Permian Basin
PAIN MANAGEMENT

Dr. Frank O. McGehee IV
1802 W. Wall St.
Midland, TX 79701
Ofc: (432) 683-3121 Fax: (432) 685-3135

Last Name: _____ **Primary Care Physician:** _____
First Name: _____ **Referring Physician:** _____
Previous Last Name: _____ **Date Of Birth:** _____
Address: _____ **Sex:** M/F (circle)
City: _____ **Marital Status:** _____
State: _____ **Zip Code:** _____ **Social Security #:** _____
Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____ ext: _____
What is your preferred number for leaving messages: home / cell / text / work (circle)
What is your preferred time for us to call and leave messages: morning / afternoon / evening (please circle one)
E-Mail Address: _____
Would you like to communicate via e-mail? Yes / No (circle)

Preferred Language: English / Spanish (circle)
Responsible Party (person to receive billing statements): Name: _____
Phone: _____
Relation: _____
Emergency Contact #1: Name: _____ Phone #: _____ Relation: _____
Address: _____
Emergency Contact #2: Name: _____ Phone #: _____ Relation: _____
Address: _____
Insurance Information:
Primary Insurance: _____ Group # _____ ID# _____
Insured's Name: _____ Insured's DOB: _____ Insured's SS# _____
Secondary Insurance: _____ Group #: _____ ID# _____
Insured's Name: _____ Insured's DOB: _____ Insured's SS# _____

Ethnicity: Hispanic / Not Hispanic / Refused to Report (circle)
Race (circle):
Asian
Native Hawaiian or Other Pacific Islander
Black or African American
White
Hispanic
Other Race
Other Pacific Islander
Unreported/Refused to Report

Employer: Name: _____
Address: _____
Phone: _____
Preferred Pharmacy: Name: _____
Address: _____
Phone #: _____

I DO ❑ I DO NOT ❑ have an Advance Directive or Surrogate Decision Maker

I hereby assign to Permian Basin Pain Management all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. The above registration information is correct to the best of my knowledge, and I understand and accept the above payment policy.

I hereby authorize Permian Basin Pain Management to furnish information, including medical and billing information, to my insurance carriers and referring physician concerning my medical care and that of my dependents.

_____ _____
Date **Signature of Patient (or Parent/Legal Guardian if Patient is a minor)**

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F. O. McGehee IV, M.D.

PATIENT PREFERENCE REGARDING COMMUNICATION OF HEALTH INFORMATION

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of their home.

I wish to be contacted in the following manner (check all that apply)

- ❑ Home Telephone
  - ❑ OK to leave messages with detailed information
  - ❑ Leave message with call-back number only
- ❑ Cell Telephone
  - ❑ OK to leave messages with detailed information
  - ❑ Leave message with call-back number only
- ❑ Work Number
  - ❑ OK to leave messages with detailed information
  - ❑ Leave message with call-back number only
- ❑ Written Communcations
  - ❑ OK to mail to my home address
  - ❑ OK to mail to work/office address
  - ❑ OK to fax to this number _____

I hereby give permission to Permian Basin Pain Management to disclose and discuss any information related to my medical conditions to/with the following member (relatives or close personal friends):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that the request for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

_____ _____

Print Patient Name Date

_____

Signature of Patient

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Consent to Use or Disclose Health Information

Notice of Privacy Policy

I authorize **Permian Basin Pain Management** to use and disclose my health and medical information for the purposes of **Treatment, Payment,** and **Health Care Operations*.**

***Treatment** (includes activities performed by a health care provider, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, obtaining prescription history from an external source and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician).

***Payment** (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization).

***Health Care Operations** (includes the necessary administrative and business functions of our office).

I understand that I have the right to revoke this Consent provided that I do so in writing, except to the extent that Permian Basin Pain Management has already used or disclosed the information in reliance on this Consent.

_____ _____
Signature of Patient or Legal Representative Date

_____
If Legal Representative, Relationship to Patient

I have been provided for my review, with a copy of this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document if I so desire.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date of the Notice in the upper right hand corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your health information consistent with the Notice.

_____ _____
Signature of Patient or Legal Representative Date

_____
If Legal Representative, Relationship to Patient

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(Patient Label)

Confidential Pain Questionnaire

Plese take the time to fill out this medical questionnaire at the request of Dr. McGehee. Having all of the background information will facilitate your visit here, enabling us to focus on you principle concerns.

Name: _____ Today's Date: _____

Address: _____ Home Phone: _____

E-mail: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ ❑ Male ❑ Female ❑ Right handed ❑ Left Handed

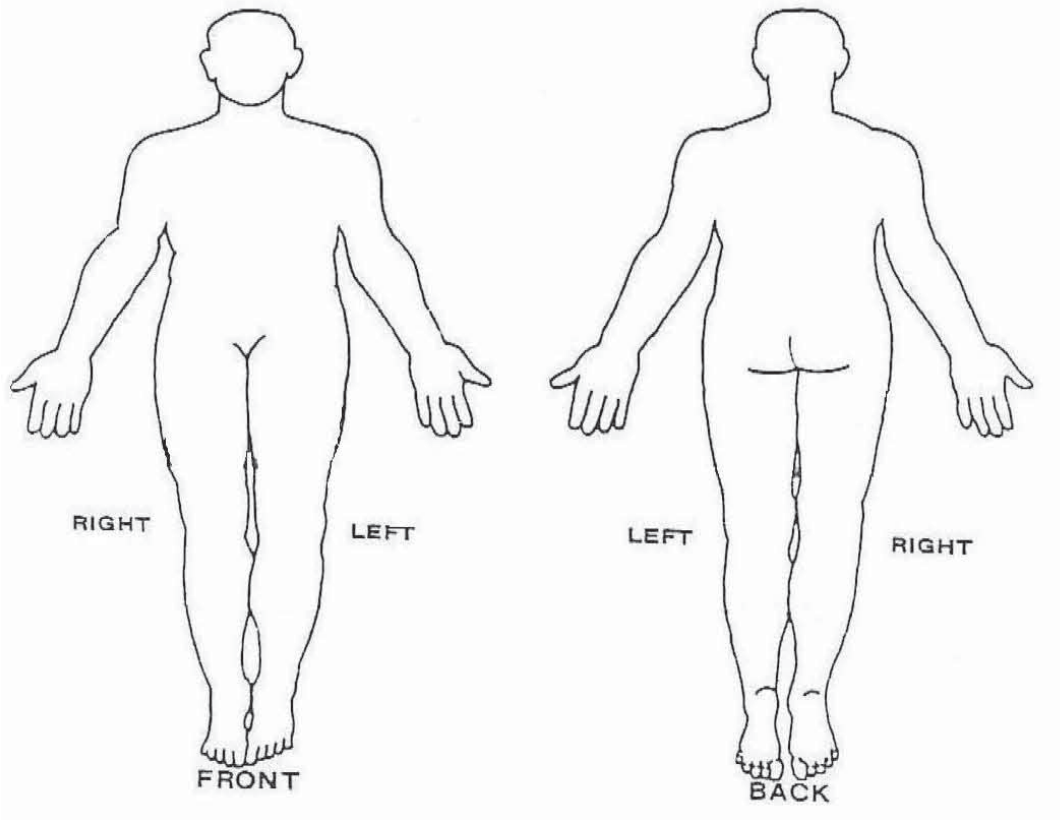
Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Additional Contact #: _____ Relationship: _____

Where is your pain primarily located? _____

(Please draw an X over any area that causes you pain. If the pain moves or radiates please draw an arrow showing the movement.)



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Patient Name _____

Please check as many as apply.

How did the pain start:

- ☐ Suddenly
- ☐ Gradually
- ☐ Lifting
- ☐ Twisting
- ☐ Fall
- ☐ Sports injury
- ☐ Bending
- ☐ Pulling
- ☐ At work
- ☐ Motor vehicle accident
- ☐ Direct blow to spine
- Other: _____

Describe: _____

What best describes your pain?

- ☐ Sharp
- ☐ Burning
- ☐ Throbbing
- ☐ Shooting
- ☐ Aching
- ☐ Cramping
- ☐ Dull
- ☐ Splitting
- ☐ Crushing
- ☐ Stabbing
- ☐ Sore
- ☐ Tingling
- Other: _____
- Other: _____

When was the first time you had pain: (Approximate Date): _____

What is your pain Score (0-10) today?___ Average: ____ Least ever? ____ Most ever?_____

Are your radiating/moving pains ☐ *constant* or ☐ *intermittent* (come and go)?

When, during the day, is the pain at its worst?_____

Does your pain awaken you during the night? ☐ *Yes* ☐ *No*

Do you have trouble controlling your bladder or bowels? _____

Do you have trouble controlling, feeling or using any portion of your arms/legs? ☐ *Yes* ☐ *No*

Explain: _____

What brings on the pain or makes it worse?

- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Running
- ☐ Twisting
- ☐ No apparent reason
- ☐ After exercise
- ☐ Sneezing
- ☐ Lifting
- ☐ Pulling
- ☐ Bending Forwards
- ☐ Bending Backwards
- ☐ During Exercise
- ☐ Using Arms
- ☐ Coughing
- Other: _____

What eases or eliminates the pain?

- ☐ Lying Down
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Arthritis Medicine
- ☐ Physical Therapy
- ☐ Exercise
- ☐ Pain Pills
- ☐ Aspirin, Tylenol, Advil
- ☐ Muscle Relaxants
- ☐ Nothing
- Other: _____

Patient Name _____

Past Medical treatments for Pain (check as many as apply) and **list approximate year** they were administered.

- ☐ Bedrest
- ☐ Chiropractic
- ☐ Acupuncture
- ☐ Muscle stimulator
- ☐ Braces
- ☐ Traction
- ☐ TENS
- ☐ Spinal cord implant
- ☐ NSAIDS
- ☐ Opiates
- ☐ Physical therapy
- ☐ Muscle relaxants
- ☐ Antidepressant drug
- ☐ Psychotherapy
- ☐ Trigger point injection
- ☐ Epidural Steroid Injection

Other (Specify) _____

_____

_____

_____

_____

What percent of relief do you receive with medicine? 10 20 30 40 50 60 70 80 90 100%

What percent of relief do you receive with other treatment? 10 20 30 40 50 60 70 80 90 100%

Number of healthcare visits within the last six months for your pain condition? _____

Number of ER visits within the last six months for your pain condition? _____

List past surgical treatments for pain:			
SURGERY	**DATE**	**SURGERY**	**DATE**

Have you had any tests for current condition?

- ☐ X-rays
- ☐ Bone Scan
- ☐ CAT Scan
- ☐ myelogram
- ☐ MRI (magnetic resonance imaging)
- ☐ Nerve conduction test
- ☐ EMG (electromyography)

Patient Name:_____

Allergies to medication: _____

Other known allergies: _____

CURRENT PAIN MEDICATIONS (bring prescription bottle with you if you are uncertain):

Medicine Name	Doses/Times per day	Which MD Prescribed?	Effect/reason stopped?

PAST PAIN MEDICINES (Please describe why this medicine was stopped):

Medicine Name	Doses/Times per day	Which MD Prescribed?	Effect/reason stopped?

CURRENT NON-PAIN MEDICATIONS (bring prescription bottle with you if you are uncertain):

Medicine Name	**Doses/Times per day**	**Which MD Prescribed?**	**Effect/reason stopped?**

Do you use any anticoagulant therapies? ☐ Yes ☐ No ☐ unsure

If yes, which do you use? ☐ Plavix ☐ Coumadin ☐ Effient ☐ Heparin ☐ Aspirin ☐ Other NSAID: _____

If more space is required, please use separate sheet of paper

Patient Name: _____

Past Medical History:

- ☐ High blood pressure
- ☐ Diabetes
- ☐ Ulcers
- ☐ Heart problems
- ☐ Epilepsy/seizure disorder
- ☐ Thyroid
- ☐ Bleeding or bruising
- ☐ Liver problems (hepatitis)
- ☐ Kidney problems
- ☐ Arthritis
- ☐ Gout
- ☐ Stroke
- ☐ Sexual difficulties
- ☐ Cancer

Other:_____

Other: _____

Past Surgical Procedures (include approximate date):

SURGERY	DATE	SURGERY	DATE

Imaging Results (MRI, CT, EMG, X-ray, etc) (May be completed with your physician visit if uncertain)

_____

_____

_____

_____

_____

Are there any diseases that run in your family? _____

Review of Symptons:

- ☐ Unusual tiredness
- ☐ Fevers
- ☐ Chills
- ☐ Unusual sweating
- ☐ Loss of appetite
- ☐ Unexplained weight loss
- ☐ Rashes
- ☐ Unusual bleeding
- ☐ Easy bruising
- ☐ Lumps or bumps
- ☐ Swollen glands
- ☐ Change in bowel habits
- ☐ Blood in the urine or stool
- ☐ Impotence
- ☐ Heavy cough
- ☐ Chest pain
- ☐ Trouble breathing
- ☐ Depression
- ☐ Change in vision
- ☐ Seizures
- ☐ Tingling (pins & needles)
- ☐ Trouble sleeping
- ☐ Suicidal thoughts
- ☐ Homicidal thoughts

Social History:

Marital Status ☐ Married ☐ Widowed ☐ Divorced/Separated ☐ Single ☐ Living with significant other

Number of children: _____ Who lives in your home? _____

Major changes/stressors:

☐ Loss of loved one ☐ Financial Change ☐ Family Changes ☐ Personal ☐ Sleep Disturbance

Describe: _____

Patient Name: _____

What are your expectations from your pain management program?

- ☐ Pain relief
- ☐ Pain reduction
- ☐ Return to work
- ☐ Increase work hours
- ☐ Increase activities of daily living
- ☐ Reduce use of pain medications

What is your current occupation? _____

☐ Part-time ☐ Full-time New employer since onset of pain? ☐ Yes ☐ No

Have you participated in vocational training/retraining since the onset of your pain: ☐ Yes ☐ No

If you do not work, do you participate in other income producing activities? (i.e., rental properties, crafts, etc)

☐ Yes ☐ No If yes, please describe: _____

If you are not working, is it due to your initial onset of pain/injury or a new pain/injury? ☐ Yes ☐ No

Any pending litigation associated with the pain?

☐ Workers compensation ☐ Personal Injury ☐ Other ☐ None

Are you receiving disability payments? ☐ Yes ☐ No

Have you applied for disability payments? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If yes, how many packs in a day? _____

How long have you smoked? _____ Years If a former smoker, how long ago did you quit? _____ Years

Do you drink alcohol? ☐ Yes ☐ No If yes, how much in an average day, week, or month? _____

Do you have a history of alcohol or drug abuse? ☐ Yes ☐ No

Have you ever felt the need to cut down on your drinking or drug use? ☐ Yes ☐ No

Have people annoyed you by criticizing your drinking or drug use? ☐ Yes ☐ No

Have you ever felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No

Have you ever needed an eye opener the first thing in the morning to steady your nerves? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No How often and what type? _____

Females: Last menstrual period _____

Could you be pregnant? ☐ Yes ☐ No Birth control method _____

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OFFICE AND FINANCIAL POLICIES

Financial

It is your responsibility to keep us aware of any changes in your health insurance coverage. Failure to do so could result in services not being covered or pre-authorized, leaving the expense to you. The filing of a medical claim is an expensive process that we extend to you at no charge as a courtesy; however, all co-pays, co-insurances, deductibles and non-covered items are expected to be paid prior to services rendered.

"No Show" and Cancellation Policy

Appointments

We make every effort to confirm your appointment in advance. Due to our heavy patient load, same day cancellations and "No Shows" are subject to a $100 fee. You will not be rescheduled until this fee is paid.

Procedures

Patients who "No Show" their scheduled procedures or do not cancel more than 24 hours in advance are subject to a $100 fee.

Repeat cancellations and/or "No Shows" are subject to dismissal from our practice.

Refill Policy

Refill requests must be called in 3 business days prior to due date so that it will give the doctor ample time to either refill the medication or notify you if it cannot be refilled. Failure to call the office 3 business days in advance could delay your prescription refill. Prescriptions may be picked up on the day they are due. Any Schedule II Narcotic refills that are filled outside your clinic appointment will incur a nominal $10 fee.

I have read and understand the above office and financial policies and accept responsibility for all charges incurred from services rendered to me by Permian Basin Pain Management. I also understand and agree to the terms of the refill policy.

_____ _____

Signature of Patient or Legal Representative Date

_____

If Legal Representative, Relationship to Patient

NOTICE OF CARE PROVIDED TO OUT OF STATE PATIENTS

The patient (including the patients's representative, heirs and beneficiaries) and the health care provider rendering or providing medical care, health care, or safety or professional or administrative services directly related to health care to patient (including employees and agents of the health care provider) agree:

1) That all health care rendered shall be governed exclusively and only by Texas Law and in no event shall the law of any other state apply to any health care rendered to patient.
2) In the event of a dispute, any lawsuit, action, or cause of which in any way relates to health care provided to the patient shall only be brought in a Texas Court in the county/district where all or substantially all of the health care was provided or rendered and in no event will any lawsuit, action or cause of action ever be brought in any other state.

The choice of law and forum selection provisions of this paragraph are mandatory and are not permissive.

_____ _____

Signature of Patient or Legal Representative Date

_____

If Legal Representative, Relationship to Patient