Even though we are committed to compassionate care, we must exercise proper due diligence when prescribing opioid analgesics for chronic pain. Prescription drug abuse has reached epidemic proportions in our society. Therefore, our clinic policy is that an appropriate workup must be completed prior to the dispensing of an opioid prescription. This workup will include review of previous pharmacy/clinic records, evaluation by diagnostic and laboratory tests, and acceptable completion of a urine drug screen yielding expected results. Common examples of opioid analgesics include hydrocodone, morphine, oxycodone, fentanyl, opana, and methadone. Prescriptions for these medications will not be given at an initial visit.

- Please bring your driver's license and insurance cards along with your **completed** new patient paperwork to your scheduled appointment. Payment for services is expected at the time of service (co- pays, co-insurance, private pay). We accept cash, check, money order and credit cards (Visa, American Express, MasterCard, and Discover).
- **If you have been instructed to obtain <u>imaging reports and/or films</u> by our staff, please bring them to your appointment. Our office requires these as part of your consultation. If we do not have your films at the time of your appointment, you may be rescheduled.**
- Your initial visit at the Practice is a consultation. If a doctor referred you for an injection, you must be seen for an office visit
  visit first. Procedures are scheduled after the initial consultation.

The Spine Group

Patient Acknowledgement Statement

Patient Name & DOB: _____

I understand that services or items that I have requested be provided to me by The Spine Group may not be covered under my insurance as being reasonable or medically necessary for my care. I understand my health plan determines the medical necessity of the services or items I request and receive. I also understand I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable or medically necessary for my care.

Advanced Practitioner Consent for Treatment

The Practice has on staff physician assistants, nurse practitioners, or advanced practice nurses to assist in the delivery of medical care of pain management.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. A nurse practitioner or advanced practice nurse is not a doctor. A nurse practitioner or advanced practice nurse is a registered nurse who has received advanced education and training in the provision of health care. Under the supervision of a physician, a physician assistant, a nurse practitioner, or an advanced practice nurse can diagnose, treat and monitor acute and chronic disease as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of the supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

A physician assistant, a nurse practitioner, or an advanced practice nurse may provide such medical services that are within his/her education, training and experience.

I have read the above and hereby consent to the services of an advanced practitioner for my health care needs. I understand that at any time I can refuse to see the advanced practitioner and request to see a physician.

Acknowledgment of Urine Testing Policy

I understand that the Practice reserves the right to perform random urine testing on any patient. I have the right to refuse the urine test but may then not be prescribed any medications or given refills of medications.

Acknowledgment of External Rx History

I understand that the Practice reserves the right to obtain an external Rx history and randomly verify past medications through the Prescription Drug Monitoring Database in order to be prescribed any medications.

Acknowledgment of Late Arrival Policy

If you are unable to make an appointment, please call within 24 hours prior to your appointment time to reschedule. If you fail to notify our office prior to missing your scheduled appointment, you will be charged a NO SHOW fee of $25 for an office visit and $50 for a procedure. Frequent NO SHOWS may result in a release from the Practice**.**

Permission to Leave Messages

I give permission for the Practice to leave appointment information, test results, and/or pre-operative instructions on voice message for the following phone numbers or with the following individuals:

_____

_____

PATIENT SIGNATURE & DATE: _____

The Spine Group

Today's Date: _____

Location of Care: _____

PATIENT'S PERSONAL INFORMATION

Name: _____ Preferred Name: _____
Last Name First Name M.I.

Date of Birth: ____/____/____ Gender: ☐ Male ☐ Female ☐ Other _____

Marital status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Address: _____

City: _____ State: _____ ZIP: _____

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

SSN: ____ - ____ - ____ Driver's License # & State: _____

E-Mail Address:

Preferred Method of Communication?* ☐Home phone ☐Cell Phone ☐Work Phone ☐E-Mail/Patient Portal

*If you provide an email or phone number, you understand that you may receive these communications from the Practice. To opt-out, fill out Communication Consent.

Do you have an Advanced Directive? (Circle One) : Yes or No (If Yes - Please select: DNR,DNI, or Full Code)

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined to Specify Preferred Language: _____

Race: ☐American Indian ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White Other _____

Referring Provider: _____ Primary Care Provider: _____

Other Providers: _____

Emergency Contact: _____ Relationship: _____

Emergency Phone: _____ Phone Type: _____

PATIENT'S RESPONSIBLE PARTY INFORMATION

Name: _____ Date of Birth: _____

Address: _____

Phone: _____ SSN: _____ Relationship: _____

INSURANCE INFORMATION

Primary Insurance Name: _____

Insured Name: _____ DOB: _____ SSN: _____

Relationship to Patient: _____ ID #: _____ Group #: _____

Secondary Insurance Name: _____

Insured's Name: _____ DOB: _____ SSN: _____

Relationship to Patient: _____ ID #: _____ Group #: _____

Is there an ongoing lawsuit related to your visit today? ☐YES ☐NO Are you currently under worker's compensation? ☐YES ☐NO

Attorney Name and Phone Number: _____

The Spine Group

Communication Consent

We want to stay connected with our patients. Patients in our Practice and all our affiliated clinics may be contacted via email and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. If you provide an email or phone number to the Practice, you understand that you may receive these communications from the Practice.

You may opt out of these communications at any time. The Practice does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan. Email and standard text messaging are not confidential methods of communication and may be insecure.

Select below to opt-out of communication via text and/or email regarding various aspects of your medical care, which may include, but shall not be limited to, reminders, feedback, and general health reminders/information, test results, prescriptions, appointments, and billing.

Please select one:

_____ I agree to receive communication via text and/or email.

_____ I decline/revoke to receive communication via text and/or email.

_____ _____

Patient Name Date of Birth

_____ _____

Patient/Patient Representative Signature Date

THE SPINE GROUP

NAME:_____ DATE OF BIRTH: _____

CLINIC POLICIES

Initials_____ Payment is due at the time services are rendered. I understand that if I have insurance that I am the responsible party, and that having insurance does not guarantee payment of the services rendered to me. I authorize submission of my claim to the insurance company listed above.

Initials_____ If you are unable to make an appointment, please call within 24 hours prior to your appointment time to reschedule. If you fail to notify our office prior to missing your scheduled appointment, you will be charged a NO SHOW fee of $25 for an office visit and $50 for a procedure. Frequent NO SHOWS may result in a release from the practice.

Initials_____ Permission for treatment: I hereby authorize physician and assistants for the care of the patient named on this record to administer treatment as may be deemed necessary including examinations of treatments that may be ordered to be performed by the clinical personnel. I acknowledge that no guarantees have been made to me to the result of examinations or treatments to be performed.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's notice of privacy practices, which explains how my medical information will be used and disclosed. I understand I a entitled to receive a copy of this document.

_____
Signature of Patient or Representative

_____
Date

_____
Witness (Spine Group Employee)

_____
Description of witness authority

***Please list the name of any person(s) you wish to have access to your medical information, including portal access:

Name:_____Relationship:_____

Name:_____Relationship:_____

The Spine Group

NAME:_____DATE OF BIRTH: _____

PAST MEDICAL HISTORY

Please indicate if you have suffered from any of the following medical conditions. Also, state the year when these occurred.

_____AIDS or HIV
_____Arthritis
_____Asthma
_____Cancer
_____Chronic skin disease
_____Depression
_____Diabetes
_____Emphysema
_____Fibromyalgia
_____Gall bladder
_____Gonorrhea
_____Gout

_____Headaches/migraines
_____Heart disease/attack
_____Heart failure
_____Heart murmur
_____Hepatitis
___ Herpes infection
_____High blood pressure
___ Hormone problems
_____Insomnia
_____Irregular heart beats
___ Jaundice
___ Kidney disease
_____Kidney stones
___ Liver disease
_____Lupus
_____Menopause
_____Multiple sclerosis
_____Nervous breakdown
___ Other blood abnormality
_____Other venereal disease
___ Panic attacks
_____Peptic ulcer disease
_____Peripheral vascular disease
_____Pneumonia
_____Prostate enlargement
_____Rheumatic heart
_____Schizophrenia/bipolar
_____Seizures/convulsions
_____Shingles
_____Stroke
_____Syphilis
_____Thyroid
_____Tuberculosis
_____Urinary infection

_____Other:_____

PAST SURGICAL HISTORY

☐ _____

☐ _____

☐ _____

☐ _____

☐ _____

FAMILY HISTORY

Please list any disease, illness, or ailments in your IMMEDIATE FAMILY (i.e. mother-breast cancer, father- diabetic, paternal grandfather-heart disease, maternal grandmother-hypertension).

☐ _____

☐ _____

☐ _____

☐ _____

☐ _____

The Spine Group

NAME:_____ DATE OF BIRTH: _____

SOCIAL HISTORY

Any tobacco use? ☐ Yes ☐No If yes, how many per day?_____ Years?_____

Any alcohol use? ☐Yes ☐No If yes, how much? _____

Recreational drug use? ☐Yes ☐No If yes, which drug? _____

Do you live alone? ☐ Yes ☐No If no, who do you live with? _____

REPRODUCTIVE HISTORY

Are you Pregnant: ☐Yes ☐No If **YES**, how many weeks? _____

Date of last period?_____

Date of last Pap smear?_____ Date of last mammogram? _____

PHARMACY NAME & LOCATION

_____

ALLERGIES

_____

_____

CURRENT MEDICATIONS

***Please list pain medications and blood thinners first**

Medication (ex. Ibuprofen)	Dosage (ex. 400 mg)	Frequency (ex. three times a day)

The Spine Group

NAME:_____DATE OF BIRTH: _____

REVIEW OF SYSTEMS

In the past few months, have you had any of the following symptoms or difficulties? If you have any difficulty that bears further explanation, please indicate so and explain in the additional notes section.

✓**CHECK** ALL APPLICABLE

General:
☐ Chills ☐ Fatigue ☐ Fever ☐ Change of Appetite ☐ Weight Loss

Allergy/Immunology:
☐ Hay fever ☐ Hives ☐ Frequent infections

Ophthalmologic:
☐ Blurred Vision ☐ Diminished visual acuity ☐ Double Vision ☐ Eye pain ☐ Light sensitivity

ENT:
☐ Decreased hearing ☐ Difficulty Swallowing ☐ Ear pain ☐ Hoarseness ☐ Ringing in ears

Endocrine:
☐ Cold Intolerance ☐ Heat Intolerance ☐ Thyroid problems

Respiratory:
☐ Cough ☐ Shortness of breath ☐ Wheezing

Cardiovascular:
☐ Leg Swelling ☐ Palpitations ☐ Swelling in hands/feet

Genitourinary:
☐ Bladder incontinence ☐ Blood in urine ☐ Frequent urination ☐ Painful urination

Gastrointestinal:
☐ Blood in stool ☐ Change in bowel habits ☐ Constipation ☐ Heartburn ☐ Nausea ☐Vomiting

Musculoskeletal:
☐ Back problems ☐ Joint stiffness ☐ Muscle aches ☐ Painful joints

Hematology:
☐ Bleeding problems ☐ Easy bruising ☐ Swollen glands

Skin:
☐ Itching ☐ Rash ☐ Skin lesions

Neurologic:
☐ Dizziness ☐ Numbness ☐ Seizures ☐ Tingling ☐ Tremor ☐ Weakness

Psychiatric:
☐ Anxiety ☐ Depression ☐ Insomnia ☐ Substance abuse

The Spine Group

NAME:_____ DATE OF BIRTH: _____

PAIN EVALUATION

Location of pain _____

Onset of pain _____(days, weeks, months, or years)

Cause of pain _____(accident, unknown)

Your occupation _____ Is this work related? ☐Yes ☐No

Other physicians/specialties you have seen for this pain, including other pain management clinics:

_____

Characteristics of your pain: ☐ Constant ☐ Intermittent Duration_____

Pain Intensity from 1 – 10 (where 10 is the worst):_____at its worst; _____at its least

Your pain is: ☐sharp ☐ shooting ☐ burning ☐ stabbing ☐ electrical shocks ☐ numbness ☐ aching

Other _____

What makes your pain worse? _____

What makes your pain better? _____

Do you have: ☐ numbness ☐ localized weakness ☐ bowel incontinence ☐ bladder incontinence

How many hours per night do you sleep? _____

Medications

☐Topical Compounded Pain Creams ☐Yes ☐No **If yes, which cream?**

☐Prescribed Medications (circle all that apply): Pain Medications Muscle Relaxers Anti-Inflammatory Steroids

☐Please **CIRCLE** all tried medications below. Also mark **X** in the box if tried for at least 6 weeks.

	Amitriptyline		Baclofen		Celebrex		Cymbalta		Depakote
	Effexor/Venlafaxine		Fentanyl Patch		Gabapentin		Ibuprofen		Meloxicam
	Morphine Sulfate ER		Nabumetone		Naproxen		Nucynta		Tizanidine
	Topamax		Tramadol/Ultram		Tramadol ER		Tylenol #3		Tylenol #4

Were these medications helpful or unhelpful?

_____

_____

The Spine Group

NAME:_____DATE OF BIRTH: _____

How has this pain affected your physical function, quality of life and ability to participate in activities (including activities required for daily living and self-care)?

What treatments have you tried in the past? When did you have these treatments? Did it help? (Indicate below)

Treatments	Tried (yes or no)	When (year)	Helped (yes or no)
Chiropractor			
Traction			
Braces			
Nerve Block			
Physical Therapy			
Hypnosis			
Acupuncture			
Biofeedback			
Ice/heat Pack			
Opioids			
Massage			
Religious Counseling			
Psychological Counseling			
TENS/ Electrical Stimulation			
Pain Medication			
Surgery			
Advanced Imaging (MRI)			
At home Physical Therapy Program			

Which treatment above has helped you the most?

_____

If you have had surgery for the pain, please list what kind, how many, when, and if it helped:

_____

_____

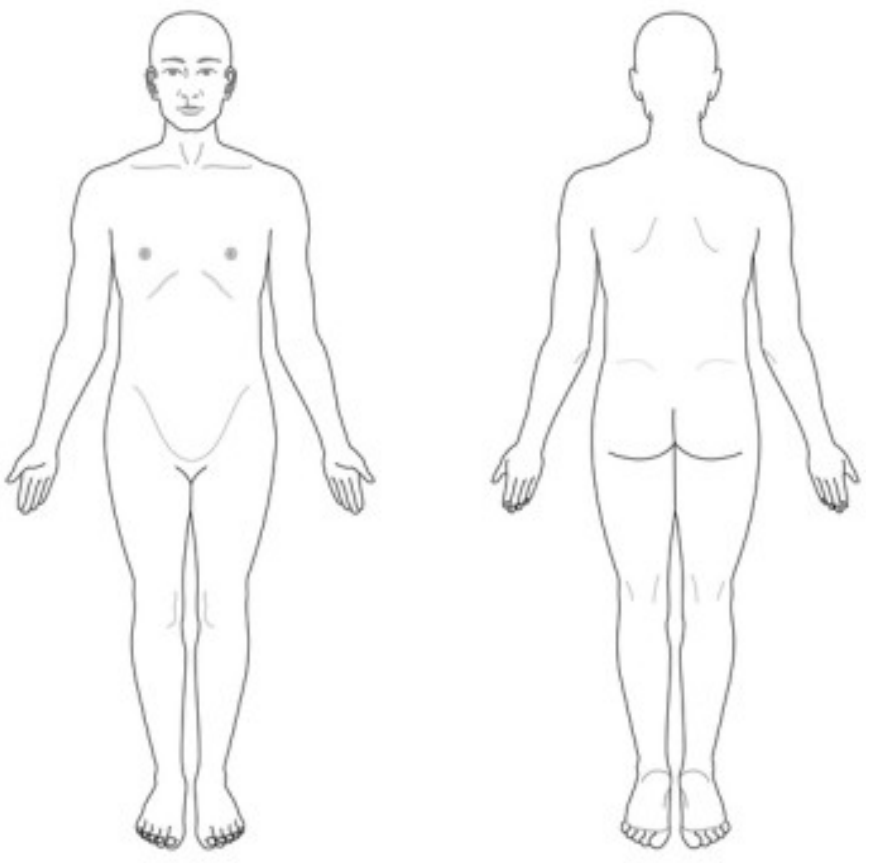
_____

Have you tried any interventional pain modalities such as epidural or facet injections, nerve blocks or ablations, or spinal cord stimulation? If so, please indicate the type ofprocedure, where and when it was done, and your response:

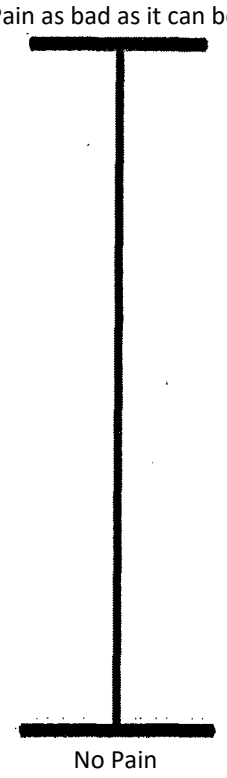
_____

_____

NAME:_____DATE OF BIRTH: _____



If the top line indicates "pain as bad as it can be" and the bottom line is "no pain", where on that line would your pain be right now?



Using the appropriate symbol, mark the area(s) on your body where you feel each of the sensations above.

Numbness	**Pins & Needles**	**Burning**	**Aching**	**Stabbing**
----------	o o o o o o o o	^ ^ ^ ^ ^ ^ ^	X X X X X X X	Φ Φ Φ Φ Φ Φ

Constant	**Intermittent**	**Deep**	**Superficial**
ccccccc	iiiiiiiiiiiiiiii	ddddd	sssssssssss

How long can you be comfortable until pain increases?

Sitting	0 min	1-30 min	31-60 min	1 hour
Standing	0 min	1-30 min	31-60 min	1 hour
Resting or reclining	0 min	1-30 min	31-60 min	1 hour

How much time do you spend each day....?

Sitting	Less than 2 hrs	2-5 hrs	5-8 hrs	8-12 hrs	12 hrs
Standing/Walking	Less than 2 hrs	2-5 hrs	5-8 hrs	8-12 hrs	12 hrs