## PATIENT INFORMATION

| | | | |
|---|---|---|---|
| Name: | Date of Birth: | Age: | Sex: M / F |
| Address (City, State, Zip): | | | |
| Billing Address: | Social Security #: | Marital Status: | |
| Primary Phone #: | Work Phone #: | Secondary Phone #: | |
| Email: | Employment: None/Part/Full | Employer: | |
| Referring Physician: | Primary Care Provider: | | |
| How did you hear about us? (Referring doctor, friend, family, self-referred, internet, magazine, newspaper, advertisement, other) | | | |

## EMERGENCY CONTACT INFORMATION

| | |
|---|---|
| Emergency Contact Name: | Cell Phone #: |
| Relationship: | Home Phone #: |

## INSURANCE INFORMATION

| | |
|---|---|
| Primary Insurance:<br>Copay: | Secondary Insurance:<br>Copay: |
| Certificate #/Policy ID: | Certificate #/Policy ID: |
| Group Number: | Group Number: |
| Subscriber Name: | Subscriber Name: |
| Subscriber DOB/Relationship: | Subscriber DOB/Relationship: |

Please circle the best option to describe your race and ethnicity.

| | | |
|---|---|---|
| Race:<br>Asian, Native American, Other Pacific Islander, Black/African American, American Indian/Alaska Native, White, More than 1 race | Ethnicity:<br>Hispanic/Latino, Not Hispanic/Latino, Not reported, Refuse to report | Primary Language: |

**Authorization to Pay Benefits to Physician:** I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to my provider when they accept assignment.

**Authorization to Release Medical Information:** I hereby authorize my provider to release any information necessary for my course of treatment.

**I certify that the above information is correct as of the date signed.**

| | | |
|---|---|---|
| _____ | _____ | _____ |
| Patient Name (PRINTED) | Patient / Guarantor Signature | Date |

## MEDICATION RISK ASSESSMENT

| Please circle the answer that applies to you for each question | | | *Office Use Only* | |
|---|---|---|---|---|
| **1. Has anyone in your family ever had a history of substance abuse?** | | | **Female** | **Male** |
| • Alcohol | Yes | No | 1 | 3 |
| • Illegal Drugs | Yes | No | 2 | 3 |
| • Prescription Drugs | Yes | No | 4 | 4 |
| **2. Have you ever had a personal history of substance abuse?** | | | | |
| • Alcohol | Yes | No | 3 | 3 |
| • Illegal Drugs | Yes | No | 4 | 4 |
| • Prescription Drugs | Yes | No | 5 | 5 |
| **3. Is your age between 16 – 45?** | Yes | No | 1 | 1 |
| **4. Do you have a history of pre-adolescent sexual abuse?** | Yes | No | 3 | 0 |
| **5. Have you every been diagnosed with ADD, OCD, or Schizophrenia?** | | | | |
| | Yes | No | 2 | 2 |
| **6. Have you ever been diagnosed with depression?** | Yes | No | 1 | 1 |
| | | **Total Score:** | | |

## SLEEP RISK ASSESSMENT

*Please mark all that apply.*

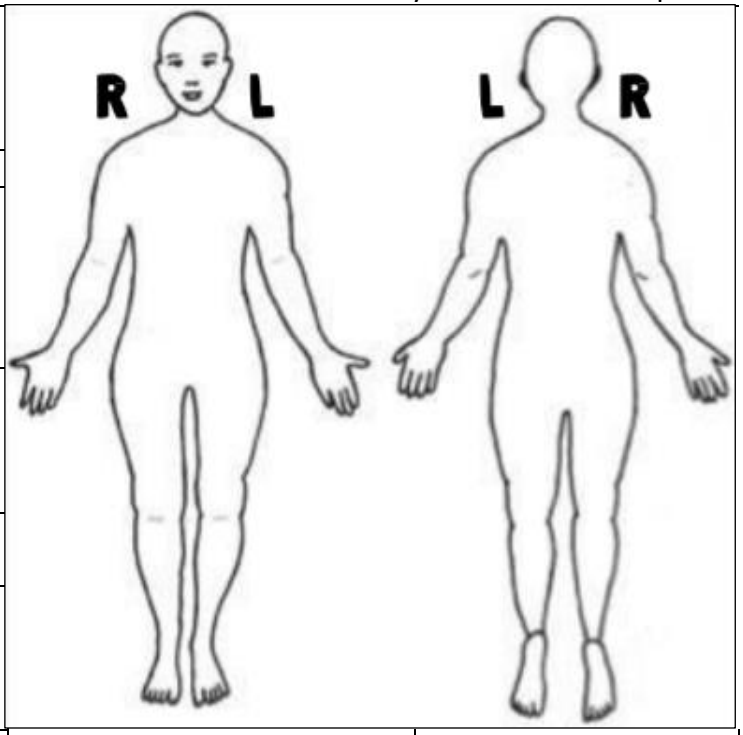
| | | |
|---|---|---|
| □ Excessive daytime sleepiness | □ Snoring | □ Hypertension |
| □ Apnea witnessed by partner | □ Obesity | □ Heart Disease |
| □ Hypnogogic hallucinations | □ Acid reflux | □ Heart Attack |
| □ Nighttime sweating | □ Morning headaches | □ COPD |
| □ Short term memory problems | □ Frequent arousals | □ Stroke/TIA |
| □ Lack of concentration | □ Arousals with gasping | □ Diabetes |
| □ Sexual dysfunction/impotence | □ Arousals with SOB | □ Seizures |
| □ Frequent bathroom trips | □ Arousals with choking | □ Depression |
| □ Cataplexy (sudden episodes of muscle weakness accompanied by full consciousness awareness) | □ Restless sleep | □ Moodiness |

_____ _____ _____

Patient Name (PRINTED) Patient/Guarantor Signature Date

Please identify your **worst** area of pain

Please shade the area where you feel the **worst** pain




- ○ **HEADACHES**
  - ○ Frontal Area (Left / Right)
  - ○ Temples (Left / Right)
  - ○ Back of Head (Left / Right)
- ○ **FACIAL PAIN** (Left / Right)
- ○ **NECK**
  - ○ Radiates into Shoulder (Left / Right)
  - ○ Radiates into Mid-Back (Left / Right)
  - ○ Radiates into Arm (Left / Right)
  - ○ Radiates into Hands (Left / Right)
- ○ **UPPER BODY PAIN**
  - ○ Shoulders (Left / Right)
  - ○ Arms (Left / Right)
  - ○ Hands (Left / Right)
- ○ **UPPER BACK PAIN**
  - ○ Radiates to Ribs (Left / Right)
- ○ **ABDOMINAL PAIN**
  - ○ Radiates to Pelvis (Left / Right)
  - ○ Radiates to Lower Back (Left / Right)
  - ○ Radiates to Legs (Left / Right)
- ○ **LOW BACK PAIN**
  - ○ Radiates to Hips (Left / Right)
  - ○ Radiates to Buttocks (Left / Right)
  - ○ Radiates to Legs (Left / Right)
  - ○ Radiates to Foot (Left / Right)
- ○ **PELVIC PAIN**
  - ○ Coccyx
  - ○ Radiates to Legs (Left / Right)
- ○ **LOWER BODY PAIN**
  - ○ Groin (Left / Right)
  - ○ Pelvis (Left / Right)
  - ○ Hips (Left / Right)
  - ○ Buttocks (Left / Right)
  - ○ Knees (Left / Right)
  - ○ Feet (Left / Right)
- ○ **DIFFUSED BODY PAIN**
  - ○ Face
  - ○ Head
  - ○ Neck
  - ○ Chest
  - ○ Arms (Left / Right)
  - ○ Back
  - ○ Legs (Left / Right)

**How did your pain begin?**
- ○ Gradually, after NO accident
- ○ Suddenly, after NO accident
- ○ Gradually, after an accident
- ○ Suddenly, after an accident

**Incident Type:**
- ○ Trauma
- ○ Vehicle Accident
- ○ Other: _____

_____

**Pain Pattern:**
- ○ Always Present
- ○ Sometimes Present
- ○ Present with certain activities

**Describe the quality of your pain** (Check all that apply)

- ○ aching
- ○ burning
- ○ cramping
- ○ deep
- ○ dull
- ○ pins and needles
- ○ sharp
- ○ shooting
- ○ stabbing
- ○ throbbing

**Severity of Pain:**

○ Mild ○ Moderate ○ Severe

**Last Height: _____** **Last Weight: _____**

**Current Pain Level: ____ / 10**

**Duration of Pain:**
○ _____ weeks / months / years
○ Other: _____

**Assisted Devices:**
○ None ○ Cane ○ Walker
○ Brace ○ Corset ○ Wheelchair

**Course of Pain:**
○ Without Change ○ Improving
○ Worsening

**Intensity of Pain at Best: _____ / 10**
**Intensity of Pain at Worst: _____ / 10**
**Intensity of Pain on Average: _____ / 10**

**Pain Relieved By:**
○ Rest ○ Ice
○ Changing Position ○ Sitting
○ Exercise ○ Standing
○ Pain Medication ○ Bending Forward
○ Heat ○ Physical Therapy
○ Other: _____ ○ Nothing

**Previous Evaluations:**
○ Primary Care ○ Psychologist
○ Urgent Care ○ Pain Management
○ Emergency Room ○ Orthopedic Surgeon
○ Rheumatologist ○ Neurologist
○ Physiatrist ○ Neurosurgeon
○ Chiropractor ○ None

**Pain Worsened By:**
○ Sneezing ○ Lifting
○ Coughing ○ Sitting
○ Bowel Movements ○ Standing
○ Bending ○ Walking
○ Twisting ○ Lying Down
○ Other: _____ ○ Nothing

**Physical Therapy:**
○ None ○ TENS unit
○ Ice ○ Massage
○ Heat ○ Aquatic
○ Stretching Exercises ○ Other: _____
○ Strengthening Exercises _____

**Associated Factors:**
○ None ○ Hip Pain
○ Tingling: _____ ○ Flank Pain
○ Numbness: _____ ○ Incontinence of Stool
○ Leg Weakness ( L / R ) ○ Incontinence of Urine
○ Arm Weakness ( L / R ) ○ Chills
○ History of Malignancy ○ Fever

**Previous Spine Surgery:**
○ None
○ Type: _____
Date: _____ Surgeon: _____
○ Type: _____
Date: _____ Surgeon: _____

**Daily Activities Impaired by Pain:**
○ Work ○ Dressing
○ Sleeping ○ Bathing
○ Leisure ○ Intimacy
○ Chores ○ None

**Previous Injection Therapy:**
○ None ○ Vertebroplasty
○ Joint Injection: _____ ○ Kyphoplasty
○ Facet Injection ○ Other: _____
○ Epidural Steroid Injection _____

**Accident / Injury:**
1. Are you currently involved in a **litigation** regarding your injury? Y / N
2. Is your pain a **work-related** injury? Y / N
3. Is **workman's compensation** involved? Y / N
4. **Date** of injury/ accident? _____

**Previous Imaging Studies:**
○ X-RAY: _____
○ CT: _____
○ MRI: _____
○ Bone Scan: _____
○ EMG Study: _____

## Current Medications

**(Please include dose and frequency)**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____

□ No current medications

## Past Surgery History

□ Adenoidectomy
□ Knee Arthroscopy
□ Back Surgery
  □ Neck
  □ Thoracic
  □ Lumbar
□ Brain Surgery
□ Carpal Tunnel (Left / Right)
□ Cataract Surgery
□ CABG
□ Coronary Artery Dilation
□ Detached Retina Repair
□ Gallbladder
□ Hemorrhoidectomy
□ Hernia Repair
□ Hysterectomy
□ Lumpectomy
□ Bowel Res. (Large / Small)
□ Mastectomy
□ Prostate Surgery
□ Plastic Surgery
□ Shoulder Surgery (Left / Right)
□ Thyroidectomy
□ Hip Replacement (Left / Right)
□ Knee Replacement (Left/Right)
□ Tubal Ligation
□ Vasectomy
□ Pace Make
□ Other: _____
_____

## Past Medical History

□ Anemia
□ Arthritis
□ Anxiety
□ Asthma
□ Atrial Fibrillation
□ Bipolar Disorder
□ Bleeding Disorder
□ BPH
□ Breast Cancer
□ Bronchitis
□ CHF
□ Clotting Disorder
□ COPD
□ Coronary Artery Disease
□ Depression
□ Diabetes
□ Emphysema
□ GI Ulcer
□ Heart Attack
□ Hepatitis (_____)
□ HIV / AIDS
□ Hypertension
□ Kidney Disease
□ Liver Disease
□ Osteoporosis
□ Cancer (_____)
□ Prostate Cancer
□ Seizures
□ Shingles
□ Stroke
□ Thyroid Disease
□ Other: _____
_____

## Social History

**Marital Status**

□ Single
□ Married
□ Divorced
□ Widowed/Widower

**Alcohol Use**

□ None
□ Drinks per day: _____
□ Occasional

**Drug Use**

□ History of Drug Abuse: _____ □ N/A
□ Current Drug Abuse: _____ □ N/A

**Tobacco Use**

□ Current Smoker
- Cigarettes Per Day: ___
□ Former Smoker; Quit _____
□ Never Smoker

**Work Status**

□ Unemployed
□ Employed (Full / Part)
□ Disabled since _____
□ Retired since _____

## Allergies

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

□ No known drug allergies

## Family History:

(Please specify who if applicable)

□ Adopted
□ Anxiety _____
□ Alzheimer's _____
□ Cancer _____
□ Diabetes _____
□ Depression _____
□ Mental Illness _____
□ Heart Disease _____
□ Heart Attack _____
□ High Blood Pressure _____
□ Migraine _____
□ Osteoporosis _____
□ Stroke _____
□ Thyroid Disease _____

## Review of Systems

**Please mark all that apply**

### Constitutional

- □ Fatigue
- □ Chills
- □ Fever
- □ Sleep Disturbances
- □ Weight Gain
- □ Weight Loss

### Eyes

- □ Redness
- □ Blurred Vision
- □ Pain
- □ Double Vision
- □ Vision Change
- □ Dry

### E.N.M.T

- □ Decreased Hearing
- □ Earache
- □ Dry Mouth
- □ Ringing in Ears
- □ Nasal Congestion
- □ Nose Bleeds
- □ Sinus Pain
- □ Sore Throat

### Cardiovascular

- □ Chest Heaviness
- □ Chest Pain
- □ Chest Tightness
- □ Irregular Heartbeat
- □ Palpitations
- □ Shortness of Breath
- □ Leg Swelling

### Respiratory

- □ Short of Breath
- □ Wheezing
- □ Sleep Apnea
- □ Chronic Cough
- □ Pain with Breathing

### Gastrointestinal

- □ Diarrhea
- □ Constipation
- □ Nausea
- □ Vomiting
- □ Bloody Stool
- □ Tarry Stool
- □ Loss of Appetite
- □ Abdominal Pain

### Genitourinary

- □ Burning Urination
- □ Painful Urination
- □ Incontinence – urine
- □ Incontinence - stool

### Musculoskeletal

- □ Back Pain
- □ Neck Pain
- □ Joint Pain
- □ Muscle Pain
- □ Muscle Cramps
- □ Muscle Weakness
- □ Limited range of motion
- □ Gout

### Skin

- □ Dry
- □ Itchy
- □ Lesions
- □ Sores
- □ Lump
- □ Rash
- □ Brittle Nails
- □ Pigmentation Change

### Neurological

- □ Dizziness
- □ Trouble Walking
- □ Headache
- □ Migraine
- □ Restless Legs
- □ Tingling
- □ Speech Difficulty
- □ Fainting

### Psychiatric

- □ Anxiety
- □ Depression
- □ Mood Changes
- □ Memory Disturbances
- □ Stressed

### Endocrine

- □ Cold Intolerance
- □ Heat Intolerance
- □ Thyroid Problems

# 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.

**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.**

This notice was published and becomes effective on/or before **April 14, 2003**

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.

| Patient Name (PRINTED) | Patient/Guarantor Signature | Date |
|---|---|---|

# Patient Payment Policy

Thank you for choosing Idaho Pain Clinic, LLC. We are committed to providing you with the highest quality of healthcare and strive to keep healthcare affordable in our office. As such, we provide this document to ensure your understanding of the payment policies. Please read the following office payment policy carefully and feel free to ask us any questions that you may have. Once you accept this policy, kindly sign in the space provided. A copy will be provided to you upon request.

## Payment Policy

- At the time of service, and before you are seen by the practitioner, you are required to pay any applicable co-pay or balance.
- Payment for service is due in full at the time of service provided you have no insurance. Please ask our front office staff for a fee schedule.
- We accept cash, check, Visa, MasterCard and Discover. Any returned check is subject to a $35.00 return check fee.
- Unless canceled **two business days** in advance, your account will be charged $25.00 for a missed appointment. Three no show or three canceled appointments will results in a discharge from the facility.
- Please note that your insurance company will not cover any of the additional fees listed above.
- If a patient has a balance of $500 or greater, the patient will not be seen without payment on the account.
- If you are in need of a payment plan, you can discuss options with the office staff.
- Patient Statement will be mailed to you if you have an outstanding balance after we have billed your insurance. If your account is overdue for longer than 90 days, it may be referred to a collection agency.

As a courtesy, we file your insurance claims. It is your responsibility to notify us of any changes to your insurance coverage. It is your responsibility to know your policy in regards to benefits, maximums, waiting periods, benefits, and patient coverage. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays.

| _____ | _____ | _____ |
|---|---|---|
| Patient Name (PRINTED) | Patient/Guarantor Signature | Date |

## Thank you for your time!

Please give completed paperwork to the front desk receptionists