PRECISION PAIN MANAGEMENT

PATIENT REGISTRATION

Date:

PATIENT DEMOGRAPHICS

Patient Name:		DOB:		Sex: Male ☐ Female ☐ Decline to answer ☐
Address:		City:	State:	Zip:
Home Phone:	Cell:	Can we text and/or leave messages on the phone numbers listed? YES ☐ NO ☐		
Email:		Would you like to receive appointment information at the email listed? YES ☐NO ☐		
Emergency Contact:		Phone:		Relationship:
Spouse:		Spouse Phone:		
PCP/Referring provider:		PCP/Referring provider phone:		

RESPONSIBLE PARTY (Person Responsible for Payment)

Relationship to patient:			
Responsible Party Name	Phone	DOB	
Address	City	State	Zip
Employer	Employer Phone		

INSURANCE INFORMATION

Primary Insurance	Policy #
Secondary Insurance	Policy #

ASSIGNMENT AND RELEASE

I, undersigned certify that I (or my dependent) have the above stated insurance coverage and assign directly to PPM all insurance benefits payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize PPM to release any information necessary to secure payment of benefits on all insurance submissions. Further, I authorize the release of my medical records from the office either myself, or any and all medical personnel necessary for my continued medical care. In providing this consent, I am fully aware that the physicians of PPM, the staff, and employees cannot be responsible for the confidentiality of the information disclosed after medical records have been released. Therefore, the physicians of PPM, the staff, and employees are released from any liability arising from such disclosure.

Patient Signature	Date
Responsible Party Signature	Date

HIPAA RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name:_____ Date of Birth: _____

Please provide us with a list of names of whom you would allow our office to release medical info to.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with Precision Pain Management's (PPM) Notice of Privacy Practices:

- It tells me how PPM will use my health information for the purposes of my treatment, payment for my treatment, and its health care operations.
- The Notice explains in more detail how PPM may use and share my health information for purposes other than treatment, payment, and health care operations.
- PPM will also use and share my health information as required/permitted by law.

Patient's Legal Name: _____

Patient's Signature:_____Date:_____

Employee Signature:_____ Date:_____

Do you want to receive a copy? YES ☐ NO ☐

NURSE PRACTIONER CONSENT

A Nurse Practitioner is a Registered Nurse (RN) who has received advanced education and training in the provision of health care. The Nurse Practitioners of PPM can diagnose, treat, and monitor substance/alcohol abuse disorders. Your care could be monitored primarily by a Nurse Practitioner under the supervision of a Physician.

By signing this agreement, I affirm that I have read, understand, accept, and consent to the services of a Nurse Practitioner for my health care needs.

Patient Name	DOB
Signature	Date

CONSENT TO TREAT

I am voluntarily seeking treatment for pain management from Precision Pain Management. I understand that I have right and responsibilities regarding my participation in treatment, including the right to discontinue substance abuse treatment. I am strongly encouraged to discuss my treatment plan and status in treatment with my provider. My provider will discuss alternatives, procedures, qualifications, and drawback to continuing or discontinuing treatment. **By signing below, I acknowledge that I have read, understand, and agree to all the above.**

Signature	**Date**

CANCELLATION POLICY

In order to give you, the patient the best treatment, we ask that if you are not able to keep your appointment for any reason that you please contact our office to cancel or re-schedule your appointment at least 24 hours in advance. Please be aware that repeated cancellations or no showing of appointments could cause discontinuation of care in the clinic. Please be aware that by signing below you agree to cancel appointments 24 hours in advance and agree to a $25 no show fee if the appointment is not cancelled in advance.

Signature	**Date**

PATIENT HISTORY

Name	DOB	Date

Where is your pain located?

What date did your pain start?	Was this work comp related? YES NO

Have you been arrested or convicted on a drug related charge(s)? YES NO

If yes, please explain:

_____

_____

_____

Please provide any other information that might be helpful in treating your pain:

_____

_____

_____

_____

_____

_____

MEDICAL HISTORY

Name	DOB	Date

DRUG ALLERIGES

Drug	Reaction

CURRENT MEDICATIONS

Medication	Dose	Quantity

SURGERY HISTORY

Surgery	Date of surgery

D.I.R.E

Score	Factor	Explanation
	Diagnosis	1 = Benign chronic condition with minimal objective findings or no definite medical diagnosis. Examples: fibromyalgia, migraine headaches, headaches, abdominal pain, chronic back pain in young adults, chronic pelvic pain, phantom limb pain, RSD. 2= Slowly progressive condition concordant with moderate pain, or fixed condition with moderate objective findings. Examples: failed back surgery syndrome, back pain with moderate degenerative changes, neuropathic pain. 3= Advanced condition concordant with severe pain with objective findings. Examples: severe ischemic vascular disease, advanced neuropathy, severe spinal stenosis
	Intractability	1 = Few therapies have been tried and the patient takes a passive role in his/her pain management process. 2 = Most customary therapies have been tried but the patient is not fully engaged in the pain management process, or barriers present (insurance, transportation, medical illness). 3 = Patient fully engaged in a spectrum of treatments but with an inadequate response.
	Risk	
	Psychological	1 = Serious mental illness or personality dysfunction interfering with care. Examples: personality disorder, severe affective disorder, significant personality issues. 2 = Personality or mental health interferes moderately. Example: depression, anxiety disorder. 3 = Good communication with clinic. No significant personality dysfunction or mental illness.
	Chemical Health	1 = Active or very recent use of illicit drugs, excessive alcohol or prescription drug abuse. 2 = Chemical coper (uses chemicals to cope with stress) or hx of CD in remission. 3 = No CD hx, not chemically focused or reliant.
	Reliability	1 = Hx of numerous problems: medication misuse, missed appts, rarely follows through. 2 = Occasional difficulties with compliance but generally reliable. 3 = Highly reliable patient with meds, appts & treatment.
	Social Support	1 = Life in chaos, little family support, few close relationships. Loss of most normal life roles. 2 = Reduction in some relationships and life roles. 3 = Supportive family/close relationships. Involved in work or school or no social isolation.
	Efficacy Score	1 = Poor function or minimal pain relief despite mod to high doses. 2 = Moderate benefit with function, improved in a # of ways. Or insufficient info (Hasn't tried opioids, low doses, too short a trial). 3 = Good improvements in pain, function, and quality of life. Stable doses over time.

Score 7-13: Not a suitable candidate for long-term opioids.
Score 14-21: May be a suitable candidate for long-term opioid treatment.

Precision Pain Management

4110 S 100th E Ave., Suite 201, Tulsa, OK 74146
P.918-857-7246 F.918-359-5828

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME (LAST, FIRST, MIDDLE)	AGE	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER

ADDRESS	CITY, STATE	ZIP CODE	HOME PHONE

I hereby authorize, Precision Pain Management to __ RELEASE or __ OBTAIN (Check one)
Information and copies of records pertaining to my medical care and treatment.

I request my medical records__ ENTIRE **CHART** __ **OTHER**_____

RELEASE TO	DOCTOR/FACILITY/HOSPITAL NAME Precision Pain Management	✓	**PURPOSE OF REQUEST**
	ADDRESS 4110 S 100th E Ave., Suite 201		Self, Employment or Other
	CITY, STATE, ZIP CODE Tulsa, OK 74146 Ph.918-857-7246 Fax 918-359-5828		Attorney
OBTAIN FROM	DOCTOR/FACILITY/HOSPITAL NAME		Insurance Company
	ADDRESS		Physician
	CITY, STATE, ZIP CODE		Disability

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE, OR RELATE TO MENTAL HEALTH, OR DRUG, SUBSTANCE OR ALCOHOL ABUSE.
I understand that if I am requesting records/information for release to me or patient representative:

- Laws may prevent certain records being released to the patient
- In certain situations, records denied for release to the patient may all patient to request and obtain a review of the denial

Drug/Alcohol Abuse Treatment Records: This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

This Authorization:

- Will expire in 12 months or on _____ (Date)
- May be revoked in writing care of the Medical Records Custodian, according to the Facility's Notice of Privacy Practices, but prior disclosures will not be affected
- Is not required for obtaining treatment or reimbursement for treatment, unless the sole purpose of this Authorization is to determine payment of a claim for benefits
- Is required for employment-related substance/alcohol screening

WARNING: We have no control over any information and records released to any person, firm or agency under this Authorization and it is therefore possible that a release of this information or records may occur by such party.
Release: I release Precision Pain Management of Oklahoma listed above, its employees and agents from any liability in connection with the use or disclosure of the information and records released to any party pursuant to this Authorization.

I understand that the information authorized for use or disclosure may include information which may indicate the presence of a communicable or non-communicable disease and may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and human immunodeficiency viruses also known as Acquired Immune Deficiency Syndrome (AIDS) I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

SIGNATURE OF PATIENT DATE

PERSON AUTHORIZED TO SIGN FOR PATIENT DATE

RELATION SHIP TO PATIENT