SOUTHWEST PAIN CENTER

1501 S Don Roser Dr, Las Cruces NM 88011

Registration Date _____ Registration Time _____

Patient (Legal) Name:_____ Phone: _____
Patient Address:_____
Cell Phone: _____ Email: _____
Patient Date Birth: _____ Sex: _____ Martial Status: _____
Race: _____ Religion (Optional): _____
Patient Employer: _____ Employer Phone: _____
Employer Address: _____ Occupation: _____
Admitting Provider: _____ Primary Provider: _____

Preferred Pharmacy:_____ Address :_____

Reason for Visit: _____

Emergency Contact Name: _____ Phone: _____
Address: _____
Relation to Patient: _____

Guarantor Name: _____ Phone:_____
Guarantor Employer: _____ Employer Phone: _____

PRIMARY INSURANCE

Name of Insurance Company: _____

Name of Insured: _____ Insured Policy No: _____

Relation To Patient: _____ Insured Date of Birth: _____

SECONDARY INSURANCE

Name of Insurance Company: _____

Name of Insured: _____ Insured Policy No: _____

Relation To Patient: _____ Insured Date of Birth: _____

Patient Information

SOUTHWEST PAIN CENTER

1501 S Don Roser Dr, Las Cruces NM 88011

Phone (575) 525-3980 Fax (575)5238660

Cancellation / No Show Policy

In order to ensure the effective scheduling and patient flow, Southwest Pain Center requires a 24-hour cancellation notice for all scheduled appointments.

- **A $100.00 charge will be billed directly to you if you cancel or no-show for a** scheduled **procedure with less than 24-hour notice without the presence of any emergency that could not be avoided.**

- **A $25.00 charge will be billed directly to you if you cancel or no-show for a scheduled appointment with less than 24-hour notice without the presence or an emergency that could not be avoided.**

The determination of an emergency shall be at the sole discretion of Southwest Pain Center.

Southwest Pain Center will not bill your insurance company for this charge.

Thank you for your cooperation and understanding. Feel free to call our office anytime with questions or concerns at (575) 525-3980 or (575) 523-5857.

Patient Name: _____

Patient Signature: _____

Date: _____

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HIPPA Privacy Consent to Privacy Act

The department of Health and Human Services has established a "Privacy Rule" to help ensure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of patient we want you to know that we respect the privacy of your personal medical information and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel need your health care information, treatment information, payment or health care operation in order to provide health care that is in your best interest. We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you such as laboratories that only interact with physicians and not patients and may have to disclose personal health information for purposes of treatment, payment, or health care operations.

These entities are most often not required to obtain patient consent. You may refuse to consent to the use of disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your personal health information. If you choose to give consent in this document as some future time you may request to refuse all or part of your personal information. You may not revoke actions that have already been taken which relied on this or previously signed consent. If you have any objections to this form, please ask to view our HIPPA Compliance Reference. If you have the right to review our privacy notice after you have reviewed our policy notice.

Patient Name: _____

Date: _____

Patient Signature: _____

SOUTHWEST PAIN CENTER

PERMISSION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION

Patient's Name	Date of Birth	SS#

I give permission to verbally discuss the following medical information about me (Check all boxes that apply):

- ☐ Medical Information, including my symptoms, diagnosis, medications, and treatment plan
- ☐ Lab/test results
- ☐ Other (describe)_____
- ☐ Other (describe)_____

The physician practice has my permission to discuss the above information with:

1._____
Name/Relationship to Patient

_____ _____ _____ _____
Street Address City State Zip

_____ _____
Home Telephone Number Work Telephone Number

2._____
Name/Relationship to Patient

_____ _____ _____ _____
Street Address City State Zip

_____ _____
Home Telephone Number Work Telephone Number

I understand that I have the right to revoke my permission at any time, except where the physician practice has already made disclosures in reliance upon this request. **I understand that I must notify the physician practice in writing if I want to revoke my permission.**

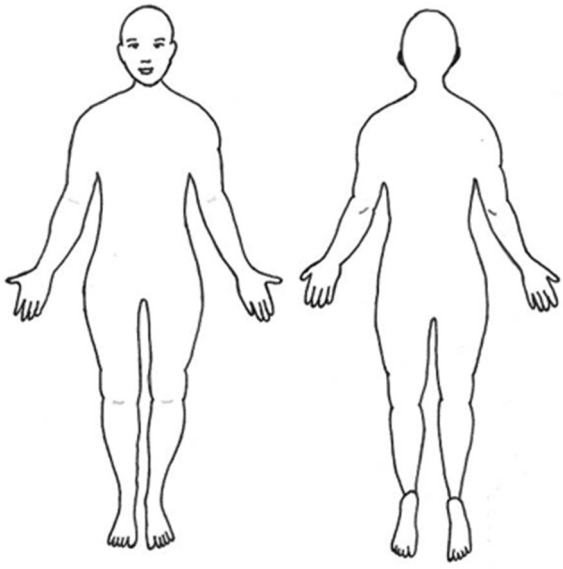
Patient Signature or Legal Representative	Date/Time
Relationship to Patient	
Witness Signature	Date/Time

Pain Clinic Questionnaire

Name: _____ DOB:_____ Age:_____ Today's Date:_____
Address: _____
Home Phone:_____ Cell:_____
Primary Care Physician:_____ Phone:_____
Chief Complaint:(use your own words to describe why you are here today)_____
_____
_____
_____

1. **Where is your pain located? Shade the areas that you have pain and make an "X" on the area(s) that hurt you the most**

FRONT **BACK**



2. Circle the words that describe your pain.

Aching	Sharp	Penetrating	Throbbing
Tender	Nagging	Shooting	Burning
Numb	Stabbing	Pinching	Pins and needles
Gnawing	Tiring	Unbearable	Exhausting

Other words that describe your pain: _____

3. Do you notice any increased weakness? Y__ N __Where? _____

4. Do you notice and increased numbness/tingling? Y __N__ Where? _____

5. When did your pain begin? _____
Did something happen when your pain began? _____

6. How often do you have pain? Occasionally Constantly

7. How much pain are you having right now?
(Least)0—1—2—3—4—5—6—7—8—9—10 (Most)

8. What is the worst your pain has ever been?
(Least)0—1—2—3—4—5—6—7—8—9—10 (Most)

9. Does anything make your pain better?

Sitting	Lying down	Walking	Standing
Resting	Stretching	Medications	Nothing at all
Heat	Ice	Massage	OTC Meds

Other things: _____

10. Does anything make your pain worst?

Sitting	Lying down	Walking	Standing
Bending	Stretching	Riding in the car	Exercise

Other things: _____

11. Is your sleep affected by this? Y__ N __ How many times per week? _____

Please check all prior pain management treatments:

___ Epidural Steroid Injection ___ Sacroiliac joint injection ___ Tens Unit
___ Facet Joint Injections ___ Psychiatrist ___ Acupuncture
___ Exercise therapy ___ Physical Therapy ___ Traction
___ Trigger point injection ___ Piriformis muscle injection ___ Biofeedback
___ Chiropractor ___ Hypnosis ___ Trigger point injection
___Others (List)_____
Prior treatments above that helped the most:_____

Have you had any of the following tests performed in the last 3 years:

___ X-Ray ___ CT Scan ___ MRI
___ Bone Scan ___ Lab Test ___ Myelogram
___ Thermography ___ EMG ___ Discography

___ Other (List):_____

Where were these tests done: _____

Please List Allergies:_____

Past Medical History:

___ Hypertension ___ Coronary artery disease ___ Depression ___ Liver disease
___ Arthritis ___ Kidney problems ___ Cancer ___ Diabetes
___ Back injury ___ Anxiety ___ Mental Illness ___ Stroke
___ Stomach Ulcers ___ Neck Injury ___ Drug Abuse ___ Head Injury
___ Kidney problems ___ Alcoholism ___ Seizures ___ Oxygen use
___ Respiratory problems ___ Previous evaluation/treatment for mental issues

___ Other (List) _____

Indicate your work:_____

___ Fill time without restriction ___ Light Duty ___ Medical Leave Status:
___ Temporary disability ___ Disability pending ___ Unemployed ___ Retired

Patient Signature_____ Date:_____

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MEDICATION LIST

Patient Name: _____
Date of birth: _____

Medications:

Name	Dosage	Frequency

Allergies to Medications: **Reaction:**

1.
2.
3.

Patient Signature: _____

Date: _____

Assumption of the Risk and Waiver of Liability Relating to Coronavirus/Covid-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations prohibited the congregation of groups of people.

SOUTHWEST PAIN CENTER has put in place preventative measures to reduce the spread of COVID-19; however, the clinic cannot guarantee that you or your child(ren)'s will not become infected with COVID-19

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I may be exposed to or infected by COVID-19 by visiting the clinic and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at the clinic may result from the actions, omissions, or negligence of myself and others, including, but not limited to staff employees, the physician, representatives, or other patients visiting the clinic.

I voluntarily agree to assume all the foregoing risk and accept sole responsibility for any injury to myself (including but not limited to, personal injury disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I may experience or incur in connection with my visit to the clinic. On my behalf, I hereby release, covenant not to sue, discharge, and hold harmless to the Clinic, its staff employees, physicians, representatives, patient, or anyone visiting the clinic, of and from the Claims, including all liabilities, claims, actions, damages, costs, or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any claims based on the actions, omissions, or negligence of the clinic, its employees, physicians, representatives, patients, or anyone visiting the clinic, whether a Covid-19 infection occurs before, during or after my clinic visit.

_____ _____

Signature of Patient/Guardian Date

_____

Print Name