APT

New Patient Packet

(Initials: _____ DOB: ____/____/___)

Date: ____/____/_____

Legal First Name: _____ **Legal Middle Name:** _____ **Legal Last Name:** _____

Former legal last name (if applicable): _____ **DOB:** ____/____/_____ **Age:** ____

Phone Number:_____ **Email:**_____

Gender: □ Male □ Female **SSN#:** _____-_____-_____ **Driver's License #:** _____

Street address: _____ **City:** _____ **State:** _____ **Zip:** _____

Referring Physician: _____

Primary Care Physician: _____

Preferred Pharmacy (name and address): _____

INSURANCE INFORMATION

Please provide your insurance card(s) to the receptionist

Primary Insurance: _____ **Patient's Relationship to Subscriber:** □ Self □ Spouse □ Child □Other: _____

Policy #: _____ **Group #:** _____

Subscriber's Name: _____

Subscriber's SSN#: _____-_____-_____ **DOB:** ____/____/_____

Secondary Insurance: _____ **Patient's Relationship to Subscriber:** □ Self □ Spouse □ Child □ Other: _____

Policy #: _____ **Group #:** _____

Subscriber's Name: _____

Subscriber's SSN#: _____-_____-_____ **DOB:** ____/____/_____

Is this a Worker's Compensation Injury? □ NO □ YES Phone # of your WC adjuster: (_____)_____

IN CASE OF EMERGENCY

Name of Emergency Contact: _____

Relationship to patient: _____ **Contact Phone #:** (_____)_____

PATIENT PRIVACY

Please list anyone that we may inform of your medical condition and diagnosis (including: treatments, payments, appointments and health concerns). If name is not listed on this form we are legally unable to release any information regardless of relationship to the patient.

Name: _____ **Relationship:** _____ **Phone #:** (_____)_____
Name: _____ **Relationship:** _____ **Phone #:** (_____)_____
Name: _____ **Relationship:** _____ **Phone #:** (_____)_____

By signing below, you confirm that the information you have provided above is correct and true to the best of your knowledge. It is your responsibility to inform Pain Treatment Centers of Georgia of any changes to any of the information above.

_____/____/_____
Patient's or Authorized Representative's Name and Signature **Date**

When did the pain start? (please provide date): _____

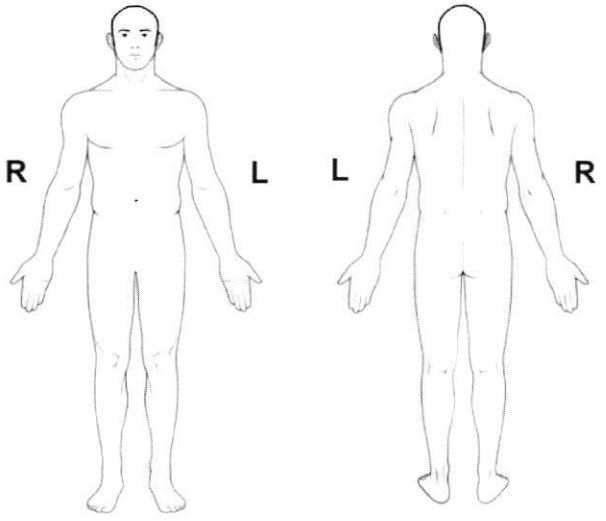
Since your pain began it has: □ Increased □ Decreased □ Remained the same □ Other: _____

Under what circumstances did your pain start?

□ Home Accident □ Work Accident □ Auto Accident □ Sports □ Fall □ Surgery □ Other: _____

Is there currently an ongoing litigation (lawsuit) related to your pain? □ NO □ YES Which areas of your body are included in the lawsuit: _____

Where is your pain located? (please mark the diagram below):



Indicate your pain level (please circle one number on each line):

Current pain level: (NO PAIN) 1 2 3 4 5 6 7 8 9 10 (WORST PAIN)

Least pain level last week: (NO PAIN) 1 2 3 4 5 6 7 8 9 10 (WORST PAIN)

Highest pain level last week: (NO PAIN) 1 2 3 4 5 6 7 8 9 10 (WORST PAIN)

Average pain level last week: (NO PAIN) 1 2 3 4 5 6 7 8 9 10 (WORST PAIN)

Your pain is mostly: □ Constant □ Off and On □ Other: _____

Describe your pain briefly in your own words (please include location and quality of the pain):

_____

Does your pain feel like any of the following?

□ Aching □ Burning □ Throbbing □ Stabbing □ Sharp □ Dull □ Shooting □ Other: _____

Do you experience any of the following?

□ Numbness □ Tingling □ Weakness □ Coldness □ Spasms □ Other: _____ Where? _____

Does your pain interfere with sleep? □ Occasionally □ Frequently □ Doesn't interfere

What makes your pain WORSE? (please list) _____

What makes your pain BETTER? (please list) _____

PREVIOUS IMAGING/DIAGNOSTIC TESTS (related to pain)
Please circle all that apply

X-ray (when/where? _____)	CT Scan (when/where? _____)	MRI (when/where? _____)
Myelogram (when/where? _____)	EMG/NCS (when/where? _____)	Other: _____

PREVIOUS TREATMENTS (related to pain)
Please circle all that apply

Bedrest	TENS unit/braces	Home exercises	Acupuncture
Chiropractor	Muscle relaxants	NSAIDs	Opioid medications
Trigger point injections	Epidural steroid injections	Joint injections	Nerve blocks
Facet joint injections	Radiofrequency ablations (i.e. "Nerve Burning")	Spinal cord stimulator	Pain pump
Physical Therapy: What body area(s): _____, Where done: _____, Dates done: _____			

PREVIOUS MEDICATIONS TRIED (at any point in the past)
Please circle all that apply

Tylenol	Ibuprofen	Advil/Aleve	Meloxicam	Celebrex
Naproxen	Diclofenac	BC Powder	Tramadol	Tylenol #3/4
Hydrocodone	Hysingla	Roxicodone	Morphine	Hydromorphone
Nucynta	Methadone	Buprenorphine	Butrans	Fentanyl patch
Belbuca	Oxycodone	Percocet	Fioricet	Celexa/citalopram
Zyprexa/olanzapine	Paxil/paroxetine	Effexor/venlafaxine	Lexapro/escitalopram	Prozac/fluoxetine
Zoloft/Sertraline	Trintellix/vortioxetine	Wellbutrin/bupropion	Remeron/mirtazapine	Luvox/fluvoxamine
Viibryd/vilazodone	Cymbalta/duloxetine	Other: _____	Other: _____	Other: _____

ALLERGIES AND MEDICATIONS

Allergies: List ALL medications (or other drugs) to which you are allergic: □ I am NOT allergic to anything

Medication you are allergic to?	Type of reaction

Medication you are allergic to?	Type of reaction

Please attach additional sheet of paper if needed

Do you have an allergy to Latex? □ NO □ YES Reaction: _____

Do you have an allergy to Contrast Dye or Iodine? □ NO □ YES Reaction: _____

Are you taking anti-coagulants or "blood thinners"? □ NO □ YES (please check below)

□ Plavix □ Coumadin □ Eliquis □ Xarelto □ Pradaxa □ Aspirin □ Other: _____

Who is prescribing you the blood thinner? Physician's name and phone #: _____

If you do take anti-coagulants or "blood thinners," will the prescribing physician allow you to discontinue this medication for any length of time? □ NO □ YES Please note that you must have permission from your prescribing physician to discontinue your anti-coagulants or "blood thinners" for any length of time.

Medications: List ALL your medications (including over-the-counter and herbal medications):

Medication name	Medication dose	Frequency
Example: Lisinopril	*20mg*	*One time daily*

Please attached additional sheet of paper if needed

PAST MEDICAL & SURGICAL HISTORY

Have you ever been diagnosed with or treated for any of the following health problems?

Cardiac
- □ Aortic regurgitation/stenosis
- □ Coronary artery disease (CAD)
- □ Heart attack (MI)
- □ Heart stent (angioplasty)
- □ Congestive heart failure (CHF)
- □ Irregular pulse (arrhythmia)
- □ Pacemaker/defibrillator (AICD)
- □ High blood pressure
- □ Deep vein thrombosis (DVT)
- □ Other: _____

Respiratory
- □ COPD
- □ Asthma
- □ Sarcoidosis
- □ Pneumonia
- □ Pulmonary embolism (PE)
- □ Sleep apnea
- □ Other: _____

Gastrointestinal
- □ Heartburn (GERD)
- □ Constipation
- □ Peptic ulcer disease
- □ Inflammatory bowel disease
- □ Crohn's disease
- □ Bulimia/anorexia
- □ Other: _____

Musculoskeletal
- □ Osteoporosis
- □ Arthritis (type: _____)
- □ Joint degeneration (DJD)
- □ Gout
- □ Fibromyalgia
- □ Scoliosis
- □ Psoriasis or lupus
- □ Spinal Stenosis
- □ Connective tissue disease
- □ Carpal tunnel syndrome
- □ Other: _____

Neurologic
- □ Headaches or migraines
- □ Diabetic neuropathy
- □ Myasthenia gravis
- □ Seizures or epilepsy
- □ Multiple sclerosis
- □ Alzheimer's/Parkinson's disease
- □ Stroke or TIA ("mini stroke")
- □ Other: _____

Psychiatric
- □ Anxiety or panic attacks
- □ Depression
- □ Bipolar disorder
- □ Schizophrenia
- □ Insomnia
- □ PTSD
- □ ADHD/ADD
- □ Other: _____

Other
- □ Diabetes (type: _____)
- □ Easy bleeding
- □ HIV/AIDS
- □ Hepatitis (type: _____)
- □ Cancer (type: _____)
- □ Kidney or liver disease
- □ Other: _____

Please list all surgeries that you have had:

Surgery type	**Date** (month and year)	**Location** (which hospital)

Please attached additional sheet of paper if needed

FAMILY & SOCIAL HISTORY

Please list all medical conditions that your immediate family members have:

Is your **mother** still living? □ YES □ NO Cause of death: _____

Is your **father** still living? □ YES □ NO Cause of death: _____

Family member	Conditions

Family member	Conditions

Work status: □ Employed full time □ Employed part time □ Unemployed □ Student □ Disabled □ Retired

Occupation and employer: _____

Do you use street (recreational) drugs? □ NO □ YES Please tell us all street drugs that you have ever used and the last date of use: _____

Have you ever been treated for alcohol/drug dependence or addiction? □ NO □ YES Year? _____

Have you ever abused or taken "not as prescribed" any prescription drugs? □ NO □ YES Comment: _____

Do you have history of physical or sexual abuse? □ NO □ YES Comment: _____

Do you have any thoughts of hurting yourself or someone else? □ NO □ YES Comment: _____

Do you have a pending lawsuit related to your pain? □ NO □ YES Which areas of your body are included in the lawsuit?: _____. Contact information of your attorney?: _____

I certify that I have answered all of the above questions truthfully and to the best of my ability:

_____ /____/_____

Patient's or Authorized Representative's Name and Signature **Date**

OPIOID RISK TOOL (ORT)

Please mark each question as either "Yes" or "No" depending on if the question applies to you. Use "✓" to indicate your answer.

	Yes	No
Has there been family history of alcohol abuse?		
Has there been family history of illegal drug use?		
Has there been family history of prescription drug use?		
Has there been personal history of alcohol abuse?		
Has there been personal history of illegal drug abuse?		
Has there been personal history of prescription drug abuse?		
Aged between 16 - 45 years?		
Has there been a history of preadolescent sexual abuse?		
Has there been a personal history of Attention Deficit Disorder (ADD or ADHD), bipolar or schizophrenia?		
Has there been a personal history of depression?		

PATIENT HEALTH QUESTIONAIRE – 9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please use "✓" to indicate your answer.

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching TV				
Moving or speaking so slowly that other people could have notice? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead or of hurting yourself in some way				

Alcohol (Audit-C)

How often did you have a drink containing alcohol in the past year?

Frequency	Response (use "✓" to indicate your answer)
Never	
Monthly or less	
2 to 4 times a month	
2 to 3 times a week	
4 or more times a week	

If "Consuming Alcohol": How many drinks did you have on a typical day when you were drinking in the past year?

Frequency	Response (use "✓" to indicate your answer)
1 to 2 drinks	
3 to 4 drinks	
5 to 6 drinks	
7 to 9 drinks	
10 or more drinks	

If "Consuming Alcohol": How often did you have 6 or more drinks on one occasion in the past year?

Frequency	Response (use "✓" to indicate your answer)
Never	
Less than a month	
Monthly	
Weekly	
Daily or almost daily	

Tobacco use (including e-cigarettes and vapes)

Indicate current status	Response (use "✓" to indicate your answer)
Currently smoke	
Used to smoke	
Never smoked	
2 to 3 times a week	
4 or more times a week	

If "current smoker": When did you start smoking? _____

If "current smoker": How often do you smoke?

Indicate current status	Response (use "✓" to indicate your answer)
Every day	
Some days, but not every day	

If "current smoker": How many cigarettes a day do you smoke?

Indicate current status	Response (use "✓" to indicate your answer)
5 or less	
6-10	
11-20	
21-30	
31 or more	

If "current smoker": How soon after you wake up do you smoke your first cigarette?

Indicate current status	Response (use "✓" to indicate your answer)
Within 5 minutes	
6-30 minutes	
31-60 minutes	
After 60 minutes	

If "current smoker": Are you interested in quitting?

Indicate current status	Response (use "✓" to indicate your answer)
Ready to quit	
Thinking about quitting	
Not ready to quit	

Patient Financial Responsibility Form

Thank you for choosing Arkansas Pain Therapy for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient's individual Financial Responsibilities

- I understand that I am responsible for my health insurance's copayment, deductible, coinsurance, or non-covered services.
- Co-payments are due at the time of service.
- If my plan requires a referral, I must obtain it prior to my visit. Failure to provide a referral will result in my appointment being rescheduled.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the charges and agree to pay the cost of all services provided.

Insurance Authorization for assignment of benefits

I hereby authorize and direct payment of my medical benefits to Arkansas Pain Therapy on my behalf for any services furnished to me by the providers.

Authorization to release records

I hereby authorize Arkansas Pain Therapy to release to my insurer, governmental agencies, or any other entity responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for pre-certification, authorization or referral to other medical provider.

Medicare Request for Payment

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished to me by Arkansas Pain Therapy. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

_____

Signature of Patient, Authorized Representative or Responsible Party Date

_____

Print Name of Patient, Authorized Representative or Responsible Party Date

Notice of Privacy Practice (HIPAA)

Notice of Privacy Practices Acknowledgment I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Pain Agreement

At Arkansas Pain Therapy, we are committed to doing all that we can to treat your chronic pain. This agreement serves to prevent any misunderstanding about certain medications that you will be taking for your pain management. This agreement also serves as a tool to protect both you and your provider by establishing guidelines that comply with the law regarding controlled pharmaceuticals.

***Please initial next to all of the following statements once you have read and fully understand them. ***

_____ 1. I understand that if there is any belligerent behavior towards any of Arkansas Pain Therapy staff that it will be grounds for immediate dismissal as a patient.

_____ 2. I understand that there is a risk of psychological and/ or physical dependence and addiction associated with the long-term use of controlled substances.

_____ 3. I understand that this agreement is essential to the trust and confidence of a provider/patient relationship and that my provider embarks to treat me based on this agreement.

_____ 4. I understand that if I violate this agreement in any way, my provider will stop prescribing my controlled medications.

_____ 5. If my provider discontinues my controlled medications due to a contract violation, I understand I will be tapered off the medications over a small period of time to avoid any withdrawal symptoms. And, that a drug-dependence treatment program may be recommended.

_____ 6. I will be submissive to psychiatric treatment, psychotherapy, and/or psychological treatment if my provider deems it necessary.

_____ 7. I will fully communicate the degree and intensity of my pain with my provider, along with the effects of pain on my daily life and how well my controlled medications are helping to relieve said pain.

_____ 8. I will not use any illicit substances, including marijuana, cocaine, methamphetamine, etc., nor will I misuse or self-prescribe/medicate with any legal controlled substances.

_____ 9. I will not consume excessive amounts of alcohol in tandem with my narcotic medications. Also, any use of alcohol will be restricted to times when I am not driving or operating any machinery and will not be consumed frequently.

_____ 10. I will NOT share, sell or permit anyone other than myself to have access to my controlled medication/s.

_____ 11. I will not attempt to secure any controlled substances, including opioid medications, controlled stimulants or anti-anxiety medications from any other provider other than the one I am in agreement with.

_____ 12. I will do my best to safeguard all my pain medications from being lost, stolen or used by others. I understand that if my meds are lost, destroyed, get wet, are left somewhere or are stolen, they will NOT be replaced under any circumstances.

_____ 13. I understand that refills of my pain medications will be made ONLY when I am at my office visit or during regular office hours. I understand that NO REFILLS will be made available to me during hours when the clinic is closed or on weekends and holidays.

_____ 14. I agree that all the controlled medications that I am prescribed will be obtained from the SAME pharmacy, when possible. Should I need to change my pharmacy, I understand that 48-hour notice must be given.

_____ 15. I authorize my provider and pharmacy to cooperate fully with any city, state or federal law enforcement agency, including but not limited to the state of Arkansas' Board of Pharmacy, in the event of any possible misuse, sale or other diversion of my pain
medications.

_____ 16. I understand and authorize that a copy of my pain agreement will be sent to my primary care physician (and referring physician, if not PCP), pharmacy and local emergency department. I agree that I waive any applicable privilege or right to privacy or confidentiality with respect to these authorizations.

_____ 17. I understand that I may be called to the clinic for a urine or serum toxicology screening and/or pill count at any random time my provider requests it, and that I am required to comply with said requirements by the end of the same business day. I understand that failure to comply with said request might result in cessation of my controlled medication therapy by this provider.

_____ 18. I understand that my provider will verify that I am receiving controlled substances from only ONE provider/prescriber and only one pharmacy by checking the Prescription Monitoring Program website periodically throughout my period of treatment.

_____ 19. I agree that I will use my controlled medication at a rate NO HIGHER than what is prescribed to me. I also agree that taking my medication at a higher rate than what is prescribed to me will result in being without my medications for a period of time.

_____ 20. I understand that I am to bring my medication in the bottle with me to EVERY office visit and/or procedure. I am aware that failure to do so will result in a delay in my medication refills.

_____ 21. I agree to follow these guidelines and that they have been fully explained to me. I also agree that failure to comply with any of the listed policies might result in my termination of receiving controlled medications or termination of care altogether.
This agreement has been entered into on this _____ day of _____,
202____.

Patient Signature: _____ **Patient Name (Printed):** _____

Provider Signature: _____ **Provider Name (Printed):** _____

Witness Signature: _____ **Name (Printed):** _____

Informed Consent Form

I give my consent to receive scheduled medication/s, which can potentially lead to addiction or habit forming. I have been explained the risk of each of these by my doctor or nurse. By Signing, I assume all responsibility of taking these pain- relieving medications. I acknowledge the _____ day of _____, 20_____, that Dr. Michael S. Adams, MD has explained to me the risks and benefits of the following medications.

1. _____ _____mg/mcg SIG_____
2. _____ _____mg/mcg SIG_____
3. _____ _____mg/mcg SIG_____
4. _____ _____mg/mcg SIG_____
5. _____ _____mg/mcg SIG_____

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name: _____ **DOB**: ____/____/_____ **SSN#**: _____-_____-_____

Street address: _____ **City**: _____ **State**: _____ **Zip**: _____

Phone #: (_____)_____ **Alternate Phone #**: (_____)_____

I (the patient) **authorize Arkansas Pain Thearpy to**:

- Obtain medical records from another doctor or medical facility: _____ (please initial)
- Release medical records to another doctor or mental facility: _____ (please initial)
- Share medical information/records with the persons(s) indicated below: _____ (please initial)

Doctor/facility: _____ **Phone #**: (_____)_____ **Fax**: (_____)_____

Street address: _____ **City**: _____ **State**: _____ **Zip**: _____

RELEASE THESE RECORDS (check one): □ All Medical Records □ Specific Records: _____

I authorize the release of the above information with the <u>exception of</u> (check all that apply):
□ Substance abuse (if any)
□ AIDS/HIV (if any)
□ Psychological/psychiatric records (if any)

This authorization will remain in effect indefinitely or until revoked in writing.

Photocopy: I further authorize that a photocopy of this authorization form will be fully acceptable as an original and that the healthcare organization may deny the release of protected health information, if it has reason to believe (1) the authorization has been altered or (2) is not a true and accurate authorization initiated by the patient or (3) is dated prior to the treatment dates for which the records are being requested.

I understand that I have the right to:

- Revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and send my written revocation to Arkansas Pain Therapy. I understand that the revocation will not apply to the information that has already been released in response to this authorization. I understand it does not apply to Arkansas Pain Therapy when the law provides it the right to contest a claim under my policy.
- I understand that I do not have to sign this authorization and that Arkansas Pain Therapy may not condition treatment, payment, enrollment in health plan, or eligibility for benefits on whether I sign this authorization.
- I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by Federal Policy Regulations.
- Right to Copy/Voluntary Disclosure: I know I have the right to receive a copy of this authorization after I sign it and that authorizing the disclosure of my health information is voluntary.

_____/____/_____
Patient's or Authorized Representative's Name and Signature **Date**

If signed by a legal representative, please provide representative's documentation as required by state law (i.e. Power of Attorney, Health Care Surrogate, Living Will or Guardianship papers)

Arkansas Pain Therapy
1102 Crestwood Circle
Mena, Arkansas 71953
Office: (479) 234-4433 Fax: 479-234-4445