Comprehensive Pain Center Intake Form

Name: _____ Referring Doctor: _____

My pain is located in my _____

My pain will radiate to my _____

The pain started _____

It is described as _____

Did something happen that started your pain, (car accident, fall, surgery, or did it come on slowly with time and has since progressed? _____

Have you had episodes of this pain in the past? _____

Using a 1-10 scale, 1 being the least pain and 10 being the worst pain,

Now: _____ When is your pain the best? _____

Average: _____ When is your pain the worst? _____

What makes your pain better? Heat, ice, P/T, blocks, meds, etc. _____

What makes your pain worse? Walking, standing, bending, etc. _____

Do you have any associated numbness, tingling, or weakness of your arms or legs? (Circle which applies)

In the past I have tried the following to treat my pain (Circle):

Anti-inflammatory (advil, aleve, etc) Muscle relaxants (Robaxin, flexeril)

Anticonvulsants (gabapentin, lyrica) Opioids (tramadol, norco, Percocet, etc.)

Chiropractor Physical Therapy Epidurals Facets Radiofrequency Ablation

Surgery Spinal cord stimulation Stem cells Acupuncture Behavioral therapy/counseling

I AM //AM NOT involved with workman's compensations (circle)

I AM // AM NOT involved with a lawsuit or an attorney(circle)

My goals of care are: (be more active with family, reduce my pain, be more active,etc)

1._____

2._____

3._____

Comprehensive Pain Center New Patient History

Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell/Alt Phone: _____

Referring Provider: _____ Primary Care Physician: _____

Email Address: _____

PREFERRED PHARMACY:

Pharmacy Name: _____ Phone Number: _____

ALLERGIES:

Please list anything you are allergic to (medications, food, insects, etc.) and the reaction that it caused:

ALLERGY: REACTION: (Hives, nausea, difficulty breathing, cardiac/respiratory arrest, etc.)

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

MEDICATIONS:

Please list all medications you currently take (include vitamins/supplements, inhalers, & over the counter drugs):

Medication:	Strength:	Frequency:
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

IMMUNIZATIONS (if applicable):

Flu Vaccine – Most Recent Date: _____

Pneumonia Vaccine – Most Recent Date: _____

Shingles Vaccine – Most Recent Date: _____

MEDICAL HISTORY:

PROBLEM		PROBLEM		PROBLEM		PROBLEM	
ADHD/ADD	YES/NO	Breast Problem	YES/NO	Gout	YES/NO	Muscle Disease	YES/NO
HIV/AIDS	YES/NO	COPD	YES/NO	Headaches	YES/NO	Joint Disease	YES/NO
Abused	YES/NO	Cancer	YES/NO	Heart Attack	YES/NO	Bone Disease	YES/NO
GERD	YES/NO	Chicken Pox	YES/NO	Heart Disease	YES/NO	Obesity	YES/NO
Allergies	YES/NO	Ear Infections	YES/NO	Heart Problems	YES/NO	Osteoporosis	YES/NO
Anemia	YES/NO	Heart Failure	YES/NO	Hepatitis	YES/NO	Ovarian Cancer	YES/NO
Anesthesia Issue	YES/NO	Constipation	YES/NO	Hernia	YES/NO	Polyps	YES/NO
Anxiety	YES/NO	Coronary Disease	YES/NO	High Cholesterol	YES/NO	Pre-Eclampsia	YES/NO
Arthritis	YES/NO	Depression	YES/NO	Hypertension	YES/NO	PE/DVT	YES/NO
Asthma	YES/NO	Behavior Issue	YES/NO	Hyperthyroid	YES/NO	Seizures/Epilepsy	YES/NO
Autism	YES/NO	Diabetes	YES/NO	Hypothyroid	YES/NO	Skin Problems	YES/NO
Back Injury	YES/NO	Swallowing Disease	YES/NO	Infertility	YES/NO	Stroke	YES/NO
Bedwetting	YES/NO	Diverticulitis	YES/NO	Kidney Disease	YES/NO	Substance Abuse	YES/NO
Birth Defect	YES/NO	Hearing Problems	YES/NO	Kidney Stones	YES/NO	Thrombophilia	YES/NO
Bladder Issue	YES/NO	Eating Disorder	YES/NO	Liver Disease	YES/NO	Thyroid Disease	YES/NO
Bleeding Problem	YES/NO	Eczema	YES/NO	Lung Disease	YES/NO	Tuberculosis	YES/NO
Blood Disease	YES/NO	Endometriosis	YES/NO	MRSA	YES/NO	Ulcers	YES/NO
Blood Transfusion	YES/NO	Fibromyalgia	YES/NO	Meniere's Disease	YES/NO	Varicosities	YES/NO
Breast Cancer	YES/NO	GI Problems	YES/NO	Mental Disease	YES/NO	Vision/Eye Disease	YES/NO

REVIEW OF SYSTEMS (Circle all that apply):

CONSTITUTIONAL: Fever, Night Sweats, Weight Gain _____ lbs., Weight Loss _____ lbs., Exercise Intolerance, Lethargy, Sedated, Chills, Malaise

EYE: Dry Eyes, Irritation, Vision Changes, Eye Disease, Injury

EARS: Difficulty Hearing, Ear Pain, Ringing in Ears

NOSE: Nosebleeds (Frequency _____) Nose Problems, Sinus Problems

MOUTH/THROAT: Sore Throat, Bleeding Gums, Snoring, Dry Mouth, Oral Abnormalities, Moth Ulcers, Teeth Abnormalities, Mouth Breathing, Sinusitis

CARDIOVASCULAR: Chest Pain on Exertion, Arm Pain on Exertion, Shortness of Breath When Walking

RESPIRATORY: Cough, Wheezing, Shortness of Breath, Coughing Up Blood, Sleep Apnea

GASTROINTESTINAL: Abdominal Pain Nausea, Vomiting, Constipation, Change in Appetite, Black or Tarry Stools, Frequent Diarrhea, Vomiting Blood, Dyspepsia, GERD

GENTTOURINARY: Loss of Control of Bladder, Difficulty Urinating, Increased Urinary Frequency, Hematuria, Incomplete Emptying

MUSCULOSKELETAL: Muscle Aches, Muscle Weakness, Joint Pain, Arthralgias, Back Pain, Swelling in Extremities, Neck Pain, Difficulty Walking, Cramps, Osteoporosis, Fractures

SKIN: Abnormal Moles, Jaundice, Rash, Itching, Dry Skin, Growths, Lesions, Laceration, Non-Healing Areas, Changes in Hair or Nails, Psoriasis, Change in Skin Color, Breast Lump

NEUROLOGIC: Loss of Consciousness, Weakness, Numbness, Seizures, Dizziness, Frequent or Severe Headaches, Migraines, Restless Legs, Tremor, Gait Dysfunction, Paralysis

PSYCHIATRIC: Depression, Sleep Disturbances, Feeling Unsafe in Relationship, Restless Sleep, Alcohol Abuse, Anxiety, Hallucinations, Suicidal Thoughts, mood Swings, Memory Loss, Agitation, Dementia, Delirium

ENDOCRINE: Fatigue, Increased Thirst, Hair Loss, Increased Hari Growth, Cold Intolerance

HEMATOLOGIC: Swollen Glands, Easy Bruising, Excessive Bleeding, Anemia, Phlebitis

IMMUNOLOGIC: Runny Nose, Sinus Pressure, Itching, Hives, Frequent Sneezing

FAMILY HISTORY:

Please only include immediate family members: (Mother, Father, Siblings; Onset Age; +/- Deceased)

Disease (Dz)	Family Member	Disease (Dz)	Family Member	Disease (Dz)	Family Member
Alcohol Abuse		Depression		CA: Cervix	
Alzheimer's Disease		Diabetes Mellitus		CA: Colon	
Anemia		Disease of Liver		CA: Lung	
Anxiety		Nervous System Disease		CA: Ovary	
Arthritis		Thyroid Disease		CA: Prostate	
Asthma		Epilepsy		CA: Other	
ADHA		Headache		Mental Disorder	
BRCA1 Carrier		Heart Disease		Migraine	
BRCA2 Carrier		High Cholesterol		Multiple Sclerosis	
Back Problems		Hypertension		Heart Attack	
Blood Clotting Issue		Kidney Disease		Obesity	
Stroke		CA: Endometrium		Osteoporosis	
COPD		Liver Problems		Seizure Disorder	
Coronary Disease		CA: Uterus		Sleep Disorder	
Dementia		CA: Breast		Substance Abuse	

SOCIAL HISTORY:

Tobacco: Never/ Former/ Current – What Type? (Cigarettes, Vape, Dip, etc.) _____ How Much? _____ packs per day. How many years did you smoke, vape, dip, etc.? _____ When did you quit? _____ years ago.

Alcohol: Are you currently or have you ever been an alcoholic? _____
Current Alcohol Intake? (Please circle the answer that applies) Never/ Seldom: 1 drink per month
Occasional: 1-3 drinks per week Moderate: less than 2 daily Heavy: 3+ drinks per day

Illicit Drugs: Are you currently or have you ever used or abused illegal drugs? If so, what type and how often? _____

Education: Highest level of schooling you completed: _____

Current Employment (if applicable): _____

SURGICAL HISTORY:

Surgery:	Reason:	Year:	Hospital:
1.			
2.			
3.			
4.			
5.			

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Patient Name: _____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	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
Add the score for each column				

Total Score (add your column scores): _____

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

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

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	Not At All	Several Days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

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

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

OSWESTRY LOW BACK DISABILITY QUESTIONNAIRE

Instructions: this questionnaire has been designed to give us information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you at this time. We realize you may consider 2 of the statements in any section may relate to you, but please mark the box which most closely describes your current condition.

1. PAIN INTENSITY
❑ I can tolerate the pain I have without having to use pain killers
❑ The pain is bad, but I manage without taking pain killers
❑ Pain killers give complete relief from pain
❑ Pain killers give moderate relief from pain
❑ Pain killers give very little relief from pain
❑ Pain killers have no effect on the pain, and I do not use them

2. PERSONAL CARE (e.g. Washing, Dressing)
❑ 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 don't get dressed, I was with difficulty and stay in bed

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 positioned, i.e. 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

4. WALKING
❑ Pain does not prevent me walking any distance
❑ Pain prevents me walking more than one mile
❑ Pain prevents me walking more than ½ mile
❑ Pain prevents me walking more than ¼ mile
❑ I can only walk using a stick or crutches
❑ I am in bed most of the time and have to crawl to the toilet

5. SITTING
❑ I can sit in any chair as long as I like
❑ I can only sit in my favorite chair as long as I like
❑ Pain prevents me from sitting more than one hour
❑ Pain prevents me from sitting more than ½ hour
❑ Pain prevents me from sitting more than 10 minutes
❑ Pain prevents me from sitting at all

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 one hour
❑ Pain prevents me from standing for more than 30 mins
❑ Pain prevents me from standing for more than 10 mins
❑ Pain prevents me from standing at all

7. SLEEPING
❑ Pain does not prevent me from sleeping well
❑ I can sleep well only by using medication
❑ Even when I take medication, I have less than 6 hrs sleep
❑ Even when I take medication, I have less than 4 hrs sleep
❑ Even when I take medication, I have less than 2 hrs sleep
❑ Pain prevents me from sleeping at all

8. 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, i.e. dancing etc.
❑ Pain has restricted my social life I do not go out as often
❑ Pain has restricted my social life to my home
❑ I have no social life because of pain

9. TRAVELLING
❑ I can travel anywhere without extra pain
❑ I can travel anywhere but it gives me extra pain
❑ Pain is bad, but I manage journeys over 2 hours
❑ Pain restricts me to journeys of less than 1 hour
❑ Pain restricts me to short necessary journeys under 30 minutes
❑ Pain prevents me from traveling except to the doctor or hospital

10. EMPLOYMENT/ HOMEMAKING
❑ My normal homemaking/ job activities do not cause pain.
❑ My normal homemaking/ job activities increase my pain, but I can still perform all that is required of me.
❑ I can perform most of my homemaking/ job duties, but pain prevents me from performing more physically stressful activities (e.g. lifting, vacuuming)
❑ Pain prevents me from doing anything but light duties.
❑ Pain prevents me from doing even light duties.
❑ Pain prevents me from performing any job or homemaking chores

NECK DISABILITY QUESTIONNAIRE

This questionnaire is designed to help us better understand how your neck pain affects your ability to manage everyday life activities. Please mark in each section the one box that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that most closely describes your present-day situation.

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
❑ 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 causing extra pain.
❑ I can lift heavy weights, but it gives me extra pain.
❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if items are conveniently positioned, ie. on a table.
❑ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
❑ I can lift only very light weights.
❑ I cannot lift or carry anything at all.

SECTION 4 – WORK
❑ I can do as much work as I want.
❑ I can only do my usual work, but no more.
❑ I can do most of my usual work, but no more.
❑ I can't do my usual work.
❑ I can hardly do any work at all.
❑ I can't do any work at all.

SECTION 5 – HEADACHES
❑ I have no headaches at all.
❑ I have slight headaches that come infrequently.
❑ I have moderate headaches that come infrequently.
❑ I have moderate headaches that come frequently.
❑ I have severe headaches that come frequently.
❑ I have headaches almost all the time.

SECTION 6 – CONCENTRATION
❑ I can concentrate fully without difficulty.
❑ I can concentrate fully with slight difficulty.
❑ I have a fair degree of difficulty concentrating.
❑ I have a lot of difficulty concentrating.
❑ I have a great deal of difficulty concentrating.
❑ I can't concentrate at all.

SECTION 7 – SLEEPING
❑ I have no trouble sleeping.
❑ My sleep is slightly disturbed for less than 1 hour.
❑My sleep is mildly disturbed for up to 1-2 hours.
❑ My sleep is moderately disturbed for up to 2-3 hours.
❑ My sleep is greatly disturbed for up to 3-5 hours.
❑ My sleep is completely disturbed for up to 5-7 hours.

SECTION 4 – WORK
❑ I can do as much work as I want.
❑ I can only do my usual work, but no more.
❑ I can do most of my usual work, but no more.
❑ I can't do my usual work.
❑ I can hardly do any work at all.
❑ I can't do any work at all.

SECTION 8 – DRIVING
❑ I can drive my car without neck pain.
❑ I can drive as long as I want with slight neck pain.
❑ I can drive as long as I want with moderate neck pain.
❑ I can't drive as long as I want because of moderate neck pain.
❑ I can hardly drive at all because of severe neck pain.
❑ I can't drive my care at all because of neck pain.

SECTION 9 – READING
❑ I can read as much as I want with no neck pain.
❑ I can read as much as I want with slight neck pain.
❑ I can read as much as I want with moderate neck pain.
❑ I can't read as much as I want because of moderate neck pain.
❑ I can't read as much as I want because of severe neck pain.
❑ I can't read at all.

SECTION 10 – RECREATION
❑ I have no neck pain during all recreational activities.
❑ I have some neck pain with all recreational activities.
❑ I have some neck pain with a few recreational activities.
❑ I have neck pain with most recreational activities.
❑ I can hardly do recreational activities due to neck pain.
❑ I can't do any recreational activities due to neck pain.

CPC
Comprehensive Pain Center

Patient Information

❑ Mr. ❑ Mrs. ❑ Miss ❑ Dr. ❑ Single ❑ Married ❑ Other ❑ Male ❑ Female

Full Name: _____ Date of Birth: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Preferred Contact

❑ Home Phone: _____ ❑ Mobile Phone: _____

❑ Work Phone: _____ ❑ Other Phone: _____

❑ Email: _____

Emergency Contacts

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Responsible Party for Patient ❑ same as patient information

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Relationship: _____

Employer: _____

Insured Party ❑ same as patient information

Full Name: _____ ❑ Mr. ❑ Mrs. ❑ Miss ❑ Dr.

Date of Birth: _____ Social Security Number: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Employer: _____

Insurance Company Information – Primary

Company: _____ Policy Holder Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Ext. _____ Fax Number: _____

Effective Date: _____ Plan Name: _____ Plan Type: _____

Policy Number/I.D.: _____ Group Number or FECA: _____

Insurance Company Information – Secondary

Company: _____ Policy Holder Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Ext. _____ Fax Number: _____

Effective Date: _____ Plan Name: _____ Plan Type: _____

Policy Number/I.D.: _____ Group Number or FECA: _____

Authorizations

Consent for Treatment I consent to necessary treatment, including drugs, medicine, performance of operations, conduct of X-ray and or other studies, including Telehealth/Telemedicine that may be used by the provider(s), nurse(s) and/or staff.

Patient/Guardian (if patient is younger than 14) _____ Date: _____

Authorization for Release of Information

I authorize COMPREHENSIVE PAIN CENTER to furnish any medical information requested by insurance companies with whom I have coverage, any public agency which maybe assisting in payment of my care, or my employer who is providing payment of my medical bills due to an on-the-job injury.

Assignment of Benefits

I hereby authorize payment directly to COMPREHENSIVE PAIN CENTER to benefits otherwise payable to me, including major medical insurance and payment of surgical and medical benefits, but not to exceed the COMPREHENSIVE PAIN CENTER charges for these services. I understand that I am financially responsible to COMPREHENSIVE PAIN CENTER for charges not covered by this assignment.

Financial Consent

In consideration of all services and supplies provided by COMPREHENSIVE PAIN CENTER, I understand and fully agree that I have full responsibility to pay COMPREHENSIVE PAIN CENTER. I understand that COMPREHENSIVE PAIN CENTER will bill my insurance carrier as a courtesy to me. I accept full financial responsibility for the immediate payment of any charges not covered by my insurance contract. I accept the fees charged as a legal and lawful debt and agree to pay said fee, including any and all costs of collections up to 33 1/3%, attorney fees and or court costs, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other state.

I agree, in order for COMPREHENSIVE PAIN CENTER to service my account or to collect monies I may owe, COMPREHENSIVE PAIN CENTER and or their agents may contact me by telephone at any telephone number associated with my account, including my wireless telephone numbers, which could result in charges to me. COMPREHENSIVE PAIN CENTER may also contact me by sending text messages or emails, using any e-mail address I provide to them. Methods of contacting may include using prerecorded or artificial voice messages and or use of automatic dialing devices, as applicable.

Please mark one of the following options:

❑ **I would like to receive statements online.**

❑ **I would like to receive paper statements.**

Patient/Guardian (if patient is younger than 19) _____ Date: _____

Comprehensive Pain Center

2700 Highway 280 South

Suite 212

Birmingham, Al 35223

205-878-4368

Patient Name: _____

Social Security Number: _____

Any physician, staff, employee or representative of COMPREHENSIVE PAIN CENTER has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment:

_____	_____	_____
Name	**Relationship**	**Phone Number(s)**
_____	_____	_____
Name	**Relationship**	**Phone Number(s)**
_____	_____	_____
Name	**Relationship**	**Phone Number(s)**
_____	_____	_____
Name	**Relationship**	**Phone Number(s)**

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to COMPREHENSIVE PAIN CENTER or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals, it may be subject to redisclosure by the individual(s).

Patient Signature: _____ Date: _____

❑Copy given to patient (May use carbonless form to eliminate copying at front receptionist)

Acknowledgement of Receipt of the Notice of Privacy Practices (Select and Sign)

❑I acknowledge that I received the Notice of Privacy Practices upon registration as a patient for COMPREHENSIVE PAIN CENTER

❑I acknowledge that I was offered a copy of the Notice of Privacy Practices upon registration as a patient for COMPREHENSIVE PAIN CENTER but declined receipt.

Patient's Name (please print): _____

Patient's Signature: _____ Date: _____

Comprehensive Pain Center
2700 Highway 280 Suite 212
Birmingham, Alabama 35223
Phone: 205-878-4368
Fax: 855-809-8099

AUTHORIZATION TO RELEASE MEDICAL RECORDS
(This authorization complies with HIPAA)

Printed Name of Patient (first, middle, last name)	Birthdate (mm/dd/yyyy)
Address (Street Address, City, State, Zip Code)	
Phone Number	E-mail

I hereby authorize any health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, employer, and family member to release all health information about me.

I hereby authorize the following health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, employer, or family member to release all health information about me:

Person/Organization to Release Information		
Street Address		
City	State	Zip Code
Phone Number	Fax Number	

By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.

The following health information that relates to service beginning from _____ to _____, may be released:

- Entire Medical Record including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent by other health care providers.
- Patient Histories
- Office Notes (except psychotherapy notes)

- Test Results
- Radiology Studies
- Films
- Referrals
- Consults
- Billing Records
- Insurance Records
- Records Sent by Other Health Care Providers

I further understand that my medical record may include one or more of the following:

- Treatment of communicable diseases, including sexually transmitted diseases, venereal diseases, tuberculosis, or hepatitis
- HIV-Related Treatment
- Mental Health Information or Psychological Conditions
- Alcohol or Substance Abuse Treatment
- Genetic Testing

The above person/organization, its employees, representatives and any other persons performing services for them or on their behalf, may need to obtain, use or disclose any and all information about my physical and mental health, including but not limited to, services for preventative, diagnostic and therapeutic care, tests, counseling, and medical prescriptions for the purpose of:

□ Change of Doctor

□ Individual Request

□ Specialist Referral

□ Workers Compensation

□ Insurance Purposes

□ Continued Treatment

□ Legal Investigation

□ Other: _____

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law.

This authorization is valid for 24 months following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

Signature of Patient or Persona Representative	Date Signed:	Description of Personal Representative's Authority:

Cancellation and No-Show Policy & Procedures

Effective October 1, 2022

Comprehensive Pain Center's goal is to provide quality treatment and care in a timely manner to all our patients. We schedule our appointments so that each patient receives the right amount of time to be seen by our providers and staff. We have implemented a cancellation and no-show policy which enables us to better utilize available appointments for our patients in need of pain care. The following policy is regarding patients who fail to keep their scheduled appointments. This is effective October 1, 2022.

Please be courteous and call our office promptly if you are unable to attend an appointment. This time will be given to someone who is in urgent need of treatment. Available appointments are in high demand and your early cancellation will give another person the opportunity to have access to timely care.

Clinic Appointments

- Patients that reschedule their clinic visits 36 hours before their appointment will not be penalized.
- If you reschedule or cancel your visit the day before your scheduled appointment you will be rescheduled 1 time without penalty. If this happens again, you will be charged $50 before you are rescheduled.
- If you reschedule or cancel the day of your scheduled appointment, or miss your appointment, you will be charged $75 before you are rescheduled.
- Once a penalty has been processed, your balance must be paid in full prior to being provided treatment.

Procedure Appointments

- Patients that reschedule their procedure 36 hours before their appointment will not be penalized.
- If you reschedule or cancel your procedure the day before your scheduled appointment you will be rescheduled 1 time without penalty. If this happens again, you will be charged $50 before you are rescheduled.
- If you reschedule or cancel the day of your scheduled procedure, or miss your appointment, you will be charged $150 before you are rescheduled.
- Once a penalty has been processed, your balance must be paid in full prior to being provided treatment.

All account balances must be paid in full prior to being rescheduled

In the event of an emergency when prior notice could not be given, you may submit a letter of appeal within 72 hours of the scheduled appointment to our office manager and we will respond within 48 hours.

_____ _____

Patient Signature Date