of Medical Information

I hereby grant my permission for release of medical information to/between the following parties, including any information concerning treatment for psychiatric illness, alcohol and or substance abuse, HBV test results AIDS/ARC (AIDS related complex) diagnoses and/or other communicable disease.

Patient Name:_____ **Patient DOB:**_____

Patient Address: _____

Patient Phone Number:_____ **Patient SS#:**_____

This consent expires 60 days from the date signed and is subject to revocation by the patient at any time prior to the expiration date.

Patient Signature:_____ **Date:** _____

NOTE: Please do not write below this line (FOR OFFICE USE ONLY)

*****Released From:***
Physician Name:_____

Phone Number:_____ **Fax Number:**_____

*****Released To:***
Physician Name:_____

Phone Number:_____ **Fax Number:**_____

Information Requested: ____ Progress Notes ____All Diagnostic tests (X-rays, MRI, CT etc.) ____ Lab Results
____Complete record ____ Other- Please Specify_____
_____

For the purpose of:_____

Any re-disclosure of medical information by recipient is strictly prohibited. Please note: All matters relating to alcohol and drug abuse records are considered privileged and confidential and are regulated by Federal Law section 231 of Pl.93.282, 42 CFR, and part 2. This prohibits further disclosure without specific written consent of the patient.

Interventional Pain Center

Sachit Manocha, MD, ABIPP
Board Certified in Interventional Pain Management
Board Certified in Anesthesiology

Controlled Substance Agreement

This agreement is between the patient and the Interventional Pain Center [IPC]. It is agreed that controlled medicines for pain will be given **ONLY** if the following terms are met :--

- By signing the contract for the pain medicine treatment, the patient indicates that he / she understands the discussion about the use of these medicines, their side effects and agrees to start this treatment under the terms set by the IPC.

- The patient has the chance to ask questions about the alternatives to the use of narcotic medicines.

- IPC should be the **one and only source** of narcotic medicines, unless written permission is given by our physician to get medicines from another doctor. The EMERGENCY room can certainly write medicines for you, but if they give you a script, you have to call and get documented permission from us before you fill that medicine.

- Only one pharmacy will be used: Name: _____
  Phone: _____

- If you are getting a dental procedure or another surgery, discuss this with Dr. Manocha at your preceding office visit. It is always a good idea tell your surgeon / dentist to call Dr. Manocha to discuss the pain medicine plan.

- The patient agrees to have urine tests done whenever asked for. You may have to come in for a pill count at a short notice. Failure to do so may result in discharge from practice.

- The patient agrees to allow the IPC physician to communicate with the referring or other treating physicians and the pharmacists regarding the patient's use of narcotic medicines.

- The patient must supply documentation of treatment by another physician for coexisting or related condition, including psychiatric conditions.

- **The patient understands that the IPC MAY not replace any lost, stolen, misplaced or inaccessible prescriptions or medicines EVEN if accompanied by a police report – for any REASON.**

- The medicines must be taken as instructed by your doctor. Most pain medicines are written for a month or less and they have to last a month or the period they have been written for.

- Unauthorized increase in the consumption of medicine, loosing medicines repeatedly, repeated running out early, may be viewed as a cause of discontinuation of treatment.

- If a patient demonstrates unacceptable behavior patterns, the IPC physician may discontinue prescribing the pain medicines.

- All regular appointments that have been scheduled must be kept for you to get your prescriptions. Failure to keep your appointments may result in discontinuation of treatment from us.

- You must comply with all aspects of the treatment plan, including but not limited to behavioral therapy, physical therapy, injections, surgery consults.

- ALL PRESCRIPTIONS MUST BE PICKED UP BY THE PATIENT HIMSELF / HERSELF. IF A PATIENT IS TOO DEBILITATED OR SICK, AN EXCEPTION WILL BE MADE, BUT THE PERSON PICKING UP THE SCRIPT SHOULD HAVE THE PATIENT'S ID AND HIS OWN ID, AND IF ASKED FOR, HAVE ACCESS TO THE PATIENT ON THE PHONE FOR THE IPC STAFF TO TALK TO.

- **No prescriptions will be filled over the weekend and no medication increase or change will be made unless you are being seen in the office. If your medicines are due, you have to call and leave us a message on the medication line a week or more in advance of your due date, so we can get your prescription ready and signed for you to pick up.**

- **PRESCRIPTIONS WILL NOT BE FILLED EARLY.**

- The patient understands that the benefit of the narcotic medicines will be evaluated periodically using the criteria of pain relief, increase in function, completion of rehab program, maintenance of job, etc..

The patient understands that the narcotic medicines can be discontinued at the treating doctor's discretion, if the terms of this agreement are not fulfilled. They can also be discontinued if there is lack of effectiveness or side effects.

- THE PATIENT AGREES TO THE FOLLOWING:

  - **That he or she is not abusing drugs – illicit or prescription**
  - **That he or she has never been involved in the sale, illegal possession, diversion or transport of controlled substances.**
  - **That she is not pregnant and will use appropriate contraception during the course of the treatment.**

- Evidence of medication hoarding, increasing the amount of medicines without permission from the physician at an office visit, refilling or trying to refill prescriptions too frequently, getting medicines from other physicians without permission, altering prescriptions, selling medicines, unapproved use of other drugs like alcohol, sedatives, during treatment with narcotics will result in tapering and discontinuation or abrupt cessation as the physician may see fit, of the treatment.

- IF THE PATIENT OR ACCOMPANYING FAMILY MEMBER IS NONCOMPLIANT WITH THE SUGGESTED TREATMENT PLAN, OR UNCOOPERATIVE WITH THE PHYSICIAN OR STAFF, OR OTHERWISE ABUSIVE OR UNRULY WITH THE STAFF OF THE IPC, WE RESERVE THE RIGHT TO DISCHARGE YOU AT ANY TIME.

I fully understand the explanations regarding the benefits and the risks of this method of treatment. I understand the concepts of addiction and tolerance. I agree to the use of narcotic medicines for the treatment of my chronic pain issues.

This form has been read by me or has been read to me and I understand it. I have had the opportunity to ask questions, and have received acceptable answers. I agree to the terms of the contract.

Date: _____

Patient's signature: _____

Patient's printed name: _____