Center for Spine & Pain Medicine

2024 Patient Information

Name _____ Social Security #_____-_____-_____
Last First Middle

Date of Birth: ___/___/___ Age: ____ Marital Status: ____ Single ____ Married ____ Widowed ____ Divorced

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Best time to call: ____ Morning ____ Afternoon ____ Evening Preferred number to call: HOME WORK CELL

Name of Employer _____ Address _____ Phone _____

Spouse's Name _____ Spouse's Employer _____ Phone _____

Referring Physician _____ Specialty _____ Phone _____

Primary Care Physician _____ Phone _____

Emergency Contact _____ Phone _____ Relationship _____

Primary Insurance

Insurance Company _____ ID # _____ Group # _____

Policy Holder _____ Date of Birth: ___/___/___ Social Security #_____-_____-_____

Relationship to the Insured _____ Policy Effective Date: ___/___/___

Secondary Information

Insurance Company _____ ID # _____ Group # _____

Policy Holder _____ Date of Birth: ___/___/___ Social Security #_____-_____-_____

Relationship to the Insured _____ Policy effective date: ___/___/___

Worker's Compensation Insurance

Insurance Company _____ Claim Number _____

Adjuster _____ Phone _____ State of Accident _____

Attorney's Name _____ Phone _____ Date of Injury : ___/___/___

Please check all that may apply: I authorize Center for Spine & Pain Medicine to

____ Leave messages on my answering machine /voicemail regarding appointments

____ E-Mail information regarding appointments (e-mail address _____)

____ Mail information to the address provided above regarding appointments

____ Speak with a family member or other individual when returning calls or concerning appointments
(Please specify with whom we may speak (_____)

This section is voluntary

Race: ___Asian ___Native Hawaiian ___African American ___Hispanic ___White ___Not Reported

Language: ___English ___Spanish ___Indian ___Russian ___Other ___Not Reported

I certify that the information provided on this form is accurate and complete.

Patient / Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

SADIQ SOHANI, MD, DACPM, DABPM MEDICAL DIRECTOR

1413 Chattanooga Ave. Dalton, GA 30720 | 715 Queen City Pkwy Ste 106 Gainesville, GA 30501 | 7446 Shallowford Rd. Ste 110 Chattanooga, TN 37421

All Locations Fax # 706-279-2679

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Full Name of Patient: _____

Patient's Birth Date: _____

Name of Facility/Office records requested from: _____

Fax Number: _____

INFORMATION REQUESTED (X): ( )Medical Records ( )Psychiatric Records

******If only a portion of the Medical record or Psychiatric record is required please specify******

( ) Discharge Summary ( ) Emergency Room ( ) Laboratory Results
( ) History & Physical ( ) X-Ray Report ( ) Immunization Records
( ) Orders ( ) Operative Reports ( ) Progress Notes
( ) Radiology Film/Imaging ( ) Entire Record ( ) Other (Specify):

Identify dates of service or date ranges requested including month and year: _____

THE ABOVE RECORD IS TO BE RELEASED TO THE FOLLOWING INDIVIDUAL:

Name & Title: _____

Street Address: _____

City/State/Zip: _____ Phone Number: _____

THIS RECORD IS REQUESTED FOR THE FOLLOWING REASON (X):

( ) Continued Medical Care ( ) Legal Purposes ( ) Insurance Purposes
( ) Personal Interest ( ) Other (Specify): _____

The authorization must be signed and dated and may be revoked by notifying Center for Spine & Pain Medicine, P.C. in writing any time except to the extent action has been taken prior to revocation. This consent will expire 60 days after the date below or sooner by my choice, in which case this consent will expire on this date or event _____. Such expiration date or even has not occurred.

REQUEST FOR RECORD COPY RELEASE WILL BE HANDLED ON A FIRST COME, FIRST SERVE BASIS.

I understand that the medical record released pursuant to this authorization could contain information concerning drug related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or blood borne infectious disease, which are subject to federal and/or state restrictions on disclosure. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. I hereby affirm that I have read and fully understand the above statements and consent to the disclosure of the medical record for the purpose and extent stated above.

Signature _____ Date _____

Patient, Parent or Legally Authorized Representative

Relationship to the Patient: _____

Social Security Number: _____ Phone Number: _____

Advance Directive

By signing this form, I acknowledge that I have marked the appropriate box with regards to an Advanced Directive.

- o I have executed an advanced directive or living will and will make a copy available for my records.
- o I have not executed an advanced directive or living will but would like more information.
- o I have not executed an advanced directive or living will and would not like more information.

Patient Name: _____

Date of Birth: _____

Patient Signature: _____

Date Completed: _____

To Be Completed by Employee

- o Advanced Directive forms given to patient as requested.
- o Chart marked with information given by patient.
- o This signed form scanned into patient's chart

Completed by: _____

Center for Spine & Pain Medicine

Opioid (Pain Relieving) Drug Information
and
Pain Medication Agreement

We ask that each of our patients read this Pain Medication Agreement on their first visit to our office. We also feel that it is important to review this agreement yearly with our patients.

It is important that you understand the risks of taking opioid (pain relieving) drugs and our commitment to work with you to make sure that your pain is managed in a safe and effective way.

Before being prescribed any pain medication by Center for Spine & Pain Medicine, you must first read the attached information regarding opioids, and then sign the Consent and Agreement to Treatment with Opioid (Pain Relieving) Drugs.

An agreement must be signed before any patient can receive a prescription for pain medicine of any kind.

Thank you for actively participating in your care.

-The physicians and medical team of:
Center for Spine & Pain Medicine

Center for Spine & Pain Medicine

OPIOID (PAIN RELIEVING) DRUG TREATMENT AGREEMENT

You have agreed to take opioid (pain relieving) drugs to manage your pain. You must understand the risks and responsibilities that go along with this treatment. Please read each statement and then sign this agreement.

YOUR HEALTH PROBLEM > You have a problem with pain that cannot be controlled. You have asked to be treated with opioid drugs because other treatment(s), and/or drug(s) have not worked well. Your other choice is to stay on your current treatment.

THE GOAL OF OPIOID DRUGS > The purpose of these drugs is to decrease pain and improve function. It is not likely that any drug(s) will completely get rid of your pain. Taking this drug(s) should improve function.

FACTS > Over half of all patients taking oral opioid drugs will have at least one side effect or problem. Even though opioid drugs are prescribed to reduce pain and improve function, in some cases they do the opposite.

SIDE EFFECTS > Common side effects include nausea, vomiting, itching, feeling sleepy, constipation, and difficulty urinating.

POTENTIAL COMPLICATIONS > Many problems are possible, including:

- mental problems or problems thinking
- slowed breathing
- lower testosterone levels
- irregular menstrual periods
- reduced sexual desire
- feeling more anxious or depressed
- psychological dependence on the drugs
- physical dependence on the drugs
- physical dependence of a newborn if taken during pregnancy
- opioid withdrawal
- drug tolerance
- addiction
- suppression of the immune system and being more sensitive to pain.

LIFE THREATENING COMPLICATIONS can include suicide, overdose, coma, organ damage or failure, especially of kidney and liver and death. Use of these drugs is one of the top causes of injury or death in the United States.

Center for Spine & Pain Medicine

Narcotic Administration Agreement

By signing the final page of this form and initialing each line, you agree that you understand the rules for taking opioid drugs to relieve pain. You must agree to follow the rules below when taking these drugs.

Please Read and Initial Each One

1. _____ The patient will provide a complete history including past pain treatment, any alcohol or drug addiction/ dependency history, medical/psychiatric/legal history.
2. _____ Follow the doctor's recommendations, DO NOT take more/less of any prescribed medications without discussing this with the physician and receiving permission to do so. By doing so it may lead to discontinuation of medication and/or termination from practice.
3. _____ DO NOT share or take medications from any other persons including family members; DO NOT sell any of your medications. By doing so it may lead to discontinuation of medication and/or termination from practice.
4. _____ Patient will agree to store their medications in a safeguarded place to keep others from stealing and/or abusing them.
5. _____ CSPM will be the only source of pain medication. Written/Verbal authorization will be given when and if another care provider is going to assume medication prescribing responsibilities. (This includes Post-Surgical Prescriptions)
6. _____ Regularly scheduled appointments will be kept on a frequency determined by the physician. The patient will be seen at least once every 4-8 weeks. Cancellations or missed appointments may lead to discontinuation of the medication and/or termination from practice.
7. _____ I will submit to a urine and/or saliva sample on request at ANY time without prior notification to detect the use of non-prescribed medications, illicit drugs and to confirm the use of prescribed medications. I will submit to random pill counts without notification as per Physicians request.
8. _____ Any evidence of drug-seeking behavior such as; the use of illegal drugs, use of alcohol, frequent request for dose increases, or early refills can lead to discontinuation of the medication and/or termination from practice.
9. _____ No prescriptions for controlled substances will be provided on the weekends, holidays, or outside of regular business hours.
10. _____ The patient will utilize the pain medication for their medically intended purpose only. CSPM provider may prescribe you pain medication with off label indication.
11. _____ The patient authorizes CSPM to cooperate fully with any city, state, or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of medicine. The patient authorizes to provide a copy of this agreement to the pharmacy. The patient waives any right of privacy or confidentiality with respect to these authorizations.
12. _____ If your physician determines that you are not a good candidate to continue with the medication, the physician may discontinue treating you at his/her own discretion and you may be referred to a detoxification program/ addiction specialist.
13. _____ The patient agrees to immediately inform CSPM if they become pregnant or intend on becoming pregnant.
14. _____ In case of adverse reaction or inefficiency, the patient will not destroy his/her medication on their own. The patient would need to bring medication back to CSPM for pill count before any other medications will be prescribed.

15. _____ Do not operate a motor vehicle if you feel mentally impaired while using controlled medications. The patient is responsible for exhibiting good judgment in daily affairs, including the use of your controlled medications. Alcohol use should be abstained from while using controlled medication.

16. _____ The patient understands that the controlled substance can be discontinued immediately If the patient does not fulfill the terms of this agreement.

Use of narcotic/opiate pain medicines has certain risks including but not limited to: sleepiness, drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing and slowing of reflexes or reaction time.

Chronic use of narcotic medicines in males may be associated with low testosterone levels. This may affect mood, stamina, sexual desire, and physical performance. Females who become pregnant need to contact this office immediately. Appropriate contraception will be used while on the narcotic medication.

The patient understands that the use of narcotic medication has potential complications including: the development of tolerance (reduced effect over time), dependency (potential for withdrawal symptoms upon abrupt discontinuation), and the possibility of "addiction" (loss of control, compulsive use and continued use despite adverse social, physical or psychological consequences).

Consent and Agreement to Treatment with Opioid (Pain Relieving) Drugs

_____Patient Initial. The first two pages of this form explained the risks, likely results, alternative choices, and problems that could result from taking opioid (pain relieving) drugs. If, after you have read and reviewed this form with your doctor, you do not believe that you fully understand the risks, likely results, other choices, and possible problems of opioid drugs, do not sign the form. Please have all your questions answered before signing.

I _____agree to obey the rules and follow the standards described in the first two pages of this form. I agree to submit to random and/or scheduled urine and/or blood screens. I understand that if I breach this contract, my doctor will stop prescribing opioid drugs immediately. I also agree that information about my opioid drugs may be shared with my other doctors and the state of Georgia prescription drug database, and no one has given me a guarantee about success or outcome. I understand that only one pharmacy may be used for filling opioid prescriptions:

Pharmacy Name _____ Pharmacy #_____

I understand all the facts given to me in the first two pages of this form. I give my consent for the providers of Center for Spine and Pain Medicine to prescribe opioid and/or any other pain-relieving medications for me. My signature below certifies that a provider has discussed all the facts in this form with me, that I have had the chance to ask questions, and that all my questions have been answered.

Signature of Patient or Responsilble Party _____ Date and Time _____

Witness _____ Date and Time _____

PROVIDER I confirm with my signature that I have given the patient two pages of educational material and have discussed with the above-named patient the risks, likely results, other choices, and possible problems of opioid medication. The patient has had the chance to ask questions, all questions have been answered, and he or she has expressed full understanding. Thus informed, the patient has asked that I prescribe opioid medication for him or her.

Provider Signature _____ Date and Time _____

Center for Spine & Pain Medicine

Release of Medication Authorization

Due to new regulations in patient confidentiality, it is necessary for you to provide a list of people that you have authorized to pick up your prescriptions, if you are unable to do so. Please list up to 3 people that are over the age of 18. They must present a picture ID upon picking up your prescriptions. We will not release your prescriptions to anyone who we do not have written authorization.

In addition, when you call for your prescriptions to be picked up, if you are not planning to pick your prescriptions up personally, please indicate the name of the designee that will be picking up your prescription. When leaving a message on the refill line, please include the medication information and the name of the person who will be picking up the prescription. If you do not leave the name of the person picking up the prescription, we will assume that you are picking up your prescription and we will not release the prescription to anyone but you.

We appreciate your cooperation in this matter as we strive to provide more excellent care to you as our patient.

Sincerely,

Center for Spine & Pain Medicine

I give the following people authorization to pick up medication/prescriptions on my behalf.

****THEY MUST BE AT LEASE 18 YEARS OF AGE AND HAVE A PICTURE ID****

1. _____

2. _____

3. _____

Patient Signature: _____ Date: _____

Center for Spine & Pain Medicine

Financial Policy

The objective of this office is to provide you with the highest quality health care in the most cost-effective manner. However, the ability of **Center for Spine & Pain Medicine** to achieve this depends greatly on your understanding of our financial policy.

IF YOU HAVE MEDICAL INSURANCE, WE WILL FILE YOUR CLAIMS ON YOUR BEHALF. This is done as a courtesy to our patients. We are glad to help you receive the maximum allowable benefits from your insurance. Even though we will file the insurance claim for you, we also need your active participation in the insurance claims process. Your insurance contract is between you and your insurance company. If your insurance pays only part of your bill or rejects your claim, you are financially responsible for the balance and the balance is due upon receipt of your statement. We also check your eligibility as a courtesy. If your eligibility status changes and we are made aware of the change after you have already been seen, you will be responsible for either providing an alternate insurance or payment of the balance in full. You are responsible to pay your copay/deductibles/coinsurance at the time of service. It is your responsibility to make sure that the insurance information that we have on file is correct. If you get a new insurance card in the mail from your insurance company, please bring it with you to your next appointment.

Authorization for Request of Medical Records

I hereby authorize **Center for Spine & Pain Medicine** physicians to release information from my records verbally, via fax or mail to insurance companies, utilization review companies, lawyers and other physicians. This may include diagnosis and test results, which may include drug, alcohol, psychological conditions and Acquired Immunodeficiency Syndrome.

Authorization to Release Information to Center for Spine & Pain Medicine

I hereby authorize my physicians to release information from my records verbally, via fax or mail to **Center for Spine & Pain Medicine**. This may include diagnosis and test results, which may include drug, alcohol, psychological conditions and Acquired Immunodeficiency Syndrome.

Photography Authorization

I hereby authorize **Center for Spine & Pain Medicine** to take photographs necessary to document my physical condition & identity. The photograph can/will be used for documentation & identity verification only.

Medicare Patients

As a participating provider of Medicare Part B (Physician Services), **Center for Spine & Pain Medicine** will only bill you your Medicare co-insurance, deductible or any services rendered that are not covered by Medicare. All other services will be billed directly to Medicare. PAYMENT FOR SERVICES NOT COVERED BY MEDICARE ARE TO BE PAID THE DAY SERVICE IS PERFORMED. For covered services, you will be responsible for paying your 20% co-insurance amount at the time of service if you do not have secondary insurance. If you have Medicare Part A only our services will not be covered by Medicare and payment is due at the time of service.

HMO/PPO/Managed Care Insurance Patients

Many HMO/PPO/Managed Care Plans require that you obtain a referral from your assigned primary care provider to receive care from a specialist. IT IS YOUR RESPONSIBILITY TO OBTAIN THIS REFERRAL IF REQUIRED. Services will be the financial responsibility of the patient if not done properly.

Patients with NO Insurance

ALL PATEINTS WITH NO INSURANCE WILL BE REQUIRED TO PAY FOR THEIR VISIT IN FULL AT THE TIME OF SERVICE. As a courtesy to our cash patients we will give a discount for office visits, urine drug screens, and injections. If special arrangements are deemed necessary, you will be given information regarding whom to contact to discuss arrangements

Cancellation Policy

It is the policy of Center for Spine & Pain Medicine to require 48-hour notice for all our patients who wish to cancel their office or procedure appointments. There will be a $50 cancellation fee for office visits and $200 cancellation fee for procedure appointments which are canceled without proper notice. This fee must be paid before scheduling the next visit to our office. This fee is not insurance responsibility.

Financial Responsibility Agreement

FOR AND IN CONSIDERATION of the health care and health care related services and treatment rendered or to be rendered to the patient identified below, and the extension of credit to the patient. I promise to pay in full to **Center For Spine & Pain Medicine** upon demand, all charges incurred (including out- patient or clinic service) at our offices, Ambulatory Surgery Center, and other locations. Payments received from insurance or third-party payers for services rendered will be applied to the patient account. All outstanding balance will be patient responsibility.

I have read this Financial Agreement; understand its terms and conditions and I am signing the agreement voluntary for the purposes stated in this agreement.

Assignment of Benefits

I certify that the information given by me is correct. I hereby authorize payments directly to **Center for Spine & Pain Medicine** of the insurance benefits otherwise payable to me. I understand I am financially responsible to Center for Spine & Pain Medicine for any charges not covered by this authorization.

If any Collection Agency or Attorney is utilized to collect unpaid balances, any fees associated with the collection agency or attorney will be the responsibility of the patient. This includes the **Collection Fees** charged to us by the Collection Agency as well as any **Legal Fees** incurred as a result of non-payment.

Patient Name: _____ Date: _____

Signature: _____

Authorized Representative: _____ Relationship: _____

Signature: _____ Date: _____

HIPAA Privacy Authorization Form

1. Authorization

I authorize Center for Spine and Pain Medicine to use and disclose the protected health information described below to the following people.

Name: _____ Relationship: _____ Date: _____

Name: _____ Relationship: _____ Date: _____

Name: _____ Relationship: _____ Date: _____

2. Effective Period

This authorization for release of information covers the period of healthcare from:
a. ☐ _____ to _____ Specific Date Range. OR b. ☐ all past, present, and future periods.

3. Extent of Authorization

☐ I authorize the release of my COMPLETE health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

☐ I authorize the release of my complete health record except for the following information:
Please Specify: _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. **This authorization shall be in force and effect until it is revoked in writing, at which time this authorization expires.**

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the Insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

9. A copy of CSPM Privacy Practices is available upon request and is also posted in the lobby.

Patient Signature: _____ Date: _____

Printed Name of Patient or Personal Representative: _____

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.

Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. Example: results of laboratory tests and diagnostic procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. Example: your health plan may request and receive information on dates of service, services provided, and the medical condition being treated. Your health information may be used as necessary to support the day to day activities and management of Center for Spine & Pain Medicine Ambulatory Surgery Center. Example: information on the services you received may be used to support budgeting and financial reporting or activities to evaluate and promote quality.

Your health information may be disclosed to law enforce agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Your health information may be disclosed to public health agencies as required by law. Example: we are required to report certain communicable diseases to the states Public Health Department. Disclosure of your health information or use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your revocation will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional use of information: your health information will be used by our staff to call or send your appointment reminders.

You have certain rights under Federal Privacy Standards. These include:

1. The right to request restrictions on the use and disclosure of your protected health information
2. The right to receive confidential communications concerning your medical condition and treatment
3. The right to inspect and copy your protected health information
4. The right to amend or submit corrections to your protected health information
5. The right to receive an accounting of how and to whom your protected health information has been disclosed
6. The right to receive a printed copy of this notice

Grievance Policy

Center for Spine & Pain Medicine Ambulatory Surgery Center is required by law to maintain the privacy of your protected health information and to provide you with this notice of Privacy Practices. We are required to abide by the privacy policies and practices that are outlined in this notice.

To File a Complaint With The State Agency that Licenses This Facility, Call 1-800-878-6442.
Health Care Facilities
Attn: Complaints Unit
227 French Landing Ste. 501
Nashville, TN 37243
(800) 287-0010
Website for Office of Medicare Beneficiary Ombudsman:
www.cms.hhs.gov/center/ombudsman.asp

To File a Complaint With Accreditation Association for Ambulatory Health Care
Call 1-847-853-6060
5250 Old Orchard Road
Suite 200, Skokie IL 66077

Center for Spine & Pain Medicine

E-PRESCRIBING CONSENT FORM

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy from the point of care. E-Prescribing greatly reduces medication errors and enhances convenience for the patient while maximizing patient safety. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribe program.

These include:

- Formulary and benefit transactions - Gives the prescriber information about which drugs are covered by the patient's drug benefit plan.
- Medication history transactions - Provides the physician with information about medications the patient is already taking to minimize adverse drug events.
- Fill status notification - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription needs to be refilled, has been picked up, not picked up, or partially filled.

By signing this consent form, you are agreeing that Center for Spine & Pain Medicine, can electronically transmit your prescriptions directly to your pharmacy. E-Prescribing is an optional service, and you may choose to decline. Please note that consenting to E-Prescribing also permits the use of your prescription medication history from other healthcare providers and/or third-party benefit payors (i.e., your insurance company) for treatment purposes only. Understanding all of the above, I hereby provide informed consent to Center for Spine & Pain Medicine to enroll me in the E-Prescribe Program. This authorization will remain in effect until otherwise requested by the patient.

Signature of Patient	Date of Birth
Print Patient Name	Today's Date

Center for Spine & Pain Medicine

RECORDING OFFICE VISITS
-PRACTICE POLICY-

With the proliferation of smart phones, tablets, micro recorders, and other video and audio recording devices which capture and store video and audio files (collectively, "Recorders"), we wanted to make you aware of our office policy on the use of these Recorders within our practice and during your visit with a provider, either in person or via telehealth (our "Recording Policy"). Please ask the provider or any staff member if you ever have any questions about our Recording Policy.

Please understand that the genesis of our Recording Policy is to protect your personal health information, and that of other patients, from being accessed by non-authorized parties. As a medical provider, we are subject to certain state and federal privacy laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which require us to take reasonable measures to prevent the unauthorized access of our patients' protected health information (PHI). Recorders used during an office visit may result in the unauthorized recording of another patient's PHI, intentionally or inadvertently, or you may misplace or lose your Recorder once you leave the office, providing others with access to your PHI and potentially subjecting us to fines and penalties. Center for Spine and Pain Medicine will not be responsible for and cannot be held liable for lost Recorders or recordings.

Therefore, we have developed the following Recording Policy, and we ask that you carefully read and sign where indicated to signify your (i) understanding of the Recording Policy, and (ii) agreement to adhere to same.

1. **While in the office lobby, administration areas, receptionist area, billing office, hallways, and other common areas (collectively, the "Common Areas"):**
   The use of all Recorders is **strictly prohibited** in the Common Areas unless (1) the Recorder is needed for communication purposes in accordance with the Americans with Disabilities Act (ADA) or other state/federal access to healthcare laws (collectively, "Access Laws"), OR (2) the Recorder is needed to help the patient remember what a staff member told him/her about billing questions, follow up instructions, future appointments, etc. If the latter, we ask that the patient first ask the staff member for permission to record the interaction. Under no circumstances, however, is a patient permitted to video record in the Common Areas unless authorized by Access Laws.

2. **While in a patient room communicating with a provider (the "Patient Room"):**
   The use of all Recorders is **strictly prohibited** in the Patient Room unless (1) the Recorder is needed for communication purposes in accordance with Access Laws, OR (2) the Recorder is needed to help the patient remember what the provider told him/her at the time of the visit. If the latter, we ask that the patient first ask the provider for permission to record the interaction. Under no circumstances, however, is a patient permitted to video record a provider visit unless authorized by Access Laws.

3. **While on a telehealth visit (the "Telemedicine Exam"):**
   The subsequent posting of a recorded Telemedicine Exam on any public social media platform, including but not limited to, YouTube, Facebook, Instagram, and Snapchat, is **strictly prohibited**.

If a provider or staff member has a reasonable belief that a patient has used a Recorder (or posted a Telemedicine Exam) in violation of this Recording Policy, the patient will be (i) asked to turn the Recorder off, (ii) reminded of the Recording Policy, (iii) asked to delete any audio/video recordings taken within the Common Areas or Patient Room, (iv) asked to remove/take-down a social media posting of a Telemedicine Exam, if applicable, and (v) potentially, terminated from the practice.

By signing below, I am confirming that I have been able to ask questions about the Recording Policy, that all of my questions (if any) have been answered, and I agree to abide by the Recording Policy.

Patient Name & DOB _____ Signature _____

_____ Patient Signature Date _____

Pain Management Initial Evaluation

Patient Name: _____ Date: _____

Referring Physician: _____ Date: _____ Age: _____

Referring Physician: _____ Sex: ☐Male ☐Female

Location of Your Pain: _____

Date Your Pain First Started: _____

What Caused Your Pain: _____

How intense is your pain?

0 1 2 3 4 5 6 7 8 9 10

NO Pain — Moderate Pain — Worst Possible Pain

Describe your pain (circle the most descriptive words)

Constant / Intermittent (Sometimes): Stabbing - Shooting - Sharp - Dull - Aching

Tingling - Numbness - Throbbing - Burning

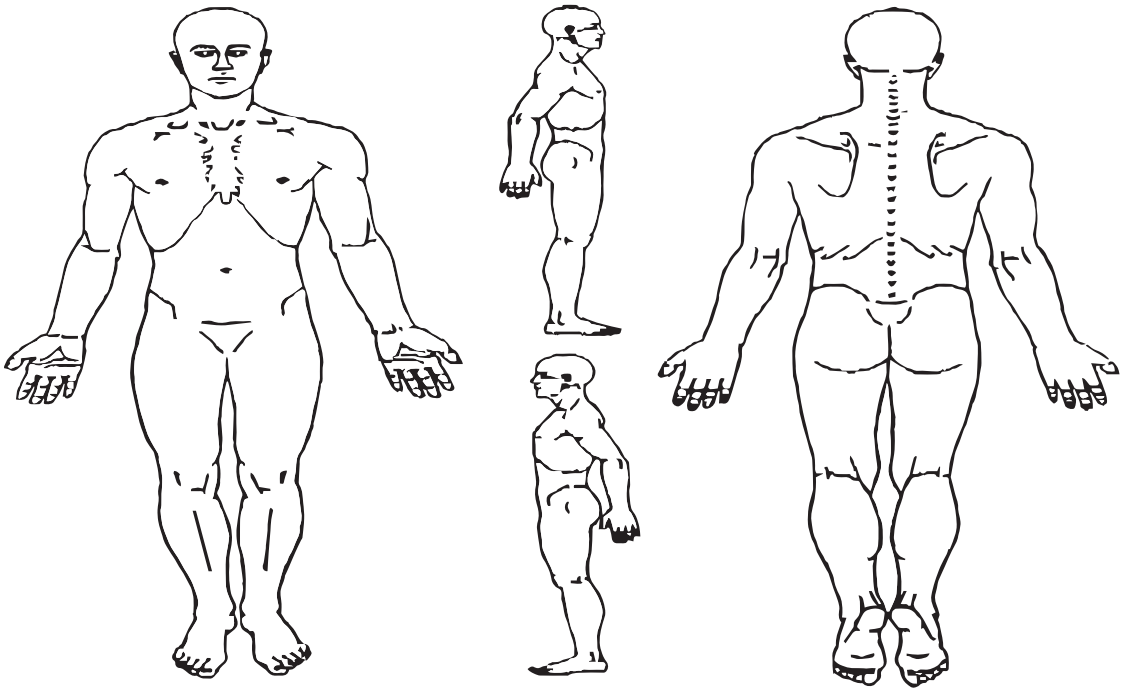
My pain is made WORSE by (circle the most descriptive words):

Laying - Sitting – Standing - Walking - Exercise - Bending - Lifting - Cold Weather

My pain is made BETTER by (circle the most descriptive words):

Sitting - Standing - Walking - Repositioning - Lying - Exercise - Medications - Heat - Ice

Using the drawing below, please shade all the areas of pain as specifically as possible.



Has your pain affected any of the following? If yes, please describe how it has affected you.

- ☐ Daily Activities _____
- ☐ Weight _____
- ☐ Sleep _____
- ☐ Mood Nerves _____
- ☐ Relationships _____
- ☐ Work (Job) _____

Which diagnostic tests have you had for your pain?
Please list where and when you had these tests performed.

- ☐ X-Rays _____
- ☐ CT Scan _____
- ☐ UltraSound _____
- ☐ Bone Scan _____
- ☐ MRI _____
- ☐ EMG/NCS _____

Have you tried any of the following to help manage your pain? Did it help? Y-Yes N-No

☐ Bed Rest	Y/N	☐ TENS Unit	Y/N	☐ Exercise Program	Y/N
☐ Traction	Y/N	☐ Biofeedback	Y/N	☐ Physical Therapy	Y/N
☐ Heat Therapy	Y/N	☐ Acupuncture	Y/N	☐ Psychotherapy	Y/N
☐ Ultrasound	Y/N	☐ Chiropractor	Y/N	☐ Work Hardening	Y/N

Medication History
Please ONLY check the medications you have tried in the past to help manage your pain and if they helped.

☐ Ibuprofen	Y/N	☐ Flexeril	Y/N	☐ Lyrica	Y/N	☐ Sonata	Y/N
☐ Naproxen	Y/N	☐ Robaxin	Y/N	☐ Risperdal	Y/N	☐ Ambien	Y/N
☐ Relafen	Y/N	☐ Soma	Y/N	☐ Pristiq	Y/N	☐ Lunesta	Y/N
☐ Arthrotec	Y/N	☐ Zanaflex	Y/N	☐ Savella	Y/N	☐ Klonopin	Y/N
☐ Celebrex	Y/N	☐ Valium	Y/N	☐ Midrin	Y/N	☐ Restoril	Y/N
☐ Mobic	Y/N	☐ Roxicodone	Y/N	☐ Fioricet	Y/N	☐ Ativan	Y/N
☐ Tramadol	Y/N	☐ Dilaudid	Y/N	☐ Amerge	Y/N	☐ Xanax	Y/N
☐ Tylenol	Y/N	☐ Percocet	Y/N	☐ Imitrex	Y/N	☐ Topamax	Y/N
☐ Hydrocodone	Y/N	☐ Oxycontin	Y/N	☐ Maxalt	Y/N	☐ Neurontin	Y/N
☐ Demerol	Y/N	☐ MS Contin	Y/N	☐ Zomig	Y/N	☐ Cymbalta	Y/N
☐ Stadol	Y/N	☐ Kadian	Y/N	☐ Trazodone	Y/N	☐ Butrans	Y/N
☐ Baclofen	Y/N	☐ Duragesic	Y/N	☐ Elavil	Y/N	☐ Exalgo	Y/N
☐ Skelaxin	Y/N	☐ Methadone	Y/N	☐ Remeron	Y/N		

Past Medical History

Which of the following do you have or have you had in the past?

- ☐ Stroke
- ☐ Ulcers
- ☐ Hepatitis
- ☐ Emphysema
- ☐ Heart Disease
- ☐ Bronchitis/Sinusitis
- ☐ Parkinson's Disease
- ☐ Reflux
- ☐ Cancer
- ☐ Asthma
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Arthritis
- ☐ Currently Pregnant
- ☐ Osteoporosis
- ☐ Migraines
- ☐ Diabetes
- ☐ Syphilis
- ☐ Drug/Alcohol Abuse
- ☐ High Blood Pressure
- ☐ Trying to become Pregnant
- ☐ Seizures
- ☐ Diverticulitis
- ☐ HIV
- ☐ Gonorrhea
- ☐ Gout
- ☐ Congestive Heart Failure

Past Surgical History

Which, if any, of the following have you had? Please include the approximate date.

- ☐ Brain Surgery
- ☐ Facial Surgery
- ☐ Eye Surgery L or R
- ☐ Oral Surgery
- ☐ Tonsillectomy
- ☐ Thyroid Surgery
- ☐ Lung Surgery
- ☐ Heart Surgery
- ☐ Hysterectomy
- ☐ Stomach Surgery
- ☐ Gallbladder Surgery
- ☐ Bowel Surgery
- ☐ Appendectomy
- ☐ Hand/Wrist Surgery L or R
- ☐ Kidney Surgery L or R
- ☐ Bladder Surgery
- ☐ Tubal Ligation
- ☐ Blood Vessel Surgery
- ☐ Spine Surgery Neck
- ☐ Spine Surgery Back
- ☐ Shoulder Surgery L or R
- ☐ Hernia Repair
- ☐ Hip Surgery L or R
- ☐ Knee Surgery L or R
- ☐ Foot Surgery L or R

Please list and indicate current dosage and frequency of ALL medications currently being taken including herbs, vitamins, and supplements.

Name of Medication	Dosage	Frequency

List ALL your medication allergies and their reactions:

Medication	Reaction	Other allergies:	
		Are you allergic to latex?	Y/N
		Are you allergic to metals?	Y/N
		Are you allergic to tape?	Y/N
		Are you allergic to any vaccines?	Y/N

Family History
Grandparents, Parents, Brothers, Sisters

☐ Stroke	☐ Reflux	☐ Osteoporosis
☐ Seizures	☐ Ulcers	☐ Cancer
☐ Migraines	☐ Diverticulitis	☐ Other: _____
☐ Asthma	☐ Diabetes	☐ Other: _____
☐ Emphysema	☐ Liver Disease	☐ Other: _____
☐ Heart Disease	☐ Kidney Disease	☐ Other: _____
☐ Congestive Heart Failure	☐ Arthritis	☐ Other: _____
☐ High Blood Pressure	☐ Gout	☐ Other: _____
☐ COPD	☐ High Cholesterol	☐ Other: _____

Social History (Circle all that apply)

Marital Status: Single Married Divorced Widowed

Living Situation: Alone Spouse Family/Friend Homeless

Your Habits: Alcohol Tobacco Caffeine Illicit Drugs

If you use tobacco, do you: Smoke Dip/Chew How much??_____

Work Status

Are you currently: ☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired
☐ Full Time or ☐ Part Time

If you are disabled, is it: ☐ Long Term ☐ Short Term

On what date did you become disabled: _____

Are you being treated for a Work Camp Injury? ☐ Yes ☐ No

Are you being treated for an automobile accident? ☐ Yes ☐ No

Are there legal issues to your pain problem? ☐ Yes ☐ No

Have you retained an attorney? ☐ Yes ☐ No

Name of your Attorney: _____

Address of your Attorney: _____

Phone#: _____ Fax#: _____

In your own words please describe what type of work you do or were doing prior to your injury.

_____

_____

_____

_____

_____

_____

Review of Systems

Check all that you have

General

- ☐ Good general health lately
- ☐ Poor sleep
- ☐ Fatigue

Cardiovascular

- ☐ Angina
- ☐ Fluid retention
- ☐ Cardiac arrhythmia
- ☐ Heart murmur

Respiratory

- ☐ Asthma
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Wheezing

Musculoskeletal

- ☐ Neck pain
- ☐ Back pain
- ☐ Difficulty walking
- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Joint swelling
- ☐ Muscle cramps

Neurological

- ☐ Lightheaded or dizzy
- ☐ Stroke
- ☐ Head injury
- ☐ Paralysis
- ☐ Frequent headaches
- ☐ Memory loss
- ☐ Seizures
- ☐ Tingling/Numbness
- ☐ Tremors

Psychiatric

- ☐ Addiction
- ☐ Anxiety
- ☐ Nervousness
- ☐ Depression
- ☐ Mental illness
- ☐ High stress level
- ☐ Suicidal thoughts

Endocrine

- ☐ Diabetes
- ☐ Hypothyroid
- ☐ Hyperthyroid

Gastrointestinal

- ☐ Asthma
- ☐ Chronic cough
- ☐ Loss of appetite
- ☐ Peptic ulcers
- ☐ Blood in stool
- ☐ Hepatitis/Jaundice
- ☐ Abdominal pain
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting

Hematological

- ☐ Abnormal bleeding
- ☐ Anticoagulant therapy/blood thinners

SOAPP Questionaire

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There is no right or wrong answer.

Patient Name	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?					
2. How often have you felt a need for higher doses of medication to treat your pain?					
3. How often have you felt impatient with your doctors?					
4. How often have you felt that things are just too overwhelming that you can't handle them?					
5. How often is there tension in the home?					
6. How often have you counted pain pills to see how many are remaining?					
7. How often have you been concerned that people will judge you for taking pain medication?					
8. How often do you feel bored?					
9. How often have you taken more pain medication than you were supposed to?					
10. How often have you worried about being left alone?					
11. How often have you felt a craving for medication?					
12. How often have others expressed concern over your use of medication?					
13. How often have any of your close friends had a problem with alcohol or drugs?					
14. How often have others told you that you had a bad temper?					
15. How often have you felt consumed by the need to get pain medication?					
16. How often have you run out of pain medication early?					
17. How often have others kept you from getting what you deserve?					
18. How often, in your lifetime, have you had legal problems or been arrested?					
19. How often have you attended an AA or NA meeting?					
20. How often have you been in an argument that was out of control that someone got hurt?					
21. How often have you been sexually abused?					
22. How often have others suggested that you have a drug or alcohol problem?					
23. How often have you had to borrow pain medications from your family or friends?					
24. How often have you been treated for an alcohol or drug problem?					

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____ Date: _____

Over the past 2 weeks, how often have you been bothered by any of the following problems? If you answered 'Not at all' to the first 2 questions, do not proceed to other questions

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

Total Score:_____

Interpretation:

- Minimal Depression
- Mild Depression
- Moderate Depression
- Moderately Sever Depression
- Severe Depression

Interpretation of Total Score for Depression Severity

- 1-4 Minimal depression
- 5-9 Mild depression
- 10-14 Moderate depression
- 15-19 Moderately severe depression
- 20-27 Severe depression

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PEG SCALE

Patient Name: _____ Date: _____ ID: _____

Primary Care Physician: _____

What number best describes your pain on average in the past week?

No Pain — Horrible Pain

0 1 2 3 4 5 6 7 8 9 10

What number best describes how, during the past week, pain has interfered with your enjoyment in life?

Does not Interfere — Completely Interferes

0 1 2 3 4 5 6 7 8 9 10

What number best describes how, during the past week, pain has interfered with your general activity?

Does not Interfere — Completely Interferes

0 1 2 3 4 5 6 7 8 9 10

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ALCOHOL MISUSE/ABUSE (AUDIT C)

Name: _____ Gender: _____ Date: _____

Did you have a drink containing alcohol in the past year?

- Yes
- No

Points: _____

Interpretation:

- Positive
- Negative

Interpretation:
The AUDIT-C is scored on a scale of 0-12 (scores of 0 reflect no alcohol use). In men, a score of 4 or more is considered positive
In women, a score of 3 or more is considered positive.

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OPIOID RISK TOOL (2018 Edition)

Name: _____ Date: _____ Sex: _____

Age: _____

FAMILY HISTORY OF SUBSTANCE ABUSE
Check only those boxes that apply!

Family Hx Alcohol?	◯ Yes	◯ No
Family Hx Illegal Drugs?	◯ Yes	◯ No
Family Hx Rx Drugs?	◯ Yes	◯ No

PERSONAL HISTORY OF SUBSTANCE ABUSE
Check only those boxes that apply!

Personal Hx Alcohol?	◯ Yes	◯ No
Personal Hx Illegal Drugs?	◯ Yes	◯ No
Personal Hx Rx Drugs?	◯ Yes	◯ No
Age between 16-45 years?	◯ Yes	◯ No
History of Preadolescence Sexual Abuse?	◯ Yes	◯ No

PSYCHOLOGIC DISEASE
Check only those that apply!

ADD, ODC Bipolar, Schizophrenia?	◯ Yes	◯ No
Depression?	◯ Yes	◯ No

TOTAL SCORE: _____

SCORING RISK: 0-3: Low 4-7: Moderate ≥8: High

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TOBACCO SCREENING

Name _____ **Date** _____

Are you a:

- o Current smoker
- o Former smoker
- o Nonsmoker
- o Current every-day smoker
- o Current some-day smoker
- o Smoker, current-status unknown
- o Unknown if ever smoked
- o Light tobacco smoker
- o Heavy Tobacco Smoker

Additional Findings: Tobacco User

- o Chain Smoker
- o Chews fine cut tobacco
- o Chews loose leaf tobacco
- o Chews plug tobacco
- o Chews tobacco
- o Chews twist tobacco
- o Heavy cigarette smoker (20-39 cigs/day)
- o Light cigarette smoker (1-9 cigs/day)
- o Moderate cigarette smoker (10-19 cigs/day)
- o Pipe Smoker
- o Rolls own cigarettes
- o Snuff user
- o Trivial cigarette smoker (less than one cigarette/day)
- o User of most powdered tobacco
- o Very heavy cigarette smoker (40+ cigs/day)

AdditionalFindings:TobaccoNon-User

- o Aggressive non-smoker
- o Current non-smoker
- o Current non-smoker, but past smoking history
- o Does not use moist powdered tobacco
- o Ex-cigar smoker
- o Ex-cigarette smoker
- o Ex-cigarette smoker amounts unknown
- o Ex-heavy cigarette smoker (20-30/day)
- o Ex-light cigarette smoker 1-9/day)
- o Ex-moderate cigarette smoker (10-19/day)
- o Ex-pipe smoker
- o Ex-trivial cigarette smoker (<1/day)
- o Ex-user of moist powdered tobacco
- o Ex-very heavy cigarette smoker (40+/day)
- o Intolerant ex-smoker
- o Intolerant non-smoker
- o Never chewed tobacco
- o Never used moist powdered tobacco
- o Non-smoker for medical reasons
- o Non-smoker for personal reasons
- o Non-smoker for religious reasons
- o Tolerant ex-smoker
- o Tolerant non-smoker

Referral Source:

Please check all that apply.

- ☐ Self referred
- ☐ Google
- ☐ Social media
- ☐ TV
- ☐ Youtube
- ☐ Email
- ☐ Other: _____

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