SPECIALTY PAIN MANAGEMENT
Treating Your PAIN With Compassion

New Patient Intake

Welcome and thank you for choosing Specialty Pain Management (SPM) for your pain management needs. Your completed intake paperwork helps our providers get to know you and your medical history better. We rely on its accuracy and its completeness to provide you with the best care possible. Please take your time and if you have any questions or are unsure how to complete any section of this form, inquire at our front desk or call **480-496-2699**.

Today's Date: _____

Patient Information

Your Name: _____

DOB: _____ **Age:** _____ **Gender:** ❑ Male ❑ Female

Address: _____

City/State/Zip: _____

Preferred Phone: _____ ❑ Home ❑ Cell ❑ Work ❑ Ok to leave message

Secondary Phone: _____ ❑ Home ❑ Cell ❑ Work ❑ Ok to leave message

Social Security #: _____-_____-_____ **Driver's License #/State:** _____

Email address: _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed Other: _____

Race: ❑ American Indian ❑ Asian or Pacific Islander ❑ Black ❑ White ❑ Refuse to report

Primary Language: ❑ English ❑ Spanish ❑ Other **Ethnicity:** ❑ Hispanic ❑ Non-Hispanic

Advance Directive

Do you have a: ❑ Living Will ❑ Medical Power of Attorney, if so, please provide the office a copy for your chart.

Employment Status

❑ Employed ❑ Unemployed ❑ Retired ❑ Disabled Employer: _____

Phone: _____ Occupation: _____

Referral and Physician Relationships

Who is your primary care physician? _____ Phone: _____

Who can we thank for referring you to our clinic? _____

If you were not referred, how did you hear about us? ❑ Insurance company ❑ PCP ❑ Family ❑ Friend ❑ Yelp

❑ www.specialtypainmanagement.com ❑ Facebook ❑ Google ❑ Other website: _____

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

May we leave information with your emergency contact? ❑ Yes ❑ No

Preferred Pharmacy

Pharmacy Name: _____ Phone: _____

Address: _____ City/State/Zip: _____

Primary Insurance

Primary Insurance Company and Plan: _____

Policy ID #: _____ Group #: _____

Claims Address: _____

City/State/Zip: _____ Phone: _____

Insurance Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other

Complete this box if you are *not* the policy holder for your primary insurance

Policy Holder Name: _____ DOB: _____

Social Security #: _____-_____-_____ Phone: _____

Address: _____ City/State/Zip: _____

Policy Holder Gender: ❑ Male ❑ Female Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other

Secondary Insurance

Secondary Insurance Company and Plan: _____

Policy ID #: _____ Group #: _____

Claims Address: _____

City/State/Zip: _____ Phone: _____

Insurance Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other

Complete this box if you are *not* the policy holder for your secondary insurance

Policy Holder Name: _____ DOB: _____

Social Security #: _____-_____-_____ Phone: _____

Address: _____ City/State/Zip: _____

Policy Holder Gender: ❑ Male ❑ Female Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other

Workers Compensation Claim Information

Complete this section only if your visit today is related to a Workers Compensation claim

Employer: _____ Date/Time of Injury: _____

Employer Address: _____ Phone: _____

Employer Insurance Carrier: _____ Claim #: _____

Insurance Address: _____ Phone: _____

Agent/Adjuster Name: _____ Phone: _____

Injury Claim

Is your pain the result of a motor vehicle accident or other accident? ❑ Yes ❑ No

Have you hired an attorney for purposes of making any claims arising from that accident? ❑ Yes ❑ No

If yes to either question, you will be required to complete additional forms.

Consent for Treatment

I certify that the above information is accurate, complete and true.

I authorize Specialty Pain Management and its associates, assistants and other health care providers it may deem necessary to treat my condition. I understand that no warrant or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

Patient Signature: _____ Date: _____

MEDICAL / CLINICAL HISTORY

Your Name: _____ DOB: _____

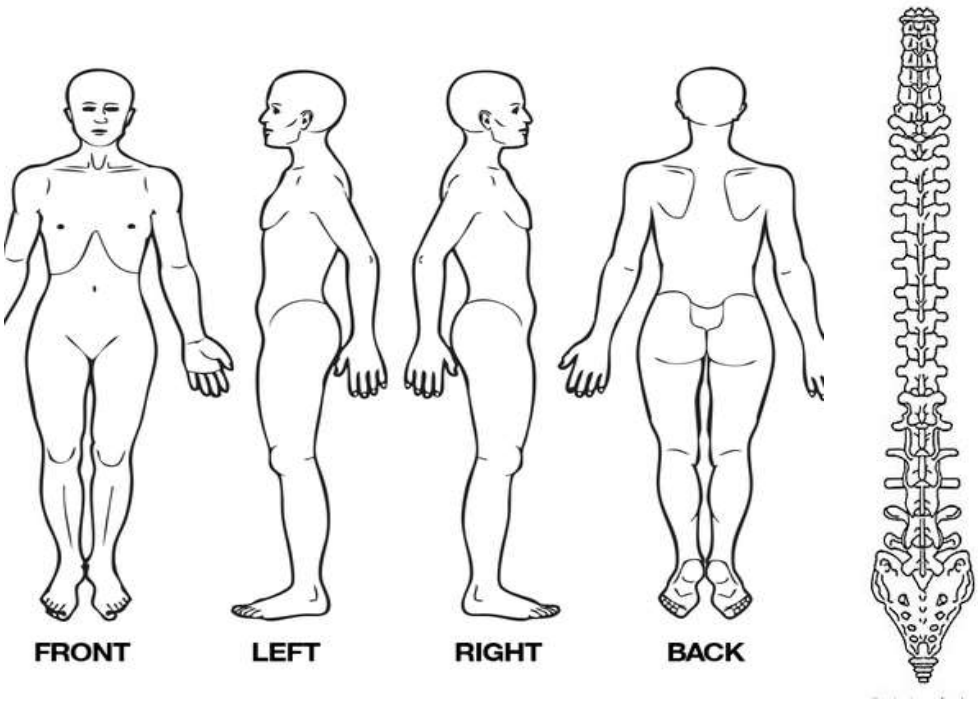
Primary reason for today's visit: _____

Height (inches): _____ Weight: _____ lbs

Pain Location

Use this diagram to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms:

"A" = Aching
"B" = Burning
"N" = Numbness
"P" = Pins and needles
"S" = Stabbing



Current Medications

Are you currently taking any aspirin, blood thinners or anticoagulants? ❑ Yes ❑ No

If yes, which ones? ❑ Coumadin ❑ Plavix ❑ Lovenox ❑ Aggrenox ❑ Other: _____

Please list ***all*** medications you are currently taking. Attach an additional sheet, if required.

Medication Name Dose Frequency

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Past Medical History/Problem List

Mark all conditions/diseases that **YOU** have been **DIAGNOSED** with:

Cardiovascular/Hematologic
- ❑ Anemia
- ❑ Clotting Disorder **(Blood Thinners)**
- ❑ Coronary Artery Disease
- ❑ Heart Attack
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Mitral Valve Prolapse
- ❑ Pacemaker/Defibrillator
- ❑ Poor Circulation
- ❑ Stroke

Gastrointestinal
- ❑ Bowel Incontinence
- ❑ Constipation
- ❑ Gastrointestinal Bleeding
- ❑ GERD (Acid Reflux)

General Medical
- ❑ Cancer- Type _____
- ❑ Diabetes- Type _____
- ❑ HIV/AIDS

Head/Eyes/Ears/Nose/Throat
- ❑ Glaucoma
- ❑ Headaches
- ❑ Head Injury
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Migraines

Hepatic-list active/inactive/unsure

Hepatitis ❑ A ❑ B ❑ C

❑ active ❑ inactive ❑ unsure

Musculoskeletal
- ❑ Amputation/Phantom Limb Pain
- ❑ Bursitis
- ❑ Carpal Tunnel Syndrome
- ❑ Chronic Low Back Pain
- ❑ Fibromyalgia
- ❑ Joint Injury _____
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Rheumatoid Arthritis
- ❑ Tennis Elbow
- ❑ Vertebral Compression Fracture

Nephrology/Genitourinary
- ❑ Bladder/Kidney Infections
- ❑ Dialysis
- ❑ Kidney Stones
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Urinary Incontinence

Neuropsychological
- ❑ Alcohol Abuse
- ❑ Alzheimer Disease
- ❑ Anxiety
- ❑ Bipolar Disorder
- ❑ Depression
- ❑ Epilepsy
- ❑ Multiple Sclerosis
- ❑ Neuropathy
- ❑ Paralysis
- ❑ Prescription Drug Abuse

Neuropsychological, cont.
- ❑ Schizophrenia
- ❑ Seizures
- ❑ Reflex Sympathetic Dystrophy (RSD)/ Chronic Regional Pain Syndrome (CRPS)
- ❑ Spinal Cord Injury
- ❑ Traumatic Brain Injury (TBI)

Respiratory
- ❑ Asthma
- ❑ Bronchitis
- ❑ Chronic Obstructive Pulmonary Disease (COPD)
- ❑ Emphysema
- ❑ Pneumonia
- ❑ Tuberculosis (TB)
- ❑ Valley Fever

Other diagnosed conditions:

_____

_____

_____

_____

_____

_____

❑ I HAVE NO SIGNIFICANT MEDICAL HISTORY

Allergies

Do you have any known drug allergies? ❑ Yes ❑ No

If so, please list all medications you are allergic to:

Medication Name	Allergic Reaction Type

Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the date, type or other pertinent details:

Abdominal Surgery
- ❑ Gallbladder removal _____
- ❑ Appendectomy _____
- ❑ Other _____

Female Surgeries
- ❑ Caesarean section _____
- ❑ Hysterectomy _____
- ❑ Laparoscopy _____
- ❑ Ovarian _____
- ❑ Other _____
- ❑ Other _____

Heart Surgery
- ❑ Aneurysm repair _____
- ❑ Stent placement _____
- ❑ Valve replacement _____
- ❑ Other _____

Joint Surgery
- ❑ Hip _____
- ❑ Knee _____
- ❑ Shoulder _____

Spine/Back Surgery
- ❑ Discectomy (levels) _____
- ❑ Laminectomy _____
- ❑ Spinal Fusion (levels) _____
- ❑ Other _____
- ❑ Other _____

Other Common Surgeries
- ❑ Hemorrhoid surgery _____
- ❑ Hernia repair _____
- ❑ Thyroidectomy _____
- ❑ Tonsillectomy _____
- ❑ Vascular surgery _____

Please list any other surgeries and dates

❑ I HAVE **NOT** HAD ANY SURGICAL PROCEDURE DONE

Hospitalizations

Please list any recent hospitalizations:

Month/Year Reason Hospital

_____

_____

_____

❑ I HAVE **NOT** HAD ANY RECENT HOSPITALIZATIONS

Family History

Mark all appropriate diagnoses as they pertain to your biological **MOTHER AND FATHER** only.

	Arthritis	Cancer	Depression	Diabetes	High blood pressure	High cholesterol	Bleeding disorder	Seizures	Heart disease	Asthma	Stroke
Mother											
Father											

❑ I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY ❑ I AM ADOPTED (No Medical History)

Social History

Are you capable of becoming pregnant? ❑ Yes ❑ No If so, are you currently pregnant? ❑ Yes ❑ No

Alcohol Use: ❑ Current Alcoholism ❑ Daily Limited Use ❑ Drinks Alcohol Socially
❑ History of Alcoholism ❑ Never Drinks Alcohol

If you are a **current drinker**, how many drinks per week? ❑ 1-3 ❑ 4-6 ❑ 7-9 ❑ 10-12 ❑ 13+

Tobacco Use: ❑ Current Tobacco User ❑ Former Tobacco User ❑ Never Used Tobacco

If you are a **current smoker**, how many cigarettes do you smoke a day?
❑ 5 or less ❑ 6-10 ❑ 11-20 ❑ 21-30 ❑ 31 or more

Illegal Drug Use: ❑ Current Illegal Drug Use ❑ Current Marijuana Use ❑ Denies Any Illegal Drug Use
❑ Current Use of Someone Else's Prescription Medications ❑ Former Illegal Drug Use

If you currently use illegal drugs, which one (s)?: _____

Do you have a Medical Marijuana card? ❑ Yes ❑ No

Have you filed for disability? ❑ Yes ❑ No

ORT Assessment

Patient Name: _____ DOB: _____

Mark each box that applies	Yes	No
Do your <u>PARENTS</u> or <u>SIBLINGS</u> have a history of substance abuse		
Alcohol		
Illegal drugs		
Rx drugs		
Do <u>YOU</u> have a history of substance abuse		
Alcohol		
Illegal drugs		
Rx drugs		
Are you between the age of 16 – 45 years		
History of preadolescent sexual abuse		
Psychological disease		
ADD, OCD, bipolar, schizophrenia		
Depression		

❑ If none of this applies, please check here

Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk too. Pain Med. 2005; 6 (6) : 432

PEG Scale

Please answer to the best of your ability in order to provide the best care possible, we rely on its accuracy and its completeness.

1) What number on the pain scale (0-10) best describes your pain on average in the past week? _____
2) What number on the pain scale (0-10) best describes how, during the past week, pain has interfered with your enjoyment of life? _____
3) What number on the pain scale (0-10) best describes how, during the past week, pain has interfered with your general activity? _____

Diagnostic Tests and Imaging

Mark all the following tests you have had that are related to your current pain complaints:

❑ MRI of the _____ Date: _____ Facility: _____
❑ X-ray of the _____ Date: _____ Facility: _____
❑ CT of the _____ Date: _____ Facility: _____
❑ EMG/NVC study of the _____ Date: _____ Facility: _____
❑ Ultrasound of the _____Date: _____ Facility: _____
❑ Other diagnostic testing: _____

❑ I HAVE **NOT** HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT COMPLAINTS.

Pain Treatment and Providers Seen History

Mark all the following pain treatments you have undergone prior to today's visit:

❑ Chiropractic ❑ Spine surgeon ❑ Pain Management ❑ Physical Therapy ❑ Rheumatology
❑ Discogram - (circle all levels that apply) Cervical / Thoracic / Lumbar
❑ Epidural Steroid Injection - (circle all levels that apply) Cervical / Thoracic / Lumbar
❑ Joint Injection – Joint(s) _____
❑ Medial Branch Blocks or Facet Injections - (circle all levels that apply) Cervical / Thoracic / Lumbar
❑ Nerve Blocks – Area/Nerve(s) _____
❑ Radiofrequency Ablation - (circle all levels that apply) Cervical / Thoracic / Lumbar
❑ Spinal Column Stimulator – (circle one) Trial Only / Permanent Implant – Which Company _____
❑ Trigger Point Injection – Where _____
❑ Vertebroplasty / Kyphoplasty – Level(s) _____
❑ Other: _____❑ Other: _____

❑ I HAVE **NOT** HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS

Previous Medications Tried

Mark all the following medications you have previously tried.

Over the Counter medications: ❑ Aspirin ❑ Acetaminophen/Tylenol ❑ Advil/Motrin/Ibuprofen
❑ Aleve/Naproxen ❑ Excedrin

Prescription Anti-Inflammatories: ❑ Ibuprofen Naproxen ❑ Diclofenac/Voltaren
❑ Meloxicam/Mobic ❑ Celecoxib/Celebrex ❑Ketorolac/Toradol ❑ Etodolac ❑ Indomethacin
❑ Piroxicam

Muscle Relaxers: ❑ Flexeril/Cyclobenzaprine ❑ Robaxin/Methocarbamol ❑ Tizanidine/Zanaflex
❑ Soma/Carisoprodol ❑ Baclofen ❑ Skelaxin/Metaxalone ❑ Orphenadrine/Norflex
❑ Lorzone/Chlorzoxazone

Nerve Pain Medications: ❑ Gabapentin/Neurontin ❑ Pregabalin/Lyrica ❑ Duloxetine/Cymbalta
❑ Amitriptyline/Elavil ❑ Nortriptyline/Pamelor ❑ Oxcarbazepine/Trileptal
❑ Topiramate/Topamax

Opiates:

Short Acting: ❑ Tramadol/Ultram ❑ Tylenol w/ Codeine ❑ Hydrocodone/Vicodin
❑ Oxycodone/Percocet ❑ Dilaudid/Hydromorphone ❑ Immediate Release Morphine ❑ Opana IR

Extended Release: ❑ Butrans Patch ❑ Fentanyl/Duragesic Patches ❑ MS Contin/Morphabond/Morphine ER
❑ OxyContin ❑ Opana ER ❑ Methadone

Opiate Induced Constipation: ❑ MiraLAX ❑ Docusate ❑ Senokot ❑ Colace
❑ Movantik ❑ Amitiza ❑ Linzess ❑ Relistor

Conservative Therapies History/Past treatments tried

Mark all the following conservative therapies you have tried for pain relief:

	Helped pain	Worsened pain	No change
Acupuncture/Acupressure	❑	❑	❑
Aqua/Cold Therapy	❑	❑	❑
Bed rest x 4-6 weeks	❑	❑	❑
Biofeedback	❑	❑	❑
Heating pad	❑	❑	❑
Ice packs	❑	❑	❑
Injection/Interventional Therapy	❑	❑	❑
Inversion table	❑	❑	❑
Massage Therapy	❑	❑	❑
Naturopathic Therapy	❑	❑	❑
Neuromuscular Therapy	❑	❑	❑
Pain Medications	❑	❑	❑
Physical Therapy	❑	❑	❑
Relaxation Technique	❑	❑	❑
Stretching Exercises	❑	❑	❑
Surgery	❑	❑	❑
TENS Unit	❑	❑	❑
Traction/Decompression	❑	❑	❑
Yoga	❑	❑	❑

Onset of Symptoms

Approximately when did this pain begin? _____

What caused your current pain episode? _____

_____

Is your pain the result of a Motor Vehicle Accident or Personal Injury? ❑ Yes ❑ No

How did your current episode begin? ❑ Gradually ❑ Suddenly

Since your pain began, has it changed? ❑ Decreased ❑ Increased ❑ Remained the same

Pain Frequency

Describe the frequency of your pain? ❑ Constant ❑ Intermittent ❑ Constant w/ intermittent severities

Quality of Pain Description

Check all the following that describes your pain:

❑ Aching	❑ Numbness	❑ Sharp	❑ Stabbing
❑ Burning/hot	❑ Piercing	❑ Shock-like	❑ Stiff
❑ Cramping	❑ Pinching	❑ Shooting	❑ Stinging
❑ Dull	❑ Pins and needles	❑ Sore	❑ Throbbing
❑ Grinding	❑ Popping	❑ Spasming	❑ Tingling
❑ Heavy	❑ Pressure	❑ Squeezing	❑ Tiring/Exhausting

Pain Scale with Descriptions

Use the pain scale described below to rate your pain for the questions below:

0-Pain free
1-Very minor annoyance, occasional minor twinges
2-Minor annoyance, occasional strong twinges
3-Annoying enough to be a distraction
4-Can be ignored if you are really involved in your work/task, but still distracting
5-Cannot be ignored for more than 30 minutes
6-Cannot be ignored for any length of time, but you can still go to work and participate in social activities
7-Makes it difficult to concentrate, interferes with sleep, but you can still function with effort
8-Physical activity is severely limited. You can read and talk with effort. Nausea and dizziness caused by pain
9-Unable to speak, crying or moaning uncontrollably, near delirium
10-Unconcious, pain makes you pass out

What number on the pain scale (0-10) best describes your pain **right now**? _____

What number on the pain scale (0-10) best describes your **average pain**? _____

What number on the pain scale (0-10) best describes your **least pain**? _____

What number on the pain scale (0-10) best describes your **worst pain**? _____

Where is your worst area of pain located? _____

Does your pain radiate (travel)? If yes, where? _____

Mark the effect of each of the following on your pain

Please indicate which body part next to box. **SEE EXAMPLE BELOW:**

	WORSENS my pain	RELIEVES my pain	BODY PART
SAMPLE:			
Increased activity:	✓	❑	LOW BACK
Bending	❑	❑	_____
Driving	❑	❑	_____
Going downstairs	❑	❑	_____
Going up stairs	❑	❑	_____
Increased activity	❑	❑	_____
Lifting	❑	❑	_____
Lying flat	❑	❑	_____
Movement	❑	❑	_____
Sitting	❑	❑	_____
Prolonged sitting	❑	❑	_____
Standing	❑	❑	_____
Prolonged standing	❑	❑	_____
Walking	❑	❑	_____
Prolonged walking	❑	❑	_____

Use of Supportive Devices

Do you use supportive devices? ❑ Yes ❑ No

If so, please check which supportive device you use.

❑ Back brace ❑ Cane ❑ Crutches ❑ Knee brace ❑ Power/motorized scooter
❑ Walker ❑ Wheel chair ❑ TENS Unit

Review of Systems

Mark the following symptoms that you currently suffer from. *Note: Diagnosed conditions/diseases should be noted under Past Medical History, above on (page 11)*

CONSTITUTIONAL: ❑ Significant Weight Gain/Loss ❑ Appetite Reduced ❑ Chills
❑ Fatigue ❑ Fever ❑ Insomnia ❑ Difficulty Sleeping

HEENT/NECK: ❑ Headaches ❑ Dental Pain ❑ Double/Blurred Vision
❑ Ringing in Ears ❑ Neck Stiffness ❑ Pain on Rotation or Movement ❑ Neck Tenderness

RESPIRATORY: ❑ Snoring ❑ Cough ❑ Shortness of Breath ❑ Wheezing

CARDIOVASCULAR: ❑ Chest Pain ❑ Dizziness ❑ Palpitations

GASTROINTESTINAL: ❑ Difficulty Controlling Bowels ❑ Abdominal Pain ❑ Constipation
❑ Diarrhea ❑ Nausea ❑ Vomiting

HEMATOLOGIC/LYMPHATIC: ❑ Bleeding Tendency

GENITOURINARY: ❑ Urination Problems ❑ Low Sex Drive ❑ Flank Pain

MUSCULOSKELETAL: ❑ Foot/Ankle Pain ❑ Shoulder Pain ❑ Muscle Spasms
❑ Arm Pain ❑ Elbow Pain ❑ Low Back Pain ❑ Mid Back Pain ❑ Hip Pain
❑ Joint Pain ❑ Knee Pain ❑ Neck Pain ❑ Sciatica

SKIN: ❑ Rash ❑ Itching ❑ Tattoos

NEUROLOGICAL: ❑ Numbness ❑ Tingling ❑ Recent Falls
❑ Fainting ❑ Headaches ❑ Memory Loss ❑ Weakness

PSYCOLOGICAL/PSYCHIATRIC: ❑ Anxiety ❑ Depression ❑ Hallucinations
❑ Suicidal Thoughts

General Consent, Medical History and Authorization to Proceed with Treatment

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. This consent will remain fully effective until it is revoked in writing. You have the right to discontinue services at any time.

I voluntarily request that Specialty Pain Management provide pain management care, treatment, and services to me, as deemed reasonable and necessary by the assigned healthcare provider(s). I consent to reasonable and necessary medical examination, evaluation, testing and treatment which may include diagnostic, radiology and laboratory procedures. I understand I may be asked to provide urine, oral swab, and/or blood samples. I have the right to refuse specific tests, but understand this may impact my pain management treatment. If invasive interventional treatment is recommended, I will be informed of the benefits and risk prior to performance of such treatment and will be provided with a separate consent form outlining such benefits and risk.

PHOTOGRAPHS I consent to taking pictures of me. These pictures will be used for purposes related to billing, coordination of care, and healthcare operations, such as quality assurance, patient safety and identification.

RELEASE OF INFORMATION I specifically authorize the uses and disclosures of my health information as described in the Notice of Privacy Practices available to me. I authorize Specialty Pain Management physicians, and/or their staff, to obtain my medication history and other relevant health care information, verbally, written or electronically, that is deemed necessary for my treatment. I consent to release of my health information to federal or state health plans, insurance companies, collection agencies, employers or other organizations responsible for payment of services, as appropriate. I understand that this may include information relating to my diagnosis, care, payment for my care, or demographic information.

I certify that the above medical/clinical history information is accurate, complete and true. I authorize Specialty Pain Management to proceed as indicated in above consents.

Patient Signature: _____ Date: _____

Consent for Concurrent Narcan Prescription

According to the U.S. Centers for Disease Control and Prevention (CDC) there were 63,632 drug overdose deaths in the United States in 2016. This equals one death every 8.28 minutes, or 174 deaths every day. 42,249 (66.4%) of those deaths were due to opioids. Accidental overdose is now a more common cause of death than motor vehicle accidents, gun violence, homicide, or suicide.

In an effort to help combat this national health crisis, beginning in April 2018 all patients on Schedule II opiate medications prescribed by this office will receive a prescription for Narcan. Narcan (also known as Naloxone) is a rescue drug designed specifically to reverse opiate overdose. The American Medical Association has recommended that this medication be prescribed specifically to patients who meet any or all the following guidelines:

- Patient is on a high dose of opiates (more than 50mg Morphine Milligram Equivalent (MME) per day)
- Patients with a history of illicit or prescription drug addiction or abuse
- Patients with respiratory disease, sleep apnea, or any other medical condition that could contribute to opioid toxicity or exacerbated breathing problems with opiate medication
- Patients with a psychiatric or psychological disorder that may contribute to accidental overdose.

This prescription will require you to appoint a person in your home or close to you to have access to the Narcan, and that the individual (named below) be trained in its use. Please have the person you designate with this responsibility sign this form and return it at your next office visit.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND HAVE RECEIVED A COPY OF THE NARCAN FACT SHEET.

_____

Patient Name DOB

_____

Signature Date

I have designated the person below to have access to and administer my Narcan:

_____

Print Name Phone

I have been educated and agree to administer Narcan to this patient in the event of an opiate emergency.

_____

Print Name Signature Date

Financial Agreement, Cancellation Policy, Notice of Privacy Practices, Statement of Patient Rights

PLEASE READ THE FOLLOWING AGREEMENT. IT EXPLAINS YOUR FINANCIAL OBLIGATIONS WHILE UNDER OUR CARE, OUR POLICIES REGARDING CANCELLATIONS AND NOTICE OF PRIVACY PRACTICES.

AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT: I authorize treatment of the person named above and agree to pay all fees and charges for such treatment promptly upon presentation of statement, unless prior credit arrangements have been agreed upon in writing. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing date. Although this office may assist me in filing an insurance claim, I understand that I am fully responsible for the balance and agree that payment will not be delayed because of any pending insurance claim. In the event legal action should become necessary to collect an unpaid balance, I agree to pay all reasonable attorney's fees or other costs the court may determine proper.

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION: I authorize all insurance benefits, unless previously paid by myself, to be paid directly to this physician/facility and authorize the physician/facility to release any information required in the processing of the insurance claim. I authorize the physician/facility to release medical information to my referring physician, primary care physician, spouse, children, parents and any physician he/she may refer me to.

ALL MEDICARE PATIENTS MUST SIGN THE FOLLOWING STATEMENT: I request that payment under the medical insurance program be made on my behalf to Specialty Pain Management Center for any services furnished me by its physician(s) and/or practitioners. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Name: _____ Signature: _____

Insurance Benefits

Arizona State Law (HB2600) requires that medical claims be paid by insurance carriers within 90 days. If your insurance carrier has not appropriately paid the submitted claim within 90 days, I understand that outstanding balances will become the responsibility of the policy holder.

Insurance Co-Payments, Deductible and Co-insurance

In accordance with my insurance contract, I understand that **co-payments are due at time of service**. If my insurance deductible has not been met, I understand that outstanding deductible amounts will be collected at the time of service unless other payment arrangements have been made. I understand that co - insurance amounts may be collected at time of service, and at the time interventional procedures are scheduled.

Private Pay

If I have no insurance coverage, or insurance with which Specialty Pain Management does not participate, or Specialty Pain Management is unable to verify current insurance coverage, I understand **full payment is expected at time of service**. We do accept SELF-PAY patients (i.e. Patients with NO insurance), Initial consultation is $450.00 that is due at the time of service. Follow up visits are $150.00 due at time of service, if a urinalysis is required it will be $200.00. If a procedure is scheduled- a fee schedule will be discussed with you prior to the appointment day. The amount discussed will be due at the time of service.

Verification of Benefits and Non-Covered Services

Insurance policies are individualized per patient plan. Specialty Pain Management may provide services that my insurance plan excludes. I understand that it is my responsibility to verify coverage benefits and exclusions. I understand that all non-covered services are my responsibility.

Notice to Medicare Patients

If we are unable to verify from Medicare that there is automatic submission of claims to the secondary insurance carrier, you may be responsible for secondary insurance balances at the time of service and at the time interventional procedures are scheduled.

Refund Policy

I understand that amounts collected from me (including co-payments, co-insurance and deductibles) are based on information received by Specialty Pain Management from my insurance carrier. Refunds are to be requested from your insurance company. Specialty Pain Management is not responsible for reimbursements.

Collections

I understand that once an account is placed in a collection status, all future services must be paid in full at time of service (no checks accepted). If my account is placed into collections, I will be responsible for all collection and interest costs.

Returned Checks

Returned checks will be subject to a $30.00 returned check fee.

NO SHOW, LATE CANCELLATIONS OR RESCHEDULING

Regretfully, we have been forced to institute this policy due to a large volume of last-minute cancellations, scheduling changes, and "no-shows."

- We have a very busy practice. Assuring that all our established patients have access to their doctor when necessary is a constant challenge. When you cancel or reschedule at the last minute, or fail to show for your appointment, you are depriving another patient of the care they need. **You must cancel or reschedule within 24 hours.**
- New patient visits require our doctor to block out large time slots, making last minute cancellations and rescheduling of visits even more problematic. We provide a large amount of time and attention with each one of our new patients because we are committed to providing the highest quality care.

NEW PATIENT APPOINTMENTS:

- IF YOU FAIL TO SHOW FOR YOUR APPOINTMENT, YOU MAY BE CHARGED $50.

FOLLOW- UP VISITS:

- IF YOU FAIL TO SHOW FOR YOUR APPOINTMENT WITHOUT NOTIFICATION YOU MAY BE CHARGED $50.
- IF YOU CONTINUE TO CANCEL, RESCHEDULE, OR FAIL TO SHOW FOR YOUR SCHEDULED APPOINTMENTS YOU MAY BE DISCHARGED FROM OUR PRACTICE.

PROCEDURE APPOINTMENTS:

- IF YOU NO SHOW FOR YOUR PROCEDURE APPOINTMENT YOU MAY BE CHARGED $100.00

**** PAYMENT FOR THESE CHARGES MUST BE MADE IN FULL PRIOR TO BEING SEEN FOR YOUR NEXT APPOINTMENT ****

ADDITIONALLY, I ACKNOWLEDGE THAT IF I HAVE 3 OR MORE "NO SHOW" OR "LATE CANCELLATIONS" FOR ANY SERVICE, I MAY BE REFERRED TO ANOTHER CLINIC FOR CONTINUED TREATMENT.

Medical Records

We are happy to provide you with copies of your medical records upon request. However, because of time restrictions, please allow up to 30 business days to fulfill this request. Please note there is a charge for personal use, however, medical records sent to another medical provider will be done free of charge.

Other Forms

We will respond (at the provider's discretion) to requests for the completion of certain medical forms (FMLA, Short Term Disability & **Temporary** Disability Parking Permit) assuming the patient is in good standing and has been active with SPM for six (6) consecutive months. Other forms not listed may be considered for completion. In these cases, the fee will be determined by the office manager. **All requests require an office visit.**

Notice of Privacy Practices and Statement of Patient Right's

I have read or been given the option to review Specialty Pain Management's "Notice of Privacy Practices" and "Specialty Pain Management's Statement of Patient Rights". These documents explain how my personal health information will be used and my rights as a patient. I am also aware that I may request a copy of either document at any time.

I HAVE READ AND AGREE TO ABIDE BY THIS FINANCIAL AGREEMENT, CANCELLATION POLICY AND NOTICE OF PRIVACY PRACTICES. By signing this, you are indicating that you understand and agree to the terms of service explained above.

Name: _____ DOB: _____

Signature: _____ Date: _____

Office Policies and Procedures

PLEASE READ AND **INITIAL** ALL SECTIONS BELOW:

_____ **1).** A cordial and cooperative tone will facilitate communication with our staff and providers. Specialty Pain Management has a very strict **ZERO** tolerance for abusive and aggressive behavior toward its staff; we do not permit patients to swear at our staff, nor be rude, aggressive, belligerent or disruptive. Thank you for remaining calm and friendly.

_____ **2).** All patients with pain perceive their symptoms to be special and urgent. We acknowledge that you may be experiencing physical and emotional distress. However, all the patients referred to this clinic feel this same urgency to obtain treatment. Extra-special consideration cannot routinely be granted in scheduling your visits and treatments due to time, space, and staff limitations. Please know that we will do everything possible to serve you in a timely and effective manner within our limitations. Occasionally, a medical emergency arises which may delay the day's schedule – we appreciate your patience in these situations.

_____ **3).** Chronic pain is **NOT** considered to be a medical emergency. Therefore, emergency access to our clinic is rarely indicated. You may be referred back to your primary care physician or to an emergency facility if we cannot accommodate your urgent needs. Please do not wait until the last minute to seek care for an escalating problem.

_____ **4).** Arriving late for your appointment is very disruptive and makes it nearly impossible to maintain our commitment to serve you in a timely manner. Therefore, our office has a 10-minute late policy. If you arrive 10 minutes after your scheduled appointment, we will usually not be able to see you that day. We will reschedule your appointment for the next available time. Arriving late on a routine basis for your scheduled appointments may be reason for dismissal from our clinic. ***THERE ARE NO EXCEPTIONS.*** Please keep in mind this rule ***DOES NOT*** apply for the last appointment before lunch, nor the last appointment of the day, there is ***NO*** leeway for these appointments. Out of courtesy, if you are running late please call the office to confirm we are still able to see you. ***PLEASE REMEMBER THAT ANY LEEWAY IS A COURTESY AND NOT A GUARANTEE.*** We make every effort to give reminder calls for upcoming appointments, but it is ultimately the patients' responsibility to keep all scheduled appointments or give appropriate notice for rescheduling or cancelling.

_____ **5).** Missed appointments will be rescheduled at the next available time (possibly up to 3-4 weeks). We will not refill medications in the interim, so try not to miss your scheduled appointment. Missing several appointments may be reason for dismissal from our clinic.

_____ **6).** When you call our clinic, you may be routed to a voice mailbox. Please leave your message. We listen to our messages daily and will return your call within 24-48 business hours. Multiple phone calls on the same day for the same problem are very disruptive and may cause delay in a call back. If you do this, you will be given a warning to desist. If this behavior continues, you may be dismissed from our clinic.

_____ **7).** If narcotics or other potent medications to treat your pain are prescribed, you will be asked to enter into a formal narcotic agreement that outlines rules, risks, and conditions of continued access to these medications. Please remember, it is up to the physician's discretion if opiate medications are prescribed on the first visit.

_____ **8).** Pain medication prescriptions are written for a 30-day supply. Medications are refilled once a month during a scheduled office visit. As a rule, we do not call or fax narcotic prescription refills to the pharmacy. Lost or stolen medication will **NOT** be replaced with a new prescription. Pain medication should be taken as directed as we do **NOT** provide early refills. Six months of pharmacy records may be required before a narcotic prescription can be issued. Non-urgent calls regarding medication may be returned within 72 hours. Medication changes are addressed during scheduled office visits, not during/between procedure series. Before leaving the office, it is recommended that patients schedule their next appointment to avoid any last-minute requests for an appointment which we may not be able to accommodate.

_____ **9).** Obtaining pain medications elsewhere without our specific written or verbal approval may be considered a sign of possible narcotic addiction and may be reason for dismissal from our clinic.

_____ **10).** It is your responsibility as the patient to inquire if you are due for a urine drug screen (UDS). Please ask the front desk upon arrival if you are due for one **BEFORE** using the restroom. If a UDS is required, you may **NOT** leave the lobby/office once you have checked in. If you do leave the office your urine is considered a fail and you may not receive your prescription and you may be discharged from the practice. Furthermore, if we find reason you may be given a specific time limit to complete your UDS.

_____ **11). For female patients only:** To the best of my knowledge I am **NOT** pregnant. If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment. I accept that it is MY responsibility to inform my physician immediately if I become pregnant. If I am pregnant or am uncertain, **I WILL NOTIFY MY PHYSICIAN IMMEDIATELY**. All the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and **DO NOT** hold my physician liable for injuries to the embryo/fetus/ baby.

Following these guidelines is important for continued success in managing your pain. If our clinic guidelines are unacceptable to you, you may choose to seek care from another source more suited to your desires. Thank, you for your understanding. We consider it a privilege to serve you. We look forward to a happy and productive working relationship.

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

Statement of Patient Rights

Patients Have the Right To:

- Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
- Receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities.
- Receive privacy in treatment and care for personal needs.
- Review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01.
- Receive a referral to another health care institution if this facility is not authorized or not able to provide physical health services or behavioral health services needed by the patient.
- Participate or have the patient's representative participate in the development of, or decisions concerning treatment.
- Participate or refuse to participate in research or experimental treatment.
- Receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.
- Be treated with dignity, respect, and consideration.
- Not be subjected to abuse, neglect, exploitation, coercion, manipulation, sexual abuse, sexual assault or except as allowed in R910-1012(B), restraint or seclusion.
- Not be subjected to retaliation for submitting a complaint to the Department or another entity.
- Not be subjected to misappropriation of personal and private property by any clinic personnel member, employee, volunteer, or student.
- Consent to or refuse treatment, except in an emergency and to refuse or withdraw consent for treatment before treatment is initiated.
- Be informed of alternatives to medications or surgical procedure and associated risks and possible complications of medications or surgical procedure, except in an emergency.
- Be informed of the clinic's policy on health care directives, and the patient complaint process.
- Consent to photographs before a patient is photographed, except that a patient may be photographed for identification and administrative purposes.
- Provide written consent to the release of information in the patient's medical records or financial records, except as otherwise permitted by law.

Patients Have the Responsibility To:

- Be honest about matters that relate to you as a patient.
- Provide staff with accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters pertaining to your health.
- Report any perceived risks in your care.
- Report any unexpected changes in your condition to those responsible for your care and welfare.
- Follow the care, service, or treatment plan developed.
- Ask any questions when you do not understand or have concerns about your plan of care.
- Understand the consequences of the treatment alternatives and not following your plan of care.
- Know the staff who are caring for you.
- Be considerate and respectful of the rights of both fellow patients and staff.
- Honor the confidentiality and privacy of other patients.
- Be considerate of the property of Specialty Pain Management.
- Assure the financial obligations of your healthcare are fulfilled as promptly as possible.

- **How to File a Complaint**

Patients or patient's representatives that have any concerns about patient rights, safety, or complaints or grievances may contact us at 1466 W. Elliot Rd., Gilbert, AZ 85233. Any patient or patient's representative may submit a grievance without retaliation.

Patients also have the right to contact the Department of Health at any time at:

Arizona Department of Health Services
Attn: Licensing Medical Facilities
150 N. 18th Ave., Suite 450
Phoenix, Arizona 85007
(602) 364-3030

Per A.R.S. § 36-436.01(C) – The Practice's schedule of rates is available for review upon request. Per A.R.S. § 36-425(D), State inspection records will be maintained in the* office *of the practice manager located at 1466 W. Elliot Rd., Gilbert, AZ 85233. Requests may be made by calling 480-496-2699 and asking to speak with the office manager.

Agreement for Chronic Pain Medication Administration

PLEASE READ AND **INITIAL** ALL SECTIONS BELOW:

_____ I understand the purpose of this agreement is to prevent misunderstandings about certain medications that I will be taking for pain management. This is to help me, and my doctor comply with the law regarding controlled medications.

_____ I understand that if I break this agreement, Specialty Pain Management will stop prescribing my pain medications.

_____ I agree that I will not mix alcohol with pain medication.

_____ I agree that I will not use any illegal substances, including marijuana.

_____ I agree that driving or operating any type of machinery will not be allowed while I am being prescribed opioid medication as this could be considered “driving under the influence” by law.

_____ I will not increase or decrease the dosage of my medication without the consent of the prescribing physician. If I feel that adjustments in the medication dosage is required, I agree to contact the prescribing provider at Specialty Pain Management for an appointment.

_____ I will not share or sell my medications with anyone, nor will I take another person’s medication.

_____ I will not receive any pain medications from any other doctors. If I am given a prescription for a controlled substance, I agree not to fill the prescription until I have contacted the office and have discussed it with a provider at Specialty Pain Management.

_____ I understand that it is my responsibility to safeguard my prescription and medications. Should my prescription or medication be lost, stolen, or destroyed, under no circumstances will it be replaced.

_____ I will not contact the office to schedule for an earlier appointment if I have over-taken my medication.

_____ I understand that there may be risks associated with the use of pain medication, including risk of death, respiratory depression, bowel and bladder dysfunction, sexual dysfunction, change of appetite with possible weight gain or loss, change of coordination (which may interfere with driving, operating machinery and fine motor movement) and others.

_____ I understand that the continuous use of pain medication may result in dependence, addiction, change in personality, and sleep changes.

_____ I will report any changes in my mental state, as well as possible side effects from my medication.

_____ I understand and agree that I will not receive anti-anxiety medications known as benzodiazepines, or Soma, unless decided jointly by myself and my pain provider.

_____ I agree to submit to random urine drug testing and/or pill counts at the request or need of the providers on an as needed basis to monitor medication compliance with recommended treatment.

_____ I understand that sudden stopping of pain medication can lead to rebound pain, withdrawal symptoms, seizures and other symptoms. I have been informed not to stop any pain medication suddenly unless decided jointly by myself and my pain provider.

_____ I agree to allow my pain provider to review any of my past medical or psychological records.

_____ I agree that when I have any contact with Dr. Narwani or any staff member, I will not be rude, aggressive, swear and/or be disruptive with any member of the office or other patients.

_____ I have read and understand the above information. I agree and understand that non-compliance with the above will result in formal discharge with notification to my primary care physician and other treating physicians.

Patient name: _____ DOB: _____

Signature: _____ DATE: _____

Provider signature: _____ Witness signature: _____

Consent for Chronic Opioid Therapy

Patient Name: _____ **DOB:** _____

I understand that Dr. Narwani and associates are recommending opioid medicine, sometimes called narcotic analgesics, to treat my chronic pain.

I understand that this medication is being recommended because my pain complaints are moderate to severe and other treatments have not sufficiently helped my pain. I understand that many medications can have interactions with opioids that can either increase or decrease their effect. Therefore, I have told my physician about all other medicines and treatments that I am receiving – and that I will promptly advise my physician if I start to take any new medications or have new treatments. Likewise, I have told my physician about my complete personal drug history and that of my family.

I have been informed by my physician that the initiation of a narcotic/opioid medication is a trial. Continuation of the medication is based on evidence of benefit to me from, associated side effects of, and compliance with instructions on, usage of the medication. I have also been informed by my physician that continuation and any changes in dosage of the medication will be determined by pain relief, functional improvement, side effects, and adherence to usage restrictions. Lack of significant improvement, the development of adverse side effects, or other considerations may lead my physician to discontinue this treatment or to change dosage.

It has been explained to me that taking narcotic/opioid medication has certain risks associated with it. These include, but are not limited to, the following: •Allergic reactions •Overdose (which could result in harm or even death) •Slowing of breathing rate •Slowing of reflexes or reaction time •Sleepiness, drowsiness, dizziness, and/or confusion •Impaired judgment and inability to operate machines or drive motor vehicles •Nausea, vomiting, and/or constipation •Itching •Physical dependence or tolerance to the pain relieving properties of the medication (This means that if my medication is stopped, reduced in dose, or rendered less effective by other medications I may be taking, I may experience runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body, and a flu-like feeling. These can be very painful but are generally not life-threatening.) •Addiction •Failure to provide pain relief •Changes in sexual function (This is generally caused by reduced testosterone levels. Such reduced levels may affect mood, stamina, sexual desire and physical and sexual performance.) •Changes in hormonal levels

In addition, use of these medications poses special risks to women who are pregnant or may become pregnant. If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetrician and this office to inform them. I have been advised that, should I carry a baby to delivery while taking this medication, the baby will be physically dependent upon opioids. I also understand that birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid. Furthermore, I recognize that the long-term consequence on a child's development who was exposed to opioids is not understood.

It has been explained to me that there are other treatments that do not involve use of narcotic/opioid medications.

Having been informed of these risks and potential benefits both of such medications and possible alternative treatments, I have freely consented to taking the narcotic/opioid medication.

I would note that I have been given the opportunity of ask any questions that I may have – and that any questions that I have raised have been discussed to my satisfaction.

I will take this/these medication(s) only as prescribed and I will not change the amount or dosing frequency without authorization from my physician. I understand that unauthorized changes may result in my running out of medications early, and early refills are not allowed. I also understand that if I do not take the medication correctly, I may have withdrawal reactions that may include stomach pain, sweating, anxiety, nausea, vomiting and general discomfort.

I have been advised by my physician that certain other medicines such as nalbuphine (Nubain™), pentazocine (Talwin™), buprenorphine (Buprenex™), and butorphanol (Stadol™), may reverse the action of the medicine I am using for pain control. I understand that taking any of these other medicines while I am taking my pain medicines can cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of these medicines and to tell any other doctors that I am taking an opioid as my pain medicine and cannot take any of the medicines listed above.

I will obtain all opioids prescriptions from my physician or, during his or her absence, by the covering physician. Requests for pain medications from the on-call physician (nights and weekends) will not be honored. I will not request medications outside of normal business hours.

I will obtain all scheduled medications from one pharmacy. I will notify my physician if I change pharmacies. The pharmacy that I have selected is: _____, its phone number is: _____

I hereby authorize my physician to discuss all diagnostic and treatment details of my condition with the pharmacists at the dispensing pharmacy.

I will submit to random pill counts and urine and/or blood drug tests as requested by my physician to monitor my treatment. I understand that the presence of any unauthorized substances in my urine or blood may prompt referral for assessment of addiction or chemical dependency and could result in discontinuation of further opioid prescriptions. I also understand that failure to follow these rules may lead to my no longer being treated by my physician after a 30-day, emergency only period.

I will not share, sell or otherwise permit others to have access to these medications.

I HAVE READ THIS FORM OR HAVE HAD IT READ TO ME. I UNDERSTAND ALL OF IT. I HAVE HAD A CHANCE TO HAVE ALL OF MY QUESTIONS REGARDING THIS TREATMENT ANSWERED TO MY SATISFACTION. BY SIGNING THIS FORM VOLUNTARILY, I GIVE MY CONSENT FOR THE TREATMENT OF MY PAIN WITH OPIOID PAIN MEDICINES.

I UNDERSTAND AND AGREE THAT FAILURE TO ADHERE TO THESE POLICIES WILL BE CONSIDERED NONCOMPLIANCE AND MAY RESULT IN CESSATION OF OPIOID PRESCRIBING BY MY PHYSICIAN AND POSSIBLE DISMISSAL FROM THIS CLINIC.

Patient Signature: _____ Date: _____

HIPAA Privacy Rights Form

PATIENT INFORMATION

_____
Date

_____ _____ _____
Name (Last, first, middle initial) DOB Social Security # or Patient ID

_____ _____ ____ _____
Street address City State ZIP Code

I AUTHORIZE THE FOLLOWING INFORMATION TO BE RELEASED

❑ MEDICAL RECORDS ❑ TEST RESULTS ❑ APPOINTMENTS

❑ PHONE MESSAGES ❑ MEDICATION INFORMATION ❑ ALL INFORMATION

_____ I authorize Specialty Pain Management to leave confidential information on my provided home/cell phone, answering machine/voicemail and/or email

_____ _____ _____
Primary phone number Other phone number E-mail address

I authorize Specialty Pain Management (providers and staff) permission to discuss and/or disclose my health information with the following person/persons listed below:

_____ _____ _____
Name Relationship Phone

_____ _____ _____
Name Relationship Phone

_____ _____ _____
Name Relationship Phone

_____ **I DO NOT** authorize any medical information to be released to any other individuals

Signature _____ Date _____

No information will be released to any persons without the permission of the patient. All authorized persons receiving any information will need to show proper identification before any information will be released. HIPAA Privacy Rights Form