PAIN CARE CENTERS
Treatment Options Close to Home

Dear Patient,

We are happy you are considering seeing us for your pain management needs. We pride ourselves on providing the best, comprehensive pain care available in our communities. Please find and complete the following documents prior to your first appointment. Please come at least 30 minutes early. If you haven't completed the forms prior to your appointment, please come 45 minutes early.

NOTICE: A "NO SHOW" FEE OF $35 WILL BE CHARGED FOR NO SHOWS AND CANCELLATIONS LESS THAN 24 HOURS PRIOR TO YOUR APPOINTMENT. *Certain exclusions apply.

Forms:

- ❏ Information Form Including ALL Insurance Info
- ❏ New Patient Intake Form (Do not complete pages that say "Office Use Only"
- ❏ Consent Forms and Agreements

Items of note or needed in addition to the above-listed forms:

- ❏ Driver's License or Other ID and ALL Insurance Cards
- ❏ List of ALL Medications
- ❏ Medical Records From Other Providers Relative to the Reason for Your Appointment (Imaging, Dr. Notes, etc.)
- ❏ An Email Address: We will establish a "Patient Portal" for you which allows you to access records and communicate with our office.
- ❏ Spouse or Other Family: We encourage you to involve your family in your Pain Management.
- ❏ Urine Drug Testing: Be prepared to provide a sample.
- ❏ Payment of Deductibles and Copays are Always Due at Time of Service.

Please be sure to thoroughly review all documents and forms and complete as accurately and truthfully as possible as this information will provide a basis for your care going forward.

You may bring the forms into our practice ahead of time, fax them or simply bring them with you to your appointment. See the list of our locations below.

Please call 307.212.6270 for any questions or concerns. We look forward to serving you.

2620 Commercial Way, #20
Rock Springs, WY 82901
(307) 212-6270 Office
(307) 212-6271 Fax

329 Main Street
Lander, WY 82520
(307) 212-6270 Office
(307) 212-6271 Fax

170 Arrowhead Dr, #2
Evanston, WY 82930
(307) 212-6270 Office
(307) 212-6271 Fax

5850 E 2nd Street, Ste 100
Casper, WY 82609
(307) 212-6270 Office
(307) 212-6271 Fax

Patient Demographic/Insurance Information Form | Date:

Name: _____
Last First M.I.
Sex: _____ Date of Birth: _____ S.S.# _____

Address: _____
Street City State Zip Code

Phone Numbers : Home: _____ Work:_____ Cell:_____

Employer: _____ □ Full Time □ Part Time

Emergency Contact: _____ Phone Number:_____

Who is your primary care physician? _____

Who is your referring physician? _____

Race:
□ American Indian/Eskimo/Aleut □ Afro-American □ White □ Hispanic/Latino □ Asian
□ Native Hawaiian/Pacific Islander □ Other □ Decline to respond

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other

Insurance Information

Primary Insurance Company: _____

Insurance Address: _____
Street City State Zip Code

Subscriber (policy holder) _____
Policy Number: _____Group Number: _____
Policy Type: □ Individual □ Group □ Supplemental □ Other:_____
Policy type: Patient relationship to subscriber(policy holder): _____
Policy holder's S.S. # _____ Policy holder DOB:_____

Secondary Insurance Company:_____

Insurance Address: _____
Street City State Zip Code

Subscriber (policy holder) _____
Policy Number: _____Group Number: _____
Policy Type: □ Individual □ Group □ Supplemental □ Other:_____
Policy type: Patient relationship to subscriber(policy holder): _____
Policy holder's S.S. # _____ Policy holder DOB:_____

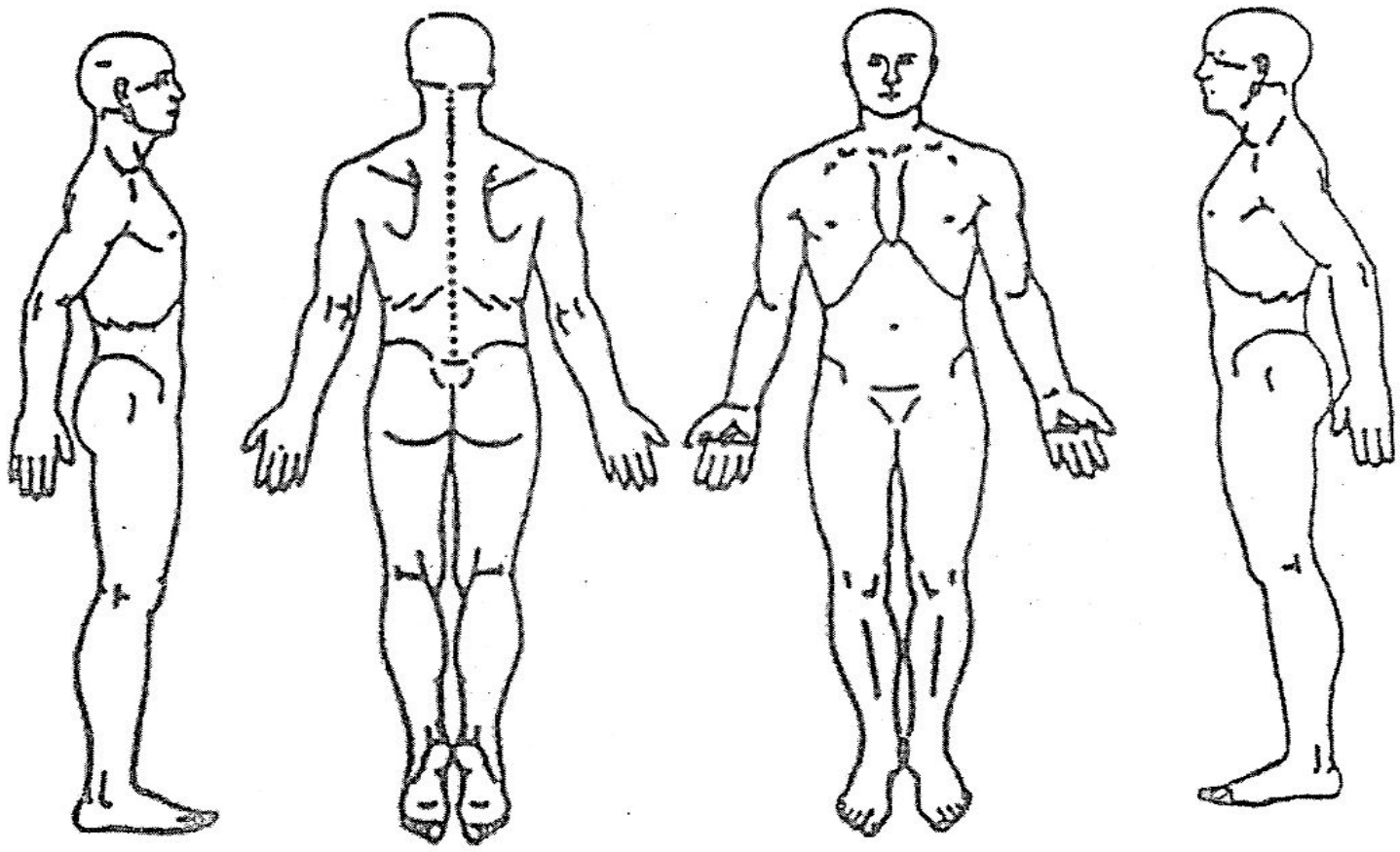
Name:_____ DOB:_____ Date:_____ Pain Intake page 1/7

Please answer questions 1-27.

1. If this is a Work Related Injury**: Body parts** injured:_____ **Date of Injury**:_____

2**. WHO** referred you for pain management?_____

3**. Where** do you hurt? Please place an **"X"** where you hurt the most.



5**. WHEN** did the pain start (write date)?_____

6**. WHAT** is the cause of your pain? _Surgery _Injury _Arthritis _Fibromyalgia _Migraine _Other:___

7**. Pain QUALITY**: _aching _burning _electrical _dull _pins and needle _sharp _throbbing

8**. Pain INTENSITY** (Over the **past week**)

a) What number best describes your **pain on average**?

(Circle your best answer) No pain 0—1—2—3—4—5—6—7—8—9—10 As bad as it can get

b) What number best describes your **pain interfering with enjoyment of life?**

(Circle your best answer) No interference 0—1—2—3—4—5—6—7—8—9—10 Complete interference

c) What number best describes your **pain interfering with general activity**?

(Circle your best answer) No interference 0—1—2—3—4—5—6—7—8—9—10 Complete interference

PEG SCORE: _____ (Ave of three scores: Total score of a, b and c, divided by 3)

9**. Pain RADIATION:** Does your pain travel/radiate from one area to another?
__NO: My Pain is localized and does not radiate
__YES: _From neck to Right arm _From neck to Left arm
__YES: _From low back to Right leg _From low back to Left leg

10. **Pain FREQUENCY:** __once in a while __occasionaly __frequently __constanly

11**. Pain DURATION:** ___min(s) ___hrs.

12. **Pain AGGRAVATED BY**: (Mark as many as applies) _standing _sitting _laying on back _laying on stomach _walking _lifting _bending backward _bending forward _coughing _light _sound _other:_____
Of these, choose **ONE** single activity that makes the pain the **WORST?**: _____

13. **Pain IMPROVED BY:** (Mark as many as applies) _standing _sitting _laying on back _laying on stomach _walking _bending backward _bending forward _no activity _taking medication _Other:_____
Of these, choose **ONE** single activity that makes the pain the **LEAST**?_____

15. Treatment modalities tried, %Pain Relief and any side effects:

_NO _YES: Chiropractic/PT:	Current user?: _Yes _No	Past User?: _Yes _No	%Pain relief? ___	Side effects?_____
_NO _YES: TENS Therapy:	Current user?: _Yes _No	Past User?: _Yes _No	%Pain relief? ___	Side effects?_____
_NO _YES: Cervical Traction:	Current user?: _Yes _No	Past User?: _Yes _No	%Pain relief? ___	Side effects?_____
_NO _YES: Lumbar Traction:	Current user?: _Yes _No	Past User?: _Yes _No	%Pain relief? ___	Side effects?_____
_NO _YES: Topical Meds:	Current user?: _Yes _No	Past User?: _Yes _No	%Pain relief? ___	Side effects?_____
_NO _YES: Ibuprofen(Motrin):	Current user?: _Yes _No	Past User?: _Yes _No	%Pain relief? ___	Side effects?_____
_NO _YES: Naproxen/Aleve:	Current user?: _Yes _No	Past User?: _Yes _No	%Pain relief? ___	Side effects?_____
_NO _YES: Celecoxib(Celebrex):	Current user?: _Yes _No	Past User?: _Yes _No	%Pain relief? ___	Side effects?_____
_NO _YES: Meloxicam (Mobic):	Current user?: _Yes _No	Past User?: _Yes _No	%Pain relief? ___	Side effects?_____
_NO _YES: Other NSAIDS:_____	Current user?: _Yes _No	Past User?: _Yes _No	%Pain relief? ___	Side effects?_____
_NO _YES: Cyclobenzaprin (Flexeril):	Current user?: _Yes _No	Past User?: _Yes _No	%Pain relief? ___	Side effects?_____
_NO _YES: Methocarbamol (Robaxin):	Current user?: _Yes _No	Past User?: _Yes _No	%Pain relief? ___	Side effects?_____
_NO _YES: Tizanadin (Zanaflex):	Current user?: _Yes _No	Past User?: _Yes _No	%Pain relief? ___	Side effects?_____
_NO _YES: Baclofen:	Current user?: _Yes _No	Past User?: _Yes _No	%Pain relief? ___	Side effects?_____
_NO _YES: Corispordal (Soma):	Current user?: _Yes _No	Past User?: _Yes _No	%Pain relief? ___	Side effects?_____
_NO _YES: Clonazepam (Klonopin):	Current user?: _Yes _No	Past User?: _Yes _No	%Pain relief? ___	Side effects?_____
_NO _YES: Diazepam (Valium):	Current user?: _Yes _No	Past User?: _Yes _No	%Pain relief? ___	Side effects?_____
_NO _YES: Alprazolam (Xanax):	Current user?: _Yes _No	Past User?: _Yes _No	%Pain relief? ___	Side effects?_____

_NO _YES: Other Anxiety meds: Current user?: _Yes _No Past User?: _Yes _No %Pain relief? ___ Side effects?_____

_NO _YES: Gabapentin (Neurontin): Current user?: _Yes _No Past User?: _Yes _No %Pain relief? ___ Side effects?_____
_NO _YES: Pregabalin (Lyrica): Current user?: _Yes _No Past User?: _Yes _No %Pain relief? ___ Side effects?_____
_NO _YES: Duloxetine (Cymbalta): Current user?: _Yes _No Past User?: _Yes _No %Pain relief? ___ Side effects?_____

_NO _YES: Tramadol (Ultram): Current user?: _Yes _No Past User?: _Yes _No %Pain relief? ___ Side effects?_____
_NO _YES: Hydrocodone/apap (Norco): Current user?: _Yes _No Past User?: _Yes _No %Pain relief? ___ Side effects?_____
_NO _YES: Oxycodone/apap (Percocet): Current user?: _Yes _No Past User?: _Yes _No %Pain relief? ___ Side effects?_____
_NO _YES: Morphine IR pills: Current user?: _Yes _No Past User?: _Yes _No %Pain relief? ___ Side effects?_____
_NO _YES: Morphine ER pills: Current user?: _Yes _No Past User?: _Yes _No %Pain relief? ___ Side effects?_____
_NO _YES: Oxycodone IR: Current user?: _Yes _No Past User?: _Yes _No %Pain relief? ___ Side effects?_____
_NO _YES: Oxycodone ER (Oxycontin): Current user?: _Yes _No Past User?: _Yes _No %Pain relief? ___ Side effects?_____
_NO _YES: Hydromorphone IR(Dilaudid): Current user?: _Yes _No Past User?: _Yes _No %Pain relief? ___ Side effects?_____
_NO _YES: HydromorphoneER (Dilaudid): Current user?: _Yes _No Past User?: _Yes _No %Pain relief? ___ Side effects?_____
_NO _YES: Oxymorphone IR (Opana): Current user?: _Yes _No Past User?: _Yes _No %Pain relief? ___ Side effects?_____

_NO _YES: Oxymorphone ER (Opana): Current user?: _Yes _No Past User?: _Yes _No %Pain relief? ___ Side effects?_____
_NO _YES: Fentanyl Patch: Current user?: _Yes _No Past User?: _Yes _No %Pain relief? ___ Side effects?_____
_NO _YES: Methadone: Current user?: _Yes _No Past User?: _Yes _No %Pain relief? ___ Side effects?_____
_NO _YES: Suboxone/Subutex: Current user?: _Yes _No Past User?: _Yes _No %Pain relief? ___ Side effects?_____
_NO _YES: Other Narcotics:_____ Current user?: _Yes _No Past User?: _Yes _No %Pain relief? ___ Side effects?_____

_NO _YES: Trigger Point Injection: Current user?: _Yes _No Past User?: _Yes _No %Pain relief? ___ Side effects?_____
_NO _YES: Joint Injection: Current user?: _Yes _No Past User?: _Yes _No %Pain relief? ___ Side effects?_____
_NO _YES: Epidural Injection: Current user?: _Yes _No Past User?: _Yes _No %Pain relief? ___ Side effects?_____
_NO _YES: Facet injection: Current user?: _Yes _No Past User?: _Yes _No %Pain relief? ___ Side effects?_____
_NO _YES: Rhizotomy ("Nerve Burning): Current user?: _Yes _No Past User?: _Yes _No %Pain relief? ___ Side effects?_____
_NO _YES: Spinal Cord Stim/Pump: Current user?: _Yes _No Past User?: _Yes _No %Pain relief? ___ Side effects?_____
_NO _YES: Other Blocks:_____ Current user?: _Yes _No Past User?: _Yes _No %Pain relief? ___ Side effects?_____

16. Activity: Does pain medication or current treatment help you with the following activities?

_Yes _No: My sitting tolerance is improved because of my pain treatment.
_Yes _No: My standing tolerance is improved because of my pain treatment.
_Yes _No: My walking ability has improved because of my pain treatment.
_Yes _No: My lifting ability is improved because of my pain treatment.
_Yes _No: My overhead work ability is improved because of my pain treatment.
_Yes _No: My ability to perform Activities of Daily Living is improved because of my pain treatment.
_Yes _No: I am able to continue to work because of my pain treatment.
_Yes _No: I am able to exercise because of my pain treatment.
_Yes _No: I am able to enjoy my hobbies because of my pain treatment.
_Yes _No: I am able to sleep better because of my pain treatment

17. Employment: _Unemployed _Retired _Homemaker _Disability benefits _Working as_____

18. Education Level: _High School _2yr. College _4 yr. college _Masters _Doctorate/Ph.D

19. Tobacco: _Never Smoker _Former Smoker _Current Smoker _Chews

20. Alcohol : _Never Drinker _Former Drinker _Current Drinker _Drinks per week:_____

21. Marital Status: _Single __Divorced __Separated __Widowed __Married

22. Allergies: _NONE (NKDA), Yes:_____

23. ROS (Symptoms): Have you had any of these in the last 30 days? _NONE

_ Anxiety
_ Depression
_ Insomnia
_Suicidal Thought

_Constipation
_Diarrhea
_Tarry Stool
_Nausea/Vomit
_Heartburn

_ Difficulty Breathing
_ Persistent cough
_ Sleep Apnea

_Sweating a lot
_General Achiness
_Goose flesh skin
_Cold/Heat intolerance
_Craving
_Runny Nose/Teary Eyes

_Frequent Falls
_Slurred Speech
_Sedation
_Tremors

_Hearing Loss
_Yellow Eyes
_Vision changes
_Dry Mouth

_Easy bruising
_On Blood thinner
_Enlarged Lymph Node

_Hair loss
_Yellow skin
_Nail changes

_Wt Loss
_Fatigue

_Leg Swelling
_Fast Heart Rate

24. Medication List: _NONE, I do not take any.

Your **Pharmacy Name:_____**

Medication	Dosage	Per day	Medication	Dosage	Per day
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

25. Medical Conditions you have had: **__NONE**

_ADD
_Anxiety
_Arthritis
_Asthma
_Bipolar
_Cancer
_Chronic Fatigue
_COPD

_Cirrhosis
_Depression
_Diabetes
_DVT
_Fibromyalgia
_GERD
_Glucoma
_GOUT

_Heart Attack
_Heart Disease
_High BP
_High Cholesterol
_Hepatitis
_HIV
_IBS
_Kidney Disease

_Migraine
_Osteoprosis
_PVD
_Sleep Apnea
_Seizure Disorder
_Stroke
_Hypothyroid
_Other:_____

26. Surgical Operations you have had: **__NONE**

_Neck
_Back
_Shoulder
_Elbow

_Wrist (Carpal Tunnel)
_Hip
_Knee
_Ankle

_Appendectomy
_Breast
_Heart bypass surgery
_C Section

_Gallbladder
_Hernia
_Hysterectomy
_Other:_____

27. Family History: __NONE

_Arthritis
_Asthma
_Cancer
_Chronic Pain

_Dementia
_Depression
_Diabetes
_Heart Disease

_High BP
_High Cholesterol
_Kidney Disease
_Liver diseases

_Osteoporosis
_Stroke
_Obesity

Signature: _____

Office use only:

28. MA please complete ORT___ DSM5___ COMM___ PDQ___ PHQ9___ AUDIT__ QuickDash__ LL____

29. MA please complete BP:_____/____ P: ____ RR: _____ WT:_____ Ht: _____

Provider:
Diagnostics Reviewed: _UDS _PDMP _Imaging _EKG/ QTC: _Records

Presentation: General**:** _Well groomed, clean, casually dressed, ambulating on own power. _Cognition: Oriented to time place, person. _Memory is intact. _Attention/Concentration: appear normal. _Behavior: Cooperative, calm, with normal eye contact. _Speech: Normal rate, and rhythm. _Mood/Affect: normal mood with congruent affect and appropriately reactive. _Thought process: Linear and goal oriented. _Insight/Judgment: good insight and intact judgment. _Fund of knowledge: _average _above average intellect and knowledge.

Cervical and Thoracic Spine:
INSPECTION: _No atrophy _No deformity _Loss of lordosis _Scoliosis/deformity _Guarded movement _Surgical scar c/w history
ROM: _Full _Mild reduction _ Moderate reduction _Severe reduction _Causes pain: _Extension _Flexion
PALPATION: _Non tender , _No spasm, _Tender Facet : _R _ L, _Tender Occiput : _R _L, Paraspinal spasm: _R _L _Trigger points: _R _L
PROVOCATION :_Spurling's: _Negative OR _R _L

Lumbar/Sacral Spine:
INSPECTION: _No atrophy _No deformity _Loss of lordosis _Scoliosis/deformity _Surgical scar consist with medical history
ROM: _Full _Mild reduction _Moderate reduction _Severe reduction _Causes pain: _Extension _Flexion
PALPATION: _Non tender _No spasm _Tender Facet : _R _ L, _SI Tenderness: _R _ L _Sciatic notch tenderness: _R _L _Trigger points: _R _L _Paraspinal spasm: _R _L _Piriformis Spasm : _R _L
PROVOCATION: _SLR: _ R _L _SI: Comp: _R _L _Distraction: _R _L _FABER: _R _L _Gaenslen's: _R _ L _Thigh Thrust _R _L

Motor: _5/5 bilateral upper extremities _5/5 bilateral lower extremities.
Sensation: _Normal pinwheel sensation bilaterally along the _Cervical _Lumbar/sacral dermatomes.
Rreflexes: _2+ biceps _2+ brachioradialis _2+ triceps _2+ patellar _2+ Achilles

Shoulder Right: INSPECTION: _No atrophy _No deformity _Surgical scar consistent with surgery
ROM: _Full _Mild limited ROM _Moderate limited ROM _Severe limited ROM
PALPATION: _Non tender _No instability _Tender: _Biceps groove _ A/C Joint _SAB _GHJ _Trigger points

Shoulder Left: INSPECTION: _No atrophy _No deformity _Surgical scar consistent with surgery
ROM: _Full _Mild limited ROM _Moderate limited ROM _Severe limited ROM
PALPATION: _Non tender _No instability _Tender: _Biceps groove _ A/C Joint _SAB _GHJ _Trigger points

Elbow Right: INSPECTION: _No atrophy _No deformity _Surgical scar consistent with surgery
ROM: _Full _Mild limited ROM _Moderate limited ROM _Severe limited ROM
PALPATION: _non tender _Tender _Medial _Lateral

Elbow Left: INSPECTION: _No atrophy _No deformity _Surgical scar consistent with surgery
ROM: _Full _Mild limited ROM _Moderate limited ROM _Severe limited ROM
PALPATION: _non tender _Tender _Medial _Lateral

Wrist Right: INSPECTION: _No atrophy _No deformity _Surgical scar consistent with surgery
ROM: _Full _Mild limited ROM _Moderate limited ROM _Severe limited ROM
PALPATION: _non tender Tinnels +: _R _L

Wrist Left: INSPECTION: _No atrophy _No deformity _Surgical scar consistent with surgery
ROM: _Full _Mild limited ROM _Moderate limited ROM _Severe limited ROM
PALPATION: _non tender Tinnels +: _R _L

HIP Right: INSPECTION: _No atrophy _No deformity _Surgical scar consistent with surgery
ROM: _Full _Mild limited ROM _Moderate limited ROM _Severe limited ROM
PALPATION: _non tender Tender: _ Trochanteric _Anterior hip

HIP Left: INSPECTION: _No atrophy _No deformity _Surgical scar consistent with surgery
ROM: _Full _Mild limited ROM _Moderate limited ROM _Severe limited ROM
PALPATION: _non tender Tender: _ Trochanteric _Anterior hip

Knee Right: INSPECTION: _No atrophy _No deformity _Surgical scar consistent with surgery
ROM: _Full _Mild limited ROM _Moderate limited ROM _Severe limited ROM
PALPATION: _Nontender _Tenderness _Crepitation _Heat

Knee Left: INSPECTION: _No atrophy _No deformity _Surgical scar consistent with surgery
ROM: _Full _Mild limited ROM _Moderate limited ROM _Severe limited ROM
PALPATION: _Nontender _Tenderness _Crepitation _Heat
Ankle Right: INSPECTION: _No atrophy _No deformity _Surgical scar consistent with surgery
ROM: _Full _Mild limited ROM _Moderate limited ROM _Severe limited ROM
PALPATION: _non tender
Ankle Left: INSPECTION: _No atrophy _No deformity _Surgical scar consistent with surgery
ROM: _Full _Mild limited ROM _Moderate limited ROM _Severe limited ROM
PALPATION: _non tender

HEENT: normocephalic, atraumatic, sclera is anicteric.
LYMPHATICS: no lymphadenopathy.
RESPIRATORY: clear to auscultation, equal breath sounds, no wheezes.
CARDIAC: regular rate & rhythm.
ABDOMEN: soft and non-tender, no rebound or guarding.
SKIN: no hyperalgesia and/or allodynia, no temperature asymmetry or skin color changes, no edema, and/or sweating asymmetry, no skin/nail trophic changes and/or motor dysfunction (weakness, tremor, dystonia) and/or decreased ROM.

Assessment:

Primary Diagnosis: __Chronic Pain __Long Term Opioid Therapy __Opioid UD

Comorbid Diagnosis: __Depression _Anxiety __Tobacco Use __Alcohol Use__Obesity __OIC __OUD, history of

Medical/Surgical/Radiological Diagnosis:
_DDD: _C _L Spondylosis: _C _LS _Post Laminectomy _S/P(__surgery) _FM _Osteo _ RA _CRPS _Other

Differential Diagnosis includes: (for the Primary Diagnosis):
_LBP _Sciatica Suspect: _SI dysfunction _GTB _Piriformis Syndrome _Facet disease _Disc disease _TP
_Cervicalgia Suspect: _Facet Disease _Disc Disease _TP
_Thoracicalgia Suspect: _Facet Disease _Disc Disease _TP
_Shoulder pain: Suspect: _AC Arthritis _Bicipital Tendinitis _SAB _GHJ Arth _TPI
_Elbow pain: Suspect: _Medial _lateral _Epicondylitis
_Wris/hand pain: Suspect: _CTS
_Hip pain: Suspect: _Hip Arthropathy _GTB
_Knee pain: Suspect: _Knee Arthropathy
_Ankl/ Foot pain Suspect: _Ankle Arthropathy _Plantar Fasciitis

Plan/ Objectives:
Objectives for Pain Management: Improving quality of life and function using the following measures.

Comorbid Diagnosis treatment:
Discussed Anx/Dep/Pain: _Tobacco/Alcohol cessation _Wt reduction _Family Participation
Used CBT to train behavior. Used MET to implement change in behavior.
RX: Anti depressant: Start _Continue Anti Anxiety Start _Continue

Primary Diagnosis treatment:
_Rec Home Exercise _Pt to Evaluate and treat

_LSO: _Rec _Given _Continue _Needs PA _Not Covered _Has tried, not helpful

_C traction _Rec _Given _Continue _Needs PA _Not Covered _Has tried, not helpful

_TENS _Rec _Given _Continue _Needs PA _Not Covered _Has tried, not helpful

_Knee Brace _Rec _Given _Continue _Needs PA _Not Covered _Has tried, not helpful

_Topical : _NSAIDS _Compound somatic _Compound Neuropathic _Education

_NSAIDS: _Start _Continue _Stop _Education/ Side effects: GI, Cardiac, Renal, Anti-coagulant

_MSK Relaxants: _Baclofen _Cyclobenzaprine _Tizanadine _Start _Continue _Stop _Education: Sedation, Anticholinergic, CV effect

_Adjunct: _Gabapentin _Pregabalin _Duloxetin _Start _Continue _Stop _Education / side effects

_Opioids: _Taper _Continue _Start _Stop _Rotation (Suboxone) _Education/Side effects _Drug-drug Interaction _Med Agmt

_Opioids: _ Naloxone: _Recommended _Evzio/SC/Nasal discussed _Education to patient _Education to family/caregiver

_Opioids: _Constipation RX: _LOC _Movantik

Differential diagnosis treatment (IPM)
_IPM Options discussed: _Not candidate or interested. _Referred for evaluation

_SI _GTB _Piriformis _TPI _AC _GHJ _Bicipital _SAB _GHJ _Elbow _CT/Wrist _Hip _Knee _Ankle _Plantar Fascia _TPI _CFB _ CESI _LFB _Caudal ESI _TLLESI _TFLESI _Rhizotomy(Needs Diagnostics: Facet: X ray, MRI, ESI: MRI, Rhizotomy: Past hx of)

Plan for Aberrant Behavior:
_Medication agreement discussed _Frequent visits _UDS/UDT _Pill Count _PDMP _Pain to OUD Reclassification _Informed Consent was obtained.

MRI Orders, Lab Orders, Other others
_MRI _Blood work _SPECT _PT _EKG _EMG/NCV _Obtain Records::_____

_FU Date:_____

Provider:_____

Name:_____ Date:_____

Medication Agreement

The purpose of this agreement is to give you information about the medications you will be taking for your condition and to assure that you and your provider comply with all state and federal regulations concerning the prescribing of controlled substances. The provider's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the Provider(provider)/patient relationship and full agreement and understanding of the risks and benefits of using opioids to treat your pain related conditions.

1. You should use only use **Pain Care Centers** to prescribe and monitor all opioid medications and adjunctive analgesics. The providers may allow you to receive certain medication by other providers when notified.
2. You should use one pharmacy to obtain all opioid prescriptions and adjunctive analgesics prescribed by your Provider. An exception to this is allowed when your regular pharmacy does not carry the medication or the medication can be obtained cheaper at another pharmacy.
3. You should inform your Provider of all medications you are taking, including herbal remedies, since opioid medications can interact with over-the-counter medications and ALL other prescribed medications.
4. You will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment.
5. Prescriptions for pain medicine or any other prescriptions will be done only during an office visit or during regular office hours or as authorized by your provider.
6. You agree to bring in controlled medication being taken when asked to do so and be prepared to submit to urine drug testing.
7. You are responsible for keeping your medication in a safe and secure place, such as a locked cabinet or safe. You are expected to protect your medications from loss or theft. Stolen medications should be reported to the police and a case number obtained. You need this to get a replacement medication. However, we may choose to not to replace the medications or to taper and discontinue the medications.
8. You may not give or sell your medications to any other person under any circumstances. If you do, you may endanger that person's life and it could be a violation of the law.
9. Any evidence of drug hoarding, acquisition of any opioid medication or adjunctive analgesia from other providers (includes emergency room providers), uncontrolled dose escalation or reduction, loss of prescriptions, or failure to follow the agreement may result in termination of the doctor/patient relationship.
10. You agree to report any concern or complaint about your treatment when you come in for a visit. You agree to report, fully and truthfully, your pain level and functional activity along with any side effects of the medications at each office visit on the forms provided to you.
11. You should not use any illicit substances, such as cocaine, marijuana, etc. while taking these medications. If you do, it may result in a change to your treatment plan, including discontinuation of your opioid medications when applicable or complete termination from the practice.
12. The use of alcohol and opioid medications is contraindicated. The mixture can be lethal.
13. There are side effects with opioid therapy, which may include, but not exclusively, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, impaired breathing, impaired cognitive (mental status) and/or motor ability, and immunosuppression.
14. Physical dependence and/or tolerance can occur with the use of opioid medications.

Physical dependence means that if the opioid medication is abruptly stopped or not taken as directed, a withdrawal symptom can occur. This is a normal physiological response. The withdrawal syndrome could include, but not exclusively, sweating, nervousness, abdominal cramps, diarrhea, goose bumps, and alterations in one's mood. It should be noted that physical dependence does not equal addiction. One can be dependent on insulin to treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to the insulin or prednisone. Addiction is a primary, chronic neurobiologic disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases one's quality of life. Tolerance means a state of adaptation in which exposure to the drug induces changes that result in diminution of one or more of the drug's effects over time.

15. If you have a history of alcohol or drug misuse/addiction, you must notify us of such history since the treatment with opioids for pain may increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one for opioid treatment of pain, but starting or continuing a program for recovery is a must.
16. At any time during or after your treatment at this office, you agree to allow us to contact any health care professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about your care or actions *if we feel it is necessary for your safety or the safety of public.* You agree to a family conference or a conference with a close friend or significant other *if we feel it is necessary for your treatment, safety or the safety of public.*

Signature:_____

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may us or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers’ Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy note; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your

care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.
You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e., electronically).
You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.
Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**
We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.
Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

HIPAA Privacy Rule of Patient Authorization Agreement Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my health care, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.
I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement
Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))
I understand that:

- I have the right to review this Practice's Notice of Information practices prior to signing this consent;
- That this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;

- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested
- ;I may revoke this consent in writing at any time, except to the extent that this Practice has already taken action in reliance thereon.

Consent to Treat

I hereby give my permission for **Pain Care Center** to give me medical treatment.
I allow the Practice to file for insurance benefits to pay for the care I receive.
I understand that:

- the Practice will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my provider.

Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.
The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.
It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.
Also over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.
I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

By signing this consent form:

1) You acknowledge the **receipt of TWO HIPPA notices.**
2) You are giving your healthcare provider **permission to collect and share your** pharmacy and your health insurer **information about your prescriptions** that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.
3) You give **consent to obtain your medication history.**
4) You give you **consent to treat.**

Signature:_____