NEW PATIENT INFORMATION

Today's Date ____/_____/_____ E-mail: _____

Name: _____ DOB: _____/_____/_____
Home Phone: _____ Mobile Phone: _____ Consent to Text: Yes/No
Home Address: _____
City _____ZIP_____
Referring Physician: _____Phone: _____
Primary Care Physician: _____Phone: _____
Other Physician: _____Phone: _____
Preferred Language: _____Race: _____Ethnicity: _____
Chief Complaint: _____
Describe onset of symptoms: _____
When did your pain start? _____/_____/_____

Pain Intensity: Please mark this line with intensity of average pain using all of the letters below.

No Pain Severe Pain

0 1 2 3 4 5 6 7 8 9 10

P=Present Pain M=Most of the time W=Worst it gets L=Least it gets

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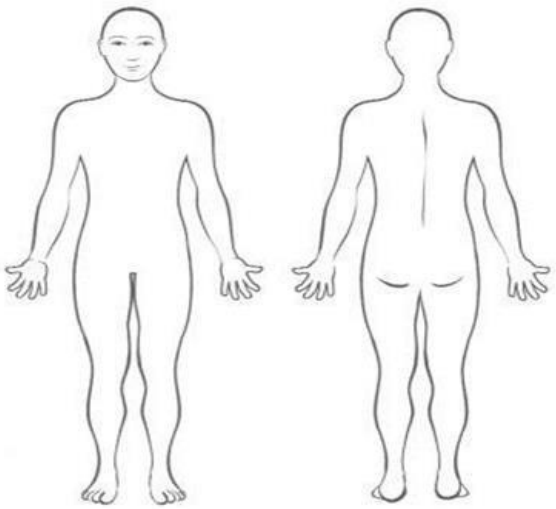
Pain Diagram: Please mark or shade areas below where you have your pain. Put an **X** where it hurts the most.



OFFICE USE:

Vitals

Height: _____
Weight: _____
BP: _____/_____
Pulse: _____
Pain: _____/ **10**
UDS: _____

Current Medications:

Medication	Dosage	Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Medications:

Medication	Dosage	Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies:	***Reaction:***
_____	_____
_____	_____

Review of Systems: (Circle all that apply)

Hand Dominance: left, right, ambidextrous

Constitutional: intolerance, fever, night sweats, weight gain (___lbs), weight loss (___ lbs), exercise intolerance
Eyes: eye injury right/left, irritation right/left, vision change right/left
Ears: difficulty hearing, ear pain
Nose: frequent nosebleeds, nose problems, sinus problems
Mouth/Throat: sore throat, bleeding gums, snoring, dry mouth, oral abnormalities, mouth ulcer, teeth abnormalities, mouth breathing
Cardiovascular: 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 on standing
Respiratory: cough, wheezing, shortness of breath, coughing up blood, sleep apnea
Gastrointestinal: abdominal pain, vomiting, change in appetite, black or tarry stools, frequent diarrhea, change in bowel habit, vomiting blood, indigestion, GERD (gastroesophageal reflux disease)
Genitourinary: urinary loss of control, difficulty urinating, increased urinary frequency, blood in urine, incomplete emptying
Musculoskeletal: muscle aches, muscle weakness, joint pain, back pain, swelling in the extremities
Skin: jaundice, rash, itching, dry skin, growths/lesions, laceration
Neurologic: loss of consciousness, weakness, numbness, seizures, dizziness, frequent or severe headaches, migraines, restless legs, tremor
Psychologic: depression, sleep disturbances, feeling unsafe in relationship, restless sleep, alcohol abuse, anxiety, hallucinations, suicidal thoughts
Endocrine: fatigue, increased thirst, hair loss, increased hair growth, cold intolerance

History of Present Illness: (Circle all that apply)

Location: left, right, bilateral, anterior, posterior, medial, lateral, deep, superficial
Quality: aching, burning, gnawing, stabbing, throbbing, sharp, dull, superficial, deep, occasional, frequent, constant, worsening, improving, no change
Severity: no pain, mild, moderate, severe, pain level ____/10, worst pain ____/10
Duration: ____ days, ____ weeks, ____ months, ____ years, continuous since onset
Timing: cannot identify, acute, chronic, abrupt, gradual, morning, daytime, nighttime, recurrent, rare, occasional, intermittent episodes lasting
Context: cannot identify, fall, bending, lifting, twisting, sports injury, work injury, MVA, assault, overuse, atraumatic, laceration
Alleviating Factors: nothing helps, sitting, standing, lying down, position change, heat, ice, rest, elevation, exercise, stretching, limited weight bearing, PT/OT, chiropractic care, ESI, OTC medication, narcotics, NSAIDs, cortisone injection, vicosupplement injection, orthotics, previous surgery, brace, sling, flexion, extension
Aggravating Factors: cannot identify, sitting, standing, lying down, walking, lifting, carrying, twisting, pushing/pulling, gripping, grasping, squeezing, throwing, ROM, weight bearing, exercise, previous surgery, computer use, changing clothes, getting out of bed, going from sit to stand, morning, daytime, nighttime, cold weather, damp weather, flexion, extension, sneezing, coughing, bowel movements

Associated Symptoms: weakness, numbness, tingling, swelling, redness, warmth, ecchymosis, catching/locking, popping/clicking, buckling, grinding, instability, radiation down arm, drainage, fever, chills, weight loss, change in bowel/bladder habits

Previous Surgery: Yes No

Prior Imaging: none, no recent studies, x ray, MRI, CT scan, bone scan, EMG
Location: _____ Date: _____

Previous Injections: none, did not help, helped a little, helped temporarily, helped significantly
Trigger Point Injections, Epidurals, Facet Injections, Radiofrequency, Other: _____
Previous Therapy: none, did not help, helped a little, helped temporarily, helped significantly
Physical Therapy, Chiropractic, Massage Therapy, Acupuncture, Other: _____

Work Related: Yes No
Working: No Regular Duty Modified Duty

Past Medical History:
Have you ever had problems with any of the following? (Circle all that apply)
High Blood Pressure Asthma/Lung Disease Cancer Arthritis
Diabetes Gastritis/Ulcers Endocrine Disease Stroke/Seizure
Heart Attack (MI) HIV/Exposure Sleep Apnea Kidney/Liver Disease
Heart Disease Arrhythmia Congestive Heart Failure

Other Explain: _____

***Family History*:**

Mother	Father	Brother	Sister	Grandparents
☐ Alive & Well	☐ Alive & Well	☐ Alive & Well	☐ Alive & Well	☐ Alive & Well
☐ Cancer Type: _____	☐ Cancer Type: _____	☐ Cancer Type: _____	☐ Cancer Type: _____	☐ Cancer Type: _____
☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes
☐ Hypertension	☐ Hypertension	☐ Hypertension	☐ Hypertension	☐ Hypertension
☐ Degenerative Spine Disease	☐ Degenerative Spine Disease	☐ Degenerative Spine Disease	☐ Degenerative Spine Disease	☐ Degenerative Spine Disease
☐ Arthritis/ Rheumatologic Disease	☐ Arthritis/ Rheumatologic Disease	☐ Arthritis/ Rheumatologic Disease	☐ Arthritis/ Rheumatologic Disease	☐ Arthritis/ Rheumatologic Disease
☐ Other:	☐ Other:	☐ Other:	☐ Other:	☐ Other:

Past Surgical History: Please list any surgeries you have had and approximate dates

Surgery	Physician	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Psychiatric History: (Circle all that apply)

Depression/Manic Depression Anxiety Bipolar Disease Schizophrenia
Mixed Personality Disorder ANY Type of Addiction History Substance Abuse
Other: _____
Are you currently seeing a Psychiatrist or Psychologist? Yes No
If YES, who are you seeing? _____
Have you had any recent thoughts or ideations of suicide or harming others? Yes No

Social History: (Circle all that apply)

What is your occupation? _____
Do you smoke? Yes No If YES, how much? _____
Do you drink? Yes No If YES, what and how much? _____
Do you use or have you ever used: Marijuana Cocaine Other illicit drug(s)
If YES, what and how much? _____
Are you involved in litigation regarding this pain? Yes No
Attorney: _____ Phone: _____

COMPREHENSIVE PAIN SPECIALISTS

AUTO INJURY

_____**Not Applicable** (please initial if your care is **not** related to an auto injury)

Please complete the following section if you are being treated here for pain after an accident:

Auto/Auto Auto/Motorcycle Auto/Bicycle Auto/Pedestrian

Date of Accident: _____/_____/_____

Describe what happened in the accident (e.g. weather, driving conditions, damage to vehicles):_____
_____
_____
_____

Were you wearing a seatbelt? Yes No
Did the airbags go off? Yes No
Were headrests in place? Yes No
Do you remember the accident happening? Yes No
Did you lose consciousness? Yes No
Did you have pain immediately? Yes No

When and where did you first seek out medical care after the accident?
_____
_____
_____

Did you have Pain before the accident? Yes No
If yes, where did you have pain? _____
Who was treating you for this pain? _____
_____
_____

How much worse is that pain now? _____

FINANCIAL POLICY

Professional fees: Our fees for medical services are comparable to other similarly trained Physicians in the community and reflect the complexity of your specific needs. The Physician's time is dedicated to your care, the specialized nature of the Doctor's training, education and supplies determines the cost associated with providing and coordinating your care. Patient understands that it is his/her obligation to know his/her Payer's requirements and ensure that they have been fulfilled, including having a valid authorization for service in place prior to his/her Medical, Psychiatric/Behavior Health Services. Comprehensive Pain Specialist's will check for prior authorization as a courtesy, but this is not a guarantee of payment by the insurance company. Insurances that fail to pay for claims filed will lead to the Patient and/or Guarantor being responsible for payment of the remaining uncovered charges. Insurance companies will often deny claims when the insurance is not presented at the time of service. Most insurance companies have requirements for authorization prior to or within 24 hours of service. If insurance information is presented after treatment, we will file a claim to your insurance company on your behalf. However, you will be held liable for the charges if the insurance denies the claim as untimely because of late presentation of coverage or for lack of timely authorization due to late presentation of coverage.

Insurance Payments: We participate with most of the insurance plans in the area. Some services such as Psychiatric/Behavioral Health may not be covered by your insurance policy. Your insurance coverage is a contract between you and your insurance plan. Co-payment, deductibles, co-insurances and services not covered by your insurance plan or outstanding balances are all patient's responsibility to pay in full. Co-payments are due at time of service. **Patient specifically agrees to pay for any services including psychiatric services, which are determined not to be covered by any health benefit plan or insurance company.**

Missed Appointments: We will charge a fee of **$100.00** for any office appointment missed or cancelled under 48 hours' notice and a fee of **$500.00** for any procedure/injection appointment missed or cancelled under 48 hours' notice. Your account will be charged if **NOT** cancelled 48 hours in advance. These fees are patient responsibility and will not be submitted through insurance or liens.

Medical Records: We offer patients free electronic records through our patient portal. You will be subjected to a fee for any printed records. We will **fax** all records for free to any Physician's Office or Other Medical Facility as courtesy to our patients. A signed HIPAA authorization may be required to send your medical record.

Collection Agencies: After 90 days your account will be considered past due and can be turned over to a third-party collection agency. If it becomes necessary to turn your account over to a third-party collection agency due to your non-payment you will be dismissed from our practice.

Self-Pay: Patients who are not billing a third party or health insurance must pay in full at the time of service.

Your signature on this page constitutes an acknowledgement and understanding of this policy. I have read and agree to the above policies and authorize payment directly to Comprehensive Pain Specialists.

_____	_____
Signature of Patient or Personal Representative	**Relationship to Patient**
_____	_____
Printed Name of Patient or Personal Representative	**Date**

PHYSICIAN-PATIENT CONTRACT FOR OPIOID MEDICATIONS

The following contract must be read, <u>initialed</u> and signed by the patient before any narcotic prescriptions will be given.

_____ I do NOT wish to receive any opioid medication at this time, but I acknowledge and will adhere to the policy below if at any time I choose to receive any opioid medication during my treatment at Comprehensive Pain Specialists.
_____ I will obtain prescriptions for opioids and other controlled medications **only** from my Provider at Comprehensive Pain Specialists.
_____ I will have my prescriptions filled at only **one pharmacy** and will notify Comprehensive Pain Specialists if this pharmacy changes.
Pharmacy Name: _____ Pharmacy Phone: _____
Pharmacy Address: _____
_____ I will take the medications only as prescribed and will promptly notify the medical staff/Physician if I do not.
_____ I agree to random Urine Drug Screens to assess my medication compliance. If I am unable to provide a urine sample I understand there will be a blood test provided in its place. If I refuse to provide an adequate sample, I understand this can result in the Provider no longer prescribing opioid medications and can result in discharge from the Practice.
_____ I understand at any time, for any reason, I may be asked to bring in my pain medications for a pill count. If I am requesting a new prescription, I must relinquish the remaining bottle of medications to be counted and destroyed prior to receiving a new prescription.

<u>The following are examples for reasons of discharge:</u>

- *Giving your Opioids to others, (for example a friend or family member in pain)*
- *<u>Taking</u> <u>more</u> of your medication than prescribed*
- *<u>Taking less</u>/Cutting your own dosage down without speaking to your provider (contact the medical staff if the medication has side effects, or you feel you do not need them)*
- *Taking medications prescribed by <u>any other practitioners</u> (such as a dentist after oral surgery, primary care provider, urgent cares,) without informing Comprehensive Pain Specialists.*

*** **Lost, Misplaced, or Stolen Medications <u>Will NOT Be Replaced</u> for any reason. *It is your responsibility to keep your medications locked and secure at all time*s.*** Refills <u>will NOT be given early</u> for any reason. ***The eventual goal of your treatment is the tapering of the opioid medication. I will meet regularly with the Physician to assess my progress.**

By signing this contract, I am acknowledging that I have read, understand and agree to the terms and conditions of the Opioid Medication contract. ***If this contract is violated in any way, it may be terms for immediate discharge from the Practice.***

_____ _____
Signature of Patient or Personal Representative **Relationship to Patient**

_____ _____
Printed Name of Patient or Personal Representative **Date**

HIPAA AUTHORIZATION

Disclaimer: This document is provided solely for reference purposes. Covered Entitles under HIPAA are advised to refer to their Institution's Privacy Policy for specific requirements for the HIPAA Authorization.

I, (legal name) _____ DOB: _____**Phone Number**: _____
Please initial to give permission to COMPREHENSIVE PAIN SPECIALISTS to:

_____ Receive and release medical information/records from other entities as listed in section A
_____ Use the following protected health information
_____ Disclose the following protected health information as listed in section D

Section A: Name of whom C.P.S can release your medical information to: (MUST put your attorney if you have a lien.)
Person/Company: _____Relationship: _____Phone: _____
PCP/Specialist: _____
Attorney/Law firm: _____Phone: _____
Address: _____

Section B: Pharmacy Information:

_____

Section C: Laboratory (designated by Comprehensive Pain Specialists)

Section D: Information to be disclosed (check all that apply):

_____ Medical Records
_____ Treatment Records
_____ Diagnostic / Imaging Records
_____ Other: _____

Can confidential messages be left on your phone answering machine or voicemail? Yes _____ No _____

Section E: Emergency Contact:
Please list the family member or significant other, if any, whom we may inform about your medical condition in an EMERGENCY ONLY. *If not an emergency: Medical information including appointment information will not be released unless the name of the individual is listed above in section A.*

Name: _____ Phone: _____ Relationship: _____

This authorization expires 12 months from the signed date.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment.

You may inspect or receive a copy the Protected Health Information to be used or disclosed under this authorization. For Protected Health Information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.

_____ _____
Signature of Patient or Personal Representative **Relationship to Patient**

_____ _____
Printed Name of Patient or Personal Representative **Date**

URINALYSIS

As part of your healthcare plan we require that you provide random urine samples prior to your visit. This is a DEA regulation and at Comprehensive Pain Specialists we abide by their standards.

The Laboratory (Lab) choice is unfortunately not up to the patient's discretion and/or insurance. The Lab is picked by our Physicians because they need specific results from the Laboratory and these are government required tests.

As a company of Practitioners, our role in the proper prescribing, administering and dispensing of controlled substances is critical to a patients' health and to safeguard society against the diversion of controlled substances. The American Society of Interventional Pain Physicians adopted guidelines based off the U.S. Department of Justice Drug Enforcement Administration (DEA) requiring its 4,000 members to implement urine tests to determine if patients are already misusing drugs or are likely to do so. In addition, three other Pain Physician Groups—including the American Pain Society—have endorsed drug testing for high-risk patients, while at least 10 states, including Kentucky, Washington, and Colorado have recommended some level of testing. The Federal controlled substance laws are designed to work in tandem with State controlled substance laws and the guidelines of the DEA. Law Enforcement Officials ensure that pharmaceutical controlled substances are prescribed, administered and dispensed for legitimate medical purposes in accordance with Federal and State Laws.

Please note that you are responsible for payment of any bill that you receive directly from the Lab. We encourage all patients to contact the Lab if you have any questions related to a bill or statement from the Lab or your Insurance Company. Often the Lab will work with our patients to determine final payment.

_____ I do NOT wish to receive any opioid medication at this time, but I acknowledge, understand and will adhere to the required testing as described in the Opioid Contract if it at any time I choose to receive any opioid medication during my treatment at Comprehensive Pain Specialists.

By signing this I acknowledge that I have been notified and have read and understand the policy surrounding medication compliance.

_____ _____

Signature of Patient or Personal Representative **Relationship to Patient**

_____ _____

Printed Name of Patient or Personal Representative **Date**

We have experienced an increase in the number of patients that have missed their appointments without notifying us. Therefore, we have had a change in our No-Show/Missed Appointment Policy.

Due to the high number of patients requesting appointments, the wait time to get into our clinics has grown. Because of this, Comprehensive Pain Specialists has a low tolerance for missed appointments that waste resources and prevent other patients from receiving the care they need.

- **PROCEDURE APPOINTMENTS- $500.00 charged fee**
- **CLINICAL APPOINTMENTS- $100.00 charged fee**

(These fees are patient responsibilities and will not be covered by insurances or liens and while we do understand that there are circumstances that arise, we ask that you call to speak to a manager prior to your appointment time, otherwise fees will only be waived with proof of emergency).

You are a no-show if you:

- Miss an appointment without speaking directly with a staff member
- Miss an appointment or reschedule an appointment with less than **48 hours** business days' notice.
- Miss an appointment because you have arrived after your scheduled appointment time.

If you no-show, or arrive past your appointment time, there is a chance you will not be able to be seen, our providers will **not** make special accommodations to get you in sooner, and you may have to be scheduled with a different provider. Also, if you no-show or arrive past your appointment time, two or more times in a 12-month period, you may be discharged from the clinic.

By signing this I am acknowledging that I have been notified and understand this policy.

_____ _____

Signature of Patient or Personal Representative **Relationship to Patient**

_____ _____

Printed Name of Patient or Personal Representative **Date**

FINANCIAL AGREEMENT FOR MENTAL HEALTH/PSYCHIATRIC VISISTS

Comprehensive Pain Specialists offers an expert in pain psychology.

A Psychotherapist is simply someone trained to be a useful tool to help our patients better identify with things that trigger pain, addiction issues, and therapeutic techniques to better cope with pain.

Health insurance companies may only cover services offered by Preferred Providers on their list. This may apply to the Provider of Physical Healthcare as well as Mental Healthcare. Health insurance companies may also only cover certain types of Providers, such as a Psychiatrist but not a Licensed Counselor. Not all insurance companies cover the cost of mental health/behavior health visits and they will deny the cost, leaving you with the financial responsibility. It is the patient's responsibility to know their health insurance plans and to find out if it covers visits with a Mental Health Provider at Comprehensive Pain Specialists.

In addition, you may be limited by the number of visits you can receive per year or the dollar amount that is reimbursed under your insurance plan, making any additional visits to be paid fully out of your own pocket. Many insurance plans may also require a co-pay for each visit that is due at the time of the appointment.

I am responsible for all the charges for all mental health services rendered to me or any member of my family where I am listed as the responsible party. I hereby agree to pay my insurance deductible, coinsurance and/or co-payment as services are provided. If for any reason there is a balance due on my account, I agree to promptly pay in full upon receipt of the monthly statement.

I understand that Comprehensive Pain Specialists will bill my insurance company as a courtesy on my behalf. I clearly understand that it is my responsibility to make sure the bill is paid in a reasonable time. If for any reason a portion of my bill is not paid by my insurance, I further agree to make a prompt payment of the bill or make payment arrangements. I fully understand that I will be charged **$100.00** for any appointments missed or **canceled less than 48 hours in advance**. I agree to pay this amount and I understand that this charge cannot be billed to my health insurance carrier or lien company.

By signing this financial agreement, I acknowledge and understand the financial agreement as detailed above.

_____	_____
Signature of Patient or Personal Representative	**Relationship to Patient**
_____	_____
Printed Name of Patient or Personal Representative	**Date**