pain & spine center

REGISTRATION FORM:

PATIENT FIRST NAME	MIDDLE NAME	LAST NAME
DATE OF BIRTH	EMAIL	

SSN	SEX □ MALE □ FEMALE	MARITAL STATUS □ MARRIED □ WIDOWED □ SINGLE □ DIVORCED □ OTHER	NUMBER OF KIDS

PERMANENT STREET ADDRESS			HOME PHONE NUMBER
CITY	STATE	ZIP	MOBILE PHONE NUMBER

WORK STATUS

□ FULL TIME □ PART TIME □ DISABLED □ UNEMPLOYED

EMERGENCY CONTACT NAME	RELATIONSHIP TO PATIENT	EMERGENCY PHONE NUMBER
PRIMARY INSURANCE NAME	SUBSCRIBER/INSURANCE ID NUMBER	GROUP NUMBER
SECONDARY INSURANCE NAME	SUBSCRIBER/INSURANCE ID NUMBER	GROUP NUMBER

PRIMARY/FAMILY PRACTICE DOCTOR	REFERRING DOCTOR
PHARMACY NAME	PHARMACY PHONE NUMBER
PHARMACY STREET ADDRESS	

CITY	STATE	ZIP	

Reason for today's visit: _____

When did your pain start: _____ How did your pain start: _____

Your current pain score: (No Pain) - 0 1 2 3 4 5 6 7 8 9 10 - (Maximum imaginable pain)

You are able to:

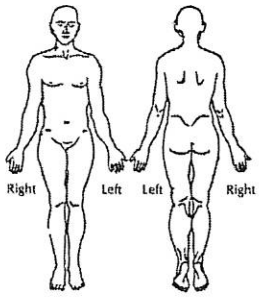
Go to store:	**(No Pain) - 0 1 2 3 4 5 6 7 8 9 10 - (With Pain)**
Do house chores:	**(No Pain) - 0 1 2 3 4 5 6 7 8 9 10 - (With Pain)**
Do exercise:	**(No Pain) - 0 1 2 3 4 5 6 7 8 9 10 - (With Pain)**
Bathe and dress yourself:	**(No Pain) - 0 1 2 3 4 5 6 7 8 9 10 - (With Pain)**
Walk up or down stairs:	**(No Pain) - 0 1 2 3 4 5 6 7 8 9 10 - (With Pain)**
Bend down to pick up things:	**(No Pain) - 0 1 2 3 4 5 6 7 8 9 10 - (With Pain)**
Stand as long as I want:	**(No Pain) - 0 1 2 3 4 5 6 7 8 9 10 - (With Pain)**
Walk as far as I want:	**(No Pain) - 0 1 2 3 4 5 6 7 8 9 10 - (With Pain)**

Your pain feels: sharp, dull, aching, burning, constant, radiating, pressure, electric-shock, numbness
Your pain gets worse when you: walk, sit, stand, activity, bend, rotate, use arms, use legs, exercise
Your pain gets better when you: take medications, rest, walk, sit, stand, stretch, pray, meditate
Most recent Physical Therapy date: _____
Most recent pain physician who has evaluated you: _____ Were you dismissed: Yes No
You have had: (please circle) MRI XRAY CT Nerve/Muscle studies NONE
Drug Allergies: Yes No - If yes, please list _____
Are you allergic to IV Dye? Yes No
Are you allergic to Latex? Yes No

- **Medical Problems you have**: Asthma, COPD, Bronchitis, Headaches, Stroke, TIA, Seizures, High blood pressure, Diabetes, Thyroid disease, Cancer, Liver disease, Kidney disease, Bleeding problems, GERD, other (please describe)_____ or NONE
- **List Surgeries you have had:** _____
- **Do your parents or other family have:** COPD, High Blood Pressure, Diabetes, Addiction to Alcohol, Drugs, Cancer, Liver Disease or NONE
- **Do You:** Smoke Drink Alcohol Take Illegal Drugs None

Please circle what applies:

Poor general health, Recent weight changes, Fever, Chills, Chronic neck or back pain, Muscle stiffness or pain, Limitation of motion, Difficulty walking, Chronic or recurring rashes or sores, Breast pain breast lumps or discharge, Hearing loss, Ear ache, Sinus problems, Headaches, Dizziness, Seizures, Nervousness, Anxiety, Depression, Suicidal or homicidal ideation, Recurring nosebleeds, Swollen lymph nodes, Recurring infections, Frequent urination, Blood in urine, Loss of sexual desire, Irregular or painful menstruation, Hay fever, HIV or AIDS

(Office Use)	**Mark where your pain is**	**List all your Medications:**
Height_____ Weight_____ BP:_____ HR:_____ Pulse:_____ Pulse Ox:_____ Temp: _____		• - • - • - • - • - • - • - • -

Dr. Shahid _____

DATE: _____ NAME: _____

SOAPP*-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.	NEVER	SELDOM	SOMETIMES	OFTEN	VERY OFTEN
	0	1	2	3	4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

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A Statement of the Patient's Responsibilities

As a patient, you should assume responsibility for the following:

The clinic expects that you or your designated/legal representative will provide accurate and complete information about present complaints, past illnesses, other clinic history, medications, "advance directives, "and other matters relating to your health history or care in order for you to receive effective medical treatment.

You are responsible for reporting whether you clearly comprehend a contemplated course of action and what is expected of you. These questions should be directed to the physician, **while you are in the exam room**. Due to HIPPA guidelines, no treatment plans will be discussed outside the exam room. This will insure your privacy and treatment guidelines, no treatment plans will be discussed outside the exam room. This will insure your privacy and treatment guidelines are kept confidential.

The clinic expects that you will cooperate with all clinic personnel and ask questions if directions and/or procedures are not clearly understood.

You are expected to be considerate of other patients and clinic personnel, to assist in the control of noise, and to observe the no-smoking policy of this clinic. You are also expected to be respectful of the property of other persons and the property of the clinic.

In order to facilitate your care and the efforts of the clinic personnel, you are expected to help the physicians, nurses, and allied medical personnel in their efforts to care for you by following their instructions and medical orders. IT IS EXPECTED THAT YOU WILL NOT SELF INCREASE/DECREASE/DISCONTINE YOUR MEDICATION DOSE WITHOUT OUR EXPRESSED PERMISSION. It is equally expected that you will not take/obtain pain drugs from any person, facility of physician other than your attending physician while in engaged in this pain clinic.

You are expected to be on time for you designated appointment time and/or procedure time. If you cannot make your appointment time, you are expected to call and notify our office of your situation. **This should be accomplished at least 24 hours in advance or we will impose broken visit charge.** You can reach us at 937-280-4970. It is important to acknowledge procedures scheduled include ancillary staff, equipment and time designated for you appointment, when you fail to call or show this creates unnecessary usage that could have been rescheduled or consideration for another patient could have been scheduled in place.

It is understood that you assume the financial responsibility of paying for all services rendered either through third-party payers (your insurance company) or being personally responsible for payment for any services that are not covered by your insurance.

Summary

Being a good patient does not mean being a silent one. If you have questions, problems, or unmet needs, please let us know.

I agree with above:

Signature:_____ Date: _____

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Prescription History Consent

I give my consent to have Pain and Spine Center to obtain my prescription history from external sources.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

I, _____ (Print Name and, or Guardian if under 18 years) hereby request and authorize an physician, dentist, pharmacist, or licensed practitioner, any institution, to fully disclosed to the pain service at Pain and Spine Center and to its authorized representative, all information and records relating to diagnosis, treatment and prognosis made or undertake for me, (or if under 18 years, for_____.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

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HIPPA - AUTHORIZATION FOR RELEASE OF INFORMATION

Due to the new HIPPA regulations it has become Pain and Spine Center policy to obtain authorization to leave voice mail messages regarding confirmation of your appointments or information regarding treatment.

I,_____, a patient of MCEP Spine Center
DO or DO NOT (please circle) authorize the personnel to leave information regarding my appointments/treatments on voicemail at the current phone number given.

I also authorize the person(s) listed below to receive information regarding my appointments or treatments while I'm a patient at Pain and Spine Center.

NAME	RELATIONSHIP
_____	_____
_____	_____

I understand that this authorization will remain in effect while I'm a patient at Pain and Spine Center unless otherwise given notice in writing to change the above information.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

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Acknowledgment of Receipt of Notice of Privacy

I have received the Pain and Spine Center Notice of Privacy Practices.

Patient Name: _____

_____ _____

Patient Signature (or Personal Representative*) Date

_____ _____

Personal Representative's Name (Printed) Relationship of Representative*

**The Person Representative is the patient's decision maker if the patient cannot act for themselves. It can be the parent, legal guardian, health care surrogate, or other person.*

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Opioid Agreement for the Treatment of Chronic Pain

Opioids, sometimes called narcotics, are medications useful for training a variety of pain problems. These medications may have significant side-effects and are tightly regulated by the state and federal government. They may be used carefully as a part of your treatment plan, with the goal of improved pain relief and a higher level of function (return to work, ability to do more in and out of your home). These medications will be used in conjunction with other treatments to accomplish these goals(ie. Physical therapy, nerve blocks psychological treatment, and other medications).

Risks of opioid use:

1. Constipation
2. Difficulty passing urine
3. Nausea, Vomiting, or Changes In Appetite
4. Itching and/or rash
5. Excessive daytime sleepiness, drowsiness, slowed ability to think and remember
6. If you have sleep apnea, opiate medications may make it worse
7. Problems with coordination, balance or reaction time that can effect your ability to drive or operate heavy equipment; Patients should not drive when therapy is being initiated, titrated upward or when new agents are introduced. Driving or operating heavy machinery should only be done if you are stable therapy that is not adversely affecting your cognition and coordination.

Initials

8. Alcohol poses significant danger when used with opioids and we advise our patients to avoid alcohol use.
9. Physical dependence: your body becomes dependent on the medication, and if stopped abruptly could cause withdrawal symptoms: abdominal cramps, diarrhea, nausea, vomiting, physically dependent if on opioid medication for extended period of time.
10. Psychological dependence: craving for the medication after it is stopped , taking for other reasons than pain (addiction).
11. Tolerance: your body may becomes used to the medication, and more is needed over time, to get the same amount of relief
12. Children born to mothers on these medication usually are dependent on the medication at birth. If you are pre-menopausal female, tell Dr. Shahid what type of birth control you are using.

Patient Obligations: **You** are ultimately responsible for your medication. We are willing to begin or continue treating you with opioid medications under the following conditions:

1. Take your medication exactly as directed by your prescribing physician/nurse practitioner. Altering your medication is an automatic dismissal from our clinic. You can reach a nurse at 937-280-4970.
2. Keep a close count of your medications. Generally these prescriptions are written to last 30 days
3. Keep your medications in a safe, secure place. It is impossible for us to determine which reports of "lost" or "stolen" medications are true. DO NOT OPEN your medications over a sink or toilet. Lost or damaged medications will not be replaced.

Initial

4. Do not give your opioid medications (or any other prescription medications) to others for any reason. If you do so, you are subject to legal action. Do not alter your prescriptions in any way. If there had been an error in writing the prescription, it should be returned to the pain service and another issued. Alteration of prescriptions is illegal.
5. If deemed necessary by the health care providers, random urine or oral swab screening may be completed to assess the effect and compliance. You must comply with these safety measures to continue your treatment within this pain clinic. Pill counts must be completed within the day of request or your treatment is in jeopardy of dismissal.

By signing this agreement, you understand that this treatment will be discontinued if:

a) The health care providers feel that these medications are not effective for your pain, or that the use of these medications have not improved your overall function or health status, or you have significant side effects.
b) You give away, sell or misuse the medications
c) You obtain the same or similar pain medications from other health care providers unless this has been discussed and approved by our office.
d) You fail to adhere to clinical guidelines or treatment protocols.

Clinical Policies:

1. There will not be any type of prescription issued after business hours, in between office visits, weekends or holidays. All requests and prescription issues will be addressed during your scheduled visits.
2. All of your opioid prescriptions should be filled at one pharmacy. If you need to change pharmacy due to relocation, you will need to fill out a new form.
3. Unless otherwise arranged, all of your opioid medications must be prescribed by one provider/office. Your primary doctor periodically (with our expressed permission).
4. If you miss/cancel/no show for you scheduled injections, you will not receive your medication (s).

Initial

Pharmacy Name: _____ Phone: _____

Address: _____

By signing this agreement, I certify that I completely understand its content and agree to comply with the guidelines/principles outlined.

Patient Signature: _____ Date: _____

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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

AUTHORIZATION:
I authorize to release the above named individual's health information.

The information to be disclosed is as listed:

_____✓_____ Assessment/History and Physical
_____✓_____ Lab Tests
_____✓_____ Radiology Reports
Other, needed information specified below: _____

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and/or drug abuse. I understand that by signing this authorization I am authorizing the release of such information unless specified otherwise above.

The information is to be released to:

PAIN AND SPINE CENTER
Dr. Abdul Q. Shahid, MD
2619 Commons Blvd, Suite 130
Beavercreek, OH 45431

PHONE: 937-280-4970 FAX: 937-630-4578

PURPOSE:
The purpose for the release of this information is: Continuity of Care _____ Other: _____

RESTRICTIONS:
I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment.

This release expires one year from the date signed below:

Patient Signature: _____ **Date:** _____

Financial Responsibility Agreement

Below you will find a statement of financial responsibility. Patients with no heath insurance coverage are asked to pay at the time of service unless financial arrangements are made in advance. This statement needs to be singed and a copy ***must*** be kept in your patient file. **Failure to sign the following statement could result in discharge from the pain management program or cancellation of set appointments.** Please read the statement carefully.

I, _____, as a patient of the PAIN AND SPINE CENTER understand that it is my responsibility to follow the rules and regulations set forth by my health insurance company regarding co-pays and coverage. Therefore, by signing this agreement, I assume responsibility for my account if my health insurance plan will not cover my visit. In addition, **I am aware that if my plan includes office visit co-pays, I shall bring payment to each office visit.** If at any time my health insurance coverage should change, I will notify the PAIN AND SPINE CENTER of the change immediately.

_____ **Worker's Compensation Patients:**

If you are treated under a Worker's Compensation claim, it is your responsibility to notify the PAIN AND SPINE CENTER if there is any change in your claim, including settlement, if you settle your claim, all treatment billed after settlement will become your responsibility.

Patient Signature:_____Date:_____

Assignment and Release (Commercial Insurance)

I, the undersigned, have insurance with (name of insurance company)_____ and assign directly PAIN AND SPINE CENTER all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all patient responsibility balances once my insurance has been billed. I hereby authorize the physician to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian:_____Date:_____

Medicare Authorization

I authorize that payment of authorized Medicare benefits be made either to me or on my behalf to providers of PAIN AND SPINE CENTER for any services furnished by the physician. I authorize an 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 understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated on the Patient Registration form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are bases upon the charge determination of the Medicare carrier.

Beneficiary Signature:_____Date:_____