COMPREHENSIVE PAIN SPECIALISTS

New Patient Information

Name: _____ Date of Birth: _____/_____/_____ SSN: _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ E-Mail: _____

Address: _____ City: _____ Zip: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Gender: □ Male □ Female Consent to Text: □ Yes □ No Consent to Email: □ Yes □ No

Primary Care Physician: _____ Office Phone: _____

Preferred Language: □ English □ Spanish □ French □ Italian □ German □Vietnamese □ Other

Race: □ American Indian/ Alaska Native □ Asian □ Black/ African American □ White
□ Native Hawaiian/ Other Pacific Islander □ Other □ Patient Declined

Ethnicity: □ Hispanic or Latino □ Non-Hispanic or Latino □ Patient Declined

Insurance & Guarantor Information

Insurance Company:_____ Member ID:_____ Group#: _____

Subscriber's Name:_____ Date of Birth:_____

Insurance holder/ Guarantor: _____ Relationship: _____

Are you involved in a litigation regarding this pain? □ YES □ NO

If yes, Attorney Name: _____ Office Phone: _____

How did you hear about our practice?

□ Referred by physician Name: _____

□ Referred by patient Name: _____

□ Insurance company list of doctors

□ Website or web-search (Google, etc.) Which one? _____

□ Other (please specify) _____

Chief Complaint: _____

Describe onset of symptoms: _____

When did your pain start? _____/_____/_____

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

No Pain _____ Severe Pain

0 1 2 3 4 5 6 7 8 9 10

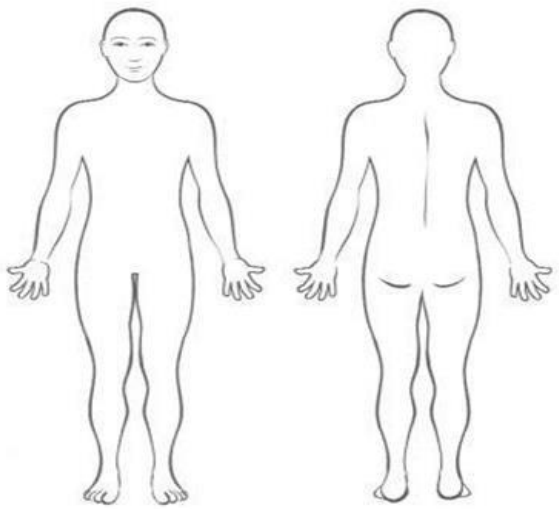
P = Present Pain **M = Most of the time** **W = Worst it gets** **L = Least it gets**

How does it affect your Range of Motion: _____

How does it affect your overall Function: _____

How long does it last: _____hours _____minutes **When do you notice it the most:** □ AM □ PM

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: _____

COMPREHENSIVE PAIN SPECIALISTS

Medications: *Please list all current medications.*

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

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

Please select all medications that you have tried in the past for pain.

Opioids

□ Fentanyl □ Morphine (MS Contin) □ Oxycodone (Oxycontin, Percocet) □ Propoxyphene
□ Demerol □ Oxymorphone (Opana, Opana ER) □ Hydromorphone (Dilaudid, Exalgo)
□ Buprenorphine (Suboxone, Subutex, Butans Patch, Belbuca) □ Other

Anti-inflammatories

□ Meloxicam □ Ibuprofen (Motrin, Advil) □ Diclofenac (Voltaren Gel) □ Naproxen □ Celebrex □ Other

Muscle Relaxants

□ Baclofen □ Methocarbamol □ Soma □ Flexeril □ Tizanidine □ Other

Other

□ Antidepressants - Please list □ Sleep Aids - Please list □ Nerve Medications - Please list

_____ _____ _____

_____ _____ _____

Psychiatric History: *Please check 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: *Please check 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? □ Other illicit drug(s)
If YES, what and how much? _____

Review of Systems: *Please check all that apply.*

Hand Dominance: □ Left □ Right □ Ambidextrous
Constitutional: □ unexplained weight loss, □ weight gain, □ night sweats, □ fatigue/malaise/lethargy, □ fever, □ exercise intolerance
Eyes: □ eye injury right/left, □ irritation right/left, □ vision changes, □ double vision, □ other vision problems?
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/lying down, □ palpitations, □ known heart murmur, □ lightheaded when standing
Respiratory: □ coughing, □ wheezing, □ shortness of breath, □ coughing up blood, □ sleep apnea
Gastrointestinal: □ abdominal pain, □ vomiting, □ change in appetite, □ black or tarry stools, □ frequent diarrhea, □ vomiting blood, □ change in bowel habit (dyspepsia), □ GERD
Genitourinary: □ urinary loss of control, □ difficulty urinating, □ increased urinary frequency, □ blood in urine (hematuria), □ incomplete emptying
Musculoskeletal: □ muscle aches, □ muscle weakness, □ arthralgia/ joint pain, □ back pain, □ swelling in extremities
Skin: □ rash, □ itching, □ dry skin, □ growths/ lesions, □ laceration, □ jaundice or change in skin color
Neurologic: □ loss of consciousness, □ weakness, □ numbness, □ seizures, □ dizziness, □ frequent or severe headaches, □ migraines, □ restless legs, □ tremor
Psychologic: □ depression, □ feeling unsafe in relationship, □ anxiety, □ hallucinations, □ alcohol abuse, □ suicidal thoughts, □ sleep problems
Endocrine: □ fatigue, □ increased thirst, □ hair loss, □ increased hair growth, □ cold intolerance

Past Medical History?

□ Joint pain/Arthritis
□ Stroke/Seizure
□ MI (Heart Attack)
□ Thyroid Disease
□ Heart Disease/Congestive Heart Failure
□ High Blood Pressure
□ Pacemaker/Arrhythmia
□ Blood Clots
□ Gastritis/Ulcers
□ Endocrine Disease
□ Abdominal Pain/Bowel Problems
□ Headaches/Migraines
□ Insomnia/Sleep Apnea
□ Depression/Anxiety
□ Asthma/Lung Disease
□ MRS
□ HIV+ / AIDS □ Other

Family History?

□ Heart Disease
□ High Blood Pressure
□ Stroke
□ Cancer
□ Diabetes
□ Epilepsy
□ Bleeding Disorder
□ Kidney Disease
□ Thyroid Disease
□ Mental Disease
□ Osteoporosis
□ Arthritis

Surgical History?

□ No prior surgeries
□ Prior surgeries?
□ Glaucoma

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

Previous Surgery:

Surgical procedure: _____
Date: _____ Physician: _____
Surgical procedure: _____
Date: _____ Physician: _____
Surgical procedure: _____
Date: _____ Physician: _____
Surgical procedure: _____
Date: _____ Physician: _____

Prior Imaging: □ None, □ No recent studies, □ X Ray, □ MRI, □ CT scan, □ Bone scan, □ EMG

Location: _____ Date: _____
Location: _____ Date: _____
Location: _____ Date: _____
Location: _____ Date: _____

History of Present Illness: *Please check 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, □ viscosupplement injection, □ orthotics, □ previous surgery, □ brace, □ sling, □ flexion, □ extension notes
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, □ escape of blood into tissues, □ catching/locking, □ popping/clicking, □ buckling, □ grinding, □ instability, □ radiation down arm, □ drainage, □ fever, □ chills, □ weight loss, □ change in bowel/bladder habits

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: □ No □ Yes

Working: □ No □ Regular duty □ Modified duty

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? _____

Do you have a Case Manager? □ Yes □ No

Case Manager Name: _____ **Case Manager Phone #:** _____

COMPREHENSIVE PAIN SPECIALISTS

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 Health Services. Comprehensive Pain Specialists 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 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 and/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 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. We will **fax** all records for free to any Physician's Office or Other Medical Facility as courtesy to our patients. You will be subjected to a fee for any printed records. A signed HIPAA authorization may be required to send your medical records.

Collection Agencies: A late fee may be charged to you at the rate of 3% of your total balance if there are no payments within 90 days and/or if no formal payment arrangement has been made. 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.

By signing this I acknowledge that I have been notified and have read and understand the Financial Policy. I agree to the above policy 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**

COMPREHENSIVE PAIN SPECIALISTS

PHYSICIAN-PATIENT CONTRACT FOR OPIOID MEDICATIONS

The following contract must be read and signed by the patient before any narcotic prescriptions will be written for the patient.

- I understand Comprehensive Pain Specialists may check my prescription history before medication will be prescribed by this Practice.
- 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 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 will discontinue the previous medication per the Providers request.
- I understand it is my responsibility to keep medications away from children, animals, and other persons.
- To justify the use of opiates, I will report improved pain control, increased functional level, no serious side effects, and no episodes of running out of medications early, and lost or stolen medications.
- I understand all medications have side effects, some of them serious, I understand almost all medications can be fatal if used inappropriately.
- I understand Alcohol is not considered safe in conjunction with the medications typically prescribed by this Practice.

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

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

By signing this contract, I am acknowledging that I been notified and have read, understand, and agree to the terms and conditions of the Opioid Medication contract. ***If this contract is violated in any way, it can 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 Entities under HIPAA are advised to refer to their Institution's Privacy Policy for Specific requirements for the HIPAA Authorization.

I, (Legal Name)_____DOB:_____Phone:_____

Give Permission to COMPREHENSIVE PAIN SPECIALISTS to:

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

Section A: Name of whom Comprehensive Pain Specialists (CPS) can release your medical information to:

Family/Friend:_____Relationship:_____Phone:_____
PCP/Specialist:_____Phone:_____

Attorney/Law Firm **(required if you have a Lien or an open Litigation Case):**

Name:_____Phone:_____
Address:_____

Section B: Pharmacy Information:_____

Section C: Laboratory (designated by Comprehensive Pain Specialists)

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

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

Can confidential messages be left on your phone answering machine, voicemail and/or email? □ Yes □ No

This authorization expires 12 months from the date signed.

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 of 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**

COMPREHENSIVE PAIN SPECIALISTS

URINALYSIS POLICY

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 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 the Laboratory will bill you separately. 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**

MISSED APPOINTMENT AND DISCHARGE POLICY

No Show and Late Arrivals

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.

Reasons for Discharge

The following are examples of reasons you may be discharged from our Clinic and asked to continue your healthcare treatment with another Pain Management Office.

- Failure to follow the Providers treatment plan
- Repeated no shows, cancellations without notice, consistently late for appointments
- Violent, rude behavior towards our Providers, Office Staff via telephone or in office (this will apply to family members and/or friends.
- Failure to pay for services rendered.
- Giving your opioids to others (for example: a friend or family member in pain).
- Taking more of your medication than prescribed.
- Taking less/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 not prescribed by any other Practitioners (such as a Dentist after oral surgery, Primary Care Provider, Urgent Care) without informing Comprehensive Pain Specialists.
- Violations of the opioid contract.

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

_____ _____

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

_____ _____

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

TELEMEDICINE INFORMED CONSENT

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable Healthcare Providers to deliver health care services to patients when located at different sites.

- I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
- I understand that I will not be physically in the same room as my health care provider.
- I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
    - If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my Healthcare Provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
- I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
    - I may revoke my right at any time by contacting Comprehensive Pain Specialists at 303-469-3182.
- I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
- I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
- I understand that my insurance carrier will have access to my medical records for quality review/audit.
- I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
- I understand that this document will become a part of my medical record.

This authorization expires 12 months from the date signed.

By signing this I acknowledge that I have been notified and have read and understand telemedicine services and I give my consent to telemedicine appointments.

_____ _____

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

_____ _____

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