PMA

Pain Management Association, PC G. David Bojrab, M.D.

Enclosed is a map of the Dupont Hospital complex along with necessary paperwork for you to complete **prior** to your appointment. Please be advised that we require 24 hours notice should you need to cancel your appointment. Failure to provide notice will result in a $50 fee charged to your account. Failure to provide notice to cancel a procedure will result in a $100 fee charged to your account.

PLEASE BE SURE TO BRING THE FOLLOWING TO YOUR APPOINTMENT

☐ Completed paperwork: Please double check to ensure **all areas are completed, dated and signed!** We do not have access to other hospital's or office's records (or pharmacy) so if you do not list it/bring it, we may not have it. If you have seen other pain doctors, please bring those records as well (especially prior injections). Failure to have completed information will result in delays at your appointment time.

☐ All patients are required to submit a valid photo identification issued by a local, state or federal agency (example: driver's license, passport, military ID, etc.). If the patient is a minor, the photo ID of the responsible party will be required. If the patient does not have a photo ID, two forms of non-photo ID (one of which must be issued by a state or federal agency) will be required (example: birth certificate, social security card, voter registration card, lawful permanent residence card or "green card", etc.).

☐ Most recent/valid insurance card (s), which we will scan into our system.

Self-Pay Patients: You will be required to pay $240.00 upon check in. We accept cash, debit or credit card or money orders; no personal checks please.

If you have any questions, please contact our office: (260) 490-2525 or toll free 866-477-7246 prior to your appointment.

Sincerely,
Pain Management Associates Scheduling Staff

ATTENTION PATIENTS

Due to heavy call volume, we have implemented the following policies to better serve you:

Appointments

We do not accept walk-in appointments! If you cannot keep your scheduled appointment, please call our office at least 24 hours in advance to cancel or reschedule. Failure to do so will result in a $50 fee being assessed to your account. Appointments scheduled at the surgery center will be assessed a $100 fee if 24 hours notice is not given.

Phone Nurse Calls

Expect to be put to voicemail. We apologize for this inconvenience and will return your call as soon as possible. Some medical situations require consulting with the doctor prior to returning the call so please be patient and **do not leave multiple messages**. Leave your name and date of birth so the nurse can access your chart quickly and clearly state your reason for calling. Any calls received after 4pm may not be returned until the next business day.

Prescription Refills

Please call our office 7 business days in advance for prescription refill requests. Do not wait until you are out of medication before requesting a refill as prescriptions cannot be ordered when Dr. Bojrab is out of the office. (Please keep in mind that Dr. Bojrab is not in the office on Fridays so plan accordingly.) **We do not accept same day or walk-in requests for refills**. If you have multiple prescriptions that need refilled, please state each medication in one message rather than making multiple calls. If you are checking to see if we have refilled a prescription you recently called in, please check with your pharmacy first to see if they have processed the order before calling our office. Pharmacies will not automatically refill a prescription that has refills on it unless a call is made by the patient requesting it.

We now send out mass texts notifying patients of upcoming office closures and we also update this information on our website at **www.painmanagementfw.com**.

X-Ray / Test results

All diagnostic imaging, labs and psychological exams ordered by Dr. Bojrab will be reviewed with the patient at the follow up office visit. These results will not be given over the phone by the office staff. If there is a significant finding, the patient will be contacted by Dr. Bojrab or his nurse for further instruction.

Again, these policies are being implemented to better serve you.

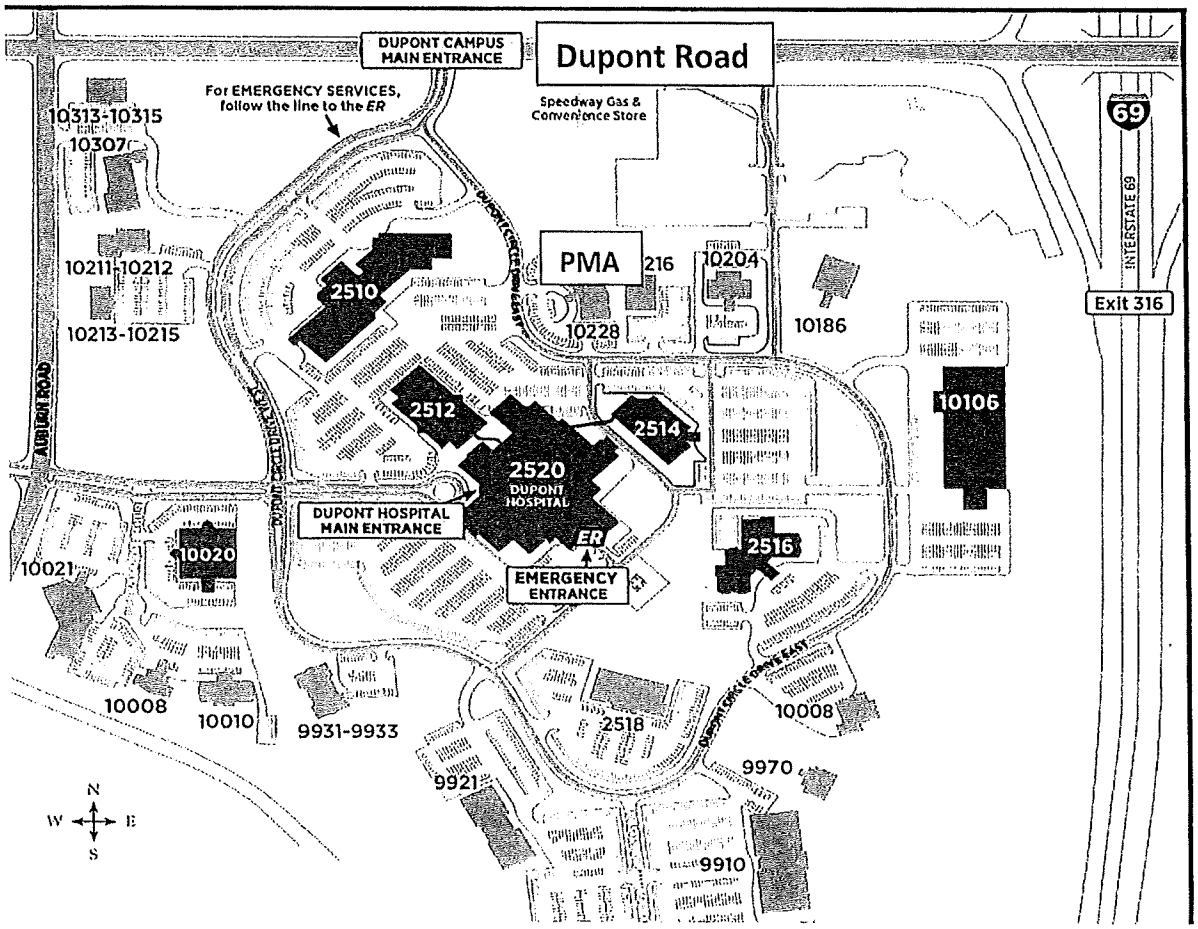
Thank you for your understanding.

From south of Fort Wayne: Take US 27 to I-469. Take I-469 to Auburn Road, exit 31C. At the stop sign, turn right. Dupont Hospital complex is located at the next right turn. Inside the complex, at the first stop sign turn left onto Dupont Circle Drive West. Follow this road until you come to Dupont Circle Drive East then turn right. Pain Management Associates (PMA) is the first building on the left.

From north of Fort Wayne: Take I-69 south to exit 316 / Dupont Road. Make a right onto Dupont Rd. Follow it to the first stoplight and turn left into the Dupont Hospital complex. Take the first left (lake is on your left) and PMA is the first building on the left.

From east of Fort Wayne: Take US 24 to I-469. Head north on I-469 to Auburn Road, exit 31C. At the stop sign, turn right. Dupont Hospital complex is located at the next right turn. Inside the complex, at the first stop sign, turn left onto Dupont Circle Drive West. Follow this road until you come to Dupont Circle Drive East then turn right. Pain Management Associates (PMA) is the first building on the left.

From west of Fort Wayne: Take US 24 to I-69. Head north on I-69. Take I-69 to the Dupont Road exit 316. Turn left at the light onto Dupont Road. Turn left at the next light into the Dupont Hospital complex. Take the first left (lake is on your left) and PMA is the first building on the left.



PMA

Pain Management Association, PC G. David Bojrab, M.D.

DEMOGRAPHICS

Answers to the following questions are used in participation with the Federal Compliance Initiative

PLEASE PRINT Date: _____

Date of Birth: _____ SS#: _____ Sex: ☐ Male ☐ Female

Patient Name: _____
Last First Middle

Home Address: _____
Street City, State Zip

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

Referring Physician: _____
Last Name First Name City, State Specialty

Family Physician: _____
Last Name First Name City, State

Patient Employed By: _____
City, State

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic ☐ White ☐ Other ☐ Native Hawaiian or Pacific Islander

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Emergency Contact: _____ Phone: _____

Relationship to Patient: _____

PATIENT INSURANCE INFORMATION

We may need to scan your insurance card for every visit

Spouse/Parent Name: _____ SSN: _____

Spouse/Parent Date of Birth: _____ Work Phone: _____

Spouse/Parent Employer: _____

Employer Address: _____
Street City, State Zip

Is this a Workman's Compensation Claim? ☐ Yes ☐ No Date of Injury: _____

Company Name: _____ Phone: _____

Contact Person: _____ Case Number: _____

PMA

Pain Management Association, PC G. David Bojrab, M.D.

DEMOGRAPHICS

Answers to the following questions are used in participation with the Federal Compliance Initiative

Primary Insurance_____ Phone_____

Address_____
Street City, State Zip

Policy Holder _____ Effective Dates_____

Contract Number_____ Group Number_____

Secondary Insurance_____

Address_____
Street City, State Zip

Policy Holder _____ Effective Dates_____

Contract Number_____ Group Number_____

Is this a Motor Vehicle Accident: ☐ Yes ☐ No Date of Injury_____

Auto Insurance Company_____ Phone_____

Agent Name_____ Claim Number_____

RELEASE OF INFORMATION / AUTHORIZATION TO PAY INSURANCE BENEFITS

I hereby authorize and direct my insurance carrier to pay Pain Management Associates any benefits due me under my insurance plan. I hereby give Pain Management Associates my permission to speak and discuss, fax, email or mail a copy of my report to my referring physician, family physician, insurance carrier and/or counseling physician or myself upon request. I also authorize the release of medical information to any insurance company.

Patient / Responsible Party_____ Date_____

AGREEMENT TO PAY

I agree to pay my physician all charges for services rendered. I understand that the charges made by my physician may be in excess of that allowed by my insurance company, if any, and I agree to be responsible for all un-reimbursed expenses not covered by insurance. I further understand that my agreement with my insurance company is independent of my agreement with my physician and agree to be responsible for all charges for services rendered. I FURTHER AGREE THAT IN THE EVENT ANY CHARGES MADE BY MY PHYSICIAN ARE NOT PAID, AND THE MATTER IS REFERED TO ANY ATTORNEY FOR COLLECTION, I AGREE TO BE RESPONSIBLE FOR ALL COSTS FOR COLLECTIONS, INCLUDING REASONABLE ATTORNEY FEES.

Signature_____ Date_____

PMA

Pain Management Association, PC G. David Bojrab, M.D.

AUTO ACCIDENT & WORK COMP POLICY INFORMATION FORM

Please fill out if treatment is auto accident or work related

Policy Holder: _____

Claim #: _____

Send Claims to: _____

_____

Insurance Phone: _____

Claims Adjuster: _____

Date of Accident: _____

IMPORTANT INFORMATION!!!

Pain Management Associates does not file claim reimbursement for an auto accident claim settlement. If the auto insurance has not accepted liability, or if the medical payment portion of the policy has been reached, the balance is the patient's responsibility. This balance will be due 30 days from the date service was provided. If the above needed information is not supplied, the account will be registered as SELF PAY and the charges will be the patient's financial responsibility. Pain Management Associates does not except liens.

If your health insurance requires a PCP referral / authorization or has a timely filing limit, it will be the patient's responsibility to ensure that the referral / authorization is received prior to services being performed. If claims have exceeded the policy's timely filing limit before you request they be filed to health insurance, the claims will be the patient's financial responsibility.

If the patient disputes financial responsibility, they will also be responsible for any legal or collection fees incurred.

I have read and understand the above:

Signature: _____ Date: _____

Pain Management Associates, PC

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relate to your past, present or future physical or mental health condition and related healthcare services.

Our practice is legally required to maintain the confidentiality of your PHI, and to follow specific rules when using or disclosing this information. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules when using or disclosing your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under the Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required by law to follow the terms of this Notice. We reserve the right to change the terms of the Notice, and to make the new Notice provisions effective for all PHI that we maintain. We will provide you with a copy of our current Notice if you call our office and request that a copy be sent to you in the mail, or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location in the practice, and if such is maintained, on the practice's web site.

You have the right to authorize other uses and disclosures - This means we will only use or disclose your PHI as described in this notice, unless you authorize other uses or disclosures in writing. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, fax, telephone), and/or to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and obtain a copy of your PHI* - This means you may submit a written request to inspect or obtain a copy of your complete health record, or to direct us to disclose your PHI to a third party. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable, cost-based fee for paper or electronic copies as established by federal guidelines. We are required to provide you with access to your records within 30 days of your written request unless an extension is necessary. In such cases, we will notify you of the reason for the delay, and the expected date when the request will be fulfilled.

You have the right to request a restriction on your PHI* - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You have the right to request an amendment to your protected health information* - This means you may submit a written request to amend your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability* - You may submit a written request for a listing of disclosures we have made of your PHI to entities or persons outside of our practice except for those made upon your request, or for purposes of treatment, payment or healthcare operations. We will not charge a fee for the first accounting provided in a 12-month period.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI and determines through a risk assessment that notification is required.

How We May Use or Disclose Protected Health Information

The following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services, we recommend for you such as making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests, to provide information that describes or recommends treatment alternatives regarding your care, or to provide information about health-related benefits and services offered by our office.

We may contact you regarding fundraising activities, but you will have the right to opt out of receiving further fundraising communications. Each fundraising notice will include instructions for opting out.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of PHI (e.g., in a disaster relief situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization, or providing you an opportunity to object, for the following purposes: if required by state or federal law; for public health activities and safety issues (e.g. a product recall); for health oversight activities; in cases of abuse, neglect, or domestic violence; to avert a serious threat to health or safety; for research purposes; in response to a court or administrative order, and subpoenas that meet certain requirements; to a coroner, medical examiner or funeral director; to respond to organ and tissue donation requests; to address worker's compensation, law enforcement and certain other government requests, and for specialized government functions (e.g., military, national security, etc); with respect to a group health plan, to disclose information to the health plan sponsor for plan administration; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Prohibited Uses/Disclosures - substance use disorder treatment records received from part 2 programs, or testimony relaying the contents of such records, will not be used or disclosed in any criminal investigation, to initiate or substantiate criminal charges, or in civil, criminal, administrative or legislative proceedings against you without you're authorization or a court order with accompanying subpoena or similar legal mandate compelling disclosure.
PHI that is potentially related to reproductive health care is prohibited from being disclosed for purposes of investigating or imposing liability on any person for the mere act of seeking, obtaining, facilitating, or providing lawful reproductive health care.

Attestation - Any person requesting disclosure of PHI potentially related to reproductive health care for purposes of health oversight, law enforcement, judicial or administrative proceedings, or about decedents to coroners or medical examiners will be required to submit an attestation signifying that the PHI will not be used for prohibited purposes (see above section).

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

You may ask questions about your privacy rights, file a complaint or submit a written request (for access, restriction, or amendment of your PHI or to obtain a disclosure accountability) by notifying our Privacy Manager at: 260-490-2525

Form 7.20

PMA

Pain Management Association, PC

G. David Bojrab, M.D.

RECEIPT OF PRIVACY ACKNOWLEDGEMENT (HIPPA)

PURPOSE: *This form is to confirm that an individual has received Pain Management Associates notice of Privacy Practices.*

I, _____. acknowledge that I have received Pain Management Associates Notice of Privacy Practices and have had the opportunity to read the contents of this Notice of Privacy Practices.

Signature_____ Date_____

If this authorization is signed by a personal representative on behalf of the individual, please complete the following:

Personal Representative's Name_____

Relation to the Patient_____

On the lines provided, please lest all individuals identified by the patient for the disclosure of medical and billing information regarding your care (spouse, children, etc...)

_____

_____

_____

_____

PMA

Pain Management Association, PC

G. David Bojrab, M.D.

FINANCIAL POLICY

Thank you for choosing PMA for your healthcare needs. It is our pleasure to provide you with the highest quality in medical care. To ensure a positive experience for everyone, please refer to the guidelines listed below to make certain that not only will your medical experience be positive but your financial experience as well.

Patients with Insurance: Our office will submit your claim to your insurance company based upon the insurance information that you provide to us. However, the responsibility for payment of services rendered rests directly with you. If payment is not received from your insurance carrier within sixty (60) days of billing, it will be your responsibility to contact your insurance company. If there is still no payment within ninety (90) days, you will be asked to make payment in full. **It is your responsibility to understand your insurance policy and benefits, and to know what services are covered and which are not, and which services require prior authorization.**

Any changes in insurance coverage need to be conveyed prior to your appointment. If your insurance is no longer in effect or does not cover the services provided, payment is your responsibility including deductibles, co-insurance, and non-covered services. Payment is due upon receipt of our statement. If at any time we discover that there has been a change in insurance coverage and you did not notify the office in a timely manner, we reserve the right to require payment of your outstanding balance within thirty (30) days.

RELEASE OF INFORMATION / AUTHORIZATION TO PAY INSURANCE BENEFITS

I hereby authorize and direct my insurance carrier to pay directly to Pain Management Associates any benefits due me under my insurance plan. I hereby give Pain Management Associates my permission to speak and discuss, fax, email or mail a copy of my report to my referring physician, family physician, insurance carrier and/or counseling physician or myself upon request. I also authorize release of medical information to any insurance company.

Self-Pay Patients: If you do not have insurance, your insurance has been terminated, or the services provided by our office are not covered by your insurance, then you are fully responsible for the cost of your care. Payment is required at the time of service. If you have questions regarding the cost, a billing representative will be happy to talk with you.

Medicaid Patients: We must have a copy of your current Medicaid card. We must also have a referral and/or authorization on file for services rendered when required by your Medicaid plan. If you are applying for Medicaid, or have applied and approval is pending, you will be responsible for all charges as outlined in the Self-Pay policy. At the time that you receive your Medicaid approval, any dollars you have paid to Pain Management Associates that are approved and paid by Medicaid will be refunded to you.

Payment Options: We accept cash, money orders, checks and credit cards. (A $25.00 fee is charged on all returned checks.) If you are unable to meet the requirements of this financial policy, we ask that you contact our Billing Department to set up a payment plan that is acceptable to both this office and to you, the patient. In the event that your account would be referred to an attorney or a collection agency, you will be responsible for all costs incurred, in addition to the balance owed. By signing below, I confirm that I have read and understand Pain Management Associate's Financial Policy.

Signature_____ Date_____

PMA

Pain Management Association, PC G. David Bojrab, M.D.

MEDICATION MANAGEMENT AND TREATMENT AGREEMENT

Patient Name_____

Dr. G. David Bojrab is willing to prescribe treatment with pain medication if other reasonable treatments have been ineffective and you agree to the following conditions:

1. I do not have current problems with substance and or alcohol abuse or dependence (addiction).
2. I am not currently involved in the sale, diversion, illegal possession, or transport of controlled substances, which include opioids ("narcotics"), sleeping pills, anxiety ("nerve") pills, and/or painkillers.
3. I will only obtain pain medication prescriptions from **Dr. G. David Bojrab** and use only the _____ pharmacy located at (address)_____ _____. Under any circumstance, if I am prescribed opioids ("narcotics"), sleeping pills, anxiety ("nerve") pills, or any other addictive medications from another physician, hospital, dentist or in-patient facility, **it will be my responsibility to contact Dr. G. David Bojrab's office to inform them of the medication prescribed and quantity given.**
4. I will take pain medications **exactly as prescribed.** I will not increase or decrease my pain medications without first consulting the office of Dr. G. David Bojrab. I also understand that prescriptions will not be filled early.
5. Under no circumstances will I allow any other individual to take my medications nor will I take any medications that are not prescribed to me (this is considered a felony under law).
6. I will actively participate in additional pain theraples as requested by Dr. G. David Bojrab, such as physical therapy, injections, or psychological counseling. I will follow the advice of my healthcare providers in regards to stopping controlled substances if it is felt that this may be necessary.
7. I agree to waive any applicable privilege or right of privacy or confidentiality to allow other relevant healthcare providers to communicate with my physician, nurses, and/or pharmacists regarding my use of pain medication. I authorize my provider and pharmacy to cooperate fully with any city, state, or federal law enforcement agency in the investigation of any possible misuse, sale, or other diversion of my pain medication. I also authorize my provider to provide a copy of this agreement to my pharmacy.
8. I will consent to random drug screening (urine or blood), as well as random pill counts, in order to properly assess compliance with prescribed treatment. **Medication will not be prescribed if I refuse testing.**
9. I will not use illegal drugs, including the use of any THC containing substances (CBD products), and/or alcohol while being prescribed narcotic medications from this office.
10. I understand that **NO ALLOWANCE** will be made for lost or stolen prescriptions or medications. It is my responsibility to safeguard my medications. I understand that it may not be replaced until the original refill date is reached.
11. I will request refills by telephone at least 7 business days (Mon-Fri) before my prescription runs out, unless I have made other arrangements in advance. I will not request refills outside of the normal business hours **nor will I receive refills from the on-call physician.**
12. I understand that refills are contingent on routinely scheduled appointments.
13. I will keep (and be on time for) all scheduled appointments. If I do need to cancel and/or reschedule an appointment, I will do so at least **24 hours** in advance.
14. **I understand that this treatment option will be discontinued if any of the following occur:**
    a. If my healthcare providers believe that the medications have not been effective in helping manage my pain.
    b. If medication-related side effects become intolerable
    c. If other, more effective, treatments become available.
    d. If I give away, sell, or misuse the medication.
    e. If I am found to be using illegal substances or alcohol.
    f. If I obtain pain medications from another source without proper consent from this office.
    g. If I fail or refuse a urine/blood drug screen or pill count.
    h. If a prescription written by our office is found to be altered in any way.
    i. If I am disrespectful to staff or disrupt the care of other patients.
    j. If I am unable to manage my pain medication according to this agreement.

I have read this document, understand it, and have had all my questions answered satisfactorily. I consent to the use of pain medications to help control my pain and understand that this treatment will be conducted in accordance with the conditions stated above.

_____

Patient Signature Date

PMA

Pain Management Association, PC Dr. G. David Bojrab, M.D.

(Please fill out in BLACK or BLUE ink only)

Patient Name _____ Date _____

Family Physician _____ Referring Physician _____

Height _____ Weight _____

(To be completed in office) B/P _____ Pulse _____ Resp _____

PRESENT ILLNESS (Please only list pain you were referred to our office for)

Date of Onset _____ Gradual _____ Sudden _____ Auto/Work Injury _____

Location of Pain _____

Does Pain Radiate? YES ☐ NO ☐ If YES, where does pain radiate to? _____

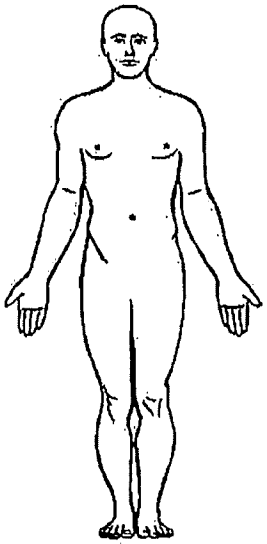
Rate your pain **TODAY** 0 – 10 (zero NO pain / 10 WORST pain) _____ Highest Pain in **LAST 2 WEEKS** _____

DRAW AREAS of PAIN

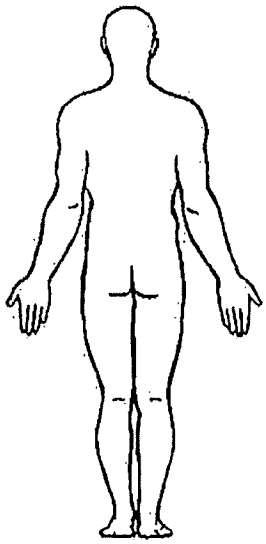
X = Pain Areas

O = Numb Areas

R FRONT L



L BACK R



Quality of Pain:

- ☐ Sharp
- ☐ Dull
- ☐ Aching
- ☐ Tingling
- ☐ Stinging
- ☐ Throbbing
- ☐ Stabbing
- ☐ Shooting
- ☐ Burning

Timing of Pain:

- ☐ Constant
- ☐ Intermittent
- ☐ Worsens as the day goes on

Allergies YES ☐ NO ☐ Please List:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Any allergy to Contrast Dye / Iodine / Shellfish YES ☐ NO ☐ List: _____

Current Medications (If more space is needed, please attach list) ☐ None

Name of Medication	Strength	Times/Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

BLOOD THINNERS:

☐ ASPIRIN 81mg or 325mg

☐ COUMADIN _____mg

☐ PLAVIX _____mg

☐ ELIQUIS _____mg

☐ XARELTO _____mg

☐ FISH OIL/OMEGA 3/COQ10_____mg

☐ OTHER _____mg

PHYSICIAN PRESCRIBING BLOOD THINNER:

_____

_____

Prior Pain Treatment:

Seen pain doctor before? YES ☐ NO ☐ Name_____

Physical Therapy: YES ☐ NO ☐ Where_____ When _____

Home exercise program YES ☐ NO ☐ Given by_____

Chiropractic: YES ☐ NO ☐ Where_____ When _____

Injection Therapy: ☐ Trigger Point ☐ Epidurals ☐ Facet ☐ Medial Branch

☐ Radiofrequency ☐ SI JOINT ☐ Knee / Hip ☐ Synvisc / Gel One ☐ Other_____

Recent imaging studies

Have you had any of the following (Related to your current pain):

MRI YES ☐ NO ☐ Where _____ When_____

CT YES ☐ NO ☐ Name_____ When_____

EMG YES ☐ NO ☐ Name_____ When_____

For insurance purposes, please circle any of these medications you may have tried for your pain:

ANTI-INFLAMMATORIES

☐ Unable to tolerate NSAIDS
Reason_____

Aleve
Arthrotec
Celebrex
Diclofenac (Cataflam, Voltaren)
Duexis
Flector Patch
Ibuprofen
Limbrel
Lodine (Etodolac)
Mobic (Meloxican)
Motrin
Naproxen (Naprosyn)
Pennsaid
Relafen (Nabumetone)
Toradol
Vimovo
Zipsor

SLEEP AIDS

Ambien
Lunesta
Sonata

ANTIDEPRESSANTS / ANXIETY

Cymbalta
Effexor
Elavil (Amitriptyline)
Lexapro
Paxil
Pristiq
Prozac
Savella
Trazodone (Desyrel)
Wellbutrin (Bupropion)
Xanax
Zoloft

MUSCLE RELAXERS

Baclofen
Flexeril
Parafon Forte
Skelaxin
Soma
Zanaflex (Tizanadine)

ANTI-SEIZURE / NERVE

Gralise
Klonopin (Clonazepam)
Lyrica (Pregabalin)
Neurontin (Gabapentin)
Topamax

PAIN MEDICATIONS

Actiq
Avinza
Butrans Patch
Demerol
Dilaudid (Hydromorphone)
Duragesic (Fentanyl)
Embeda
Exalgo
Hydrocodone (Lorcet, Lortab, Norco, Vicodin)
Hysingla
Kadian
Lidoderm Patch
Methadone
Morphine (MsContin, MSIR)
Nucynta
Opana
Oxycodone (Oxycontin, OXY IR, Percocet, Percodan, Roxicet, Roxicodone)
Stadol
Tramadol (Ultracet, Ultram)
Tylox
Tylenol with Codeine (#3, #4)
Xtampza

OTHERS

Nuvigil
Provigil
Ritalin
Oral Steroids / Prednisone

Past Medical History ***Please mark even if controlled by medication***

☐ No major health problems

Heart
☐ Arrhythmias
☐ Heart Disease
☐ Hypertension / High Blood Pressure
☐ Pacemaker (Brand_____)
☐ Defibrillator (Brand_____)

Joints
☐ Osteoarthritis
☐ Rheumatoid Arthritis

Mental Status
☐ Brain Attack / Stroke
☐ Dementia
☐ Depression
☐ Bipolar
☐ Multiple Sclerosis
☐ Parkinson's Disease
☐ Post Polio Syndrome

Cancer
☐ History of cancer
Location: _____
Type: _____

MISC
☐ Fibromyalgia
☐ MRSA

Lungs
☐ Asthma
☐ Difficulty with anesthesia
☐ COPD
☐ Emphysema

Diabetes
☐ Insulin Dependent
☐ Non-insulin Dependent

Blood Disorders
☐ Deep Vein Thrombosis DVT / Blood Clots
☐ Hepatitis (Check one) ☐A ☐B ☐C
☐ Low Platelets
☐ HIV Positive
☐ Lupus

GI / GU
☐ Pancreatitis
☐ Liver Disease
☐ Kidney Disease
☐ GI Bleed
☐ Bowel Obstruction
☐ Stomach Ulcer
☐ Cirrhosis of the Liver
☐ GERD

Past Surgical History

List all previous surgeries (specifying **LEFT** or **RIGHT** if applicable) ☐ No previous surgeries

Surgery	Date	Surgery	Date

If spine surgery, please specify surgeon

Significant Family History ***Check box if applies and use blank to specify type***

☐ Family history Unknown ☐ No pertinent family history

	Mother	Father	Brother	Sister
Genetic Disease	☐_____	☐_____	☐_____	☐_____
Neurological Disorder	☐_____	☐_____	☐_____	☐_____
Cancer	☐_____	☐_____	☐_____	☐_____
Heart Disease	☐_____	☐_____	☐_____	☐_____
Lung Disease	☐_____	☐_____	☐_____	☐_____
Diabetes	☐_____	☐_____	☐_____	☐_____

Social History

Illegal drug use ☐ Yes ☐ No Type_____ Amount per day_____

Alcohol Use ☐ Yes ☐ No Type_____ Amount per day_____

Current tobacco Use ☐ Yes ☐ No Type_____ Amount per day_____

Former Smoker ☐ Yes ☐ No

Have you ever had problems with alcohol or drug abuse? ☐ Yes ☐ No If yes, please explain:

_____

_____

Current Work Status

Occupation _____ Full time ☐ Part Time ☐ Retired ☐

☐ Temporarily Disabled ☐ Permanently Disabled

Name of physician who gave you disability _____

Disability Dates From _____ To _____

Worker's Compensation? Yes ☐ No ☐ Case manager's name _____

PATIENT INFORMED CONSENT Acct #_____

This is for educational purposes only as
our office practices primarily interventional pain management)

Alternative Modalities to Opioids for Managing Pain

Non-pharmacologic interventions - Ice or heat packs, physical and/or occupational therapy, progressive exercises, stretching, yoga, relaxation, manipulation, massage, acupuncture, cognitive behavior therapy, surgical intervention, interventional pain treatment (NSAIDS, steroid injections and other non-invasive procedures), and counseling for weight loss, nutrition and depression.

Key Elements to Your Treatment Plan

NSAIDS, physical therapy and injection therapy. Please refer to your clinical summary for treatment goals and recommended procedures provided for you after each visit.

Potential Risk and Benefits of Opioid Treatment for Chronic Pain

Risks and adverse effects of long term opioid treatment for chronic pain can include: Nausea, constipation, drowsiness, dizziness, dry skin, itching sensation, respiratory depression, and withdrawal symptoms. There is also the risk of overdose if not taken exactly as prescribed. Use of alcohol and/or illegal substances while on opioids can also increase central nervous system depression and increase the risk for overdose. Taking extended release opioids, that are not in an abuse deterrent form, can increase these risks.

Potential benefits of managed long term opioid treatment: It is generally believed that a stable dose of opioids in properly selected and monitored patients can control pain and improve patient function, without the risk for addiction or impairing the cognitive or performance capabilities of patients. The overall goal with opioid therapy should be to find the minimum opioid dose that adequately manages pain and enhances patient functions with an improved quality of life.

Goals, Proper Medication Use and Expectations related to your Prescription Requests

Goals: Improve quality of life: ensuring any medication process is effective in achieving and improving your day to day activities and providing you the ability to function in a way that pain had prevented you from performing in the past.

Medication use and expectations: Please see the Medication Management Agreement Consent for the full list of medication prescription guidelines. You are required to take any medication exactly as prescribed! This will allow you to receive the maximum level of relief your medication can provide. Any medication prescribed may not fully eliminate your pain but bring it to a manageable level to improve your quality of life.

Treatment with Opioid Analgesics and Risks for Birth Defects

Treatment with opioid analgesics has been linked to birth defects. Pregnant women have a potential risk to the fetus if the mother has taken chronic opioids during pregnancy (including risk of fetal opioid dependency and neonatal abstinence syndrome). See the link below for more information.

https://www.cdc.gov/ncbddd/features/birthdefects-opioid-analgesics-keyfindings.html (opioid linked birth defects)

For more information: https://www.cdc.gov/mmwr.preview/mmwrhtm1/mm6340a1.htm (alcohol w/opioids)

Patient signature:_____ Date:_____

Opioid Risk Tool (ORT)

Please circle YES or NO for the following questions:

			FEMALE	MALE
Any *family* history of alcohol abuse?	YES	NO	☐ 1	☐ 3
Any *family* history of illegal drug use?	YES	NO	☐ 2	☐ 3
Any *family* history of prescription drug abuse?	YES	NO	☐ 4	☐ 4

Please circle YES or NO for the following questions:

Any *personal* history of alcohol abuse?	YES	NO	☐ 3	☐ 3
Any *personal* history of illegal drug use?	YES	NO	☐ 4	☐ 4
Any *personal* history of prescription drug abuse?	YES	NO	☐ 5	☐ 5
Are you between the ages of 16 – 45?	YES	NO	☐ 1	☐ 1
Any history of pre-adolescent sexual abuse?	YES	NO	☐ 3	☐ 0

Have you ever been diagnosed with any of the following? (circle all that apply)

ADD	OCD	Bipolar	Schizophrenia	
Depression			☐ 2	☐ 2
			☐ 1	☐ 1

FOR OFFICE USE ONLY

_____ Total _____

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

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

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns			+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____