CAPITOL PAIN INSTITUTE

Name:
DOB:

Confidential Patient Database

Name: _____ Home phone #: _____

Date of Birth:_____ Social Security Number: _____ Cell Phone #_____

E-Mail: _____ Work Phone #_____

Address: _____ City_____ Zip _____

Emergency contact: _____ Tel:_____ Relationship: _____

Primary Care Physician:_____ Office Phone #_____

Gender: Male Female If worker's compensation, name of carrier & adjuster_____

Pharmacy:_____

Race: _____ Language: _____

Insurance & Guarantor Information

Insurance company:_____ Member ID_____ Group#_____

Subscriber's name:_____ Date of Birth:_____ SS#_____

How did you hear about our practice?

- ☐ Referred by physician Name_____
- ☐ Referred by patient Name_____
- ☐ Insurance company list of doctors
- ☐ Website or web-search (Google, etc) Which one?_____
- ☐ Other (please specify) _____

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CAPITOL PAIN INSTITUTE

Privacy Policy

The following notice is printed as required by Federal Law: "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." We will NOT provide your medical information to your family, friends, or others not directly involved in your medical treatment UNLESS specifically authorized by you in writing. We will NOT provide your name or other information for the purposes of marketing or fund raising. We strive to protect your health information, but there are situations where your medical information can be disclosed to others as determined by the Federal Government. Your health information may be provided to others for what the government calls "Treatment, Payment, and Operations." This includes sharing information with other physicians, providers, or pharmacists, reporting to your insurance company or worker's compensation carrier. Legal services, training programs, quality improvement programs, and the like. Your medical bills are sent by mail or by computer to the insurance carriers and may be reviewed by a billing company or clearinghouse before being forwarded to the insurance company. Finally, there are exceptions to the privacy agreement; your medical information may be provided to others without your consent in the following situations, as provided by law: (1) State of Texas reporting requirements, including, but not limited to, duty to warn individuals of a threat from a patient, duty to inform the Department of Public Safety after a seizure, or the duty to prevent a disaster; (2) State of Texas reporting requirements for worker's compensation claims; (3) State of Texas or local county public health activities; (4) Health oversight activities; (5) Legal proceedings; (6) Police investigations; (7) Any information needed on a deceased patient (i.e. by coroners, etc); (8) Any information needed for organ donation; (9) Certain types of research such as quality improvement initiatives (identity will be protected); (10) Any information needed by the government and not subject to privacy protection under Federal or State law.

Initials _____

Risks of medication use

All medications have side effects, some of them serious. Almost all medications can be fatal if used inappropriately. Almost every medication could cause sleepiness or insomnia, dizziness, confusion, hallucinations, anxiety, panic, constipation or diarrhea, headache, chest pain, and nausea or vomiting. Any of these side effects could predispose the patient to injury (e.g. dizziness could cause the patient to fall down stairs). Many of the medications can cause a drop in blood pressure, which could cause fainting, dizziness, stroke, or other problems. Some of the medications can lead to liver damage including the remote possibility of liver failure. Opioid-based pain medications significantly increase the risk of asthma attacks or other lung problems and can produce respiratory insufficiency or failure, even at low doses. Medications react differently in different people. Remember that ANY MEDICATION can cause ANY REACTION in the body, even if it never happened before and even if it is not listed among the drug side effects. Some medications used in this practice have not been in existence long enough to determine potential short term or long-term side effects. Rarely, a medication can cause the opposite effect of what was intended. This is called a paradoxical reaction and is not predictable. Medications may also worsen your condition or cause an entirely new medical condition to arise.

Many of the medications used in this practice are not FDA approved for the treatment of pain or headache. This means that although there is evidence to support their use in pain management, the medications were invented (and tested for the FDA) for other medical conditions. Using a medication to treat a non-FDA approved condition is known as off-label use. The use of medication off-label is legal, ethical, and appropriate based on medical research and is common in all fields of medicine, including pain management. If you have any questions about off-label use of medications, please ask your doctor.

Alcohol is not considered safe in conjunction with the medications typically prescribed by this practice. Illegal drugs are not considered safe in conjunction with the medications typically prescribed in this practice. Herbal supplements and Eastern (or non-traditional) medications may not be safe in conjunction with the medications typically prescribed by this practice. Medications may interfere with birth control methods. Some medications prescribed by this practice are unsafe during pregnancy and breast-feeding.

Because of potential harmful interactions, you must let each of your healthcare providers know about every medication and supplement (including over-the-counter products) that you use and every health condition you have been diagnosed with. Failure to do so may result in serious harm.

Initials_____

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CAPITOL PAIN INSTITUTE

Opioid-based Medications (Opiates):

If you have a chronic pain condition, you may be prescribed opioid-based pain medications. Opiates are very powerful medications for the treatment of pain and may have significant side effects even with normal use. Opioid medications are controlled substances, and possessors of these prescriptions are subject to the provisions set forth by the Texas legislature and the Department of Public Safety.

If you, as our patient, are prescribed opiates, it is up to you to maintain perfect responsibility for the medications. You MUST protect against loss, theft, or damage; you must keep them away from children, animals, and other persons. In order to justify the use of opiates, you should be able to report (1) improved pain control, (2) increased functional level, (3) no serious side effects, and (4) no episodes of running out of medications early, lost or stolen medications, or increasing intake without the approval of your physician. You agree to drug testing for both prescribed and illicit drugs at any time. The presence of illicit drugs may require the practice to make adjustments to your pain medication regimen, which may include the cessation of opiate medications. You specifically acknowledge that the use of illicit drugs could result in death or other severe harm. You agree to use one and only one physician for pain medication prescriptions, and one and only one pharmacy for pain medication dispensing. You understand that you may be called at any time to bring in all prescribed medication for a mandatory pill count within a specified time period (typically within 24 hours). You acknowledge that you are to bring medications prescribed by Capitol Pain Institute in the original bottles to every appointment, even when empty. Failure to comply with this section of the agreement may require the practice to make adjustments to your pain medication regimen, which may include the cessation of opiate medications.

There is a risk of addiction with the use of opiate medications. Several risk factors for addiction have been identified and may be used to determine whether or not you are a candidate for opiate medications. Unfortunately, no screening method is completely effective in selecting out patients that will misuse (or divert) opioid medications. The treating physician cannot guarantee that you will not become addicted to your medication. You freely agree to the use of the medication and understand that no guarantees regarding safety or addiction are stated or implied. Increasing your dose on your own, seeing multiple prescribing physicians, running out of medication early, or getting extra medication from friends and family are signs of addiction. Remember, it is not legal for the physician to provide early opioid refills if the patient continues to increase the dose on his or her own. If you are experiencing increased pain or more frequent pain (breakthrough pain) that is not being controlled by your medication, call your physician for instructions. Do NOT take extra pain medication beyond what is prescribed or attempt to acquire additional pain medications from other sources.

All patients receiving opiate prescriptions will be closely monitored for signs of abuse, addiction, or diversion. Patients receiving schedule II opioids (morphine, OxyContin, etc.) will have at least 1 monthly appointment to receive their prescriptions. Patients receiving schedule III (tramadol, etc) or IV (darvocet) opioids may have refills authorized for up to 3 months at the discretion of their treating physician. No refill authorizations or medication changes will be made over the phone, after-hours, or on weekends.

Patient's Signature_____

Physician's Signature_____

CAPITOL PAIN INSTITUTE

Name:
DOB:

Financial agreement, assignment of benefit, consent to treat, and exchange of information

I hereby assign to and authorize payment of all benefits due to me under any insurance policy, worker's compensation plan, auto insurance policy, Medicare, Medicaid, or any other 3rd party payor for any and all services provided by Capitol Pain Institute, P.A. ("CPI") or any of its individual practitioners directly to CPI or its individual practitioners.

I authorize CPI to disclose to, or obtain from, to the extent allowed by law, my medical and financial record to: (a) any insurance company, attorney, insurance adjuster, employer, or their representatives, agents, or employees that may be responsible for all or part of the payments due for services rendered to the patient; (b) any physician, clinic, hospital, or other healthcare provider who has provided services for me in the past or who may be providing future services (e.g. a consulting physician or a facility at which a procedure is to be performed); (c) the Centers for Medicare and Medicaid Services or any other government agency as required by local, state, or federal law; (d) any person or entity to provide quality and/or utilization review. This authorization can be revoked by submitting a request in writing to CPI, 8015 Shoal Creek Blvd #103, Austin, Texas 78757.

I understand and agree that all payments for services rendered are due at the time they are performed. I further understand and agree that I am financially responsible for all charges, including all fees assessed under this paragraph, whether or not my insurance provider accepts or denies any claim for payment, and agree to pay all sums due to CPI and/or its individual practitioners at the usual and customary charge for CPI. I understand and agree that there is a $25 fee for all missed office visits and a $100 fee for all missed surgical procedures that are not cancelled at least 24 hours in advance. I understand and agree that there is a $25 service fee for any returned checks regardless of reason. I further understand that I must leave a credit card on file with CPI if I wish to pay my bill by personal check. I authorize CPI to charge my credit card for the full balance owed plus applicable service charges if my check is returned for any reason whatsoever. I understand and agree that there is a 1.5% monthly finance charge for all past-due balances on my account. I certify that I am the patient and/or I am financially responsible for the services rendered and do hereby unconditionally guaranty the payment of all amount when and as due.

I consent to all examination procedures and/or treatments prescribed by my physician and his assistants or designees as is necessary by his judgment.

A photocopy or electronic copy (i.e scan) of this agreement shall be considered effective and valid as the original.

_____ _____

Patient or Guarantor Date

After-hours and emergencies:

If you are experiencing an emergency, you should call 911 and report your emergency immediately. If you have a non-emergent situation or question call the office directly. After-hours or on weekends, please follow instructions to reach the on-call doctor. The on-call doctor will respond to you as soon as possible. Please note that medication adjustments or refill requests cannot be handled after-hours or on weekends.

Name:
DOB:

CAPITOL PAIN INSTITUTE

Authorization for use and disclosure of Protected Health Information

Patient Identification

Name: _____

SS#: _____

DOB: _____

Address: _____

Telephone: _____

Request: Please fax the patient's pain management records, including radiology.

This information is to be released to:

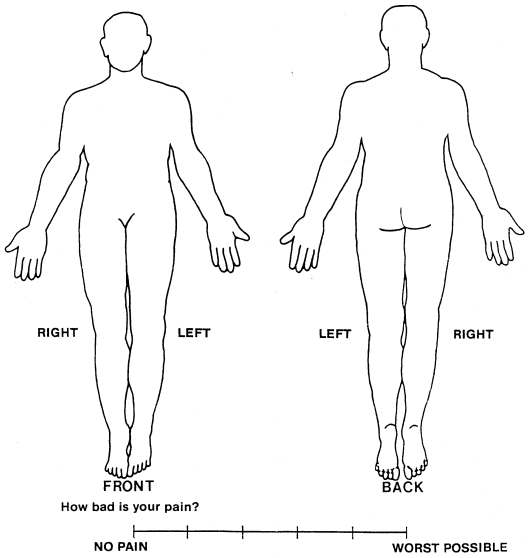
Capitol Pain Institute
8015 Shoal Creek Blvd., Ste 103
Austin, TX 78757
Tel: 512-467-7246 Fax: 512-467-7247

I authorize CPI to disclose to, or obtain from, to the extent allowed by law, my medical and financial record to: (a) any insurance company, attorney, insurance adjuster, employer, or their representatives, agents, or employees that may be responsible for all or part of the payments due for services rendered to the patient; (b) any physician, clinic, hospital, or other healthcare provider who has provided services for me in the past or who may be providing future services (e.g. a consulting physician or a facility at which a procedure is to be performed); (c) the Centers for Medicare and Medicaid Services or any other government agency as required by local, state, or federal law; (d) any person or entity to provide quality and/or utilization review. At any time I can revoke this authorization by submitting a notice in writing to Capitol Pain Institute 8015 Shoal Creek Blvd., Ste 103, Austin, TX 78757.

Signature: _____ Date: _____

CAPITOL PAIN INSTITUTE

Name:
DOB:



Area of Pain #1

_____

Average pain score in this area (0-10):

_____

What does the pain feel like?

_____

What makes it better?

_____

What makes it worse?

_____

How long have you had this pain?

_____

How did it start?

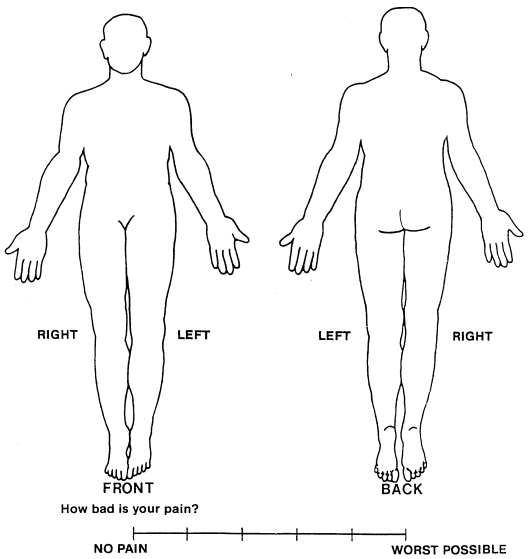
_____

Imaging or other tests for this pain?

_____

Past Treatments for pain area 1 (check all that apply)

- ☐ Physical Therapy
- ☐ Chiropractic Care
- ☐ Acupuncture
- ☐ OTC medications (NSAIDS)
- ☐ Other: _____
- ☐ Injections (Epidural/Facet/Trigger Point)
- ☐ Prescription pain medications
- ☐ Anti epileptics (Lyrica/Neurontin/Topamax)
- ☐ Anti-depressants



Area of Pain #2

_____

Average pain score in this area (0-10):

_____

What does the pain feel like?

_____

What makes it better?

_____

What makes it worse?

_____

How long have you had this pain?

_____

How did it start?

_____

Imaging or other tests for this pain?

_____

Past Treatments for pain area 2 (check all that apply)

- ☐ Physical Therapy
- ☐ Chiropractic Care
- ☐ Acupuncture
- ☐ OTC medications (NSAIDS)
- ☐ Other: _____
- ☐ Injections (Epidural/Facet/Trigger Point)
- ☐ Prescription pain medications
- ☐ Anti epileptics (Lyrica/Neurontin/Topamax)
- ☐ Anti-depressants

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Name:
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Does your pain wake you up at night?☐Yes☐No
Are you taking sleeping medications?☐Yes ☐No
How many hours do you sleep per night? _____

Medication allergies: ☐ None ☐ Yes
If yes please list them: _____
_____

Please list your current medications:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Blood Thinners (includes Aspirin): _____

Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself	0	1	2	3
Trouble concentrating on things like reading or watching TV	0	1	2	3
Moving or speaking slowly that others can notice. Or the opposite.	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself.	0	1	2	3

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Past Medical History (Check all that apply)

☐ Joint pain/Arthritis
☐ Epilepsy/Seizure
☐ Stroke
☐ Thyroid Disease
☐ Coronary Artery Disease/Angina
☐ High Blood Pressure
☐ Pacemaker/ Arrythmia
☐ Blood Clots
☐ COPD/Asthma
☐ Reflux (GERD) / Ulcer
☐ Abdominal Pain or Bowel Problems
☐ Headaches/ Migraines
☐ Insomnia/ Sleep Apnea
☐ Depression/Anxiety
☐ Incontinence
☐ MRSA
☐ HIV+ / AIDS
☐ Hepatitis or Liver Disease
☐ Diabetes
☐ Cancer
☐ Other _____

Surgical History (Please List All) ☐ **NONE**

_____ _____ _____
_____ _____ _____

Family History (Check all that apply)
(F) Father (M) Mother (PGF) Paternal Grandfather (PGM) Paternal Grandmother (MGF) Maternal Grandfather (MGM) Maternal Grandmother

	F	M	PGF	PGM	MGF	MGM
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐

Social History (Check if yes)

☐ Are you employed?
☐ Do you live alone?
☐ Do you have children?
☐ Exercise regularly?
☐ High stress level?
☐ Do you smoke? If yes how many per day?_____
Are you interested in quitting? **Y** **N**
☐ Do you use alcohol? If yes how often? _____
☐ Do you use drugs other than tobacco?
☐ Do you have a history of drug or alcohol abuse?

Review of Symptoms (Check all that apply)

Constitutional:
☐ insomnia ☐ fatigue ☐ night sweats ☐ weight loss
Eyes:
☐ double vision ☐ visual changes ☐ other vision problems
Endocrine:
☐ cold intolerance ☐ frequent urination ☐ hair loss
☐ heat intolerance
Respiratory:
☐ cough ☐ shortness of breath ☐ wheezing
Cardiovascular:
☐ chest pain ☐ exercise intolerance
☐ heart palpitations ☐swelling in hands/feet
Gastrointestinal:
☐ abdominal pain ☐ indigestion ☐ constipation
☐ diarrhea ☐ nausea ☐ vomiting
Hematology:
☐ anemia ☐ bleeding problems ☐ easy bruising
Genitourinary:
☐ urinary incontinence ☐ difficulty urinating
Musculoskeletal:
☐ muscle spasms ☐ muscle tightness ☐ joint pain
Skin:
☐ wounds ☐ lesions ☐ itching ☐ rash
Neurologic:
☐ weakness ☐ balance difficulty ☐ difficulty speaking ☐ headaches ☐numbness/tingling
Psychiatric:
☐ anxiety ☐ depression ☐ difficulty sleeping

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Name:
DOB:

Check-in –

_____Arrival time

_____Insurance card checked

_____Patient balance collected or statement given

_____Referring physician entered

_____All demographics complete

_____Time ready to be roomed

Insurance

Insurance eligibility checked _____

Traditional insurance
Copay $ _____Collected _____

HSA-type plan
Deductible met? Y / N
% co-insurance _____%

NO – collect 100% of allowed _____

YES – collect co-insurance % _____

Roomer –

_____Address & phone # checked

_____Pharmacy information checked

_____Time roomed

Orders for Medical Assistant –

Check Out –

Follow up appointment: _____ UDS today Yes ☐ No ☐

Schedule procedure: _____

Clearances needed: _____