WELCOME TO OUR OFFICE

Enclosed you will find forms to be completed in their entirety and given to us at the time of your visit. This will save you a considerable amount of time on the day of the examination.

Please bring the following items with you to the appointment:

1] **Photo ID and Insurance Card(s):** These will be photocopied. Without these cards, we cannot see you on your appointment date and will be rescheduled.

2] **List of Medications:** Just a list, you do not need to bring in the actual medications.

3] **Previous Tests (MRI, Xray, CT-Scan, Etc.):** If you have been tested previously and have the results of those examination, please bring them with you. They will be helpful in assessing your case.

4] **Co-Payments:** If your insurance requires a co-payment, they are expected at the time of your visit. **Your co-pay is usually printed on the front of your insurance card.**

If you have any questions, please call us at 479-234-4433.

Thank you,

Arkansas Pain Therapy

NO SHOW FEE and 24-Hour Cancellation Policy

Dear Patient,

We strive to provide excellent medical care to you, your family and all our patients. To do so effectively, we have developed an appointment system that sets aside ample time for a patient.

"No shows" and late cancellations inconvenience those individuals who need access to medical care prompt manner to reduce the number of such occurrences, we have implemented a Medical Appointment Cancellation Policy and it is effective immediately.

Our policy is as follows:

1. We request you give our office at least 24-hour notice if you need to reschedule your appointment. **Our office number is 479-234-4433.**
2. If you miss an appointment and DO NOT contact us with at least 24-hour prior notice, we will consider this a missed appointment and a fee will be assessed to you.

Late cancellations and "No shows"
1st - $25 fee
2nd - $50 fee
3rd - $75 fee and termination letter will be sent

$250 - Procedure/ Injections

3. If you are late for an appointment, we will try to see you, but your appointment may be rescheduled.
4. Our office makes reminder calls prior to appointment date(s). It is the patient's responsibility to remember their scheduled appointment(s).

This fee will be billed to you directly and is not covered by your insurance. This balance must be paid prior to your next appointment. If you do not have a scheduled appointment, the balance is expected in a timely fashion and if not, will be subject to collections.

We thank you for trusting Arkansas Pain Therapy Staff with your medical care.

I have read and understand the No Show Fee and 24-Hour Cancellation Policy and agree to the terms of this policy.

_____ _____

Signature: Date:

BASIC INFORMATION

Full Name: _____Date of birth: ____/____/____
Driver's License Number: _____ Social Security Number: _____
Address: _____
City: _____State: _____ Zip Code: _____
Home Phone: _____ Cell: _____ Email: _____
Emergency Contact Phone: _____ Name/Relationship: _____
Referred By (Physician, Family, Friend, Etc.) _____

RACE/ETHNICITY

Asian African American Caucasian Hispanic/Latino Native American Pacific Islander
Decline to Specify Primary Language: _____

EMPLOYMENT

Current Status: Working Not Working

Employer Name

Were you injured at work? Yes or No Employer _____Phone #: _____
Employer Address: _____ City: _____State: _____ Zip Code: _____

INSURANCE

Primary Insurance: _____Policy#_____ Group# _____
Subscriber Name: _____ Date of Birth ___/____/____
Secondary Insurance: _____ Policy#_____Group# _____
Subscriber Name: _____Date of Birth: ___/____/_____

AUTO ACCIDENT

Is injury covered by Auto Accident Insurance? Yes or No
Date of Injury: _____ Claim #_____Insurance Carrier: _____
Carrier Address: _____Carrier #:_____
Name of Insured: _____Adjuster Name: _____
Adjuster Phone #_____ Attorney Name: _____ Phone # _____

WORKERS COMPENSATION

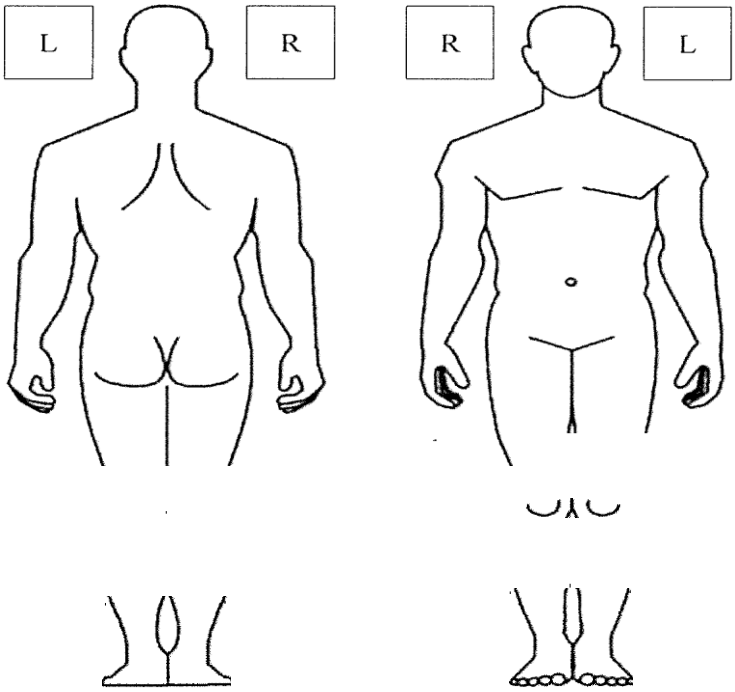
Is injury covered by Workers Compensation? Yes or No
Date of Injury: _____Claim#_____
Insurance Carrier: _____Name of Insured: _____
Do you have an attorney for this injury? Yes or No
Attorney's Name: _____Attorney's #_____

PHARMACY

Pharmacy Name: _____Phone # _____
Address: _____City: _____State: _____Zip Code: _____

Height: _____Weight_____

Shade in the area(s) below where you are experiencing pain:



Circle the number on the line below that stands for your pain today:

No Pain_____Worst Pain

0 1 2 3 4 5 6 7 8 9 10

Circle the number on the line below that stands for your pain during the past week:

No Pain_____Worst Pain

0 1 2 3 4 5 6 7 8 9 10

Do you need help with activities of daily living? Yes or No

PAIN INVENTORY - Please check all the following words that describe your pain:

Numb/Dull Sharp Tender Shooting Cramping Firing/Exhausting Tingling Aching
Heavy Stabbing Throbbing Hot/Burning

CHRONOLOGY

When did your pain start? _____
Did anything happen that triggered it? _____
What makes the pain better/worse?_____
What is the duration of your pain? Please circle
Constant Variable in intensity Intermittent Episodic

PREVIOUS TREATMENT

X-Ray CT Scan MRI Scan Myelogram EMG Bone Scan
What other treatments have you tried? Circle all that apply:
Surgery Physical Therapy Acupuncture Epidural/Steroidal Injections
Non-Steroidal Anti-Inflammatory Medications Chiropractic Non-Prescription Drugs
Other: _____

Which treatment(s) worked the best?
How much better did you feel? (i.e., 50% improvement that lasted 1 week)
_____
Which treatment(s) were least effective? _____

Are you taking any blood thinners? (Plavix, Coumadin, Etc.) If yes, which_____
Are you allergic to any medications? No Yes: _____
Do you take your medications as prescribed? **Yes or No** Do you feel impaired with your medication? **Yes or No**
Do you drive while impaired? **Yes or No**

MEDICATIONS - Please list ALL medications you are currently taking, including dosage:

PAST MEDICAL HISTORY
(CIRCLE THOSE THAT APPLY)

Asthma	Cancer	Hepatitis	Liver Problems
Anemia	Depression	High Blood Pressure	Loss of Bladder Control
Anxiety	Diabetes	DHIV	Loss of Bowel Control
Arthritis	Emphysema	Kidney Problems	Rheumatic Fever
Asthma	Eye Problems	COPD	Seizure
Blood Clots	Heart Disease	Stroke	Substance Abuse
Thyroid Issues	Tuberculosis	Anything else:	

FAMILY MEDICAL HISTORY	**Mother**	**Father**	**Aunt/Uncle**	**Grandparent**	**Child**	**Other**
Substance Abuse						
Cancer						
Tumor						
Hepatitis						
Mental Illness						
Chronic Pain						
Thyroid issues						
Ulcers						
HIV						
Stroke						

PAST SURGICAL HISTORY - Please be as specific as possible (ex. Right Knee ACL Repair) Include dates.

Date	**Location**	**Procedure**

SOCIAL HISTORY

What is your marital status?

Single Married Divorced Widowed Separated Other

Could you be pregnant?

No Maybe Yes How many weeks? Due:

How many children do you have?

O 1 2 3 4 5 6+

What is your highest level of education completed?

GED High School Trade School 2 Yrs or 4 Yrs College Masters Other: _____

Do you use tobacco? No Former 1/4 Pack/day 1/2 Pack/day 1 Pack/day l+ Pack/day

Do you drink alcohol? No Former Current - Every Day Current - Some Days

Are you currently using any of the following? None Marijuana Cocaine Heroin PCP Other: _____

Have you used any of the following in the past? Never Marijuana Cocaine Heroin PCP Other: _____

Are you currently working? Retired Short Term Disability Long Term Disability Unemployed

Duties at work? Lifting Bending Standing Reaching Other: _____

Please circle if you are experiencing any of the following symptoms:

CONSTITUTIONAL
Fever, Chill, Night Sweats, Weight Gain, Weight Loss, Fatigue, Lethargic

EYES
Dry Eyes, Eye Irritation, Vision Change

EMNT
Difficulty Hearing, Ear Pain, Frequent Nosebleeds, Nose/Sinus Problems, Sore Throat, Bleeding Gum, Snoring, Dry Mouth, Oral Abnormalities, Mouth Ulcers, Teeth Problems, Mouth Breathing

CARDIOVASULAR
Chest Pain on Exertion, Arm Pain on Exertion, Shortness of Breath When Walking, Shortness of Breath When Lying Down, Palpitations, Known Heart Murmur, Light-Headed When Standing

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

GASTROINTESTINAL
Abdominal Pain, Vomiting, Appetite Change, Black or Tarry Stools, Frequent Diarrhea, Vomiting Blood, Fecal Incontinence

GENITOURINARY
Urinary Loss of Control, Difficulty Urinating, Increased Urinating Frequency, Blood in Urine, Incomplete Emptying

MUSCULOSKELETAL
Muscle Aches, Muscle Weakness, Arthralgia/Joint, Back Pain, Swelling in the Extremities

INTEGUMENTARY Abnormal Mole, Jaundice, Rash, Itching, Dry Skin, Growths/Lesions

NEUROLOGIC
Loss of Consciousness, Weakness, Numbness, Seizures, Dizziness, Frequent or Severe Headaches, Migraines, Restless Legs

PSYCHIATRIC Depression, Sleep Disturbance, Restless Sleep, Feeling Unsafe in Relationship, Alcohol Abuse, Suicidal Idealization, Anxiety

ENDOCRINE Hair Loss, Cold Intolerance, Increases Hair Growth

HEMATOLOGIC/LYMPHATIC Swollen Glands, Easy Bruising, Excessive Bleeding

ALLERGIC/IMMUNOLOGIC Runny Nose, Sinus Pressure, Itching, Hives, Frequent Sneezing, Seasonal Allergies

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name:	• Birth Date:	Social Security Number:
Provider (Who is releasing information):		
Address 1:		
Address 2:		
City:	State	Zip
Phone:	Fax Number:	

Recipient's Name (Who is receiving information):		
Address 1:		
Address 2:		
City:	State	Zip
Phone:	Fax Number:	

This authorization will expire upon the following: (Fill in the Date or Event, but not both, If no expiration is specified, this authorization will expire 90 days from the date signed)

The following information may be disclosed (Choose one of the following):

All Medical Records covering dates Entire Medical Record Specific Medical Records

Other (Specify):___

•I acknowledge and hereby consent to such that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.(initial) _____(If not applicable, enter N/A)

I understand that:

• I may refuse to sign this authorization and that it is strictly voluntary.

• My treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization.

I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.

If the requester or receiver is not a health plan provider, the released information may no longer be protected by federal privacy regulations and may be disclosed

I understand that I may see & obtain a copy of the information described in this form for a reasonable copy fee if I ask for it.

I may keep a copy of this form after I sign it.

Signature of Patient/ Guardian/ Legal Representative:	Date:
(If not signed by the patient) Print Name:	Relationship to Patient:

Legal paperwork is needed if not signed by the patient.

PROTECTED HEALTH INFORMATION USE AND DISCLOSURE AUTHORIZATION

I authorize Arkansas Pain Therapy Staff to use and disclose protected health information for the purpose of the Disclosure Entity or Person(s) to Receive Information.

Name: _____

This authorization is effective through _____/_____/_____ - _____/____/_____

Relationship: _____

EXPIRATION, unless revoked or ended by the patient or the patient's personal representative. I understand that I have the right to end or revoke this authorization at any time. I understand that revocation is not effective if my authorization was obtained as a condition of obtaining insurance coverage.

I understand that information disclosed under this authorization may be disclosed by the recipient, so the privacy of this information may not be protected under the Federal Privacy Rule depending on whom it is disclosed to. I understand that my authorization is not needed as a condition to receive treatment, payment, enrollment, or eligibility for benefits.

_____ Date: _____/_____/_____
Name of Patient or Personal Representative (Print)

_____
Signature of Patient or Personal Representative Date: _____/_____/_____

_____
Description of Personal Representative's Authority Date: _____/_____/_____

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