REGISTRATION FORM

PATIENT INFORMATION

Patient First Name: MI: Last Name:	Age:	Date of Birth:	Gender: ☐ Male ☐ Female

Ethnicity? ☐ Hispanic ☐ Not Hispanic ☐ Refused Marital Status? ☐ Single ☐ Married ☐ Widowed/Divorced	Language Spoken? ☐English ☐ Spanish ☐Other_____ Race? ☐ White ☐ Asian ☐ Black ☐Hispanic ☐ Indian/Native ☐Other

Mailing address:	**Social Security #*(REQUIRED):***

City:	**State:**	**Zip Code:**	**Home Phone:**	**Cell Phone:**	**Work Phone:**

Email Address: ☐I do not have access to email

Primary Care Provider:

Pharmacy:

INSURANCE INFORMATION(*Please fill out ONLY if patient is on spouse or parent's insurance plan)

(Please give insurance card to the receptionist to be scanned. We are NOT responsible for filing claims if no card is on file)

PRIMARY INSURANCE ☐Medicare ☐ NC Medicaid ☐ BCBS ☐Other	Policy #:

Name on the insurance card? :	SS # of the policy holder(required):	Birth date of Policy Holder(required):	Group #:

How is the **patient** related to the policy holder? : ☐ Self(or Medicaid) ☐ Child (covered under parent's insurance) ☐Spouse ☐ Other

SECONDARY INSURANCE ☐None	Policy Holder: ☐Same as primary	Date of Birth	Policy #:

Patient's relationship to subscriber: ☐Self(Medicaid) ☐ Child(covered under parent's insurance) ☐ Spouse ☐ Other

PARENT/GAURADIAN (REQUIRED IF PATIENT IS UNDER 21 YEARS) NOTE: By Law, Both Parents can be held responsible for medical bills for minors, a medical practice is **NOT** bound by any separation agreement, divorce or child support order.

Parent/Guardian:	**Birth Date:**	Address (if different): ☐ Same as above

Social Security #(required):	Employer:	Preferred Phone #:

IN CASE OF EMERGENCY WHO WOULD YOU LIKE TO BE CONTACTED?

Contact Name:	Relationship to patient:	Home phone #: ( )	Work phone #: ( )

By signing, you agree the information above is correct and give permission for Pain Mgmt Plus, PLLC to file claims on your behalf.
HIPAA CONSENT: *Without signed consent, we can NOT share information regarding your medical care (including family). Please list anyone you would like to have this information below.* ☐ *I do not wish anyone to have information regarding my care.*

1. _____

2. _____

X _____ ***Date:*** _____
Patient/Guardian Signature

Financial/Office Policy and Signature on File

I authorize the release of any medical pertinent information to my consulting provider, if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of benefits to Pain Management Plus, PLLC.

I understand that I am financially responsible for all services rendered **including** for the following reasons: 1) no proper referral at the time of service or referral is invalid/expired 2) incorrect/invalid insurance information given or failure to give new updated insurance information 3) Expenses not covered by insurance 4) deductible not met 5) services rendered are deemed medically unnecessary by insurance. ***Failure of insurance company to pay does not excuse patient's financial responsibility. It is patient's responsibility to know what is and is not covered by their insurance policy/plan (including Medicare beneficiaries).***

Payment is required for all services at the time they are rendered including co-payments and any outstanding balances. You may be balance billed per your insurance contract guidelines for any amount not collected or known at the time of service. Outstanding balances not addressed/paid in a timely fashion may be forwarded to collections and may be reported to your credit.

Returned Checks: In the event a check is returned for Non-Sufficient Funds, we will assess a $25.00 charge in addition to your current balance to cover the bank charges incurred by our office due to Non-Sufficient Funds.

Your signature below signifies your understanding and willingness to comply with the policies of this office and your insurance plan.

Prescriptions: Please bring a list of your current medications with you at the time of your appointment. We will NEVER call in ANY pain medications, antibiotics or narcotics to any drug store.

Urine Drug Screens: Our office performs random drug screens as a routine procedure for all patients on Controlled substance therapy and is an important tool for monitoring the safety of treatment. This is an additional charge billed to you or your insurance.

Labs: We perform urine drug screens in our office and send any additional confirmation testing and/or bloodwork, if applicable, to Quest Laboratory. You may see additional charges from the lab for their services.

Missed Appointments: We charge $75.00 for any no show appointment not cancelled within 24 hrs. This charge will be billed directly to you. Please help us to serve you better by keeping all scheduled appointments. If you "no show" to 3 appointments within 1 year, we have the right to dismiss you from our practice for noncompliance.

Patient/Guardian Signature for Financial and Office Policies
(Refusal to sign does NOT prevent responsibility/obligation regarding this office's financial policy).

X_____ Date_____

HIPAA COMPLIANCE STATEMENT - *THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.*

At this practice, we are committed to protecting your privacy. We comply with all federal, state, and local laws. This notice describes how we use your health information. It describes some of your rights and some of our responsibilities.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION - Each time you visit our offices, we record your symptoms, physical examination, test results, diagnosis, and treatment. This information enables us to plan for your care, communicate with others who care for you, report to your insurance carrier, bill for our work, and improve the quality of our care to you.

YOUR RIGHTS - Although your medical chart belongs to our practice, the information contained in the chart is yours. You have the right to inspect your records, obtain a copy of your chart for a small fee, correct your records, and tell us not to release your information to certain parties.

OUR RESPONSIBILITIES - We are required to maintain the privacy of your health information, send needed health information to other medical providers, and release information to insurance companies, certain government agencies, and others. We may be required to release some information, even without your permission.

EXAMPLES OF HOW YOUR INFORMATION IS USED - Your health information will be recorded and used to plan your treatment. Reports may be sent to other doctors to help them plan your treatment. Claims will be sent to your insurance company. The information in the claims will include confidential information such as your name, address, diagnosis, and treatment. In providing your care, we may communicate with other individuals or businesses. Examples include other physicians and/or laboratories. To protect your privacy, we ask our business associates to safeguard your information.

OTHER NOTICES - We may leave a message at your home, at your business, on your answering machine or on your voicemail. We may mail you a postcard or other written notices. We may need to disclose your information to your family members or other people helping with your care. In doing so, we will use our best judgment. We may disclose information to others as required by law or if subpoenaed. If you were injured on the job, we will need to disclose your health information to your workers compensation insurance company. We may, from time to time, update these policies. *You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account. We may also contact you by email using any email address you provide us. Methods of contact may include using pre-recorded or artificial voice messages and/or the use of an automatic dialing device, as applicable.*

FOR MORE INFORMATION, QUESTIONS OR TO REPORT A PROBLEM - If you have concerns or would like additional information, you may contact the Office Manager.

Signature (HIPAA Policy)

X_____Date_____

Chief Complaint

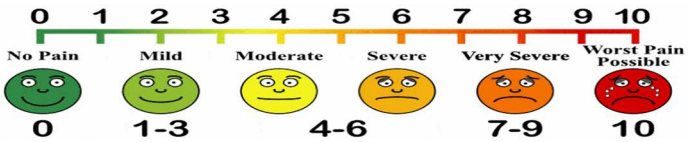
Reason for your visit today?

☐ Persistent Pain

If Pain, the PRIMARY area of concern is:

☐ Neck pain
☐ Shoulder ☐ Right ☐ Left
☐ Arm ☐ Right ☐ Left
☐ Hand ☐ Right ☐ Left
☐ Mid Back
☐ Low Back
☐ Hip ☐ Right ☐ Left
☐ Leg ☐ Right ☐ Left
☐ Knee ☐ Right ☐ Left
☐ Ankle ☐ Right ☐ Left
☐ Toes ☐ Right ☐ Left

What is your pain level: _____



Surgical History (please list surgeries and year of surgery):

_____
_____
_____
_____
_____
_____
_____
_____
_____

Family History

Do any of the following apply to your immediate `blood' relatives?

☐ Cancer	☐ Mom	☐ Dad	☐ Sis	☐ Bro
☐ Chronic Kidney Disease	☐ Mom	☐ Dad	☐ Sis	☐ Bro
☐ Diabetes	☐ Mom	☐ Dad	☐ Sis	☐ Bro
☐ Heart Attack/Stroke	☐ Mom	☐ Dad	☐ Sis	☐ Bro
☐ High blood pressure	☐ Mom	☐ Dad	☐ Sis	☐ Bro
☐ Mental Health Condition	☐ Mom	☐ Dad	☐ Sis	☐ Bro
☐ Osteoporosis	☐ Mom	☐ Dad	☐ Sis	☐ Bro

Problem Pertinent History Intake

Was this injury related? ☐ Yes ☐ No (If yes, please answer a. through d. below)

a. ☐ Motor Vehicle Accident ☐ Employment Related/Worker's Comp

b. Date the injury occurred? _____/_____/_____ b. case#_____

c. Claim Adjuster: _____Phone: _____

d. How did it happen? _____

Pain Duration:

☐ 0- 6 mo.
☐ 6-11 mo.
☐ 1-2 years
☐ 3-4 years
☐ 5-10 years
☐ 10+ years

Pain described as:

☐ Achy
☐ Burning
☐ Constant
☐ Cutting
☐ Dull
☐ Hot
☐ Numbness
☐ Piercing
☐ Pinching
☐ Sharp
☐ Shooting
☐ Stabbing
☐ Stinging
☐ Throbbing
☐ Tingling
☐ Weakness

Overall Pain Status since onset:

☐ Improving
☐ Stable
☐ Worsening
☐ No Change

Previous tests include:

☐ X Rays
☐ Nerve Studies
☐ MRI/CT
☐ Bone Scan

Activities limited due to pain:

☐ Bathing
☐ Bending
☐ Climbing
☐ Dressing
☐ Driving
☐ Feeding
☐ Managing finances
☐ Mobility
☐ Performing household chores
☐ Hygiene/ Grooming
☐ Reaching overhead
☐ Shopping /preparing meals
☐ Sitting
☐ Squatting/ Kneeling
☐ Standing
☐ Toileting
☐ Walking
☐ Working

Associated signs and symptoms:

☐ Blurry Vision
☐ Changes in skin texture and/or color
☐ Decreased ROM
☐ Headaches/ Migraines
☐ Joint stiffness ☐ Nausea
☐ Radiating to upper extremities
☐ Radiating to lower extremities
☐ Temperature sensitivity
☐ Tremors
☐ Trouble sleeping
☐ Urinary frequency
☐ Sensitivity to touch
☐ Spasms
☐ Swelling to the area(s)
☐ Weakness

Past failed treatments:

☐ Bracing
☐ Chiropractic
☐ Heat ☐ Ice ☐ Injections
☐ Occupational therapy
☐ Physical therapy
☐ Prescription Med(s)
☐ Surgery
☐ TENS

Pain decreases with:

☐ Bracing
☐ Chiropractic care
☐ Heat ☐ Ice ☐ Injections
☐ Occupational therapy
☐ Physical therapy
☐ Prescription Med(s)
☐ Surgery
☐ TENS

Name: _____ **Date:** _____

Social History:

Tobacco Use? ☐ Daily ☐ Socially ☐ Quit ☐ Never
Alcohol Use? ☐ Daily ☐ Socially ☐ Quit ☐ Never
Illicit Drug Use? ☐ Daily ☐ Socially ☐ Quit ☐ Never
Type used: ☐ Marijuana ☐ Cocaine ☐ Methamphetamine ☐ Prescription Drugs ☐ Other:_____

MEDICATION LIST:

Medication:	Dosage:	Frequency:	Reason:

Medical History:

Please check if you have any of the following:

☐ Afib
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Cancer
☐ Chronic Kidney Disease
☐ COPD
☐ Coronary Artery Disease
☐ Depression
☐ Diabetes
☐ Fibromyalgia
☐ GERD
☐ Heart Attack(s)
☐ Heart Disease
☐ Hepatitis
☐ Hernia
☐ High Cholesterol
☐ High Blood Pressure
☐ Osteoporosis
☐ Thyroid dysfunction
☐ Tuberculosis
☐ Ulcers

Allergies: _____ ☐ None

Medication/Allergen:	Reaction:

Review of Symptoms (Please check any of the following that apply to you):

Constitutional:
☐ Fever ☐ Excessive sweating
☐ Difficulty Sleeping

HEENMT:
☐ Decreased hearing ☐ Earaches
☐ Ringing in Ears ☐ Blurry vision
☐ Double vision ☐ Loss of vision
☐ Nosebleeds ☐ Sore throat
☐ Blisters in the mouth ☐ Dental pain

Cardiovascular:
☐ Chest pain ☐ Palpitations

Respiratory:
☐ Shortness of breath ☐ Wheezing
☐ Cough

Gastrointestinal:
☐ Constipation ☐ Diarrhea
☐ Vomiting ☐ Nausea

Genitourinary:
☐ Difficulty urinating
☐ Painful urination ☐ Flank pain

Integumentary:
☐ Ulcers ☐ Rash ☐ Blisters
☐ Itching

Neurological:
☐ Balance Difficulty ☐ Memory loss
☐ Difficulty speaking

Psychiatric:
☐ Depressed Mood ☐ Anxiety
☐ Thoughts of suicide

Depression Screening(PHQ2):

OVER THE PAST TWO WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?	*NOT AT ALL*	*SEVERAL DAYS*	*MORE THAN ONE-HALF THE DAYS*	*NEARLY EVERY DAY*
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐

Name: _____ **Date:** _____

PAIN MANAGEMENT PLUS, PLLC

CONTROLLED SUBSTANCE TREATMENT AGREEMENT

Patient Name: _____ Date of Birth: _____

Controlled substance (narcotic) treatment for chronic pain and/or substance dependence is used to reduce pain/withdrawal symptoms and improve what you are able to do each day. Along with Controlled substance treatment, other medical care may be prescribed to help improve your ability to do daily activities. This may include exercise, use of non-narcotic analgesics, physical therapy, psychological counseling or other therapies or treatment. Vocational counseling may be provided to assist in your return to work effort.

To the doctor: Keep signed originals in your file; give a photocopy to the patient. Renew at least every 6 months. I understand that compliance with the following guidelines is important in continuing pain treatment with our providers at Pain Management Plus, PLLC.

1. I understand that I have the following responsibilities:

a. I will take medications only at the dose and frequency prescribed.
b. I will not increase or change medications without the approval of this doctor.
c. I will actively participate in RTW efforts and in any program designed to improve function (including social, physical, psychological and daily or work activities).
d. I will not request Controlled substances or any other pain medicine from physicians other than from this doctor. This doctor will approve or prescribe all other mind- and mood-altering drugs.
e. I will inform this doctor of all other medications that I am taking.
f. I will obtain all medications from one pharmacy, when possible known to this doctor with full consent to talk with the pharmacist given by signing this agreement.
g. I will protect my prescriptions and medications. I will keep all medications from children.
h. I agree to participate in psychiatric or psychological assessments, if necessary.
i. If I have an addiction problem, I will not use illegal or street drugs or alcohol. This doctor may ask me to follow through with a program to address this issue. Such programs may include the following:

- **12-step program and securing a sponsor**
- **Individual counseling**
- **Inpatient or outpatient treatment**
- **Other: _____**

2. I understand that in the event of an emergency, this doctor should be contacted and the problem will be discussed with the emergency room or other treating physician. I am responsible for signing a consent to request record transfer to this doctor. No more than 3 days of medications may be prescribed by the emergency room or other physician without this doctor's approval.

3. I understand that I will consent to random drug screening. A drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking.

4. I will keep my scheduled appointments and/or cancel my appointment a minimum of 24 hours prior to the appointment.

5. I understand that this doctor may stop prescribing Controlled substances or change the treatment plan if:

a. I do not show any improvement in pain from Controlled substances or my physical activity has not improved. b. My behavior is inconsistent with the responsibilities outlined in #1 above.
c. I give, sell or misuse the Controlled substance medications.
d. I develop rapid tolerance or loss of improvement from the treatment.
e. I obtain Controlled substances from other than this doctor.
f. I refuse to cooperate when asked to get a drug screen.
g. If an addiction problem is identified as a result of prescribed treatment or any other addictive substance.
h. If I am unable to keep follow-up appointments.

CONTROLLED SUBSTANCE TREATMENT AGREEMENT (continued)

YOUR SAFETY RISKS WHILE WORKING UNDER THE INFLUENCE OF CONTROLLED SUBSTANCES:

You should be aware of potential side effects of Controlled substances such as decreased reaction time, clouded judgment, drowsiness and tolerance. Also, you should know about the possible danger associated with the use of Controlled substances while operating heavy equipment or driving.

SIDE EFFECTS OF CONTROLLED SUBSTANCES:

- **Confusion or other change in thinking abilities**
- **Problems with coordination or balance that may make it unsafe to operate dangerous equipment or motor vehicles**
- **Breathing too slowly – overdose can stop your breathing and lead to death**
- **Nausea**
- **Sleepiness or drowsiness**
- **Vomiting**
- **Constipation**
- **Aggravation of depression**
- **Dry mouth**

THESE SIDE EFFECTS MAY BE MADE WORSE IF YOU MIX CONTROLLED SUBSTANCES WITH OTHER DRUGS, INCLUDING ALCOHOL.

RISKS: • Physical dependence. This means that abrupt stopping of the drug may lead to withdrawal symptoms characterized by one or more of the following:

Runny nose
Difficulty sleeping for several days
Diarrhea
Abdominal cramping
Sweating
'Goose bumps'
Rapid heart rate
Nervousness

• Psychological dependence. This means it is possible that stopping the drug will cause you to miss or crave it.
• Tolerance. This means you may need more and more drug to get the same effect.
• Addiction. A small percentage of patients may develop addiction problems based on genetic or other factors.
• Problems with pregnancy. If you are pregnant or contemplating pregnancy, discuss with your physician.

PAYMENT OF MEDICATIONS: State law forbids L&I from paying for Controlled substances once the patient reaches maximum medical improvement. You and your doctor should discuss other sources of payment for Controlled substances when L&I can no longer pay.

RECOMMENDATIONS TO MANAGE YOUR MEDICATIONS:
• Keep a diary of the pain medications you are taking, the medication dose, time of day you are taking them, their effectiveness and any side effects you may be having.
• Use of a medication box that you can purchase at your pharmacy that is already divided in to the days of the week and times of the day so it is easier to remember when to take your medications.
• Take along only the amount of medicine you need when leaving home so there is less risk of losing all your medications at the same time.

I have read this document, understand and have had all my questions answered satisfactorily. I consent to the use of Controlled substances to help control my pain and I understand that my treatment with Controlled substances will be carried out as described above.

_____

Patient Signature Date