Pain Management of North Mississippi

(Please Print)

Today's Date_____ Family Doctor_____

Patient Last Name_____ First_____Middle_____

Birth Date____/____/____ Age_____Sex_____

Social Security #_____Home Phone#_____

Cell Phone #_____Secondary Phone#_____

Mailing address_____

City_____ State_____Zip Code_____

Employer_____Employer Phone #_____

Insurance Information

Primary Ins_____

Policy#_____Subscribers Name_____

Secondary Ins_____

Policy#_____Subscribers Name_____

In Case of Emergency

Name of nearest relative_____Relationship_____

Home Phone #_____Other#_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Pain Management Center of North Mississippi or insurance company to release any information required to process my claims.

Patient Signature_____Date_____

Patient Questionnaire

Patient Name (print): _____

Referred By: _____

Family Physician: _____

Pain Management Center of North Mississippi, PLLC.

2089 Southridge Drive Tupelo, MS 38801

T: (662) 407-0801 F: (662) 407-0807

- Chief Complaint (main area of pain)_____
  _____

- History of Present Illness- (*Circle all that apply)*
  - **Recent History** (improved, worsened, stable, compliant with therapy, new symptoms, recent surgery, recent hospitalization)
  - **Onset** (when did the problem occur? _____)
  - **Nature of onset** (sudden, gradual, don't know)
  - **Weakness** (R arm, R leg, L arm, L leg, R hand, L hand, None, other: _____)
  - **Associated symptoms** (uncomfortable sensations, hypersensitivity, muscle loss)
  - **Relative distribution of pain** (which pain is worse? Neck, back, arm, leg, other _____)
  - **What causes(d) the pain** (lifting heavy object, car wreck, job injury, no specific event, other:_____)
  - **Quality** (burning, aching, dull, electrical, numb, tingling, stabbing, sharp, pressure, other: _____)
  - **Made worse by** (sitting, standing, weather changes, bending, walking, exercise, other: _____)
  - **Severity** (mild, moderate, severe) (pain score 0 = normal and 10 = worst pain ___)
  - **Progression** (Is your pain: unchanged, improving slowly, or getting worse with time?)
  - **Modifying factors** (What affects your pain?)
    - Helpful medications (*Circle all that apply*)
      - Anti-inflammatories, narcotics, muscle relaxants, oral steroids, anti-depressants, anti-convulsants, other: _____

- Improved with activity Yes / No (***Circle all that apply***)
  - Resting, sitting, standing, lying down, heat, ice, stretching, other:
    _____
- Worse with activity Yes / No (***Circle all that apply***)
  - Coughing/sneezing, sitting, standing, lying down, bending, stairs, up/down, temperature change hot/cold, cooking, getting out of chair, lifting, resting, sex, stress, twisting left/right, vacuuming, walking

- **Response to prior treatments**
  - Have you ever had any of the following?

(check all that apply, otherwise leave blank)

	No response	Temporary improvement	Long term improvement	Made worse
Chiropractor				
Facet ablations				
Facet injection				
Epidural Steroid injection				
Long-acting narcotic				
Acupuncture				
Nerve block				
Physical therapy				
Spinal cord stimulator/Pump				
Spine injection				
Sympathetic block				
TENS unit				

  - Have you ever had nerve blocks/steroid injections? Yes / No
    When-where? _____
  - Physical therapy? Yes / No
    When-where? _____
  - Been to a pain specialist? Yes / No
    When-where? _____
- **Current treatment**
  - physical therapy? Yes / No
  - pain clinic? Yes / No
  - narcotic contract? Yes / No (Name provider _____)
  - psychiatrist/ psychologist? Current / past / never
    when-where _____
    name of provider _____
    diagnosis _____
- **Work status**
  - Limitation of ADLs? (mild, moderate, severe)

- Employed where? _____
- Work duty (full, light, not working due to pain, not working unrelated to pain, unemployed)
- Date of last work day _____
- Injured at work? Yes / No (describe injury _____)
- Do you have a workman's comp case? Yes / No
- Disabled? Yes / No
  when? _____ reason? _____

- **Previous studies** (dates and hospital/imaging center)
  - CT _____
  - MRI _____
  - X-ray _____
  - Myelogram _____
  - Bone scan _____
  - EMG/NCS _____
- **Clinical status** (improved, worsened, stable)
- **Context**
  - Legal action pending? Yes / No
  - Specialist following? Yes / No
    - If yes please provide physician/clinic name _____
- **Medical history** (high blood pressure, sleep apnea, high cholesterol, hepatitis, HIV/AIDS, MRSA/other infection, rheumatoid arthritis, degenerative disc disease, migraines, heart attack, stroke, diabetes, thyroid disease, liver disease, kidney disease, cancer, lung disease) other: _____
  _____
- **Family history** (hepatitis, HIV/AIDS, MRSA infection, rheumatoid arthritis, degenerative disc disease, migraines, heart attack, stroke, diabetes, thyroid disease, liver disease, kidney disease, cancer, lung disease, NONE) other: _____
  _____
- **Surgical history** (date-type)
  - _____-_____
  - _____-_____
  - _____-_____
  - _____-_____
  - _____-_____
  - _____-_____
- **Social history**
  - Do you smoke? Yes/ No How often? _____
  - Do you drink alcohol? Yes/ No
    - How often? _____
    - How much? _____

- Have you ever used illegal drugs? Yes / No
  - What drug(s)? _____
  - Date of last use? _____
  - Have you ever been in a drug rehab program? Yes / No
  - Have you ever had your pain medication stopped? Yes / No
    - If yes, why? _____

- **Medications**
  - Pharmacy name _____ City _____ Phone number _____
  - Are you on a blood thinner? Yes / No
    - If yes, circle all that apply: plavix, heparin, lovenox, coumadin, ticlid, other: _____
  - List all current medications

Name	Milligram dose	How often	Quantity per month

- **Drug Allergies** (or circle NONE)

Name of drug	Type of reaction

- ROS- Have you recently experienced any of the following? (***Please circle all that apply***)
  - **General** (chills, fever, weight loss/gain, night sweats)
  - **Pulmonary** (cough, shortness of breath, wheezing, sleep apnea-CPAP, home oxygen)
  - **Neurological** (altered mental status, memory loss, headache, bowel/bladder incontinence, leg/arm weakness, leg/arm numbness, stroke)
  - **Head** (facial pain/swelling, pain in back/front/temple, migraine/headache)
  - **Gastrointestinal** (abdominal pain, constipation, diarrhea, blood in sputum/stool, nausea, vomiting, liver problems, heart burn)

- **Skin** (dry, bruising, itching, rash, infection, wounds, sensitivity)
- **Eyes** (discharge, pain, sensitivity to light, redness, vision loss, cataracts, glaucoma, blurred vision)
- **Endocrine** (increased thirst/appetite/urination, diabetes, thyroid dysfunction, lupus)
- **Genitourinary/Renal** (difficulty starting/stopping urine stream, flank pain, frequent urination, kidney dysfunction)
- **Hematology/Oncology** (swollen lymph nodes, anemia, bleeding disorder, easy bruising, blood clots, frequent infection)
- **Cardiovascular** (chest pain, leg swelling, irregular heartbeat, heart attack, shortness of breath, pacemaker/defibrillator)
- **Musculoskeletal** (back pain, joint pain, leg cramps, muscle pain, muscle spasm, muscle weakness, osteoporosis, rheumatoid arthritis)
- **Psychiatric** (anxiety/depression, difficulty sleeping, drug/alcohol abuse, drug rehab, suicidal thoughts/plans)

- **Other comments:**
  - _____
  - _____
  - _____
- **Source of above information** (patient, spouse, friend, child, relative) Other _____

Please verify that the above information (pages 1-5) is accurate and complete.

Sign below.

This document will become a part of your medical record.

Date of Completion ____/____/____

Patient Name (print) _____

Signature of patient or responsible party _____

For Office Use Only:

Vitals BP____/____ P_____ RR_____ Ht.____'____" Wt._____lb.

Pain Management Center of North MS, PLLC

Conditions of and Consent for Treatment and Admission and
Consent for Use and Disclosure of Health Information for Payment **Patient Name:** _____

Name: _____

Patient AccountNumber: _____

1. **CONSENT FOR TREATMENT:** I request and voluntarily consent to the usual pain center services while a patient at Pain Management Center of North MS, PLLC, as well as diagnostic laboratory (testing of the blood and other bodily fluids) and x-ray procedures (including intravenous injection of contrast material) and medical and/or surgical treatment, including administration of anesthesia and other treatment as deemed necessary by my attending physician, his assistants or other designated physicians. The Facility is authorized to retain, preserve, and use for scientific or teaching purposes or dispose of at its convenience any specimens or tissue removed from my body and during surgery or treatment.

2. **Medical Care:** During treatment at Pain Management Center of North MS, I, as the patient will be under the professional care of a physician. I acknowledge that many physicians on the medical staff of the Pain Management Center of North MS Center are not employees or agents of the Facility, but are independent physicians who have been granted the privilege of using Pain Management Center of North MS facilities for the care and treatment of their patients. I understand that no guarantees have been made by any independent physician, employee of Pain Management Center of North MS or Pain Management Center of North MS itslef as a result of examination or treatment while in the Facility.

3. **Compliance with Rules and Regulations:** In consideration of admission and/or treatment, I agree to abide by the rules of Pain Management Center of North MS, including no smoking except in designated areas.

4. **Personal Valuables:** Valuables, including money, jewlry, glasses, dentures, documents and other personal items should be kept at thome. I agree that Pain Management Center of North MS will not be liable for the loss or damage to any personal property of the patient brought to the Pain Management Center of North MS Facility.

5. **Release and Responsibility:** I hereby agree, acknowledge and understand that Pain Management Center of North MS is not responsible for injuries sustained by use of my own personal equipment – electrical, mechanical or ortherwise. I further understand and agree that should I leave the Pain Management Center of North MS Facility without the consent of my physician(s), I hereby relieve my physican(s) and the Pain Management Center of North MS of all responsibility for such action and for any injuries and/or damages sustained of such actions.

6. **Consent To Destroy X-Ray and Graphic Data:** I hereby authorize Pain Management Center of North MS to dispose of at its discretion any specimens or tissues taken from my body during my surgery and to retire x-ray film and any other graphic data which may be genereated during my stay four years after they are generated if a proper report is in the medical record.

7. **Assignement of Benefits:** As a patient, I hereby make the assignment of benefits as set fourth below:
   - Medicare: I hereby request that payment of authorized Medicare benefits to or on my behalf for services furnished in or by Pain Management Center of North MS, shall be made to Pain Management Center of North MS, and I specifically assign such benefits to Pain Management Center of North MS. I hereby certify that all information given by me in connection with applying for benefits under the Title XVII of the Social Security Act is true, correct and complete in all respects. **I understand that payment for certain services not deemed medically necessary are not authorized under the Medicare Program, and that I shall be responsible for the entire charge incurred unless other third party coverage is available. I also understand all deductibles are due unless they have been met within the last sixty days.**
   - Insurance: I hereby assign to Pain Management Center of North MS all rights, benefits and interest under any insurance policy, health plan, workers; compensation or other third party liable to me, in consideration for services rendered by Pain Management Center of North MS, by any insurance policy, health plan or third party payor for treatment received at Pain Management Center of North MS. I hereby authorize payment directly to Pain Management Center of North MS of Worker's Compensation coverage for meidcal expenses for which I have received treatment at Pain Management Center of North MS. I hereby authorize payment directly to Pain Management Center of North MS of all third-party liabilty insurance, coverage, third party payor, health plan and individual liability coverage for medical expenses incurred as a result of any accident, injury or illness for which I received treatment at Pain Management Center of North MS.
   - Physicians: I also assign benefits to all physicians involved in the care of this period of treatment.

8. **Financial Responsibility:** I understand that I am financially responsible to Pain Management Center of North MS for all charges not covered or paid by insurance. I also understand and agree that all deductibles, co-insurance, non-covered charges and other items not paid by insurance, health plan or other third party payors are due and payable upon admission based on the best estimates available as determined by Pain Management Center of North MS. Any charges remaining on this account not covered by insurance are payable upon demand. I also agree that in case of default of payment and this account is placed in the hands of a collector or attorney for collection suit, all reasonable collection fees, reasonable attorney fees, court cost and other cost and expenses will be paid by me.

9. **Non-Certification of Surgical Treatment:** I hereby agree that as the policy holder/beneficiary of insurance, health plan or other third party payor, I am responsible for assuring certification obtained from the insurance company, third-party administrator or health plan for the surgical treatment. If certification is not obtained, I further agree that in the event the insurance company, health plan or other third party payor deny either all or part of the payment on the Pain Management Center of North MS account, I will pay the account in full upon demand from Comprhensive Pain Management.

10. **Consent For the Release of Health Information For Billing and Payment Purposes:** I hereby consent to the release of my health information (medical records, medical results and any and all other health information) by Pain Management Center of North MS or any physicianinvolved in my care for the purpose of: billing; claims management; medical data processing; eligibility documentation; reimbursement; and certification to any insurance company, third party payor, health plan or government agency which is necessary for the billing and payment of my account.

THIS IS TO CERTIFY THAT I, THE UNDERSIGNED, BEING THE PATIENT OR ANOTHER PERSON LEGALLY AUTHORIZED TO ACT FOR THE PATIENT, HAVE READ PARAGRAPHS 1-10 OF THIS DOCUMENT, UNDERSTAND ITS CONTENT, AND ACCEPT ITS TERMS.

Signature of Patient	Date	Time

Pain Management Center of North MS, PLLC

Notice of Privacy Practice Ackowledgement **Patient Name:** _____

I acknowledge that I have been given and received a copy of the Notice of Privacy Practices of Pain Management Center of North MS, PLLC. My acknowledgement does not mean that I agree with the Notice of Privacy Practices or that I have read the Notice of Privacy Practices; it only means that I acknowledge receipt of a copy.

_____ _____

Date Signature of Patient

When patient is a minor or incompetent to sign Acknowledgment:

I hereby acknowledge that I have been given and received a copy of the Privacy Practices of Pain Management Center of North MS, PLLC on behalf of the patient. My acknowledgment does not mean that I agree with the Notice of Privacy Practices or that I have read the Notice of Privacy Practices; it only means that I receipt of a copy.

_____ _____

Date Signature of Patient

_____

Relationship to Patient

When Patient or Authorized Person refuses to sign Acknowledgement:

Patient (or Authorized Person) was given a copy of the Notice of Privacy Practices of Pain Management Center of North MS, PLLC, but refused to sign Acknowledgement.

_____ _____

Date Signature of Patient

Pain Management Center of North MS, PLLC

Patient Name: _____

Authorization To Release Medical Records

I hereby authorize Pain Management Center of North MS, PLLC to release a copy of any and all information related to my insurance company (ies) and/or other agency (ies) for the purpose of obtaining payments for services rendered.

Assignment of Insurance Benefits/Financial Responsibility

I hereby authorize any and all insurance company (ies) to make payements directly to Pain Management Center of North MS, PLLC for services rendered.

I understand that I am financially responsible for all charges denied, not covered or paid by my insurance company (ies). I also understand that I am financially responsible for all deductibles, co-payments, non-covered charges exceeding reasonable and customary, and non-participating PPO amounts, etc. not payable by my insurance company (ies). Charges remaining on my account are payable on demand.

If I do not have any insurance coverage, I understand that I am financially responsible for payment of all charges on demand by Pain Management Center of North MS, PLLC.

_____ _____

Date Patient or Parent/Guardian

Pain Management Center of North MS, PLLC

Authorization To Release Information

Patients Name: _____

Date of Birth: _____

I hereby authorize Pain Management Center of North MS, PLLC to release or obtain a copy of any and all of my information to the following family members/Providing Physicians:

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Patient Date

Pain Management of North Mississippi

2089 Southridge Dr. Tupelo, Ms 38801

Phone: 662-407-0801

Fax: 662-407-0807