GEORGIA
PAIN & SPINE
SOLUTIONS

New Patient Packet

It is our pleasure to welcome you to Georgia Pain and Spine Solutions. We have enclosed forms to be completed at your convenience at home. **We will need these actual papers back in our office prior to scheduling an appointment for you.** Please mail them or drop them off with us ahead of time so we can prepare your chart. **Faxed copies of these documents are not acceptable.**

We will also need copies of your medical records, including MRI and X-ray reports by the time of your appointment. We only need the imaging reports--not the actual films. If you do not have copies of your reports to send to us with your new patient paperwork, please contact the rendering physician or facility and have them faxed to our office at (404) 745-8013 **prior to your appointment**.

Insurance and/or Workers Comp information needs to be filled out completely and accurately so that insurance can be verified by the time of your appointment.

Also, you must **bring with you** ALL PRESCRIPTION AND OVER THE COUNTER MEDICATIONS YOU ARE CURRENTLY TAKING IN THEIR ORIGINAL BOTTLES.

PLEASE MAKE SURE YOU HAVE NOT MISSED SIGNING AND DATING PAGES 2 – 7 AND COMPLETED YOUR PHARMACY INFO AND SIGNATURE/DATE ON PAGE 25. (Pages 9-12, Notice of Privacy Practices are yours to keep.)

We must have the following in our office before we will schedule you for an appointment:

- ☐ These completed and signed new patient forms, dropped off or mailed to
  Georgia Pain and Spine Solutions
  76 Highland Pavilion Court,
  Suite #133
  Hiram, GA 30141

- ☐ Medical records and/or imaging reports: May be faxed to (404) 745-8013

Bring with you to your appointment:

- ☐ Your current drivers license and health insurance card
- ☐ All medications in their original bottles

Please be prepared to spend at least an hour with us at your initial visit. A thorough physical examination and understanding of your medical history is vital to providing you with appropriate treatment, and we strive for nothing less.

If you are able, please visit our website at www.georgiapss.com and explore the Patient Education link to learn more about many of the procedures our doctors specialize in. Again, we welcome you and look forward to providing you with excellent care! If you have any questions or need to change your appointment, please call us at 1-800-533-8210.

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Patient Demographics

Date of Consult_____

PATIENT INFORMATION

First_____Last_____MI_____Date of Birth_____/_____/_____ Sex_____

Mail Address_____City_____State_____ ZIP_____

Physical Address_____City_____ State_____ZIP_____

Home Phone_____Work Phone_____Mobile Phone_____

☐Single ☐Married ☐Widowed ☐Divorced SS#_____Drivers Lic#_____State_____Year_____

Employer_____Address_____Phone_____

Spouse/Significant Other_____Employer_____Phone_____

Nearest Relative or friend not living at your address_____Relationship_____

Address_____Employe_____Phone_____

Pharmacy Name_____City_____Phone_____

Referring Physician_____City_____Phone_____

Reason for Visit_____

INSURANCE

☐ **Primary**: Insured's Name_____DOB_____SS#_____

Insurance Co_____Policy#_____Group#_____

Address_____Phone_____

Insured's Employer (if different than patient)_____Relationship to patient_____

☐ Secondary: Insured's Name_____DOB_____SS#_____

Insurance Co_____Policy#_____Group#_____

Address_____Phone_____

Insured's Employer (if different than patient_____Relationship to patient_____

COVERED BY WORKERS COMPENSATION? ☐ NO or ☐ YES If YES, Date of Injury_____

Description of Injury_____

Treating Physician_____City_____Phone_____

Employer at Time of Injury_____Contact Name_____

Address_____Phone_____

Workers Comp Insurance Carrier_____Phone_____

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WORKERS COMP. CONTINUED:

Address_____ _____City_____State_____Zip_____

Name of Adjustor_____Phone_____

Fax Policy/Claim#_____Group/TWCC#_____

I authorize Georgia Pain and Spine Solutions to release any necessary medical information to insurance carriers concerning this illness/accident/injury and irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

_____ _____

Patient Signature Date

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Patient Care Agreement

** Please **initial** by each bullet point and sign at the bottom of this agreement. **

As a patient of Georgia Pain and Spine Solutions, I agree to the following:

_____1. I will provide complete information about my illness/problem, medications, and health habits to enable proper evaluation and treatment,

_____2. I, and others who accompany me to my appointments or call on my behalf, will show respect to office personnel and other patients. Lack of such may lead to dismissal from the practice.

_____3. I will arrive on time for my appointments and understand that if I am more than 10 minutes late, my appointment may be rescheduled and I will be charged a $25 missed appointment fee that must be paid before I will be seen again.

_____4. I understand I will be charged a $150 missed procedure fee that must be paid before I will be seen again.

_____5. I will pay co-pays or bills in a timely manner and agree that failure to do so will result in dismissal from the practice.

_____6. I will use prescriptions or other medical devices prescribed according to directions.

_____7. I will bring ALL my medications in their original bottles to every appointment and understand that refills will not be considered otherwise. I understand I may be asked to bring my medications at any time to be counted to ensure my compliance with taking my medications as prescribed, and understand if I do not do so, I may be dismissed from the practice.

_____8. I will consent to random drug screens and understand that if I do not comply, I will be dismissed from the practice.

_____9. I understand that refills will be made only during business hours Monday – Friday, and that it is my responsibility to request refills early enough to allow at least two business days for medication refills to be called in for me, should they be approved.

_____10. I will accept responsibility for my actions including misuse of drugs (whether illicit or prescription), tobacco, alcohol or other activities.

_____11. I will follow the guidelines set for any limitations in work, activity or diet.

_____12. If I have pending litigation against a medical provider, I may be dismissed from the practice.

_____ _____

Patient Signature Date

_____

Printed Name

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Patient Acceptance of Financial Responsibility

As a courtesy to you, we will bill your primary and secondary insurance carrier(s) if you provide ALL necessary information. However, you are ultimately responsible for all charges for services rendered. In addition, your insurance company may require an authorization or precertification for certain procedures, services, drugs and supplies that may be provided to you. As a courtesy, we will contact your insurance company for authorization for services; however, it is ultimately your responsibility to understand what your insurance policy covers and assure that you have authorization for services.

- You must pay any co-payment and applicable deductible amounts at the time of service unless other arrangements have been made with our office.
- Co-Payment or deductibles toward procedures are the patient's responsibility and must be paid prior to the procedure. If payment is not received prior to a scheduled procedure, it will be postponed. We may charge a $150 fee for a missed procedure appointment.
- If you are not insured, or if the services provided are not covered by your insurance, you will be expected to provide payment in full for our services at the time they are rendered.
- The remainder of your bill will be sent to your health plan for direct payment to our office.
- In those instances where we have a participating provider agreement with your insurance company for an agreed upon negotiated rate for our services, an adjustment will be made in the amount of the difference between this rate and our normal fees at the time we receive payment from your insurance company. You will remain responsible for required co-payments, applicable deductible amounts and any services that are not covered by your insurance plan.
- If, by mistake, your health plan remits payment to you, please send it to us along with all paperwork sent to you at the time.
- Your health plan may refuse payment of a claim for some of the following reasons:
    1. This is a pre-existing illness not covered by your plan
    2. You have not met your full calendar year deductible
    3. The type of medical service rendered is not covered by your plan
    4. The health plan was not in effect at the time of service
    5. You have other insurance which must be filed first

Please understand that financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies any claim for any of these or other reasons, our office cannot be responsible for this. It is your responsibility as the patient to pay the denied amounts in full.

Workers Compensation Patients: We must have prior authorization to treat from either the employer or the insurance carrier agent. Should the employer or carrier subsequently deny validated workers compensation services, such charges will be the financial responsibility of the patient.

Missed Appointments: I understand that Georgia Pain and Spine Solutions may, but is not required to, call me to confirm any upcoming appointments. I understand that this is a courtesy and that I am ultimately responsible to keep my office appointment. I understand that Georgian Pain and Spine Solutions may charge a $25.00 missed appointment fee and that I will personally pay the fee for appointments missed and not changed or cancelled at least 24 hours prior to my scheduled appointment.

I (NAME)_____have read and understand my obligations and I acknowledge that I am fully responsible for payment of any services not covered or approved by my insurance carrier. I authorize Georgia Pain and Spine Solutions to initiate a complaint to the insurance commissioner for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

_____ _____

Patient or Responsible Party Signature Date

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Medical Records Release Form

Patient Name	Date of Birth

Address	Telephone

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below. I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), genetic testing or screening, behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

Limitations on the information you may release subject to this Release Form are:

1. Last three office visits (if applicable)
2. Radiological reports
3. Lab reports
4.

Release my protected health information to the following person(s) / entity:

Name: Georgia Pain and Spine Solutions
Street: 76 Highland Pavilion Court, #133 Fax# (404) 745-8013
City: Hiram State: GA ZIP: 30141

The reasons or purposes for this release of information are as follows:

1. For evaluation and treatment of patient
2. For continuity of care
3.

Patient Signature (or parent, guardian or legal representative)

X Date:

Print Name: DOB:

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Acknowledgement of Review of Notice of Privacy Practice

I have reviewed or have had the opportunity to review Georgia Pain and Spine Solutions's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I have received or understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Patient (or Personal Representative) Date

_____

Printed Name of Patient (or Personal Representative)

Patient's Date of Birth:_____/_____/_____

If the signer is not the patient:

_____

Description of Personal Representative's Authority

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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 THIS NOTICE CAREFULLY.

This notice describes our privacy practices. We are required by law to protect the confidentiality of your medical information; provide you with this notice of our legal duties and privacy practices; and abide by the terms of our current notice of privacy practices. We may change this notice and our privacy policies at any time and have the revised notice and policies apply to all the protected health information we maintain. If we change our notice, we will post the new notice in our office where it can be seen. You have the right to request at any time a paper copy of our current notice, even if you have agreed to receive this notice electronically.

A. How the Practice May Use or Disclose Your Health Information

1. **For Treatment** We may use and disclose your health information to those involved in your treatment. For example, your information may be used by or disclosed to a physician or other health care provider in this practice. Because your physician in this practice is a specialist, we may request that your primary care physician share your health information with us, and we may provide your primary care physician with information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any. We may also provide your information to laboratories, pharmacists, and other outside providers involved in your treatment.
2. **For Payment** We may use and disclose your health information to others for purposes of billing and collecting payment for treatment and services that we provide to you. For example, we may submit a bill to you or a third-party who is financially responsible for your treatment, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and the treatment or supplies used in the course of treatment. We may also disclose your health information to other health care providers to assist in their billing and collection efforts.
3. **For Health Care Operations** We may use and disclose your health information to perform activities that support this practice, such as cost-management and business planning activities, and activities that ensure the delivery of quality care. For example, we may engage the services of a professional (such as an accountant, auditor, or attorney) to assist us with compliance-related activities. If we do so, these professionals may review billing and medical files. We may also ask quality improvement personnel t review our charts and medical records to evaluate the performance of our staff. We may also disclose your health information to other health care providers to assist in their health care operations.

B. Disclosures That Can Be Made Without Your Authorization. There are situations in which we are permitted to disclose or use your health information without your authorization and without providing you with an opportunity to object. Provided below are descriptions of such situations.

1. **Public Health, Abuse or Neglect, and Health Oversight** We may disclose your health information to certain public health authorities (such as local and state health department s and the Centers for Disease Control and Prevention) that are authorized by law to collect information for purposes of reporting information about disease or injury; reporting vital statistics; investigating the occurrence and cause of injury and disease; and monitoring adverse outcomes related to food, drugs, biological products, or medical devices. For example, if authorized by law, we may disclose health information about a patient to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may also disclose a patient's health information to report reactions to medications, report problems with products, or notify people of recalls of products they may be using. We may also disclose your health information to your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

   Georgia law requires physicians to report child abuse or neglect. Georgia law also requires physicians who have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation to report that information to the state. We are permitted to disclose health information about a patient to a public agency authorized to receive reports of child abuse or neglect and to disclose information about a patient to report abuse or neglect of elders or the disabled.

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We may disclose your health information to a health oversight agency in connection with certain "oversight activities" authorized by law. Examples of these activities include audits; investigations; inspections; surveys' licensure and disciplinary actions; administrative, civil, and criminal actions or proceedings; and other activities necessary for the government to monitor government programs, the health care system, and compliance with civil rights laws.

2. **Disclosures Required by Law** We may disclose information about you when disclosure is required by law.
3. **Legal Proceedings /Law Enforcement** We may disclose a patient's health information in the course of judicial or administrative proceedings in response to an order of a court (or an administrative decision-maker) or other appropriate legal process. Certain requirements must be met before we disclose your information under these circumstances. We may also disclose a patient's information if asked to do so by a law enforcement official if the information: (a) is released pursuant to legal process, such as a warrant or subpoena; (b) pertains to a victim of crime and the patient is incapacitated; (c) pertains to a person who has died under circumstances that may be related to criminal conduct; (d) is about a victim of crime, and we are unable to obtain the person's consent; (e) is released because of a crime that has occurred on our premises; or (f) is released to locate a fugitive, missing person, or suspect. We also may release a patient's information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.
4. **Workers' Compensation** We may use or disclose your health information in order to comply with laws and regulations related to workers' compensation and similar programs.
5. **Decedents** We may disclose a deceased patient's health information to (a) a funeral director when such disclosure is necessary for the director to carry out his or her lawful duties; (b) to a coroner or medical examiner to identify a deceased person or a cause of death; and (c) an organ procurement organization for cadaveric organ, eye, or tissue donation purposes, if the patient is a donor.
6. **Research** We may use or disclose your health information for research purposes when an institutional review board or privacy board has reviewed the research project, approved the research, and established protocols to ensure the privacy of your health information. We may also use a patient's health information in connection with certain activities preparatory to research and in connection with research on the protected health information of decedents.
7. **Government Functions** If you are in the military, we may disclose your health information to appropriate military command officers upon request. We may also disclose your information to federal officials (a) for national security and intelligence activities authorized by law and (b) for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.
8. **Inmates** If a patient or other individual is an inmate or under the custody of a law enforcement official, we may disclose that person's health information to correctional institutions or law enforcement officials if the information is necessary to allow the institution to provide that person with medical care, to protect the health or safety of that person or others, or to maintain the safety, security, and good order of the institution.

C. **Your Rights** You have the following rights regarding the protected health information maintained by this practice:

1. **Requested Restrictions** You have the right to request that we restrict or limit how we use or disclose your protected health information for purposes of treatment, payment, or health care operations. You also may request that we limit disclosure to family members, other relatives, or close personal friends who may or may not be involved in your care. We do NOT have to agree to the requested restrictions, but if we do agree, we will comply with your request except under emergency circumstances or when otherwise required by law to use or disclose your information in violation of your request. **To request a restriction**, please submit the following information in writing: (a) the information to be restricted; (b) what kind of restriction you are requesting (for example, on the use of information, disclosure of information, or both); and (c) to whom the restrictions apply. Please send the request to our Privacy Officer at the address provided at the end of this notice. You do not need to provide us with the reason for your request.
2. **Confidential Communications** You have the right to request that we communicate with you about your health and related issues by alternative means or at an alternative location. For example, you may request that we contact you at work rather than at home. We are required to accommodate only reasonable requests. **To request a restriction**, please submit the following information in writing: exactly how you want us to communicate with you and, if you are directing us to send

3. communications to a particular place, the contact/address information. Please send the request to our Privacy Officer at the address provided at the end of this notice. You do not need to provide us with the reason for your request.

4. **Inspection and Copies of Protected Health Information** You have the right to inspect and/or receive copies of your health information that is maintained by this practice. Georgia law requires that requests for copies be made in writing. We ask that requests for inspection of your health information also be made in writing. Please send your request to our Privacy Officer at the address provided at the end of this notice.

   We may ask that a narrative of your health information be provided rather than copies. However, if you do not agree to our request, we will provide copies. We are also permitted to refuse to provide some of the information you ask to inspect or be copied if the information: (a) is psychotherapy notes; (b) reveals the identity of a person who provided information under a promise of confidentiality; (c) is subject to the Clinical Laboratory Improvements Amendments of 1988; or (d) has been compiled in anticipation of litigation. We are also permitted to refuse to provide access to or copies of your health information in other limited situations, provided that we arrange for a review of our decision on your request. Any such review will be made by another licensed health care provider who was not involved in the decision to deny access.

   Georgia law requires us to be ready to provide copies or a narrative of your health information within 15 business days of your request or, in many situations, within 15 business days of receipt of payment for such copies. We will inform you when your records are ready or if we believe access should be limited. If we deny access, we will inform you of our decision in writing. We are, under most situations, permitted to charge a reasonable fee for providing copies of medical records.

5. **Amendment of Health Information** You have the right to request an amendment of your health information maintained by this practice. Any such request must be submitted in writing to our Privacy Officer and must include the reason(s) that support your request for amendment. We will respond within 60 days of your request. We will deny your request if you fail to submit the request in writing (and/or include the reason(s) supporting your request). Additionally, we may refuse to allow an amendment if, in our opinion, the information in question is: (a) was not created by our practice, unless you supply us with a reasonable basis to believe that the person or entity that created the record is not available to amend the record; (b) is not part of our designated record set; (c) is not part of the records you would be permitted to inspect or obtain copies; or (d) is accurate and complete. If we refuse to allow an amendment, we will inform you in writing. If we deny your request, you are permitted to include a statement about the information at issue in your medical records. If we approve the request, we will inform you in writing; will allow the amendment to be made; and, upon a request from you t do so, will notify the relevant persons and entities named in your request with which the amendment needs to be shared.

6. **Accounting of Certain Disclosures** You have the right to request an accounting of disclosures made by this practice for purposes other than for treatment, payment, or health care operations, made pursuant to an authorization signed by you or your representative; or made to you or your representative. Please submit any request for an accounting to our Privacy Officer at the address provided at the end of this notice. In your request, specify the time period for which you are requesting an accounting (which may not be longer than six years from the date of disclosure or include dates before August 15, 2018). Your first accounting of disclosures within a 12-month period will be free. For additional requests within that period, we are permitted to charge for the cost of providing the list. If there is a charge we will notify you, and you may choose to withdraw or modify your request before any costs are incurred.

D. Appointment Reminders, Treatment Alternatives, and Other Benefits We may contact you by telephone, mail, or both, to provide appointment reminders, information about treatment alternatives, or other health-related benefits or services. If we contact you by telephone and no one answers the call, it is our practice to leave a message on the telephone answering machine. If we contact you by mail, we may use a postcard instead of a sealed envelope.

E. Complaints If you are concerned that your privacy rights have been violated, you may contact our Privacy Officer at the address provided at the end of this notice. We request that all complaints be submitted in writing. You may also send a written

F. complaint to the Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or the government.

G. **Patient Authorization** We will obtain your written authorization for uses and disclosures that are not identified in this notice or permitted by applicable law. If you choose to sign an authorization, you can later revoke that authorization in writing, to stop future uses and disclosures; however, any revocation will not apply to disclosures or uses already made or to disclosures made in reliance on your prior authorization.

H. **Contact Information** If you have any questions or complaints, or if you want to make a request pursuant to any of the rights described above, please contact our Privacy Officer at 76 Highland Pavilion Court, #133, Hiram, Ga 30141.

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PAIN & MEDICAL HISTORY

Patient Name_____DOB_____/____/____ Age_____

Is your pain a result of a work related injury? ☐Yes☐No

Is your pain a result of a motor vehicle accident? ☐Yes☐No
If yes, date of accident?___ ____ ___

Is there a lawsuit pending or have you hired an attorney? ☐Yes☐No
If so, Name of Attorney_____

Does your pain awake you at night?
When did your pain begin? _____
Describe your pain in your own words?_____
_____
_____

Please select the type(s) of pain you experience. (Check all that apply.)

☐ Constant	☐ Intermittent	☐ Periodic	☐ Frequent	☐ Occasional
☐ Burning	☐ Sharp	☐ Stabbing	☐ Dull	☐ Aching
☐ Pounding	☐ Shooting	☐ Other (Describe) _____		

Since your pain began, which of the following people have you consulted for treatment?

Specialty	**Name**
Internal Medicine	_____
Family Practice	_____
Orthopedic Surgeon	_____
Neurologist	_____
Neurosurgeon	_____
Psychologist	_____
Psychiatrist	_____
Chiropractor	_____
Physical Therapist	_____
Other	_____

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PAIN & MEDICAL HISTORY

Which (CHECK) of the following pain treatments have you tried?

- ☐ Ice
- ☐ Heat
- ☐ TENS Unit
- ☐ Massage
- ☐ Traction
- ☐ Physical Therapy
- ☐ OTHER_____
- ☐ Brace
- ☐ Psychotherapy
- ☐ Injections
- ☐ Bedrest
- ☐ Pain Pump
- ☐ Spinal Stimulation

Pain Indicators/Relievers (CHECK)

Activity	Makes Pain		Activity	Makes Pain	
Sitting	☐ Better	☐ Worse	Taking Medications	☐ Better	☐ Worse
Standing	☐ Better	☐ Worse	Applying Heat	☐ Better	☐ Worse
Lying Down	☐ Better	☐ Worse	Applying Ice	☐ Better	☐ Worse
Walking	☐ Better	☐ Worse	Massage	☐ Better	☐ Worse
Sneezing	☐ Better	☐ Worse	Pushing/pulling	☐ Better	☐ Worse
Straining/Coughing	☐ Better	☐ Worse	Bending/stooping	☐ Better	☐ Worse
Sleeping	☐ Better	☐ Worse	Other:_____	☐ Better	☐ Worse

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PAIN & MEDICAL HISTORY

Please list any surgeries that have been performed for treatment **for your pain condition**.

Operations	Approximate Date
1.	
2.	
3.	
4.	
5.	

Please list **any other surgeries** that you have had in the past.

Operations	Approximate Date
1.	
2.	
3.	
4.	
5.	

What diagnostic studies (X-rays, MRI's nerve studies, etc.) have you had?

Type of Study	Date	Doctor that Ordered	Results

Please list all medications you have tried or are currently taking.

Tried	Use	Medications (List Below)	What strength?	How often?	Since when?	Prescribed by?
	☐					
☐	☐					
☐	☐					
☐	☐					
☐	☐					
☐	☐					
☐	☐					
☐	☐					
☐	☐					
☐	☐					
☐	☐					

Are you currently taking any of the following or other blood thinners?

☐ Aspirin ☐ Ibuprofen ☐ Coumadin ☐ Lovenox ☐ Fragmin ☐ Plavix ☐ Other________

DO YOU HAVE ALLERGIC REACTIONS TO ANY MEDICATIONS? (Please provide specific side effects.)

____

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Lifestyle Questionnaire

Date_____ Name_____

Please check all that apply:

☐ I am currently working.

☐ I am not currently working, but not due to pain problems.

☐ I am not currently working because of my pain.

☐ I am able to work, but at a reduced level and/or reduced hours because of my pain.

☐ I choose not to work.

Please describe your employment. Be specific about physical requirements and hours.

_____

_____

Please rate your stress level. (Circle appropriate number.)

(Lowest) 0___1___2___3___4___5___6___7___8___9___10___ (Highest)

Have you ever had a substance abuse problem, emotional or nervous problem? ☐ Yes ☐ No

If Yes, please elaborate._____

_____

Have you ever seen a psychologist or psychiatrist? ☐ Yes ☐ No

If Yes, please explain reason(s) and outcome._____

_____

_____

Do you drink alcohol? ☐ No ☐ Yes If yes, how many drinks average? _____ ☐ Per day ☐ Per week

If no, did you drink in the past? ☐ No ☐ Yes If yes, how long since you last drank? _____

Do you drink alcohol to take away the pain? ☐ Often ☐ Sometimes ☐ Never

Do you smoke or use tobacco products? ☐ No ☐ Yes If yes, how many cigarettes or packs per day? _____

When did you start? _____If you used to smoke, when did you quit? _____

Have you or do you smoke marijuana or use illicit drugs? ☐ No ☐ Yes

If yes, what kind and how often? _____

Do you exercise? ☐ No ☐ Yes If Yes, what type of exercise and how often?_____

Anything else we should know to aid in your care? _____

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Review of Systems

Patient Name:_____DOB:____/_____/_____Age: _____

Have you now or have you ever had the following? (Check all that apply.)

- ☐ Swelling of the extremities
- ☐ Poor circulation in extremities
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Fainting spells
- ☐ Stroke or "mini-stroke"
- ☐ Irregular heartbeat or palpitation
- ☐ Heart attack
- ☐ Heart valve problem/Mitral Valve Prolapse
- ☐ Pacemaker or Defibrillator device
- ☐ Smoking
- ☐ COPD
- ☐ Shortness of breath with exertion
- ☐ Shortness of breath with lying down
- ☐ Asthma
- ☐ Regular, daily cough
- ☐ Regular, daily sputum production
- ☐ Coughing up blood
- ☐ Wheezing
- ☐ Sleep apnea
- ☐ History of Tuberculosis
- ☐ Use home oxygen therapy
- ☐ Nausea/Vomiting
- ☐ Peptic ulcer disease or reflux
- ☐ Acid reflux disease
- ☐ Constipation / diarrhea
- ☐ Irritable Bowel Syndrome
- ☐ Blood in the stools
- ☐ Change of bowel habits or function
- ☐ Bloating, cramping or irritable bowel
- ☐ Sexual dysfunction

- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Jaundice
- ☐ Difficulty starting urination
- ☐ Loss of bowel or bladder control
- ☐ Painful or frequent urination
- ☐ Blood in the urine
- ☐ Kidney disease
- ☐ Frequent urinary infections
- ☐ On hormone replacement
- ☐ Past menopause
- ☐ Thyroid disorder
- ☐ Parathyroid disorder
- ☐ Are you menopausal?
- ☐ Low sexual drive
- ☐ Diabetes: # of years_____
- ☐ Skin rash or unexplained skin lesions
- ☐ Itching
- ☐ Non-healing wounds
- ☐ Dry skin
- ☐ History of blood clots
- ☐ HIV or AIDS
- ☐ Autoimmune disorder
- ☐ Swollen lymph nodes
- ☐ History of Shingles
- ☐ Unexplained or prolonged infection
- ☐ Hereditary bleeding disorder or HEME
- ☐ Bleeding that is difficult to stop
- ☐ Steroid use in last 3 months
- ☐ Recurrent pneumonia
- ☐ Changes in appetite

- ☐ Blood transfusion
- ☐ Immunosuppression
- ☐ Unexplained bruising or bleeding
- ☐ Rheumatoid arthritis
- ☐ Degenerative arthritis
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Gout
- ☐ Muscle aches, frequent or repetitive
- ☐ Trigger points
- ☐ Difficulty or pain with swallowing
- ☐ Hoarseness
- ☐ Jaw pain, popping or clicking
- ☐ History of glaucoma
- ☐ Ear pain
- ☐ Vision changes
- ☐ Hearing changes
- ☐ Frequent nosebleeds
- ☐ Chronic sinus infections
- ☐ Chronic toothache
- ☐ Vertigo (room spins)
- ☐ Dizziness (light headed)
- ☐ New type of headache
- ☐ Migraine headaches
- ☐ New onset of weakness or numbness
- ☐ Head injury / concussion
- ☐ Weakness in an extremity
- ☐ Numbness in an extremity
- ☐ Fatigue
- ☐ Insomnia
- ☐ Weight change past 3-6 months

☐ Drenching night sweats

____Inc/Dec How many pounds? ____

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PAIN OSWESTRY -Page 1

Name_____Date_____

Please answer every section and mark in each section **only one answer** that best applies to you.

SECTION 1—Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is severe.
- ☐ The pain is severe and does not vary much.

SECTION 2—Personal Care

- ☐ I do not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ☐ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain I am unable to do some washing and dressing without help.
- ☐ Because of the pain I am unable to do any washing and dressing without help.

SECTION 3—Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e.on a table).
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently placed.
- ☐ I can only lift very light weights at the most.

SECTION 4—Walking

- ☐ I have no pain on walking.
- ☐ I have some pain on walking but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than ½ mile without increasing pain.
- ☐ I cannot walk more than ¼ mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5—Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can sit only in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain straight away.

SECTION 6—Standing

- ☐ I can stand as long as I want without pain.

PAIN OSWESTRY- Page 2

- ☐ I have some pain on standing but it does not increase with time.
- ☐ I cannot stand for longer than 1 hour without increasing pain.
- ☐ I cannot stand for longer than ½ hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain immediately.

SECTION 7—Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of pain my normal night's sleep is reduced by less than ¼.
- ☐ Because of pain my normal night's sleep is reduced by less than ½.
- ☐ Because of pain my normal night's sleep is reduced by less than ¾.
- ☐ Pain prevents me from sleeping at all.

SECTION 8—Social Life

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal but increases the degree of my pain.
- ☐ Pain has no significant effect o n my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- ☐ Pain has restricted my social life, and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of my pain.

SECTION 9—Travel

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while traveling which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents me from all forms of travel except that done lying down.

SECTION 10—Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at present.
- ☐ My pain is getting neither better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Please rate your pain level today with a slash (/) along the scale below.

NO PAIN _____WORST POSSIBLE

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Functional Goals

Please list your goals regarding the control of your pain and in order of importance. Write your first and most important goal first. Examples might include: Returning to work, being able to enjoy more family time, training for a new job, improving your sex life, being able to exercise or having more energy. Please be realistic but try to describe things that are really important to you as an individual.

1. _____
2. _____
3. _____
4. _____

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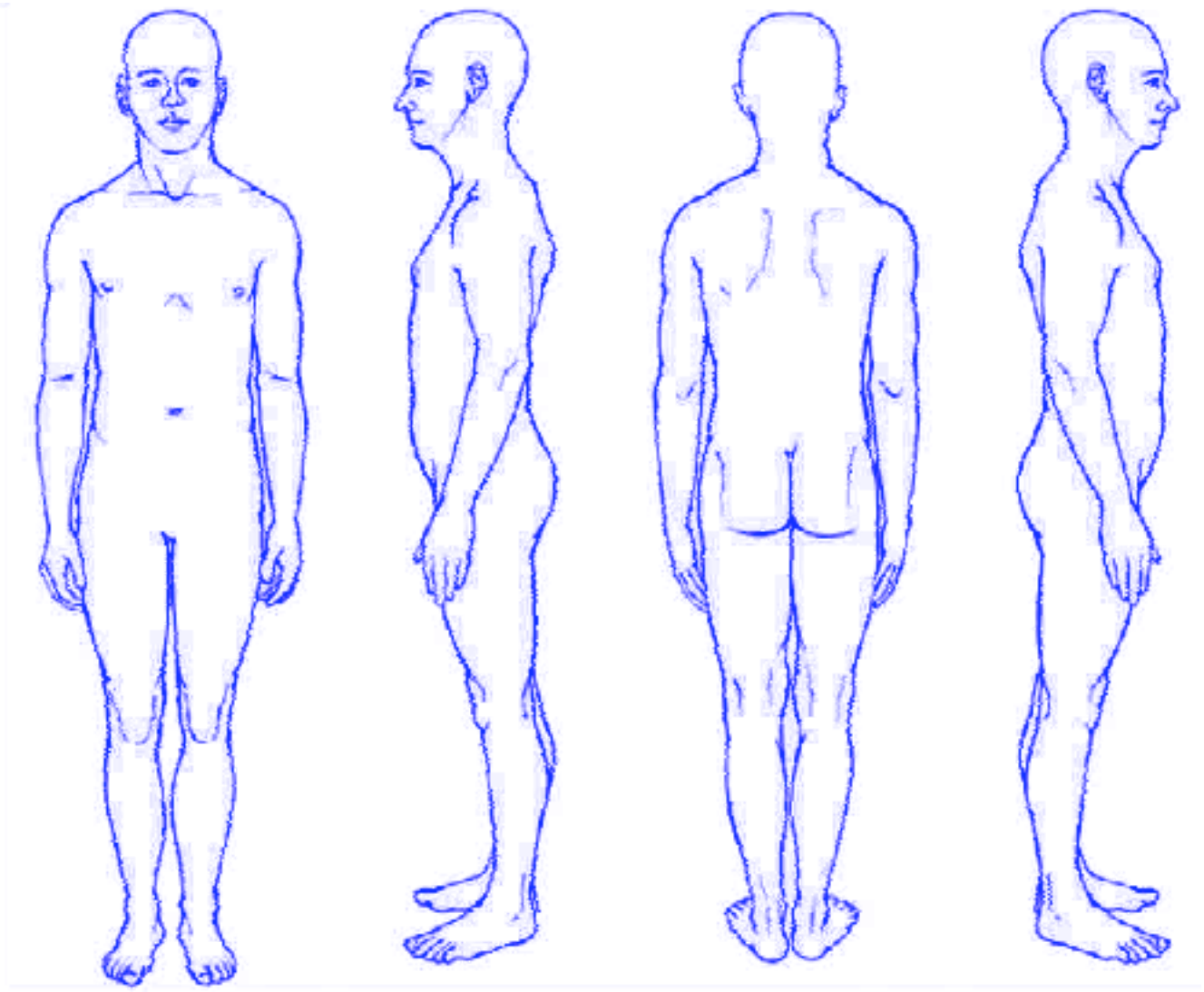
Pain Diagram

Name_____Date_____

Please mark the areas on the drawing where you feel your pain. Please use the appropriate letter(s):

N for Numbness **P** for Pins & Needles **B** for Burning **S** for Stabbing



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Long Term Opioid Therapy Agreement for Chronic, Non-Malignant Pain, page 1 of 3

Name _____ Date_____

I voluntarily request Georgia Pain and Spine Solutions Physicians to treat my chronic pain condition. I hereby authorize and give my voluntary consent for Georgia Pain and Spine Solutions Physicians to administer or write prescription(s) for dangerous and/or controlled drugs (medications) as an element in the treatment of my chronic pain. I understand that these medication(s) may include opioid/narcotic drug(s) which can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other used in the practice of medicine, produce adverse effects or results. I understand the alternative methods of treatment, the possible risks involved, and the possibilities of complications as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medications.

THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS MAY INCLUDE THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT HAS BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT. (THIS IS SOMETIMES REFERRED TO AS “OFF-LABEL” PRESCRIBING.) MY DOCTOR WILL EXPLAIN HIS TREATMENT PLAN(S) FOR ME AND DOCUMENT IT IN MY MEDICAL CHART.

I understand that I will undergo medical tests and examinations before and during my treatment. Those tests include random, unannounced checks for drugs and psychological evaluations if and when it is deemed necessary, and I hereby give my permission to perform the tests or my refusal may lead to termination of treatment. I understand that the presence of unauthorized substances may result in being discharged from the practice.

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 **Georgia Pain and Spine Solutions Physicians** immediately if I become pregnant.
- **If I am pregnant or am uncertain, I WILL NOTIFY Georgia Pain and Spine Solutions Physicians IMMEDIATELY.**

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUG(S) USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension (low blood pressure), arrhythmias (irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may

be impaired during all activities including work.

I am aware of alternative methods of treatment, the possible risks involved, and the possibilities of complications, and I still desire to receive medication(s) for the treatment of my chronic pain.

The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and active life. I realize that I may have a chronic illness and there is a limited chance for a complete cure, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of some or all medication(s). My treatment plan will be tailored specifically for me. I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time and that I will notify Georgia Pain and Spine Solutions Physicians of any discontinued use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

I understand that no warranty or guarantee has been made to me as to the result of any drug therapy or cure of any condition. The long-term use of medications to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment, or diagnostic procedure(s) to be used to treat my condition, and the hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

I UNDERSTAND AND AGREE TO THE FOLLOWING:
This pain management agreement relates to my use of any and all medication(s) (i.e. opioids, also called ‘narcotics, painkillers’, and other prescription medications, etc.) for chronic pain prescribed by Georgia Pain and Spine Solution Physicians. I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substances. **Therefore, medication(s) will only be provided so long as I follow the rules specified in this Agreement.**

Georgia Pain and Spine Solution Physicians may at any time choose to discontinue the medication(s). **Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or discharge from care and treatment.**

- **I will bring ALL my medications in their original bottles to every appointment and understand that refills will not be considered otherwise.**
- My progress will be periodically reviewed and if the medication(s) are not improving my quality of life, the medication(s) may be discontinued.
- I will disclose to my physician all medication(s) that I take at any time, prescribed by any physician.
- I will use the medication(s) exactly as directed by my physician.
- I agree not to share, sell or otherwise permit others, including my family and friends, to have access to these medications.
- I will not allow or assist in the misuse/diversion of my medication(s); nor will I give or sell them to anyone else.

- I will safeguard my medications from loss or theft. Lost or stolen medications will not be replaced.
- If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then my physician may try alternative medication(s) or may taper me off all medication(s). I will not hold Georgia Pain and Spine Solution Physicians liable for problems caused by my discontinuance of medication(s).
- I agree to submit to urine and/or blood screens to detect the use of non-prescribed and prescribed medication(s) at any time and without warning. If I test positive for illegal substance(s) such as marijuana, speed, cocaine, etc., treatment for chronic pain may be terminate.

- I must take the medication(s) as instructed my physician. Any unauthorized increase in the dose of medication(s) may be viewed as a cause for discontinuation of treatment.
- I must keep all follow-up appointments as recommended by my physician or my treatment may be discontinued.
- I will not attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants or anti-anxiety medications from any other doctor.
- I agree that I shall inform any doctor who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.
- I will receive medication(s) from only ONE physician unless it is for an emergency or my physician approves the medication(s) that is being prescribed by another physician. Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.
- I hereby give my physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).
- Refill(s) will not be ordered before the scheduled fill date. However, early refill(s) may be allowed when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.
- I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours, and understand I must allow at least 24 hours for my refill to be considered and/or authorized.
- All medications must be obtained at one pharmacy, where possible. Should the need arise to change pharmacies, I will inform my physician.

I agree to use the following pharmacy for filling all of my prescriptions for pain medication(s):

Pharmacy Name_____Pharmacy Phone_____

Pharmacy Address _____

I certify and agree to this entire Agreement and to the following:

1. I am not currently using illegal drugs or abusing prescription medication(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

2. No guarantee or assurance has been made as to the results that may be obtained from chronic pain treatment. With full

knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life.

3. I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain and I fully understand the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.

X-_____ Date_____

Print Name_____