Center for PAIN and REHAB Medicine

Manage your Pain.
Enjoy your Life!

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):	

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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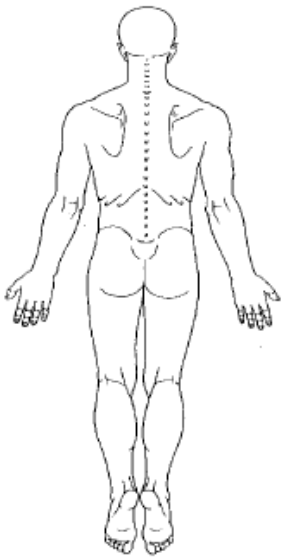
CHIEF COMPLAINT

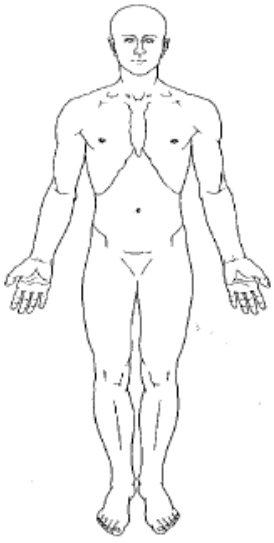
Please fill out the following form about you pain to the best of your ability.

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? _____

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

		Female	Male
1.	**Family history of substance abuse:**		
	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

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**)
***__**EXCLUDE**__ 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

CENTER FOR PAIN AND REHAB MEDICINE

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CPARM POLICIES ACKNOWLEDGMENT

Please read carefully.

USE AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI):
We may use to disclose your PHI for purposes of: a) ***Treatment*** b) ***Payment*** c) ***Healthcare Operations***. If any disclosure other than mentioned above, information will only be released with a written authorization of the individual in question.

FINANCIAL & BILLING POLICY

- Our office accepts Cash, Check, Debit Cards and Credit Cards. $50.00 will be charged for a returned check.
- All copays, deductible and coinsurance are collected in full at time of service.
- Services that are not covered by your health insurance is your responsibility.
- Our office bills your insurance carrier as a courtesy to you. After your claim is processed and your responsibility is higher than the amount we collected at time of service, we will bill you for the remaining balance(s).
- We expect you to pay your balance(s) in a timely manner and in full to avoid your account being sent to an outside collection company. If you need to make payment arrangements, please speak with our Billing Staff so we can assist you.

NO SHOW POLICY: Our office charges a NO SHOW fee for failure to give 24 hour notice to reschedule or cancel an appointment. This fee is not billable to your insurance company and must be paid in full at time of visit.

1. **$35.00** office visit No Show
2. $**60.00** Procedure No Show (Epidural Injection, Joint Injection, EMG)
3. **$75.00** Procedure No Show (Spinal Cord Stimulator Trial)

OTHER CHARGES: **$15.00** for Handicap Parking Form (1 page)
$35.00 minimum charge for completing medical forms
$175.00 minimum charge for completing Disability Forms

*****For other charges that are not indicated on this policy, please ask our Front Desk Staff.**

Charge(s) for copy and retrieval of medical records is Pursuant to O.C.G.A §31- 33-3. Your medical records will be sent to other Provider at no cost to you provided you signed an authorization to release your records.

NO CHILDREN POLICY: Children are not allowed in our facility due to our practice's insurance liability limitation, the practice's type of specialty, and the type of medications we prescribe.

OTHER POLICY: Please limit to one (1) adult companion during your visit. This allows our office to optimize our waiting areas and at the same time protect your privacy and the privacy of other patients.

NO WEAPONS POLICY: Guns, knives or any other weapons are not allowed in the building.

I am aware that the information contained on this page is a summary of CPARM policy. I acknowledge that I have read and I fully understand ALL the above Policies of the Practice and will abide by them:

Patient Name: _____ Signature: _____ Date: _____
(Patient or Legal Guardian)

I am aware that the detailed CPARM policy is available to me and by initialing the options provided below, I am confirming that:

_____ I opted NOT to read the detailed CPARM policy.
_____ I opted to read the detailed CPARM policy and fully understand the policies and will abide by them.

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Agreement for Controlled Substance Prescriptions

Patient Name: _____ **Date:** _____

You are being evaluated for Pain Management/Suboxone Therapy 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 the following (**please initial each 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 non-prescription 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.

240 Medical Blvd. Stockbridge, GA 30281
Ph: 678-284-4000 Fax: 678-284-6500

- **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.

☐ 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 may 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.

SUBOXONE PATIENTS:

☐ Failure to provide accurate information, lying, or providing false information will lead to termination.

☐ Failure to provide current and updated address, phone number, email may lead to termination

☐ I will be fully responsible for any averse outcome if I provide false information regarding my use of narcotics, illegal drugs or medical history.

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

I HAVE READ AND UNDERSTAND THE ABOVE CONDITIONS AND THAT THE CONSEQUENCES OF VIOLATING THIS CONTRACT MAY RESULT IN IMMEDIATE TERMINATION FROM THIS PRACTICE.

Patient Name _____

Signature_____ **Date:** _____

Witness Name_____ **Date:** _____

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Ph: 678-284-4000 Fax: 678-284-6500