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

Please PRINT legibly and fill out this form in its entirety.
It is your responsibility to notify our office of any changes in your address, telephone number and insurance plan.

Last Name:	First Name:	MI:	Date of Birth:

Address:	City:	State:	Zip:

Home Ph#:	Cell Ph#	Work Ph#:

Email:	Gender: ❑M ❑F	SSN:

Emergency Contact:	Phone#:	Relation:

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

Employer:	Address:	Phone#:	Occupation:

Primary Care Physician (PCP):	Address:	Phone#:	Last PCP Visit:

Referring Physician:	Address:	Phone#

***** Patient will be responsible for all financial liabilities EXCEPT when Patient is under Guardianship or Power of Attorney.**

Guardian or Power of Attorney:	Last Name:	Frist Name:	SSN:

Address:	City:	State:	Zip:

Email:	Cell Ph#:	Home Ph#:	Work Ph#:

Is your chief complaint or medical condition related to **Automobile Accident, Slip & Fall, Workman's Compensation?** ❑YES ❑ NO	If yes, Type of Injury : _____ Date of Injury: _____

PATIENT / GUARANTOR SIGNATURE **DATE**

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*****It is your responsibility to notify our office of any changes to your insurance plan.*****

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Carrier:	Insurance Carrier:
Member ID#:	Member ID#:
Group #:	Group #:
Effective Date:	Effective Date:
POLICY HOLDER – Primary Insurance	**POLICY HOLDER – Secondary Insurance**
Name:	Name:
Date of Birth:	Date of Birth:
SSN:	SSN:
Address:	Address:
Phone#:	Phone#:
Relationship to Patient:	Relationship to Patient:

ACCIDENT INFORMATION (If Applicable)

Accident Information	Work Compensation Information
❑ **Automobile Accident** **Other:**_____ ❑ **Slip and Fall**	Employer:
Date of Accident:	Date of Accident:
Auto Insurance Company: Responsible Entity (Slip & Fall):	Work Comp Carrier:
Policy#:	Policy#
Claim#	Claim#
Claim Adjuster:	W/C Case Manager:
Adjuster's Phone#:	Case Manager's Phone#:

ATTORNEY INFORMATION

Attorney Name:	Phone#	Fax#
Law Firm Name:	Contact Name:	
Address:	Email:	

PARENT/GUARANTOR SIGNATURE **DATE**

PHARMACY INFORMATION		
Primary Pharmacy Name:	**Secondary** Pharmacy Name:	
Address:	Address:	
Phone:	Phone:	
Fax :	Fax:	
Please list ALL medications that you are **currently** taking including vitamins and over the counter drugs. Attach additional sheet if required.		
Medication Name	**Dose**	**Frequency**

ALLERGIES to Medication(s) – List all known allergies:	
❑ **NO Known Allergies**	
Medication Name	**Reaction You Had**

Are you currently taking blood thinners or anti-coagulants?	❑ YES	❑ NO			
If **YES**, which ones?	❑ Aspirin	❑ Plavix	❑ Coumadin	❑ Lovenox	❑ Other:

PATIENT NAME

DATE

Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

Cancer/Oncology
- ❑ Cancer Type _____
- ❑ Cancer Type _____
- ❑ Cancer Type _____

Musculoskeletal/Rheumatologic
- ❑ Bursitis
- ❑ Carpal Tunnel Syndrome
- ❑ Fibromyalgia
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Rheumatoid Arthritis
- ❑ Chronic Joint Pain

Neurological
- ❑ Multiple Sclerosis
- ❑ Peripheral Neuropathy
- ❑ Seizures
- ❑ Head Injury
- ❑ Balance Disorder
- ❑ Headaches
- ❑ Migraines

Gastrointestinal
- ❑ GERD (Acid Reflux)
- ❑ Gastrointestinal Bleeding
- ❑ Stomach Ulcers
- ❑ Irritable Bowel Syndrome
- ❑ Crohns Disease

ENT
- ❑ Glaucoma
- ❑ Vertigo
- ❑ Hearing Problems
- ❑ Nosebleeds
- ❑ Eye Problems

Cardiovascular/Hematologic
- ❑ Presence of stent/pacemaker/defibrillator
- ❑ Heart Attack
- ❑ Stroke/TIA
- ❑ Coronary Artery Disease
- ❑ Peripheral Vascular Disease
- ❑ Heart Valve Disorder
- ❑ Anemia
- ❑ Hypertension

Psychological
- ❑ Depression
- ❑ Anxiety
- ❑ Schizophrenia
- ❑ Bipolar Disorder
- ❑ ADD/ADHD
- ❑ PTSD

Respiratory
- ❑ Asthma
- ❑ Pneumonia/Bronchitis
- ❑ Emphysema/COPD

Endocrinology
- ❑ Diabetes – Type _____
- ❑ **Hyper**thyroidism
- ❑ **Hypo**thyroidism

Urological
- ❑ Dialysis
- ❑ Chronic Kidney Disease
- ❑ Kidney Stones
- ❑ Urinary Incontinence

OTHER Diagnosed Conditions
- ❑ _____
- ❑ _____
- ❑ _____

Patient Name: _____ Date: _____

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

Are you pregnant at this time? ❑ Yes ❑ No

Have you ever had a blood transfusion? ❑ Yes ❑ No If yes, when? _____

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
❑ Exercise- How many Hrs/Wk? _____
❑ Dieting ❑Yes ❑ NO

❑ Use Tobacco - pack/day _____
❑ Smoke - pack/day _____
❑ Use of Recreational Drugs What? _____
❑ Sexually Active ❑ YES ❑ NO

Please list any Surgeries and Hospital stays (ER/Observation/Admission) you have had in the past:

Date	*Reason: (Type of Surgery or Type of Hospital Stay*	*Hospital/Physician*

Patient Name: _____ **Date:** _____

PATIENT NAME: _____ **AGE:** _____ **Date:** _____

PAIN HISTORY:

Is your chief complaint related to:

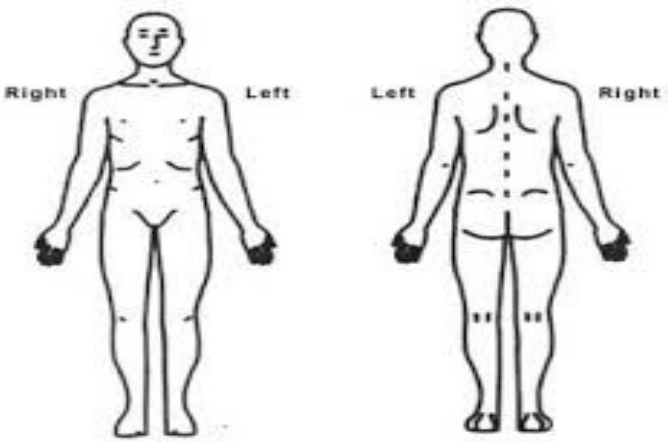
❑Automobile Accident ❑ Slip and Fall ❑ Work Compensation Date of Injury:

Chief complaint/main reason for your visit today? _____

Does this pain radiate? If so, where? _____

Please list additional areas of pain: _____

On the diagram below, please CIRCLE the location on your body where you experience pain.



ONSET OF SYMPTOMS:

Approximately, when did this pain begin? _____

How did the problem start? _____

How did your current episode begin? ❑ Gradually ❑ Suddenly

How long have you been experiencing this problem? _____

Progression of your current condition since it started? _____

What factors worsen your pain? _____

Are your symptoms constant or do they come and go? _____

Please rate your pain of 0-10 (0 being no pain and 10 being the worst pain you can think of):

Right Now? _____/10 **At its worse?** _____/10 **At its best?** _____/10

Have you seen any other doctor for this problem? If so, who?_____ when? _____

Type of pain: (Check all that applies): ❑ Sharp ❑ Tingling ❑ Throbbing ❑ Numb ❑ Aching
❑ Spasm ❑ Burning ❑ Cramping ❑ Stiffness ❑ Stabbing

What are the goals you wish to achieve with Pain Management? _____

_____

Diagnostic Test and Imaging:

Mark all of the following tests that you have had related to your current pain complaints:

- ❑ MRI of the: _____ Date: _____
- ❑ X-Ray of the: _____ Date: _____
- ❑ CT scan of the: _____ Date: _____
- ❑ EMG/NCV study of the: _____ Date: _____
- ❑ Other Diagnostic Testing: _____ Date: _____
- ❑ I have NOT had ANY diagnostic test for my current pain complaint.

Please check all of the following treatments you have had for pain relief:

- ❑ Spine Surgery
- ❑ Physical Therapy
- ❑ Chiropractic Care
- ❑ Massage Therapy
- ❑ Tens Units
- ❑ Psychological Therapy
- ❑ Brace Support
- ❑ Acupuncture
- ❑ Hot/Cold Packs
- ❑ Non-Steroidal/Anti Inflammatory Drugs (NSAID)

Interventional Paint Treatment/Procedure History:

- ❑ Epidural Steroid Injections – Which level(s) if known: _____
- ❑ Joint Injection: Which Joint(s): _____ ❑ Right ❑ Left ❑ Steroid ❑ Visco
- ❑ Medial Branch Blocks/Facet Injections – Which level (s) if known: _____
- ❑ Nerve Block – Area/Nerve: _____
- ❑ Radiofrequency Nerve Ablation: Where/Level(s):_____
- ❑ Spinal Cord Stimulator: ❑ Temporary ❑ Permanent Implant
- ❑ Trigger Point Injection: Where? _____
- ❑ Vertebroplasty/Kyphoplasty – Level(s): _____
- ❑ Other: _____

Which of these procedures listed above have helped with your pain? _____

_____

Please list the names of other Pain Physician(s) you have seen in the past 5 years:

1._____ 3._____

2._____ 4._____

Mark the following physicians or specialist you have consulted for your current pain problems;

- ❑ Acupuncturist
- ❑ Chiropractor
- ❑ Internist
- ❑ Neurologist /Neurosurgeon
- ❑ Orthopedic/Orthopedic Surgeon
- ❑ Physical Therapist
- ❑ Psychiatrist/Psychologist
- ❑ Rheumatologist
- ❑ Psychiatrist/Psychologist
- ❑ Other:_____

Patient Name: _____ Date: _____

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

	Female	Male
Family history of substance abuse:		
Alcohol	A	A
Illegal Drugs	B	B
Prescription Drugs	C	C
	None	None
Personal history of substance abuse:		
Alcohol	A	A
Illegal Drugs	B	B
Prescription Drugs	C	C
	None	None
Circle "A" if you are between the ages of 16 and 45:	A	A
Circle "A" if you have history of sexual abuse before the age of 13:	A	B
Have you been been diagnosed with one of the following:		
❑ Attention Deficit Disorder (ADD/ADHD)	A	A
❑ Obsessive Compulsive Disorder (OCD)	B	B
❑ Bipolar Disorder	C	C
❑ Depression	D	D
❑ None		

Staff Signature: _____ **Score:** _____

****

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "X" to indicate your answer)

	NOT at all	Several Days	More than Half the days	Nearly every day
1. Little interest or pleasure in doing things	◯	◯	◯	◯
2. Feeling down, depressed, or hopeless	◯	◯	◯	◯
3. Trouble falling or staying asleep, or sleeping too much	◯	◯	◯	◯
4. Feeling tired or having little energy	◯	◯	◯	◯
5. Poor appetite or overeating	◯	◯	◯	◯
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	◯	◯	◯	◯
7. Trouble concentrating on things, such as reading the newspaper or watching television	◯	◯	◯	◯
8. Moving or speaking so slowly that other people could have noticed. Or the opposite ? being so fidgety or restless that you have been moving around a lot more than usual	◯	◯	◯	◯
9. Thoughts that you would be better off dead, or of hurting yourself in some way	◯	◯	◯	◯

Staff Signature: _____ **Score:** _____

Patient Name _____ **Date:** _____

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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.
- **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 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 prescribe to me at this time. However, if in the future I change my mind, I will have to sign another agreement.**

☐ **SUBOXONE PATIENT ONLY: (in addition to above agreement)**

☐ 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 (Print): _____

Patient Signature: _____ **Date:** _____

Witness Name: _____ **Date:** _____

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AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY MEMBERS

Patient Name: _____ Date of Birth: _____

Many of our patients allow family members or friends 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 or friends, you must sign this form. By signing this form, your information will be given only to the family members/individuals 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 or friend**.

I understand that I have the right to revoke this authorization at any time and that I have the right t 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:** _____

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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** 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:

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.

Patient Name: Signature: _____ **Date:** _____