

## PATIENT INFORMATION

Name:		Da	ate of Birth:		Age:	Sex: M/F
Address (City, State, Zip):						
Billing Address:	~		Social Security #:	2	Marital Status:	
Primary Phone #:	Work Phone #	<b>#</b> :		Secor	ndary Phone #:	
Email:	Employment: No		e/Part/Full	Emple	oyer:	
Referring Physician:			Primary Care Provide	r:		
How did you hear about us? (Referring doctor, frier	nd, family, self-referred	d, int	ternet, magazine, newspaper, ac	lvertisem	ent, other)	

## **EMERGENCY CONTACT INFORMATION**

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

## **INSURANCE INFORMATION**

Primary Insurance:	Secondary Insurance:
Copay:	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:	Ethnicity:	Primary Language:	
Asian, Native American, Other Pacific Islander, Black/African American,	Hispanic/Latino, Not Hispanic/Latino, Not		
American Indian/Alaska Native, White, More than 1 race	reported, Refuse to report		

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 e	each question		Office U	se Only
1. Has anyone in your family ever had a history of substance	e 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 Schiz	ophrenia?			
	Yes	No	2	2
6. Have you ever been diagnosed with depression?	Yes	No	1	1
		Total Score		

Total Score:

#### SLEEP RISK ASSESSMENT

#### Please mark all that apply.

Excessive daytime sleepiness	Snoring	Hypertension
Apnea witnessed by partner	Obesity	Heart Disease
Hypnogogic hallucinations Nighttime sweating Short term memory problems	Acid reflux Morning headaches Frequent arousals	Heart Attack COPD Stroke/TIA
Lack of concentration	Arousals with gasping	Diabetes

- Sexual dysfunction/impotence
- Frequent bathroom trips
- Cataplexy (sudden episodes of muscle weakness accompanied by full consciousness awareness)
- Arousals with SOB
- Arousals with choking
- Restless sleep

- Seizures
- Depression
- Moodiness

Patient Name (PRINTED)

Patient/Guarantor Signature

Date

Page 2 of 12

Please identify your worst area of pain		Please shade the area where	you feel the <b>worst</b> pain
○ HEADACHES		$\cap$	$\cap$
o Frontal Area	(Left / Right)	{= =}	()
o Temples	(Left / Right)	R	LSCR
o Back of Head	(Left / Right)		
○ FACIAL PAIN	(Left / Right)		( )
O NECK			
o Radiates into Shoulder	(Left / Right)		
o Radiates into Mid-Back	(Left / Right)		1-11 1-1
o Radiates into Arm	(Left / Right)		/// \\\
o Radiates into Hands	(Left / Right)	211 116	11 11
O UPPER BODY PAIN		7. 1 0 1 457	w w
o Shoulders	(Left / Right)	~uo \	
o Arms	(Left / Right)		
o Hands	(Left / Right)		1 // /
O UPPER BACK PAIN		1-11-1	) ( ( )
o Radiates to Ribs	(Left / Right)		
O ABDOMINAL PAIN		$\langle    \rangle$	
o Radiates to Pelvis	(Left / Right)	)//(	XX
o Radiates to Lower Back	(Left / Right)		/())
<ul> <li>Radiates to Legs</li> </ul>	(Left / Right)	and the	المتعا لله
O LOW BACK PAIN		How did your pain begin?	Incident Type:
<ul> <li>Radiates to Hips</li> </ul>	(Left / Right)	o Gradually, after NO accident	o Trauma
<ul> <li>Radiates to Buttocks</li> </ul>	(Left / Right)		o Vehicle Accident
<ul> <li>Radiates to Legs</li> </ul>	(Left / Right)	o Gradually, after an accident	o Other:
O Radiates to Foot	(Left / Right)	O Suddenly, after an accident	
O PELVIC PAIN		Pain Pattern:	
о Соссух		o Always Present	o Sometimes Present
<ul> <li>Radiates to Legs</li> </ul>	(Left / Right)	o Present with certain activities	
O LOWER BODY PAIN		Describe the quality of your pair	n (Check all that apply)
o Groin	(Left / Right)	0 aching	O pins and needles
o Pelvis	(Left / Right)	o burning	o sharp
o Hips	(Left / Right)	o cramping	o shooting
0 Buttocks	(Left / Right)	o deep	o stabbing
o Knees	(Left / Right)	o dull	o throbbing
o Feet	(Left / Right)		
O DIFFUSED BODY PAIN		Severity of Pain:	
o Face			
o Head		o Mild o Moderate	e o Severe
0 Neck			
o Chest		Last Height:	Last Weight:
o Arms	(Left / Right)		
o Back		Current Pain Level:/ 10	
0 Legs	(Left / Right)		



Duration of Pain:		Assisted Devices:	
o weeks / mo	onths / years	o None o Cane	o Walker
o Other:		o Brace o Corset	0 Wheelchair
Course of Pain:		Intensity of Pain at Best:	/ 10
o Without Change	o Improving	Intensity of Pain at Worst:	/ 10
o Worsening		Intensity of Pain on Averag	e: / 10
Pain Relieved By:		Previous Evaluations:	
o Rest	o Ice	o Primary Care	o Psychologist
o Changing Position	o Sitting	o Urgent Care	o Pain Management
o Exercise	o Standing	o Emergency Room	o Orthopedic Surgeon
o Pain Medication	o Bending Forward	o Rheumatologist	o Neurologist
o Heat	o Physical Therapy	o Physiatrist	o Neurosurgeon
o Other:	0 Nothing	o Chiropractor	o None
Pain Worsened By:		Physical Therapy:	
o Sneezing	0 Lifting	o None	o TENS unit
o Coughing	o Sitting	o lce	<ul> <li>Massage</li> </ul>
o Bowel Movements	o Standing	o Heat	o Aquatic
o Bending	o Walking	O Stretching Exercises	o Other:
0 Twisting	o Lying Down	O Strengthening Exercises	
o Other:	0 Nothing		
Associated Factors:		Previous Spine Surgery:	
o None	o Hip Pain	o None	
o Tingling:	o Flank Pain	о Туре:	
o Numbness:	O Incontinence of Stool	Date: Sur	geon:
O Leg Weakness (L / R)	o Incontinence of Urine	о Туре:	
0 Arm Weakness ( L / R )	o Chills	Date: Sur	geon:
o History of Malignancy	o Fever		
Daily Activitias Impaired b	w Pain.	Provious Injustion Thorses	
Daily Activities Impaired b o Work	o Dressing	Previous Injection Therapy: o None	o Vertebroplasty
o Sleeping	o Bathing	o Joint Injection:	in the second
o Leisure	o Intimacy	o Facet Injection	
o Chores	o None	o Epidural Steroid Injection	2053 - 35 - 50 53 - 35
	<b>U</b> NUTC		

### 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:
o X-RAY:
o CT:
o MRI:
o Bone Scan:
o EMG Study:

Current Medications		Past Surgery History		
80	dose and frequency)	Adenoidectomy	Hysterectomy	
1		Knee Arthroscopy	Lumpectomy	
2		Back Surgery	Bowel Res. (Large / Small)	
3	· · · · · · · · · · · · · · · · · · ·	🗆 Neck	Mastectomy	
4		Thoracic	Prostate Surgery	
5		🗆 Lumbar	Plastic Surgery	
6		Brain Surgery	Shoulder Surgery (Left / Right)	
/	· · · · · · · · · · · · · · · · · · ·	🗆 Carpal Tunnel (Left /	Thyroidectomy	
8		Right)	Hip Replacement (Left / Right)	
9	· · · · · · · · · · · · · · · · · · ·	Cataract Surgery	Knee Replacement (Left/Right)	
10			Tubal Ligation	
11		Coronary Artery Dilation	Vasectomy	
12		Detached Retina Repair	Pace Make	
		🗆 Gallbladder	Other:	
	· · · · · · · · · · · · · · · · · · ·	Hemorrhoidectomy		
No current medication	ons	🗆 Hernia Repair		
Past Med	dical History	Soc	cial History	
🗆 Anemia	Emphysema	Marital Status		
Arthritis	GI Ulcer	Single	Married	
🗆 Anxiety	Heart Attack	Divorced	Widowed/Widower	
🗆 Asthma	Hepatitis ()	Alcohol Use		
Atrial Fibrillation	🗆 HIV / AIDS		🗆 Drinks per day:	
Bipolar Disorder	Hypertension			
Bleeding Disorder	Kidney Disease			
D BPH	Liver Disease	Drug Use		
Breast Cancer	Osteoporosis	□ History of Drug Abuse:	□ N/A	
Bronchitis	Cancer ()	Current Drug Abuse:		
	Prostate Cancer			
Clotting Disorder	Seizures	Tobacco Use		
	Shingles	🗆 Current Smoker	Former Smoker; Quit	
Coronary Artery	□ Stroke	<ul> <li>Cigarettes Per Day:</li> </ul>	Never Smoker	
Disease	Thyroid Disease	Work Status		
Depression	□ Other:	Unemployed	Disabled since	
🗆 Diabetes		Employed (Full / Part)		
A11	ergies	Family History:		
	ci Bica	(Please specify who if applicable		

(Please specify who if applied	cable)
Adopted	Heart Disease
Anxiety	🗆 Heart Attack
□ Alzheimer's	— High Blood Pressure
Cancer	🗆 Migraine
Diabetes	Osteoporosis
Depression	Stroke
Mental Illness	
	<ul> <li>Adopted</li> <li>Anxiety</li> <li>Alzheimer's</li> <li>Cancer</li> </ul>



### **Review of Systems**

## Please mark all that apply

Constitutional			Eyes
□ Fatigue	Sleep Disturbances	🗆 Redness	Double Vision
□ Chills	Weight Gain	Blurred Vision	Vision Change
🗆 Fever	Weight Loss	🗆 Pain	□ Dry
<u>E.N</u>	<u>N.M.T</u>	<u>Ca</u>	rdiovascular
Decreased Hearing	Nasal Congestion	Chest Heaviness	Palpitations
🗆 Earache	□ Nose Bleeds	🗆 Chest Pain	Shortness of Breath
Dry Mouth	Sinus Pain	Chest Tightness	Leg Swelling
Ringing in Ears	Sore Throat	□ Irregular Heartbeat	0 0
Resp	biratory	Gas	strointestinal
□ Short of Breath	Chronic Cough	🗆 Diarrhea	Bloody Stool
□ Wheezing	Pain with Breathing	Constipation	Tarry Stool
Sleep Apnea		Nausea	Loss of Appetite
I I		□ Vomiting	Abdominal Pain
		0	
Genit	ourinary	<u>Mu</u>	sculoskeletal
	ourinary	Mu □ Back Pain	
Genite □ Burning Urination □ Painful Urination			□ Muscle Cramps □ Muscle Weakness
Burning Urination	Incontinence – urine	Back Pain	<ul> <li>Muscle Cramps</li> <li>Muscle Weakness</li> </ul>
Burning Urination	Incontinence – urine	<ul> <li>Back Pain</li> <li>Neck Pain</li> </ul>	Muscle Cramps
<ul> <li>Burning Urination</li> <li>Painful Urination</li> </ul>	<ul> <li>Incontinence – urine</li> <li>Incontinence - stool</li> </ul>	<ul> <li>Back Pain</li> <li>Neck Pain</li> <li>Joint Pain</li> <li>Muscle Pain</li> </ul>	<ul> <li>Muscle Cramps</li> <li>Muscle Weakness</li> <li>Limited range of motion</li> <li>Gout</li> </ul>
<ul> <li>Burning Urination</li> <li>Painful Urination</li> </ul>	Incontinence – urine	<ul> <li>Back Pain</li> <li>Neck Pain</li> <li>Joint Pain</li> <li>Muscle Pain</li> </ul>	<ul> <li>Muscle Cramps</li> <li>Muscle Weakness</li> <li>Limited range of motion</li> </ul>
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<ul> <li>Burning Urination</li> <li>Painful Urination</li> <li>Same and the second secon</li></ul>	<ul> <li>Incontinence – urine</li> <li>Incontinence - stool</li> <li>Skin</li> <li>Lump</li> </ul>	<ul> <li>Back Pain</li> <li>Neck Pain</li> <li>Joint Pain</li> <li>Muscle Pain</li> <li>Nuscle Pain</li> </ul>	<ul> <li>Muscle Cramps</li> <li>Muscle Weakness</li> <li>Limited range of motion</li> <li>Gout</li> </ul>
<ul> <li>Burning Urination</li> <li>Painful Urination</li> <li>Solution</li> <li>Solution</li> </ul>	<ul> <li>Incontinence – urine</li> <li>Incontinence - stool</li> <li>Skin</li> <li>Lump</li> <li>Rash</li> </ul>	<ul> <li>Back Pain</li> <li>Neck Pain</li> <li>Joint Pain</li> <li>Muscle Pain</li> <li>Muscle Pain</li> </ul>	<ul> <li>Muscle Cramps</li> <li>Muscle Weakness</li> <li>Limited range of motion</li> <li>Gout</li> </ul> Heurological <ul> <li>Restless Legs</li> <li>Tingling</li> </ul>
<ul> <li>Burning Urination</li> <li>Painful Urination</li> <li>Solution</li> <li>Solution</li></ul>	<ul> <li>Incontinence – urine</li> <li>Incontinence - stool</li> <li>Skin</li> <li>Lump</li> <li>Rash</li> <li>Brittle Nails</li> </ul>	<ul> <li>Back Pain</li> <li>Neck Pain</li> <li>Joint Pain</li> <li>Muscle Pain</li> <li>Muscle Pain</li> <li>Dizziness</li> <li>Trouble Walking</li> <li>Headache</li> </ul>	<ul> <li>Muscle Cramps</li> <li>Muscle Weakness</li> <li>Limited range of motion</li> <li>Gout</li> </ul> <b>leurological</b> <ul> <li>Restless Legs</li> <li>Tingling</li> <li>Speech Difficulty</li> </ul>
<ul> <li>Burning Urination</li> <li>Painful Urination</li> <li>Sores</li> </ul>	<ul> <li>Incontinence – urine</li> <li>Incontinence - stool</li> <li>Skin</li> <li>Lump</li> <li>Rash</li> <li>Brittle Nails</li> </ul>	<ul> <li>Back Pain</li> <li>Neck Pain</li> <li>Joint Pain</li> <li>Muscle Pain</li> </ul> Nuscle Pain Nuscle Pain Nuscle Pain Nuscle Pain Muscle Pain <p< td=""><td><ul> <li>Muscle Cramps</li> <li>Muscle Weakness</li> <li>Limited range of motion</li> <li>Gout</li> </ul> <b>leurological</b> <ul> <li>Restless Legs</li> <li>Tingling</li> <li>Speech Difficulty</li> </ul></td></p<>	<ul> <li>Muscle Cramps</li> <li>Muscle Weakness</li> <li>Limited range of motion</li> <li>Gout</li> </ul> <b>leurological</b> <ul> <li>Restless Legs</li> <li>Tingling</li> <li>Speech Difficulty</li> </ul>
<ul> <li>Burning Urination</li> <li>Painful Urination</li> <li>Sores</li> </ul>	<ul> <li>Incontinence – urine</li> <li>Incontinence - stool</li> <li>Skin</li> <li>Lump</li> <li>Rash</li> <li>Brittle Nails</li> <li>Pigmentation Change</li> </ul>	<ul> <li>Back Pain</li> <li>Neck Pain</li> <li>Joint Pain</li> <li>Muscle Pain</li> </ul> Note: Comparison of the second se	<ul> <li>Muscle Cramps</li> <li>Muscle Weakness</li> <li>Limited range of motion</li> <li>Gout</li> </ul> <b>leurological</b> <ul> <li>Restless Legs</li> <li>Tingling</li> <li>Speech Difficulty</li> <li>Fainting</li> </ul> <b>Endocrine</b>
<ul> <li>Burning Urination</li> <li>Painful Urination</li> <li>Sores</li> <li>Anxiety</li> </ul>	<ul> <li>Incontinence – urine</li> <li>Incontinence - stool</li> <li>Skin</li> <li>Lump</li> <li>Rash</li> <li>Brittle Nails</li> <li>Pigmentation Change</li> <li>Chiatric</li> <li>Memory</li> </ul>	<ul> <li>Back Pain</li> <li>Neck Pain</li> <li>Joint Pain</li> <li>Muscle Pain</li> </ul> <b>N N</b>	<ul> <li>Muscle Cramps</li> <li>Muscle Weakness</li> <li>Limited range of motion</li> <li>Gout</li> </ul> <b>leurological</b> <ul> <li>Restless Legs</li> <li>Tingling</li> <li>Speech Difficulty</li> <li>Fainting</li> </ul>
<ul> <li>Burning Urination</li> <li>Painful Urination</li> <li>Sores</li> <li>Sores</li> <li>Anxiety</li> <li>Depression</li> </ul>	<ul> <li>Incontinence – urine</li> <li>Incontinence - stool</li> <li>Incontinence - stool</li> <li>Skin</li> <li>Lump</li> <li>Rash</li> <li>Brittle Nails</li> <li>Pigmentation Change</li> <li>Chiatric</li> <li>Memory</li> <li>Disturbances</li> </ul>	<ul> <li>Back Pain</li> <li>Neck Pain</li> <li>Joint Pain</li> <li>Muscle Pain</li> </ul> Note: Comparison of the second se	<ul> <li>Muscle Cramps</li> <li>Muscle Weakness</li> <li>Limited range of motion</li> <li>Gout</li> </ul> <b>leurological</b> <ul> <li>Restless Legs</li> <li>Tingling</li> <li>Speech Difficulty</li> <li>Fainting</li> </ul> <b>Endocrine</b>
<ul> <li>Burning Urination</li> <li>Painful Urination</li> <li>Sores</li> <li>Anxiety</li> </ul>	<ul> <li>Incontinence – urine</li> <li>Incontinence - stool</li> <li>Skin</li> <li>Lump</li> <li>Rash</li> <li>Brittle Nails</li> <li>Pigmentation Change</li> <li>Chiatric</li> <li>Memory</li> </ul>	<ul> <li>Back Pain</li> <li>Neck Pain</li> <li>Joint Pain</li> <li>Muscle Pain</li> </ul> <b>N N</b>	<ul> <li>Muscle Cramps</li> <li>Muscle Weakness</li> <li>Limited range of motion</li> <li>Gout</li> </ul> <b>leurological</b> <ul> <li>Restless Legs</li> <li>Tingling</li> <li>Speech Difficulty</li> <li>Fainting</li> </ul> <b>Endocrine</b>

## **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.

그는 것 같아요. 그 그는 것 ? 그는 것 같아요. 그는 것 ? 그는 것 ? 그는 것 ? 그는 그는 것 ? 그는 그는 것 ? 그는 그는 것 ? 그는 그는 그는 그는 그는 그는 요. 그는 그는 그는 그는 그는 그는 그는 그는 그는 요. 그는 그는 그는 그는 그는

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

Page 8 of 12

## 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



Page 9 of 12



Disclosure to Family Members and Friends

The new government HIPAA regulations require permission from the patient in order for any healthcare professional to speak with family, friends, or caregivers regarding your protected health information (PHI), with the exception of cases of emergency.

Please list your choice of individuals for us to disclose and/or discuss your private health information.

Please list those you authorize (ex: spouse, children, sibling, or caregiver) and remember that even your spouse needs to be listed if you authorize us to speak with them.

Name:	_DOB:	Phone:	Relationship:
Name:	_DOB:	Phone:	Relationship:
Name:	_DOB:	Phone:	Relationship:
Name:	_DOB:	Phone:	Relationship:
Name:	_DOB:	Phone:	Relationship:
Please tell us where to call you, leave message	ges, and appointme	ent reminders: Home	Cell Work
Phone:			

Can we leave messages on the phone number you have provided? \_\_\_ Yes \_\_\_ No

If yes, may we leave brief messages with NO clinical information? \_\_\_\_ Yes \_\_\_\_ No

May we leave extended messages with some clinical information? \_\_\_\_ Yes \_\_\_\_ No

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name, printed: \_\_\_\_\_

Page 10 of 12

## PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use " " to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
<ol> <li>Little interest or pleasure in doing things</li> </ol>	0	1	2	3
<ol><li>Feeling down, depressed, or hopeless</li></ol>	0	1	2	3
<ol><li>Trouble falling or staying asleep, or sleeping too much</li></ol>	0	1	2	3
<ol><li>Feeling tired or having little energy</li></ol>	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
<ol> <li>Feeling bad about yourself — or that you are a failure or have let yourself or your family down</li> </ol>	0	1	2	3
<ol> <li>Trouble concentrating on things, such as reading the newspaper or watching television</li> </ol>	0	1	2	3
<ol> <li>Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual</li> </ol>	0	1	2	3
<ol> <li>Thoughts that you would be better off dead or of hurting yourself in some way</li> </ol>	0	1	2	3

FOR OFFICE CODING \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_

=Total Score:

If you checked off any problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult Somewhat	Very	Extremely
at all difficult	difficult	difficult

Page 11 of 12

Please Turn Page Over

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Assessment and Management of Chronic Pain Second Edition/March 2007

## **Functional Ability Questionnaire**

**Instructions:** Circle the number (1-4) in each of the groups that best summarizes your ability. Add the numbers and multiply by 5 for total score out of 100.

	Self-care ability assessment
	<ol> <li>Require total care: for bathing, toilet, dressing, moving and eating</li> </ol>
	2. Require frequent assistance
	3. Require occasional assistance
	4. Independent with self-care
	Family and social ability assessment
	1. Unable to perform any: chores, hobbies, driving, sex or social activities
	2. Able to perform some
	3. Able to perform many
	4. Able to perform all
	Get-up-and-go ability assessment
	1. Able to get up and walk with assistance, unable to climb stairs
	2. Able to get up and walk independently, able to climb one flight of stairs
	3. Able to walk short distances and climb more than one flight of stairs
	<ol><li>Able to walk long distances and climb stairs without difficulty</li></ol>
	Lifting ability assessment
-	1. Able to lift up to 10 lb. occasionally
	2. Able to lift up to 20 lb. occasionally
	3. Able to lift 20-50 lb. occasionally
	4. Able to lift over 50 lb. occasionally
	Work ability assessment
-	1. Unable to do any work
	2. Able to work part-time and with physical limitations
	3. Able to work part-time or with physical limitations
	1 Able to perform normal work

Able to perform normal work

Functional Ability Score

Created by Peter Marshall, MD as a member of the ICSI Chronic Pain guideline work group.

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Page 12 of 12