Manage your Pain.
Enjoy your Life!

Center for PAIN and REHAB Medicine

D. Terrence Foster, M.D., M.A., FAAPMR, DABPM
Board Certified in Pain Medicine, Physical Medicine & Rehabilitation

PATIENT INFORMATION

You must fill out this form in its entirety. Please print all information and use legal name printed on your insurance card.

First Name:		Last Name:		MI:	SSN:
Address:		City:		State:	Zip:
Cell #:		Home #:		Work #:	
Email:		Gender:	☐ M ☐ F	DOB:	
Emergency Contact:		Phone #:		Relation:	
Referring Physician:		Phone #			
Primary Care Physician:		Phone #			
Last PCP Visit:					

Marital Status:	Ethnicity:	Race:
☐ Married	☐ Hispanic	☐ American Indian or Alaskan Native
☐ Single	☐ Non Hispanic	☐ Asian
☐ Divorced	☐ Refused to Report	☐ Black or African American
☐ Separated		☐ Native Hawaiian/Other Pacific Islander
☐ Widowed		☐ White
☐ Life Partner		☐ Other
		☐ Unreported/Refused to Report

Employment Status:	☐ Employed	☐ Unemployed	☐Retired	☐ Disabled
Employer Name:			Occupation:	
Employer Address:			Phone #:	

Responsible Party (Guarantor)				☐ Same as Patient	
Guarantor First Name:		Last Name:		MI:	SSN:
Address:		City:		State:	Zip:
Cell #:		Home #:		Work #:	
Relationship to Patient:		DOB:		Email:	
Employer Name & Address:				Occupation:	
Signature of Patient/Responsible Party:				Date:	

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INSURANCE INFORMATION

POLICY HOLDER

First Name:	**Last Name:**	**MI:**	**SSN:**
Address:	**City:**	**State:**	**Zip:**

Cell #:		**Home #:**		**Work #:**	
Relationship to Patient		**DOB:**		**Email:**	

PRIMARY INSURANCE:	**SECONDARY INSURANCE:**
Insurance Carrier:	Insurance Carrier:
Group ID:	Group ID:
Member ID:	Member ID:
Effective Date:	**Effective Date:**

ACCIDENT INFORMATION (If Applicable)

Automobile Accident	**Work Related Accident**
Date of Accident:	Date of Accident:
Auto Insurance Company:	Auto Insurance Company:
Claim Adjuster's Name & Phone #:	Claim Adjuster's Name & Phone #:
Policy #:	Policy #:
Claim #:	Claim #:

ATTORNEY INFORMATION

Attorney Name:	**Law Firm:**	
Address:	**Phone #:**	

WHO MAY WE THANK FOR REFERRING YOU TO THE PRACTICE?

Name & Contact Information:

*****It is your responsibility to notify our office of any changes in your address, telephone number and insurance plan. We will not be responsible for any returned or undeliverable mail.*****

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true, and accurate.

Signature of Patient/Responsible Party:	**Date:**
Name of Patient/Responsible Party (Please Print):	

Rehab Medicine and EMG
REMEG Center, P.C.

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PATIENT PHARMACY INFORMATION

PREFERRED PHARMACY	SECONDARY PHARMACY
Name :	Name :
Address:	Address:
Phone #:	Phone #:
Fax #:	Fax #:

Medications - List all medications you take, prescription and non prescription, and the dosage.

☐ **I do not take any medications**

Medication Name	Strength	Frequency Taken	How Long have you been taking it?

Allergies to Medication - List all known allergies:

☐ **No Known Allergies**

Medication Name	Reaction You Had

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CHIEF COMPLAINT

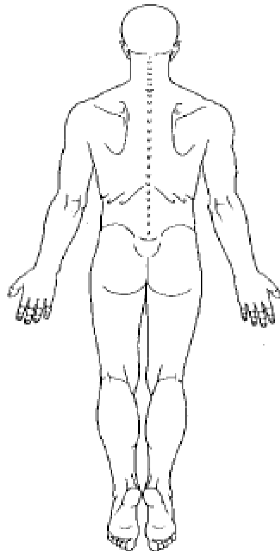
Please fill out the following form about you pain to the best of your ability.

Name		**Age**		**Date**	
How were you referred to our office?					
What is the main reason for you visit today?					
Progression of your current condition since it started	☐ **Same**	☐ **Improved**	☐ **Worse**	☐ **Other**	
How long have you been experiencing this problem (date if known)?					
How did the problem start?					
Have you seen any other doctor for this problem? If so, who and when?					
Is there anything that helps with the problem?					
Is there anything that makes the problem worse?					
Are your symptoms constant or do they come and go?					
Please rate your pain on a scale of 1-10 (1 being no pain and 10 being the worst pain you can think of).	**Right Now?** _______/10	**At its worse?** _______/10	**At its best?** _______/10		

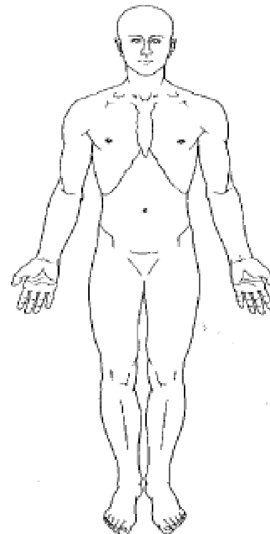
Type of Pain: Check all that applies.	☐ **Sharp**	☐ **Tingling**	☐ **Throbbing**	☐ **Numb**	☐ **Aching**	☐ **Stabbing**
	☐ **Dull**	☐ **Burning**	☐ **Cramping**	☐ **Stiffness**	☐ **Spasms**	

Please use the diagrams below to circle the location on your body where you experience pain.

Left Right



Right Left



Please use this space to describe anything else you feel the doctor should know about this problem:

___

___

___

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HEALTH HISTORY

Name: ____**Age:** __________ **Date:** _____________________

Have you ever had? ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Polio ☐ Rheumatic Fever

Do you suffer from any of the following? Please check all that apply.

☐ Head/Neck pain
☐ Pain eyes in the eyes
☐ Chest/Heart pain
☐ Backache
☐ Pain in Joints Which?
☐ Swollen Joints Which?
☐ Stiffness Where?
☐ Spasms Where?
☐ Tightness Where?
☐ Pins and Needles Where?
☐ Weakness Where?
☐ Limb Pain Where?

☐ Cancer Where?
☐ Fainting
☐ Fatigue
☐ Lungs Problems What?
☐ Diabetes
☐ High/Low Blood Pressure
☐ Thyroid Problems
☐ Bladder Infection
☐ Poor Circulation
☐ Pregnant at this time
☐ Prostate Problems
☐ Other pain/discomfort:

Recent changes in:
☐ Weight
☐ Ability to sleep
☐ Appetite
☐ Stomach/Bowel
☐ Skin What?
☐ Breathing
☐ Memory
☐ Hearing
☐ Spinal Curvature
☐ Urination Frequency

Responses to the following are **completely optional** and will be **kept strictly confidential**. Do you deal with any of the following:

☐ Depression
☐ Drink Caffeine
☐ Drink Alcohol

☐ Tobacco
☐ Recreational Drugs What?
☐ Sexually Active

☐ Dieting
☐ Exercise How many Hrs/Wk?

Please list any Surgeries/Hospital stays you have had in the past:

Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No If so, when? ____

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Please circle **EACH** statement in the following sections that apply to you.

1. Family history of substance abuse:	**Female**	**Male**
Alcohol	A	A
Illegal Drugs	B	B
Prescription Drugs	C	C
	None	None

2. Personal history of substance abuse:	**Female**	**Male**
Alcohol	A	A
Illegal Drugs	B	B
Prescription Drugs	C	C
	None	None

3. Circle “A” if you are between the ages of 16 and 45:	**Female**	**Male**
	A	A

4. Circle “A” if you have history of sexual abuse before the age of 13:

	Female	**Male**
	A	A
	None	None

5. Please circle if you have every been diagnosed with one of the following:

	Female	**Male**
Attention Deficit Disorder (ADD/ADHD)	A	A
Obsessive Compulsive Disorder (OCD)	B	B
Bipolar Disorder	C	C
Depression	D	D
	None	None

Printed Name: ___________________ Signature:________________________ Date: ________

Total: ___________________ Staff Initials: ____

Revised 11/2015

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Generalized Anxiety Disorder Assessment

Please circle only ONE statement in each section that describes how you are currently feeling or may have felt in the past two weeks.

1. **Feeling Nervous, anxious or on edge?**
   A. Not at all
   B. Several days
   C. More than half the days
   D. Nearly everyday

2. **Not being able to stop or control worrying?**
   A. Not at all
   B. Several days
   C. More than half the days
   D. Nearly everyday

3. **Worrying too much about different things?**
   A. Not at all
   B. Several days
   C. More than half the days
   D. Nearly everyday

4. **Trouble relaxing?**
   A. Not at all
   B. Several days
   C. More than half the days
   D. Nearly everyday

5. **Being so restless that it is hard to sit still?**
   A. Not at all
   B. Several days
   C. More than half the days
   D. Nearly everyday

6. **Becoming easily annoyed or irritable?**
   A. Not at all
   B. Several days
   C. More than half the days
   D. Nearly everyday

7. **Feeling afraid as if something awful might happen?**
   A. Not at all
   B. Several days
   C. More than half the days
   D. Nearly everyday

Printed Name: __________________ Signature:_______________________ Date: _______

Total: __________________ Staff Initials: ____

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Information:

_______________________________________ ______________________ __________________

Name (print) **Date of Birth** **SSN**

Information To Be Released From:
Name of Facility or Provider: ____
Address: ____
Phone#: _______________________________________ Fax#: _______________________________

Information To Be Sent To:
Name of designated recipient: **Center for Pain and Rehabilitation Medicine, PC**
240 Medical Blvd., Stockbridge, GA 30281
Fax# 678-284-6500 Ph# 678-284-4000

Information to be Released: (please check one)
_____All Medical Records
_____The most recent ______ years/month of pertinent information (chart notes, labs, x-rays, and special tests)
_____Specific information (please specify) ____

Purpose for which the disclosure is being made: (please check one)
________ Doctor ________ Attorney ________ Insurance _________ Personal
Other (specify): ____

PATIENT AUTHORIZATION:
I understand that my records may contain information regarding diagnosis or treatment of HIV/AID sexually transmitted diseases, drug and/or alcohol abuse, mental illness, psychiatric treatment.
________ I give my specific authorization for these records to be released. (**please initial**)
***<u>**EXCLUDE**</u> the following information from the records released. (**please initial**)
________ Drug/Alcohol abuse/treatment & diagnosis _________ Sexually transmitted diseases
________ HIV/AIDS diagnosis/treatment/testing _________ Mental Illness or psychiatric diagnosis/treatment

MY RIGHTS:
I understand that I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization by notifying Center for Pain and Rehab. Medicine in writing. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy.

Signature ____ Date: _______________________

This authorization will expire 90 days from the date signed. Possible copying fee required.

MR/2015

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AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY MEMBERS

Patient Name: ___________________________________ Date of Birth: ________________

Many of our patients allow family members to call and request medical or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members, you must sign this form. Signing this form will only give information to family members indicated below.

☐ I authorize ***Center for Pain and Rehab Medicine*** to release my medical and/or billing information to the following individual(s):

1. ____ ______________________________
NAME (Print) Relationship to Patient

2. ____ ______________________________
NAME (Print) Relationship to Patient

3. ____ ______________________________
NAME (Print) Relationship to Patient

☐ **I do not want my medical and /or billing information released to any of my family member**.

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect and copy the Protected Health Information to be disclosed.

I understand that information disclosed to any of the above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.

I understand that this consent will only be revoked in writing.

Patient Signature: ________________________________ Date: __________________

WITNESS: ____________________________________ Date: __________________

Mailing Address: ***P. O. Box 824***
Morrow, GA 30260
Phone: (678) 284-4000

Physical Address: ***240 Medical Blvd.***
Stockbridge, GA 30281
Fax: (678) 284-6500

MR Released-Family/2017

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Agreement for Controlled Substance Prescriptions

Patient Name: ____ **Date:** __________________

You are being evaluated for pain management which may involve the prescribing of controlled substance. Your evaluation will include a review of your medical records for possible diagnosis. You may be required to complete laboratory studies and /or diagnostic studies. Prescriptions for controlled substances are generally not ordered/written until the doctor/Rehab Medicine healthcare provider (the Provider) fully understands your condition.

Controlled substances (ex. Narcotics, opiates, tranquilizers, and barbiturates) can be useful in pain management treatment, but are commonly misused. Therefore, these substances are closely controlled by the local, state and federal governments. They are solely intended to help manage and relieve pain. **They are not intended for recreational or mind-altering purposes.** The following is a contract between, the provider and me.
With regards to the prescription given to me by the provider, I agree to (**please initial each check box**):

☐ I hereby forgo my rights to receive medications (controlled substance) from any other physician or individual while I am being treated by the Provider. I understand that doing so is, not only, illegal, but also could endanger my health. Exception will be made only for: medications that I have informed the Provider I am currently taking or medications that were given to me while I was admitted to the hospital.

☐ I have been fully informed of the possibility of psychological and physical dependence to controlled substances. I understand that once a tolerance has formed, there may be a need to increase my dosage to better manage my pain. If for any reason I become dependent on my medication, I will inform the Provider so that provisions can be made to wean me off of this controlled substance.

☐ I will maintain responsibility of the prescribed medications. If they are lost, misplaced, stolen, or I use them up sooner that the prescribed time. I understand they **WILL NOT BE REPLACED FOR ANY REASON.**

☐ **I WILL NOT** give, sell, or make available my prescribed medication to anyone else. This could endanger the health of that person and it IS ILLEGAL.

☐ **I WILL NOT** discard, flush down the toilet, give away or be neglectful with my prescribed medications. I will bring each original pharmacy pill bottle for which I have a prescription to each appointment to show whether I have any pills left or none at all.

☐ **I WILL TAKE** my medication as prescribed by the doctor as stated on the bottle. In doing so, I should not have pills left over at the end of the month or run out early. This way I can let the doctor know of the effectiveness of the treatment.

☐ Refills of these controlled substance:

- Will **Only** be provided at time of monthly appointment. None will be given outside of regular business hours.
- **Will not be made if** "I ran out early." You are responsible for making appointments for refills one or two days before you run out.
- **WILL NOT** be made on an "emergency" basis.

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☐ I understand that the Provider has the right to administer random drug screening and random pill count to monitor my compliance with proper medication use.

☐ Any drug test/screening indicating the presence of illegal substances will lead to immediate termination of treatment by this office/healthcare provider. **REFUSAL TO SUBMIT A SAMPLE FOR TESTING** will also result in termination of treatment.

☐ Violating any of the above conditions could lead to termination of prescription and/or termination of treatment by the Provider/office. If illegal use or distribution of the controlled substances (such as obtaining controlled substances from another individual or office, or providing another individual with your prescribed controlled substance) occurs, this may be reported to other healthcare providers and law enforcement.

☐ Our Office has always demonstrated professionalism and courtesy to all our patients and will continue to do so. We will not tolerate any inappropriate behavior or verbal abuse to our staff.

☐ **I understand that by initialing on this line,** I am stating that I **do not** **want any controlled substances prescribed to me at this time.** However, if in the future I change my mind, I have these conditions and agree to them.

DO NOT SIGN THIS AGREEMENT UNLESS YOU UNDERSTAND CLEARLY ALL THE TERMS AND CONDITIONS.

I HAVE READ AND UNDERSTAND THE ABOVE CONDITIONS AND THE CONSEQUENCES OF VIOLATING THIS CONTRACT.

Patient Name ________________________________ **Signature**__________________________________

Witness Name________________________________ **Date**_____________________________________

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CPARM POLICIES ACKNOWLEGMENTS

1. USE AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI) – Notice of Privacy Practices
2. FINANCIAL POLICY ***
3. BILLING POLICY
4. PATIENT NO SHOW POLICY
5. NO CHILDREN POLICY

I acknowledged that I have read and fully understand ALL the above Policies of the Practice and will abide by them.

Patient Name: ____

Signature: ____ Date: _____________
(Patient or Legal Guardian)

***Responsible Party's Name: (if not Patient): ________________________ Date: _____________

Responsible Party's Signature: _________________________________ Date: _____________

Revised 01/2015