COLUMBUS PAIN CENTER

DEMOGRAPHIC INFORMATION

Name: _____ Date of Birth: _____/_____/_____

SSN: _____-_____-_____ Sex: _____ Race: _____ Marital Status: _____

Mailing Address: _____

_____

Physical Address (if different): _____

_____

Home # (_____)_____ Cell # (_____)_____ Work # (_____)_____

Contact preference: [ ] Home [ ] Cell [ ] Work

Emergency Contact: Name: _____ Relationship: _____

Phone: (_____)_____

HEALTH INSURANCE INFORMATION

Primary Insurance Company: _____

Policy # _____ Policy Holder: _____

PH Date of Birth: _____/_____/_____ PH SSN: _____-_____-_____

PH Address (if different from the patient): _____

Secondary Insurance Company: _____

Policy # _____ Policy Holder: _____

PH Date of Birth: _____/_____/_____ PH SSN: _____-_____-_____

PH Address (if different from the patient): _____

Release of Information

If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members, please fill out this section. If not, you may leave it blank.

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand this authorization is voluntary. I further understand that if the person authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations. I also understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any effect on any actions they took before the received the revocation.

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

Patient Signature: _____ Date: _____

Columbus Pain Center
Medical History Questionnaire

Patient Name: _____ SSN: _____-____-_____

Present Medical History:

Where are you hurting? _____ How long? _____
Was this due to an injury? ___ Yes ___ No If yes, please explain: _____
_____
Please list any physicians that you have seen for this/these condition(s): _____
_____

Past Medical History:

Do you now have, or have you ever had, any of the following: **(Circle all that apply.)**

High Blood Pressure	Stroke	Ulcer	Osteoarthritis	Sleep Apnea
Heart Disease	Bleeding Disorder	GERD/Acid Reflux	Gout	High Cholesterol
Heart Attack	Blood Clots	Asthma Rheumatoid	Arthritis	Kidney Stones
Pacemaker/Implants	Hepatitis	Emphysema	Fibromyalgia	Diabetes
Depression/Anxiety	Seizures	Cancer – Type: _____		

Please list any conditions that are not listed above: _____

Please list all diagnostic studies (X-Rays, CT, MRI, etc.) that you have had for this/these conditions and the date(s): _____

Allergies: ___ Foods ___ Shellfish ___ Medications Please list: _____

Please list all medications you are currently taking and the physician who prescribed them: (Continue on the back if necessary)

Medications: _____ Prescribed by: _____ Dosage: _____
Medications: _____ Prescribed by: _____ Dosage: _____
Medications: _____ Prescribed by: _____ Dosage: _____
Medications: _____ Prescribed by: _____ Dosage: _____
Medications: _____ Prescribed by: _____ Dosage: _____
Medications: _____ Prescribed by: _____ Dosage: _____

Family History:

Please circle, if any, the significant health problems in your family:

Heart Disease Stroke High Blood Pressure Cancer Unusual medical family deaths
Other: _____

Social History: Do you do any of the following?

Drink Alcohol: ___ Yes ___ No If yes, how much and how often? _____
Use tobacco/e-cigarettes: ___Yes ___No If yes, how much and how often? _____
Social/Illicit Drugs: ___Yes ___No If yes, how much and how often? _____

Pain Scale: ___ None ___1-2 (Mild) ___3-4 (Mod) ___5-6 (Severe) ___7-8 (Very Severe) ___9-10 (Worst)

Consent for Treatment

I hereby agree and give my consent for the treatment of _____ (Patient Name) to Columbus Pain Center, P.C. I consent to any and all care which encompasses physician examination, X-ray examination, laboratory procedures, diagnostic procedures, therapeutic procedures, and any nursing and medical/surgical treatment the physician may deem necessary and advisable. The information I have provided to Columbus Pain Center, P.C. is accurate and true to the best of my knowledge.

Please initial the following:

In consideration of the care and treatment to be rendered to me by Columbus Pain Center, P.C., I agree and consent to the following conditions:

_____ (1) **ASSIGNMENT OF INSURANCE BENEFITS:** I hereby assign, transfer, and convey payment and authorize said payment to be made directly to Columbus Pain Center, P.C. of any medical benefits for which I may be entitled. I further agree that this assignment WILL NOT BE WITHDRAWN OR VOIDED at any time until this account is paid in full. **I understand that I am responsible for any charges not covered by my insurance.**

Should the account be turned over to a collection agency or an attorney for collection, the undersigned shall pay all court costs and reasonable attorney's fees. The undersigned agrees that any patient or guarantor over payments collected on the account may be applied directly to a delinquent account of the patient or any delinquent account for which the patient or guarantor is legally responsible at the time of collection of the overpayment.

_____ (2) **RELEASE OF MEDICAL INFORMATION:** I authorize Columbus Pain Center, P.C. to release medical and supporting documentation compiled in the medical record to my insurance company, my attorney (if applicable), and my referring physician.

_____ (3) **MEDICARE PATIENT CERTIFICATION:** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical, or other information about me, to release to the Social Security Administration, or its intermediaries or carries, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of authorized benefits be made on my behalf.

_____ (4) **PERSONAL VALUABLES AND BELONGINGS:** It is understood and agreed that Columbus Pain Center, P.C. is not liable for the loss or damage to any articles of personal property while on their premises.

The undersigned certifies that they have read this document, and are the patient or are duly authorized by the patient or by power or attorney, to execute the above agreement and understands and accepts its terms.

_____ _____
Patient Name (Printed) Date

_____
Witness

_____ _____
Patient Signature Date

Annual Financial Policy of
Columbus Pain Center, P.C.

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have questions regarding these policies, please discuss them with the office manager or billing specialist prior to your appointment. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Please read and initial the following

_____ You are responsible for providing us with current, active insurance as well as notifying us of any changes to your insurance ***prior to your appointment.*** Failure to notify us of any changes may result in exceeding the limits of the time allowed to file a claim with your insurance, and you will be responsible for all charges. We will scan a copy of your insurance card and photo ID to keep on file for our records.

_____ Unless otherwise specified, payment is due in full at time of service. We will collect your deductible, coinsurance, or copay at the time of your visit. Please be prepared to pay at the time of check-in before you are seen by the doctor. We will bill your insurance for covered procedures. Once they have paid, you will receive a bill for any remaining deductible or coinsurance/copay amounts owed. The balance is due in full within 30 days of receipt of the statement. Failure to do so may result in further collection activity which may include referral to an outside collection agency and/or inability to schedule any further appointments.

_____ We will file your insurance if we are providers with your plan. **Please note it is your responsibility as the policy holder/patient to understand the coverage and benefits and be knowledgeable of any deductibles, coinsurance/copayments, and/or referrals needed.** If a referral is needed, the authorization must be obtained *before* your scheduled visit. If you do not have the proper authorization, you may be asked to reschedule, or you will be responsible for any charges not paid by your insurance.

Remember, you and/or your employer pay the monthly insurance premiums. Your insurance company is accountable to you. DO NOT HESITATE TO CONTACT THEM if you disagree with their payment, to find out the status of your claims, or simply to learn the benefits of your plan.

_____ 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 a statement from our office.

____ **SELF-PAY PATIENTS:** This category includes patients with no insurance and patients who have an insurance plan with which we do not participate. Payment is due in full prior to any services being rendered. Self-pay rates are dependent upon the procedure being performed. For more information, please ask for the billing specialist.

I understand the above financial policy. I understand that Columbus Pain Center files my insurance as a courtesy only, and that the payment of my account is my responsibility.

_____	_____	_____
Patient (or Guarantor) Signature	Printed Patient Name	Date

MRN: _____

Agreement on Controlled Substances Therapy for Chronic Pain Treatment

The purpose of this agreement is to create an understanding regarding *controlled substances* (a type of medication that is regulated by states and the Federal government) that may benefit your chronic pain symptoms. My goal is to treat you safely with these potent medications and also to prevent abuse of or addiction to these medications. Although these medications may be prescribed with the goal of improving your comfort and functionality, their medical use is also associated with the risk of serious adverse effects such as development of an addiction disorder or a relapse in a person with a prior addiction history. The extent of this risk is uncertain, but it is known to be higher in certain vulnerable patients. My goal is to have you take the lowest possible dose of medication that is reasonably effective in managing your pain and improving your function, and when possible, have it tapered and eventually discontinued, while at the same time monitoring and managing these potential risks.

Medications such as opioids (narcotic analgesics), benzodiazepine, tranquilizers, barbiturate sedatives, and muscle relaxants that may be useful in managing pain, can be problematic in several ways. These medications have "street value" and potential for abuse. Because these medications have the potential for abuse or diversion (i.e. sharing, trading, or selling to ANYONE other than whose name is on the prescription), strict accountability is necessary for both medical safety and legal reasons. Therefore, the following policies are agreed to by you, the patient, to help me keep you safe and to provide you with good care.

1. You must get a prescription for all controlled substances from the physician whose name appears below or, during his absence, by the covering physician, unless specific written authorization is obtained for an exception. (Multiple sources can lead to unwelcome medication interactions or poor coordination of treatment.)
2. You must obtain all controlled substances from the same pharmacy. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is: _____. Phone: _____
3. You must inform our office of any new medications or medical conditions and of any adverse effects you experience from any of the medications that you take.
4. You must give the prescribing physician permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability and coordinating your care.
5. You may not share, sell, or otherwise permit others to have access to these medications. You must take all medications exactly as prescribed, unless you develop side effects. If you develop side effects, you must consult with your doctor or local emergency providers.
6. You must not stop these medications abruptly or without consulting the prescribing physician, as an abstinence/withdrawal syndrome may develop.
7. You should not use alcohol or illegal drugs while taking these medications. You should not use sleeping pills (unless prescribed), cold medications, or other medications that might cause drowsiness, dizziness, or changes in thinking unless you first discuss them with your provider.
8. You must agree that your urine and/or blood may be tested for controlled substances before initiation of therapy and that random urine and/or blood follow up testing may be done.
9. You must agree to submit to random pill counts and urine and/or blood drug tests as requested by your physician to monitor your treatment. You must cooperate in such testing, and you must agree that the presence of unauthorized substances, illicit substances, or absence of prescribed medications may prompt referral for assessment for addictive disorder and possible tapering and discontinuation of the controlled substances immediately or in the future.
10. You will not give your prescriptions or bottles of these medications to anyone else. These substances may be sought after by other individuals with chemical dependency, and should be closely safeguarded. You

will take the highest degree of care with your medications and prescriptions. You will not leave them where others might see or otherwise have access to them.

11. You must bring original containers of medication to each office visit.
12. You must keep all controlled substances in a secure area. Since the medications may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.
13. You must exercise extreme caution when taking these medications and driving or operating heavy machinery. The use of these medications may induce drowsiness or change your mental abilities, thereby making it unsafe to drive or operate heavy machinery. The effects of these medications are particularly problematic during any dose changes. If you are the slightest bit impaired, you must refrain from these activities.
14. You must discuss long-term use of controlled substances with your physician. Prolonged opioid use can be associated with serious health risks. You need to understand these risks.
15. You must agree that medications will not be replaced if they are lost, flushed down the toilet, destroyed, stolen, etc. If your medication has been stolen and you complete a police report regarding the theft, present that report to the prescribing physician.
16. You must agree that early refills will not be given.
17. You must understand that prescriptions may be issued early only if the physician or the patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they are not to be filled prior to the appropriate date.
18. You agree that, if the responsible legal authorities have questions concerning your treatment, as might occur for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.
19. You agree that failure to adhere to these policies my result in tapering and cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.
20. You agree that prescription renewals are contingent on keeping scheduled appointments. Do not phone for prescriptions after hours or on weekends. If you receive any controlled substances in an ER, you must report that incident to your prescriber, in writing, within 48 hours.
21. You recognize that any medical treatment is a trial, and that continued prescription is contingent on evidence of benefit and improved functionality.
22. You acknowledge that the risks and potential benefits of therapy with controlled substances have been explained to you and that you have had the opportunity to ask any questions that you may have had.

YOU UNDERSTAND AND AGREE THAT FAILURE TO ADHERE TO THESE POLICIES WILL BE CONSIDERED NONCOMPLIANCE AND MAY RESULT IN CESSATION OF OPIOID PRESCRIBING BY YOUR PHYSICIAN AND POSSIBLE DISMISSAL FROM THIS CLINIC.

YOU AFFIRM THAT YOU HAVE FULL RIGHT AND POWER TO SIGN AND BE BOUND BY THIS AGREEMENT, AND THAT YOU HAVE BEEN GIVEN THE OPPORTUNITY TO ASK ANY QUESTIONS THAT YOU MAY HAVE. YOU FURTHER AFFIRM THAT YOU HAVE READ THIS AGREEMENT (OR HAVE HAD IT READ TO YOU), AND YOU UNDERSTAND AND ACCEPT ALL OF ITS TERMS.

_____	_____
Patient Signature	Daniel H. Serrato, M.D.
_____	_____
Date	Date

MRN: _____

Consent for Chronic Opioid Therapy

I understand that Dr. Serrato (my physician) is recommending opioid medicine, sometimes called narcotic analgesics, to treat my chronic pain.

I understand that this medication is being recommended because my pain complaints are moderate to severe and other treatments have not sufficiently helped my pain. I understand that many medications can have interactions with opioids that can either increase or decrease their effect. Therefore, I have told my physician about all other medicines and treatments that I am receiving, and that I will promptly advise my physician if I start to take any new medications or have new treatments. Likewise, I have told my physician about my complete personal drug history and that of my family.

I have been informed by my physician that the initiation of a narcotic/opioid medication is a trial. Continuation of the medication is based on evidence of benefit to me from, associated side effects of, and compliance with instructions on usage of the medication. I have also been informed by my physician that continuation and any changes in dosage of the medication will be determined by pain relief, functional improvement, side effects, and adherence to usage restrictions. Lack of significant improvement, the development of adverse side effects, or other considerations may lead my physician to discontinue this treatment or to change dosage.
It has been explained to me that taking narcotic/opioid medication has certain risks associated with it. These include, but are not limited to, the following:

- Allergic reactions
- Overdose (which could result in harm or even death)
- Slowing of breathing rate
- Slowing of reflexes or reaction time
- Sleepiness, drowsiness, dizziness, and/or confusion
- Impaired judgement and inability to operate machines or drive motor vehicles
- Nausea, vomiting, and/or constipation
- Itching
- Physical dependence or tolerance to the pain-relieving properties of the medication. (This means that if my medication is stopped, reduced in dose, or rendered less effective by other medications I may be taking, I may experience runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body, and a flu-like feeling. These can be very painful, but are generally not life-threatening.)
- Addiction
- Failure to provide pain relief
- Changes in sexual function. (This is generally cause by reduced testosterone levels. Such reduced levels may affect mood, stamina, sexual desire, and physical and sexual performance.)
- Change in hormone levels

In addition, use of these medications poses special risks to women who are pregnant or may become pregnant. If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetrician and this office to inform them. I have been advised that, should I carry a baby to delivery while taking this medication, the baby will be physically dependent on opioids. I also understand that birth defects can occur whether or not the mother is on medications, and there is always the possibility that my child will have a birth defect while I am taking an opioid. Furthermore, I recognize that the long-term consequence on a child's development who was exposed to opioids is not understood.

It has been explained to me that there are other treatments that do not involve use of narcotic/opioid medications. Having been informed of these risks and potential benefits both of such medications and alternative treatments, I have freely consented to taking the narcotic/opioid medication.

MRN: _____

I would note that I have been given the opportunity to ask any questions that I may have, and that any questions that

I have raised have been discussed to my satisfaction.

I will take this/these medication(s) only as prescribed, and I will not change the amount or dosing frequency without authorization from my physician. I understand that unauthorized changes may result in my running out of medications early, and early refills may not be allowed. I also understand that if I do not take the medication correctly, I may have withdrawal reactions that may include stomach pain, sweating, anxiety, nausea, vomiting, and general discomfort.

I have been advised by physician that certain other medications such as nalbuphine (Nubain ™) pentazocine (Talwin ™), buprenorphine (Buprenex ™), and butorphanol (Stadol ™) may reverse the action of the medicine I am using for pain control. I understand that taking any of these medications while I am taking my pain medications can cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of these medicines without authorization from my physician, and to tell any other doctors that I am taking an opioid as my pain medicine and cannot take any of the medications listed above.

I will obtain all opioid prescriptions from my physician or, during his absence, by the covering physician. Requests for pain medications from the on-call physician (nights and weekends) will not be honored. I will not request medications outside of normal business hours.

I will obtain all scheduled medications from one pharmacy. I will notify my physician if I change pharmacies. The pharmacy that I have selected is: _____.
Its phone number is: _____.

I hereby authorize my physician to discuss all diagnostic and treatment details of my condition with the pharmacist at the dispensing pharmacy.

I will submit to random pill counts and urine and/or blood drug tests as requested by my physician to monitor my treatment. I understand that the presence of any unauthorized substances in my urine or blood may prompt referral for assessment of addiction of chemical dependency, and could result in discontinuation of further opioid prescriptions. I also understand that failure to follow these rules may lead to my no longer being treated by my physician after a 30-day, emergency only, period.

I will not share, sell, or otherwise permit others to have access to these medications.

I HAVE READ THIS FORM, OR HAVE HAD IT READ TO ME. I UNDERSTAND ALL OF IT. I HAVE HAD A CHANCE TO HAVE ALL OF MY QUESTIONS REGARDING THIS TREATMENT ANSWERED TO MY SATISFACTION. BY SIGNING THIS FORM, I GIVE CONSENT FOR THE TREATMENT OF MY PAIN WITH OPIOID MEDICATIONS.

I UNDERSTAND AND AGREE THAT FAILURE TO ADHERE TO THESE POLICIES WILL BE CONSIDERED NONCOMPLIANCE AND MAY RESULT IN CESSATION OF OPIOID PRESCRIBING BY MY PHYSICIAN AND POSSIBLE DISMISSAL FROM THIS CLINIC.

Patient signature: _____ **Witness: _____**

Date: _____ **Date: _____**