Comprehensive Spine and Pain Management, LLC

New patient personal and insurance in-take form

Personal information:

Name_____Date_____
Address_____
City_____State_____Zip_____
Tel# (Home)_____ Cell)_____
E-mail_____
BirthDate_____Age_____Soc.Sec.#_____Gender_____

Ethnicity: please circle one
American Indian/Alaska Native Asian Black or African American
Native Hawaiian/other Pacific Islander White Decline to specify

Referred by_____ Primary Care Physician's name_____
Primary Care Physician's Tel#_____
Primary Care Physician's Fax#_____

EmergencyContact_____Relationship_____
EmergencyContactPhone(Home)_____(Cell)_____

Employment □Full-time -□Part-time -□Self-employed - □Student -□Unemployed -□Retired
Occupation: _____ Employer's Name: _____
Employer's phone:_____ Employer's Address:_____
_____

Billing and Insurance Account paid by:

Primary Insurance Company: _____Tel#:_____
PolicyHolder'sName_____Relationship_____
Policy#/MemberID#_____Group#_____
Secondary Insurance Company: _____Tel#_____
Policy#/MemberID_____Group#_____

If Auto or Worker Compensation fill:

□Auto □Workmen's Comp
Insurance company name_____ Claim #_____
Adjuster's name_____ Phone #_____Fax #_____
Date of injury_____
Is this involving a law-suit?_____ Lawyer's name_____ Tel#_____

INITIAL PATIENT HISTORY

Name: _____ Today's Date: _____

1. Why are you coming to us? _____
2. Who referred you or how did you hear about us?
   _____
3. Describe your PAIN: (write it out or circle the words)
   Where is it?_____
   How long have you had it?_____
   What caused it? Work related, car accident, unknown or_____
   Is it constant or occasional?
   Is it sharp, dull, stabbing, cramping?
   Does it shoot or radiate anywhere—such as into an arm or leg, right, left or both?
   How severe is the pain on a scale of 0 to 10? 0 is no pain and 10 is the most severe imaginable.
   What aggravates your pain?
   What helps relieve your pain?
   What treatments have you had? —physical therapy, injections, or surgery?
   What diagnostic studies have you had in the past 2 years? MRI, X-rays, EMG
4. List your MEDICATIONS:_____
   _____
5. List your Medication ALLERGIES: _____
6. List your MEDICAL HISTORY: High blood pressure, Diabetes, heart disease, Breathing or any other
   _____
7. List all your SURGERIES:_____
   _____
8. List FAMILY ILLNESSES:
   _____
9. SOCIAL HISTORY: Are you a smoker/non-smoker; single/married/divorced; live alone/with family/with friend; education completed—grade school/high school/college/other_____
   unemployed/disabled/retired/employed—type of work_____
10. REVIEW OF SYSTEMS: (Please circle those that you are currently experiencing) General: Loss of appetite or Weight?
    Hematologic: Are you on a blood thinner or suffer your excessive bleeding?
    ENT: Difficulty swallowing or painful swallowing?
    Respiratory: Breathing problems or Cough?
    Breast: Breast pain or Nipple discharge?
    Cardiovascular: Chest pain, shortness of breath with lying flat, calf tightness with walking? Gastrointestinal: Abdominal pain, black or bloody stools?
    Genitourinary: Difficulty urinating or painful urination?
    Peripheral Vascular: Pain/tightness in calf with walking or ulceration of feet.
    Neurologic: Headache or Paralysis.
    Psychiatric: Denies Auditory/visual hallucinations.
    Endocrine: numbness in feet or excessive thirst?

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	o	o	o	o	o
14. How often have others told you that you had a bad temper?	o	o	o	o	o
15. How often have you felt consumed by the need to get pain medication?	o	o	o	o	o
16. How often have you run out of pain medication early?	o	o	o	o	o
17. How often have others kept you from getting what you deserve?	o	o	o	o	o
18. How often, in your lifetime, have you had legal problems or been arrested?	o	o	o	o	o
19. How often have you attended an AA or NA meeting?	o	o	o	o	o
20. How often have you been in an argument that was so out of control that someone got hurt?	o	o	o	o	o
21. How often have you been sexually abused?	o	o	o	o	o
22. How often have others suggested that you have a drug or alcohol problem?	o	o	o	o	o
23. How often have you had to borrow pain medications from your family or friends?	o	o	o	o	o
24. How often have you been treated for an alcohol or drug problem?	o	o	o	o	o

Please include any additional information you wish about the above answers.
Thank you.

Comprehensive Spine and Pain Management, LLC

Consent for Chronic Opiate Therapy

Medications prescribed by our office may reduce your pain, improve your function and sleep but they could make you feel drowsy, dizzy, and constipated. While tolerance and dependence may develop to these medications for many patients with prolonged treatment, addiction may develop in susceptible individuals. These medications can lead to death if over dosed or combined with alcohol, illicit drugs, or sedative medication. For males, it may decrease sex drive due to decrease in testosterone levels. For females, if pregnant or intending to get pregnant, taking these medications may affect the growth and development of a fetus and may lead to withdrawal syndrome in the new born.

When we prescribe medications, you agree to:

1. Use only one pharmacy.
2. Bring medication bottles with remaining medications at the time of next refill or medication change.
3. Provide your urine sample for drug testing whenever requested.
4. Not drive or do any activities deemed dangerous to yourself or to others if you are feeling drowsy, dizzy, or otherwise not well due to the medication.
5. If you are a female and intend to get pregnant or are pregnant---immediately let your obstetrician and us know so we can monitor/change/discontinue medications and other treatments.
6. Not obtain narcotics from other sources such as emergency rooms or other medical providers unless approved by our office.
7. Take medications at the dose and frequency prescribed and do not take additional medication from family or friends.
8. Allow medications to be changed, tapered, or discontinued for reasons including but not limited to: lack of effectiveness and violation of this agreement and office policies.
9. Not use illicit drugs such as cocaine, ecstasy, bath salts and like.
10. Keep these medications in a secured location and away from children.

If this agreement is broken, once or multiple times, it could lead to termination of further medication management by Comprehensive Spine and Pain Management, LLC.

Patient Name: Signature: _____ Date: _____

Comprehensive Spine and Pain Management, LLC office policies for ongoing treatment:

1. For any medication refill or schedule changes-please call office during office hours (8am 4:30pm) only. If you are experiencing a life-threatening event, please call 911 or go to the hospital.
2. For injections and interventional treatments: We request that you not drive, operate heavy machineries for at least 4 hours after the procedure because you may experience numbness or weakness of one or multiple limbs. You are to bring a driver for such injections. If you are not able to bring a driver, please let us know and we can alter or reschedule the treatment.
3. Payment policy: You agree to pay the following:
   A. $70 charge for missed appointments, no-show, or cancellations less than 24 hours prior to appointment. (Please do not call during weekends, holidays or after hours for these.)
   B. $25 charge for any forms that you require us to fill out/copies for your records.
   C. Any cancelled procedures must be rescheduled immediately. All planned treatments must be completed prior to medication refills. No exceptions.
   D. If you do not have a valid insurance or we are not in network with your insurance, then you are responsible and agree to pay the account balance.
   E. If your insurance has a deductible, you are responsible to pay for the office visit payment at the time of the appointment. The bill for the treatments will be separate.
   F. For patients with Medicare insurance and no secondary insurance, please note that Medicare will cover only 80% of the bill. The remaining 20% will be your responsibility.
   G. All copays and late fees are to be paid prior to the next appointment.
   H. $35 charge for all bounced checks.
   I. 5% charge for all credit card payments.
   J. All balances must be paid within 30 days.
4. I authorize contact from this office to confirm my appointments, treatment & billing information as well as convey information about my health via home phone, cell phone, text message to my cell phone or email.
5. My signature also serves as PHI (Protected Health Information) documents release should I request documents be sent to other attending doctor/treatment facilities in the future.

Patient Name: Signature: _____Date: _____

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITYS IN THE FUTURE.**

_____ _____

Please ***print*** your name Please ***sign*** your name

_____ _____

Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:
☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Text Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer

PATIENT HEALTH QUESTIONNAIRE- 9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Oswestry Low Back Pain Disability Questionnaire

Instructions

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem.

Section 1 – Pain intensity

- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

Section 2 – Personal care (washing, dressing etc)

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but manage most of my personal care
- ☐ I need help every day in most aspects of self-care
- ☐ I do not get dressed, I wash with difficulty and stay in bed

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed eg. on a table
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift very light weights
- ☐ I cannot lift or carry anything at all

Section 4 – Walking*

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me from walking more than 1 mile
- ☐ Pain prevents me from walking more than 1/2 mile
- ☐ Pain prevents me from walking more than 100 yards
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time

Section 5 – Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favourite chair as long as I like
- ☐ Pain prevents me sitting more than one hour
- ☐ Pain prevents me from sitting more than 30 minutes
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

Section 6 – Standing

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than 1 hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

Section 7 – Sleeping

- ☐ My sleep is never disturbed by pain
- ☐ My sleep is occasionally disturbed by pain
- ☐ Because of pain I have less than 6 hours sleep
- ☐ Because of pain I have less than 4 hours sleep
- ☐ Because of pain I have less than 2 hours sleep
- ☐ Pain prevents me from sleeping at all

Section 8 – Sex life (if applicable)

- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life is normal but causes some extra pain
- ☐ My sex life is nearly normal but is very painful
- ☐ My sex life is severely restricted by pain
- ☐ My sex life is nearly absent because of pain
- ☐ Pain prevents any sex life at all

Section 9 – Social life

- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests eg, sport
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

Section 10 – Travelling

- ☐ I can travel anywhere without pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad but I manage journeys over two hours
- ☐ Pain restricts me to journeys of less than one hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from travelling except to receive treatment