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Patient Contact Information

Full Name Last _____ First _____ Middle _____

Date of Birth _____ **Gender** _____ **Race** _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ **Cell Phone** _____

SSN _____ **Email** _____

Marital Status Single ____ Married ____ Divorced/Widowed ____ **Occupation** _____

Primary Care Physician _____ **Allergy** _____

Emergency Contact

Full Name _____ **Relation** _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ **Cell Phone** _____

Patient Contact Release/Consent

In accordance with HIPPA law, consent is needed from you before we can contact anyone else with regards to your appointments, account information, and health status.

If you authorize your Emergency Contact to speak with us regarding your account and medical information. _____ (Please sign & date)

Or if you authorize _____ (Name) to speak with us regarding your account and medical information. _____ (Please sign & date)

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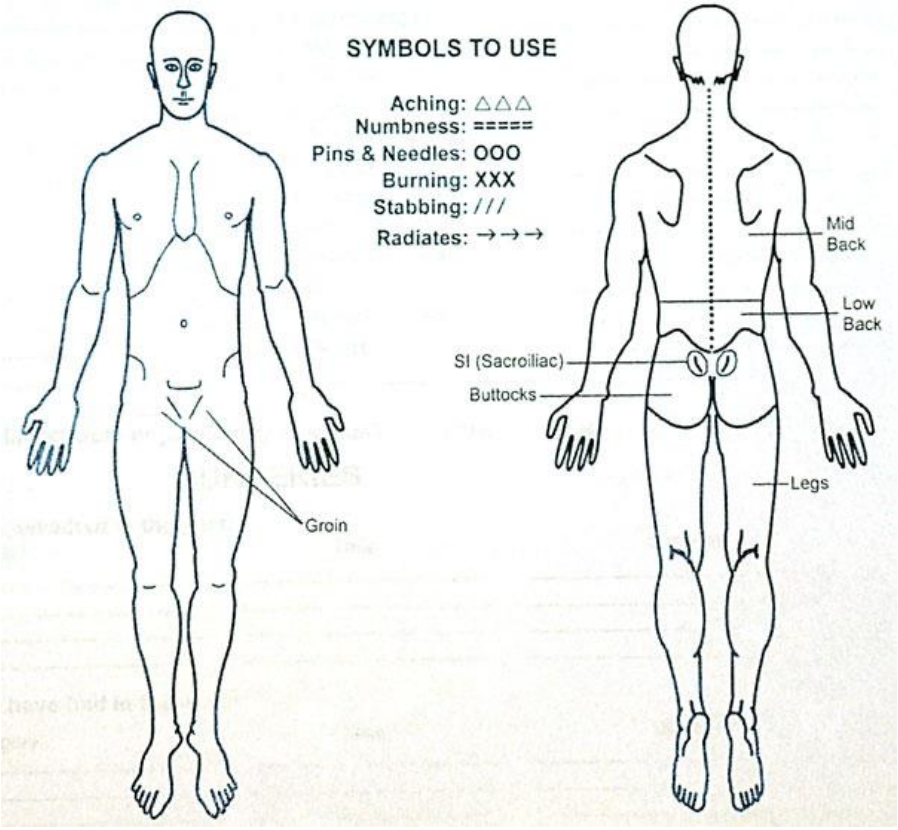
Patient Pain Profile

Patient Name _____ **Date** _____



Please mark the body diagrams according to your pain.

Pain Location	Type of Pain	Intensity (0-10)	Timing

Types of pain (throbbing, aching/dull, stabbing/sharp, shooting, burning, tingling, numbness, stiffness, cramp, swelling,)
Timing (Constant, comes & goes, sudden, chronic)

Recent Injuries or Accidents: _____

_____

Recent Changes in Pain Pattern: _____

_____

Previous Tests and Treatments

Please mark what test or treatments you have received and give an approximate date (MM/YY).

	PCP or Urgent Care	Date		Chiropractic	Date
	X-Ray	Date		Physical Therapy	*Date*
	CT Scan	Date		Massage	*Date*
	MRI	Date		Medications	*Date*
	Additional Studies	Date		Injections	*Date*
				Surgery	*Date*

Revised Oswestry Disability Index

This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. You may consider that two of the statements in any one section relate to you, please just mark the box that most closely describes your problem.

Section 1: Pain Intensity		**Section 2: Personal Care**	
	The pain comes and goes and is very mild.		I would not have to change my way of washing or dressing in order to avoid pain.
	The pain is mild and does not vary much.		I do not normally change my way of washing or dressing even though it causes some pain.
	The pain comes and goes and is moderate.		Washing and dressing increases the pain, but I manage not to change my way of doing it.
	The pain is moderate and does not vary much.		Washing and dressing increases the pain and I find it necessary to change my way of doing it.
	The pain comes and goes and is very severe.		Because of the pain, I am unable to do some washing and dressing without help.
	The pain is severe and does not vary much.		Because of the pain, I am unable to do any washing and dressing without help.

Section 3: Lifting		**Section 4: Walking***	
	I can lift heavy weights without extra pain.		I have no pain on walking.
	I can lift heavy weights, but it causes extra pain.		I have some pain on walking, but it does not increase with distance. o I cannot walk more than one mile without increasing pain.
	Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g., on a table).		I cannot walk more than 1/2 mile without increasing pain.
	Pain prevents me from lifting heavy weights off the floor.		I cannot walk more than 1/4 mile without increasing pain.
	Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.		I cannot walk at all without increasing pain.
	I can only lift very light weights at the most.		I have no pain on walking.

Section 5: Sitting		**Section 6: Standing**	
	I can sit in any chair as long as I like.		I can stand as long as I want without pain.
	I can only sit in my favorite chair as long as I like.		I have some pain on standing, but it does not increase with time.
	Pain prevents me from sitting more than one hour.		I cannot stand for longer than one hour without increasing pain.
	Pain prevents me from sitting more than 1/2 hour.		I cannot stand for longer than 1/2 hour without increasing pain.
	Pain prevents me from sitting more 10 minutes.		I cannot stand for longer than 10 minutes without increasing pain.

	I avoid sitting because it increases pain right away.		I avoid standing because it increases the pain right away.

Section 7: Sleeping		**Section 8: Social Life**	
	I get no pain in bed.		My social life is normal and gives me no pain.
	I get pain in bed, but it does not prevent me from sleeping well.		My social life is normal, but increases the degree of pain.
	Because of pain, my normal night's sleep is reduced by less than 1/4.		Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
	Because of pain, my normal night's sleep is reduced by less than 1/2.		Pain has restricted my social life and I do not go out very often.
	Because of pain, my normal night's sleep is reduced by less than 3/4.		Pain has restricted my social life to my home.
	Pain prevents me from sleeping at all.		I have hardly any social life because of the pain.

Section 9: Traveling		**Section 10: Changing Degree of Pain**	
	I get no pain while travelling.		My pain is rapidly getting better.
	I get some pain while travelling, but none of my usual forms of travel makes it any worse.		My pain fluctuates, but is definitively getting better.
	I get extra pain while travelling, but it does not compel me to seek alternative forms of travel.		My pain seems to be getting better, but improvement is slow at present.
	I get extra pain while travelling, which compels me to seek alternative forms of travel.		My pain is neither getting better nor worse.
	Pain restricts all forms of travel.		My pain is gradually worsening.
	Pain prevents all forms of travel except that done lying down.		My pain is rapidly worsening.

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Patient Health Profile

Medical & Surgical History

Please list any active or prior medical conditions _____

_____

_____

_____

Please list any past surgeries with an approximate date

_____

_____

_____

Social History

Do you smoke?_____, How many packs a day/how many years _____

Do you drink? _____, How many drinks a day/how many years _____

Do you have a history of drug/substance use? _____, If yes, please explain _____

_____

Do you have a disability? _____, If yes, please explain _____

Employment status _____

Family History

Please list pertinent family history.

Father _____

Mother _____

Grandparents _____

Immediate Siblings _____

Are you experiencing any of the following? *Mark Y for yes, and N for no.*

Fevers _____	Pain in legs _____	Palpitations _____
Weakness _____	Neck pain _____	Irregular Heartbeat _____

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Recent weight loss _____	All-over pain _____	High Blood Pressure _____
Night sweats _____	Low-back pain _____	Fainting _____
Felling tired _____	Mid-back pain _____	Cough _____
Difficulty falling asleep _____	Difficulty walking _____	Coughing blood _____
Difficulty staying asleep ____	Leg swelling _____	Respiratory Infection _____
Joint swelling _____	Headaches _____	Wheezing _____
Joint pain _____	Dizziness _____	Nausea _____
Joint stiffness _____	Ear ringing _____	Heartburn _____
Pain in legs _____	Chest Pain _____	Loss of Bowel _____
Pain in arms _____	Shortness of breath _____	Constipation _____
Diarrhea _____	Depression _____	Numbness _____
Difficulty urinating _____	Anxiety _____	Blurred vision _____
Blood in urine _____	Nervousness_____	Bruise easily _____
Urinary frequency _____	Emotional_____	Bleed easily _____
Urinary urgency _____	Lack of concentration _____	Rash _____
Loss of bladder _____	Difficulty with Balance_____	Hives _____

Please list current medications	**Dose**	**Frequency**

Please attach additional sheet of paper if needed.

Notice of Privacy Release

As a patient, you have rights to high privacy standards set forth by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

You have the right to restrict how protected health information is being used and disclosed for account management, treatment, and payment. HIPAA law allows medical practices the use of protected information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information, for treatment, payment, or practice operations. I authorize that Painlogics to release any personal information during treatment that is necessary to process insurance claims, receive payments from any payable entity, and authorize my insurance company to make payments for any medical services on my behalf. Painlogics will only share your health information with any associated consultants with consent.

It is also important to understand that the practice reserves the right to change the privacy policy as allowed by law. The practice has the right to restrict the use of the information. The patient has the right to revoke this consent in writing at any time. The practice may also condition receipt of treatment upon execution of this consent.

A copy of the Notice of Privacy Practices available for review as needed.

As a patient, you must also be vigilant with regards to cybersecurity, online attacks, and phishing scams. Painlogics will not ask for your personal information with regards to passwords login information. The practice will continue to incorporate industry standard security practices as well as effective training and exercises. It is important to understand these risks, and defend, indemnify Painlogics against evolving cyberthreats.

We want you to enjoy your experience and to be educated on your condition. Please let us know if you have any questions or concerns. Let us know how we did.

Signature _____ Date _____

Print Name _____

Insurance & Financial Policy Agreement

Release of Information

I authorize Painlogics LLC to release any medical and personal information that is necessary to process insurance claims or receive payment from any payment entity, and authorize my insurance company to make payments for my medical services directly to the physician, with the understanding that I am responsible for any amount not covered/paid by insurance provider. I also agree to provide the correct and current insurance information.

Assignment of Benefits

I assign all payments, rights and claims for reimbursement of claims, costs and expenses allowable under my insurance plan(s) directly to my provider/practice for the services rendered. I understand I will receive a statement for any balance due by me and I agree to make full payment upon receipt of the statement after insurance has met its obligation.

Agreement of Responsibility

I am aware it is ultimately my responsibility as a patient to make sure that my insurance covers my services. I am responsible for co-pays, cash-based services & procedures, deductibles, and fees not covered by insurance. I also agree to pay any outstanding balance as well as attorney fees and costs to Painlogics LLC if this matter is referred to collection.

Cancellation Policy

Painlogics LLC requires a 24-hour notice for cancellation of appointments. You will be charged a fee for appointments cancelled without a proper 24-hour notice, or if a patient does not show up for their appointment. If you show up 15 minutes past your appointment and must be worked in, there will be a late fee assessed. EMG/NCS, regenerative and fluoroscopic-guided injection may have to be rescheduled if patient no-show or is late, and a charge of $150.00 may be assessed.

Payment Due at the time of service:

- Late/Work-in fee: $35.00
- No-show/Less than 24 hours cancellation fee (appointment): $75.00
- No-show/Less than 24 hours cancellation fee (EMG or injection): $150.00
- Returned check fee: $75.00

By signing below, I agree to the financial terms and conditions presented forth in this agreement.

Signature _____ Date _____

Print Name _____

Medical Record Release Form

Patient Name _____ **DOB** _____

Patient Address _____

Patient Phone Number _____

Provider Designated to Disclose Records _____

Provider Address _____

Provider Phone Number _____

I authorize the release the of all my medical health records (including the diagnosis, records of treatment, Imaging and/or examination records rendered to me.) I request that these records be sent to:

Painlogics LLC

490 Sun Valley Dr. Suite 103

Roswell, GA 30076

Phone (678) 490-2255/ Fax (678) 799-7593

Patient Signature _____ Date _____

Patient Name _____

Patient Management and Treatment Agreement

This agreement is between (Patient Name) _____ and Painlogics, LLC for the purpose of establishing an agreement between the physician and the patient regarding treatment of pain conditions. These treatments may range from a variety of physical and behavioral modalities, medications, diagnostic and therapeutic interventions, and alternative treatments. The goals of these treatments, and the efforts of the team, are to improve overall mobility and quality of life. The agreement is unique to the field of pain medicine, and it is necessary in maintaining a basis of understanding needed for the patient-physician relationship.

To establish a patient-physician relationship, I agree and accept the following:

1. This agreement is important to my doctor's ability to treat my pain, and inability to comply with the agreement may result in the discontinuation of prescribed medication and termination of the patient-physician relationship.
2. I understand that the goal of treatment is to improve my ability to function and work. In consideration of that goal, I agree to help myself by following better health habits, especially to encourage better mobility. I must also comply with the treatment plan as prescribed by my doctor.
    - I agree that continued treatment and/or refill of medications may depend upon my compliance with other pain treatment modalities recommended by my doctor.
3. I give permission to allow sharing of medical history with other health care agencies.
    - I authorize my physician to provide a copy of this agreement to pharmacies and other healthcare providers upon request.
    - Doctors, pharmacies, and insurers must cooperate fully with state or federal investigations with regards to possible misuse or diversion of pain medication, as required by law.

I agree and accept the following with regards to medications:

4. I understand that medication regimens may be continued for a finite period of time, if there is no evidence of improvement or progress. Unless medications are used to improve or maintain a reasonable level of function or quality of life, the regimen might be tapered or discontinued.
5. I understand that medications such as opioids and other controlled substances, if deemed beneficial, may be prescribed to me for pain relief. I understand that there are potential risks and side effects involved with such medications, including addiction. Overdose of opioid medication may cause serious injury or death. Other possible complications include constipation, difficulty with urination, fatigue, drowsiness, nausea, itching, stomach cramps, loss of appetite, confusion, sweating, flushing,

depressed respiration, and reduced sexual function. Men may have decreased testosterone from chronic opioid use. Some side effects from long-term use may still be unknown.

- I understand that opioid analgesics could cause physical dependence within a few weeks of starting opioid therapy. If I stop or decrease the dose, I could have withdrawal symptoms such as nausea, vomiting, diarrhea, aches, sweats, chills, that may occur within 24-48 hours of the last dose.
- I will inform the office of any adverse effects that I experience. I understand that medications may be changed due to the side effects that I am experiencing.
- If female in child-bearing age, I understand that if I am pregnant or become pregnant while taking opioid medications, my child can become physically dependent. Fetal opioid withdrawal can be life threatening. Other medications could cause serious harm or birth defects. As the risks are significant, I will use and discuss the appropriate contraceptive measures during the course of treatment involving opioid medications.
- I realize that it is my responsibility to keep others and myself from harm, especially during driving and the operation of machinery. If there is any question of safety, I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have stopped the medication long enough for the side effects to resolve.

6. I agree that I will use my medication at a frequency no greater than prescribed.
   - I will not alter my medications or use in any other way other than it was prescribed.
   - I will not share, sell, or trade my medications or exchange medications for money, goods or services.
7. I will not discontinue any medication that I take regularly without consulting my physician.
   - I will discontinue all previously prescribed pain medications, unless explicitly told by my physician.
   - I must inform my doctor before taking newly prescribed sleeping medications. I understand that the combined use of various medications, opioids, as well as alcohol, may cause confusion, profound sedation, respiratory depression, drop in blood pressure, and even death.
8. I will not attempt or obtain pain medication from any other health care provider, unless in a case of emergency or with explicit consent from your doctor. I must also inform other providers that I am already taking pain medication prescribed by this office. I will keep this office informed of all medications I may receive from other physicians.
9. I will not use any illegal substances (cocaine, heroin, marijuana, etc.) while being prescribed controlled substances. Violation will result in the termination of my care.
10. I understand that changing the date, quantity or strength of medication or altering a prescription in any way are against the law. Forging prescriptions or physician's

signature are also against the law. Our office must cooperate fully with law enforcement agencies regarding infractions involving prescription medications.

11. I agree to submit random urine, blood, or saliva samples for toxicology testing. These tests, if requested, are to determine my compliance with my medication regimen and this agreement. Tests may include screens for illegal substances.
    - I understand that the laboratory responsible for urine processing and analysis is completely independent from Painlogics, and that there will not be any bias toward the testing process.
12. I understand medication renewals are contingent upon keeping scheduled appointments. Requests for medication refills may be denied due to frequent rescheduling or missed appointments. Medications will only be bridged until the next available appointment, during emergency circumstances.
    - Written prescriptions must be picked up at the office and cannot be mailed or delivered.
    - Refills will not be handled after hours, at night, on weekends or holidays.
    - If I run out early, lose or misplace my prescription, or if someone else has taken my medication, I understand that prescriptions cannot be replaced. I am responsible for keeping track of the amount of medications remaining. Prescriptions and bottle of medications must be safeguarded from loss and out of reach of children.

Signature _____ Date _____

Print Name _____