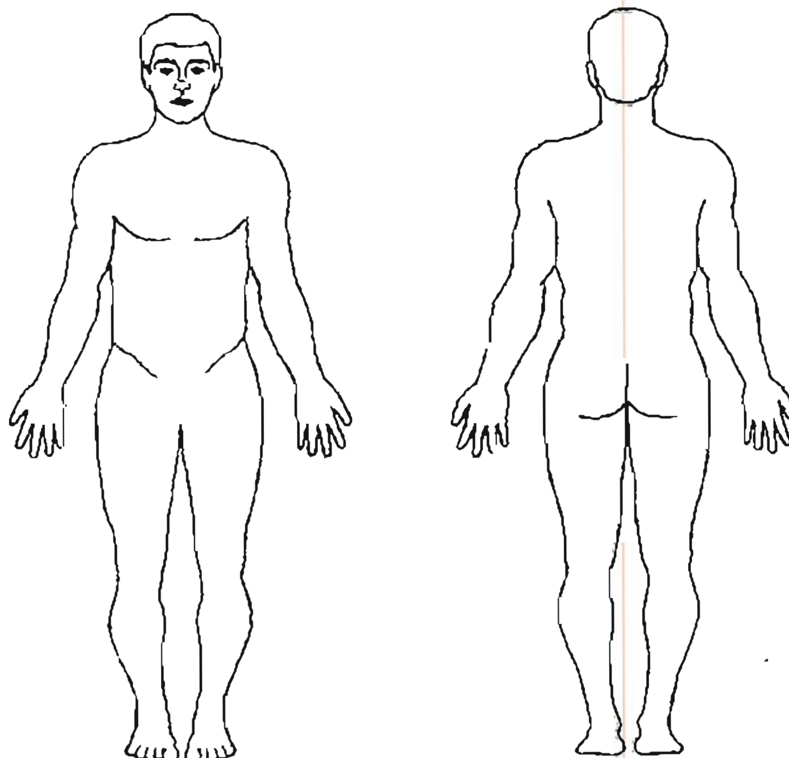
Pain Management

Mark an "X" wherever you feel the pain, including along any radiation into the arms or legs.

Name: ______________________________ Date: ____________________



Symptoms:

How long have you had this problem? ______________________________

How did it start? ( ) At work ( ) Injury ____________ date ( ) Motor Vehicle Accident

Explain: ______________________________

( ) I am off work because of this injury ( ) I have a lawyer working for me

My pain is: ( ) sharp ( ) dull/achy ( ) burning ( ) tingling ( ) shooting

I have:

( ) Weakness (from pain) in my:	( ) R arm	( ) L arm	( ) R leg	( ) L leg
( ) Specific weakness in my:	( ) R arm	( ) L arm	( ) R leg	( ) L leg
( ) Numbness of my:	( ) arms	( ) hands	( ) legs	( ) feet
( ) Tingling of my:	( ) arms	( ) hands	( ) legs	( ) feet
( ) Leg pain when I walk:	( ) less than a block		( ) 1-3 blocks	( ) > 3 blocks
	( ) This pain improves if I stand still			
	( ) This pain improves only if I sit or lean forward			
( ) Bladder (urine) trouble:	( ) Loss of urine (accidents)		( ) Can't empty	
( ) Bowel trouble:	( ) Loss of control (accidents)		( ) Constipation	
( ) Pain worst at night				

Brief Health Questionnaire

Name: ______________________________ DOB: ____________ Age: ________

Medical History

Have you had or do you have any of the following? Please give year diagnosed. If none, check NONE.

	Year Diagnosed		Year Diagnosed
( ) Diabetes	______	( ) Seizure Disorder	______
( ) High Blood Pressure	______	( ) Thyroid Disease	______
( ) High Cholesterol	______	( ) Tobacco Use	______
( ) Atrial Fibrilation	______	( ) Asthma	______
( ) Coronary Artery Disease	______	( ) Emphysema	______
( ) Congestive Heart Failure	______	( ) Allergic Rhinitis	______
( ) Acid Reflux	______	( ) Anxiety	______
( ) Irritable Bowel Syndrome	______	( ) Depression	______
( ) Migraine	______	( ) Attention Deficit	______
( ) Osteoarthritis	______	( ) Gout	______

( ) NONE

Other: ______________________________

Surgical History

Major Operations Last 5 Years — Anesthesia Problems

____

____

____

____

____

Social History

Ht ________ Wt ________ ( ) M ( ) S ( ) D ( ) W

Smoke – ppd ______________________ Alcohol – amt ______________________

Recreational drugs ______________________ Chew tobacco ______________________

Occupation ______________________ Exercise ______________________

Last complete physical ______________________ Doctor ______________________

Allergies: (other than environmental) ______________________________

Current Medications

Please list any and all medications or pills that you are presently taking regularly or from time to time. If none, please state "none".

Drug Name	mg	How often?	Regularly or as needed	Drug Name	mg	How often?	Regularly or as needed

Signature: ______________________________ Date: ____________

Treatment:

( ) None

( ) I have previously seen these physicians: ____________________

I have had the following:		Did it help?	Y	N
Medications:	( ) Anti-inflammatories ____________		( )	( )
	( ) Muscle relaxers ____________		( )	( )
	( ) Pain pills ____________		( )	( )
	( ) Others ____________		( )	( )

( ) Traction

( ) Injections (describe) ____________________

( ) Physical Therapy

( ) Chiropractor

( ) Spine Surgery (age, who was the surgeon, what was done?)

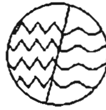
____

____

		Date		Date
Tests:	( ) X-rays	________	( ) EMG	________
	( ) MRI	________	( ) Discogram	________
	( ) CAT scan	________	( ) Mylegram	________

I feel better with: ( ) bed rest ( ) reducing activities ( ) bending forward ( ) heat
( ) massage ( ) bending backward ( ) ice
( ) other: ____________________

I feel worse with: ( ) activity ( ) sitting ( ) standing ( ) walking
( ) bending forward ( ) bending backward ( ) sneezing
( ) going to the bathroom ( ) other: ____________________



Woodlands Pain Management

Office & Financial Policies

Welcome and thank you for choosing Woodlands Pain Management for your care. We are committed to providing you with the highest quality care in an efficient, timely, and effective manner. We hope that by providing you with our policies in advance we can prevent any misunderstanding or confusion.

Initial ______ Insurance: When making an appointment with our office it is your responsibility to confirm that we are currently under contract with your plan. If your plan requires that you have a referral prior to seeing a specialist, please obtain your referral from your primary care physician and have it in hand at the time of your appointment. If you do not bring your referral with you to the appointment, we will need to reschedule your appointment unless you choose to be seen as a self pay patient.

Initial ______ Assignment of Benefits: We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of service. It is the policy of our office to collect this co-payment at the time of your appointment.

Initial: ______ Financial Policy: We have made prior arrangements with many health insurance carriers to accept assignment of benefits. This means that we will directly bill those carriers for services performed and will only require you to pay the co-payment at the time of service. In the event that your health plan determines a service to be "not covered" you will be responsible for the entire charge. When a procedure is performed in an offsite facility, charges from the facility, anesthesiology, radiology and other facility based providers will be billed separately and are not part of our fees.

Initial: ______ Check In: Please be prepared to pay any co-payments, past due balances or fees for non-covered services. Also, bring your insurance card with you to each visit.

Initial: ______ Late Arrivals: We do our best to keep to the schedule. When a patient arrives late, it is impossible to stay on schedule. If you arrive more than 15 minutes past your scheduled appointment time, your appointment may be rescheduled so that other patients are not inconvenienced. If you arrive more than 30 minutes past your scheduled appointment time, your appointment will automatically be cancelled.

Initial: _____ No Shows and Late Cancellations: We ask that you give us a courtesy call 24 hours in advance if you must cancel your office appointment. A no show will result in a $50 charge to your account. Once you have two no show appointments, you will be required to secure any future appointments with a credit card in advance.

Initial: ______ Procedure Cancellations: We ask that you give us a courtesy call 24 hours in advance if you must reschedule your surgery procedure. A no show or late cancellation will result in a $150 charge to your account. If you cancel or reschedule twice, your late charges must be paid in full before another procedure will be scheduled.

Initial: ______ Refill Requests: Please allow 48 hours to process all prescription refill requests. Prescription refill requests will not be accepted through the answering service. No exceptions.

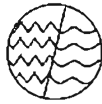
Initial: ______ Minors: The guardian(s) accompanying the minor are responsible for any financial responsibilities as well as providing current insurance information for the minor.

Initial: ______ Medical Records: Copies of your medical records are available upon request at a normal charge.

I have read, understand and agree to the above office and financial policies. I agree to be bound by its terms. I hereby attest that I have provided current and accurate demographic and insurance information. In addition, I authorize release of information necessary for insurance filing and precertification by signing this statement. You are herein authorizing payment of medical benefits to the physician when an assigned claim is filed.

Patient's Signature:______________________________ Date:______________________

Printed Name:______________________________ DOB:______________________



Patient Consent Form

In April of 2003, new federal requirements regarding privacy of information for patients took effect. HIPPA, Health Insurance Portability and Protection Act, requires that all medical providers, insurance companies and others, put in place controls to ensure that your medical information is safe. Woodlands Pain Management (WPM) requests that each patient sign this consent form which allows us to share protected health information (PHI) with other physician offices, your hospital and insurance company. By signing this form, you consent to our use and disclosure of PHI about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. Our Notice of Privacy Practices provides information about how we may use and disclose PHI about you. You have the right to review our notice before signing this consent.

Patient Signature: ______________________________ Date: ____________

Patient Name: ______________________________ Date of Birth: ____________

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents or others to call and request the results of tests, pick up prescriptions and discuss procedures. Under the requirements for HIPPA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your PHI released to family members you must sign this form. Signing this form will only give consent to discuss your PHI to the family members or other authorized person(s) indicated below. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize WPM to release my PHI to the following individuals:

1. Name: ______________________________ Relation to Patient: ____________
2. Name: ______________________________ Relation to Patient: ____________

Patient Signature: ______________________________ Date: ____________

Patient Name: ______________________________ Date of Birth: ____________

Authorization to Leave Messages with Household Members/Answering Machine

From time to time it is necessary for representatives of WPM to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss lab or procedure results, or to ask a patient to call WPM regarding an issue or concern. At no time will a representative of WPM discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Signature: ______________________________ Date: ____________

Patient Name: ______________________________ Date of Birth: ____________

Woodlands Pain Management
Authorization for Release of Medical Records

Patient's Information:

Printed Patient's Name: ________________________________

Date of Birth: ________________ Social Security #: ______________________

Medical Records Requested:

- ☐ Complete Medical Records
- ☐ MRI's and CT scans and ALL REPORTS
- ☐ EMG's
- ☐ Operative Report
- ☐ ________________________________

Request Medical Records From:

____
____
____
____

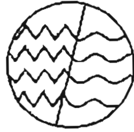
Release Medical Records To:

Woodlands Pain Management
9303 Pinecroft, Suite 310
The Woodlands, TX 77380
(281) 296-0188 phone
(281) 419-9205 fax

I hereby authorize the release of medical information as requested above. I understand that I have the right to revoke this authorization in writing at any time. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my right to confidentiality. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected.

____ ______________________

Signature of patient or representative authorized by law Date



Woodlands Pain Management

MEDICATION CONTRACT

I, ______________________________, agree to the following guidelines as part of my treatment for chronic pain with Dr. Jack Chapman, MD and Sharon Davis, PA-C. I understand that medications prescribed may not eliminate my pain but may reduce it and improve my quality of life.

1. I understand that I have the following responsibilities:
   - **I will take medications at the dose and frequency prescribed.**
   - **I will not increase or change how I take my medications without the approval of this health care provider.**
   - **I will arrange for refills at the prescribed interval ONLY during regular office hours.** ***<u>I will not ask for refills earlier than agreed, after-hours, on holidays or on weekends.</u>*** ***<u>OFFICE HOURS: MON-THURS 8-5, FRIDAY 8-12 noon</u>***
   - **I will obtain all refills for medications only at ______________ pharmacy (phone number: ______________), with full consent for my provider and pharmacist to exchange information in writing or verbally.**
   - **I will not request any pain medications or controlled substances from other providers and will inform this provider of all other medications I am taking.**
   - **I will inform my other health care providers that I am taking these pain medications and of the existence of this contract. In the event of an emergency, I will provide this same information to emergency department providers.**
   - **I will protect my prescriptions and medications. <u>I understand that lost or misplaced prescriptions will not be replaced.</u>**
   - **I will keep medications only for my own use and will not share them with others. I will keep medications away from children.**
   - **I agree to participate in any medical, psychological or psychiatric assessments recommended by my provider.**
   - **I will actively participate in any program designed to improve function, including social, physical, psychological and daily or work activities.**

2. **I will not use illegal, street drugs or another person's prescription. If I have an addiction problem with drugs or alcohol and my provider asks me to enter a program to address this issue, I agree to follow through. Such programs may include but are not limited to: 12-step program, securing a sponsor, individual counseling, and inpatient or outpatient treatment.**
   - **If in treatment, I will request that a copy of the program's initial evaluation and treatment recommendations be sent to this provider and will not expect refills until that is received. I will also request written monthly updates be sent to verify my continuing treatment.**

3. **I will consent to random drug screening to assure I am only taking prescribed drugs. I understand that a drug screen is a laboratory test in which a sample of my urine, saliva or blood is checked to see what drugs I have been taking.**

4. **I will keep all scheduled appointments. If I need to cancel my appointment, I will do so at least 24 hours before scheduled time.**

5. **I understand that this provider may stop prescribing the medications listed if:**
   - **I do not show any improvement in pain or my activity has not improved.**
   - **I develop rapid tolerance or loss of improvement from the treatment.**
   - **I develop significant side effects from the medication.**
   - ***<u>My behavior is inconsistent with the responsibilities outlined above, which may also result in being prevented from receiving further care from this clinic.</u>***

6. THE ANSWERING SERVICE IS RESERVED FOR AFTER HOUR EMERGENCIES ONLY!
   - REFILL REQUEST IS <u>NOT</u> AN EMERGENCY!!!!!!! REFILLS are during office hours only!!!!!!!!!!!!!!!!!!!!!
   - NON EMERGENCIES WILL RESULT IN A 50.00 FEE
   - IF YOU HAVE A LIFE THREATENING EVENT, DIAL 911 AND GO TO YOUR NEAREST EMERGENCY ROOM

Signed: ______________________________ Date: ______________

Provider: ______________________________ Date: ______________

9303 Pinecroft, Suite 310
The Woodlands, TX 77380

(281) 296-0188
fax (281) 419-9205