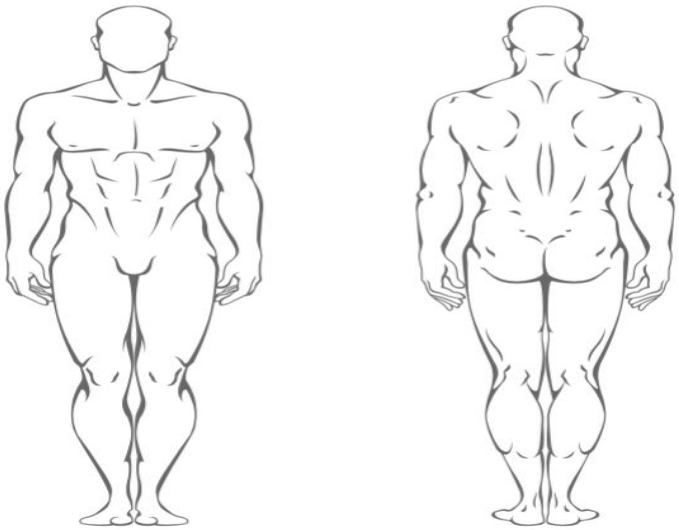
PAIN SPECIALISTS OF SOUTHERN OREGON

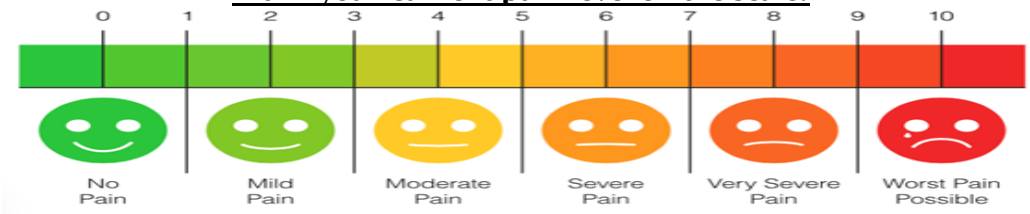
Date:_____

Patient's Name:_____ DOB:_____

Place an (X) in the area of pain that you would like to address today:



Mark your current pain level on the scale:



Please describe your pain in a few words: _____

Pain has been present for: _____

Pain is relieved by: _____

Pain is worsened by: _____

PAIN SPECIALISTS OF SOUTHERN OREGON

Patient's Name:_____

Circle any previous treatment / imaging you have had:

Physical Therapy TENS Acupuncture Chiropractic Injections_____

X-Ray MRI CT

For Internal Use Only

Ht:_____ Wt:_____ Pain Level:____/10 02Sat:_____% Resp:_____

Medication Reviewed ☐ Allergies Reviewed ☐

Past Medical History:

Check (X) the box next to and medical history which you have had.

Arthritis		Chronic Pain		Asthma		Hypertension	
Heart Disease		Hepatitis		Diabetes		Hypothyroidism	

Please describe any current or past medical treatment not listed above:

_____

_____

Surgical History:

Check (X) the box next to any surgical procedures which you have had.

Tonsilectomy		Appendectomy		Cholecystectomy		Colectomy	
Gastric Bypass		Hysterectomy		Hernia Repair		Breast	
Heart Surgery		Low Back Surgery		Neck Surgery			

Others:_____

_____

Family History:

Check (X) the box next to any disease diagnosed in your blood relatives.

Heart Disease		Cancers		Hypertension		Diabetes	

Others:_____

PAIN SPECIALISTS OF SOUTHERN OREGON

Patient's Name:_____

Allergies:

Medication	Reaction

Medications:

Name	Milligram	Amount Per Day

Social History:

	Yes (X)	Type	Duration	Amount Per Day	No (X)
Do you drink alcohol?					
Do you use tobacco?					

Do you have a history of substance abuse? If so please explain: _____

_____

PAIN SPECIALISTS OF SOUTHERN OREGON

Patient's Name:_____

Do you have any of the following conditions? Check (X) if yes.

Numbness	
Weakness	
Headaches	

Abnormal Bleeding	
Abnormal Bruising	

Nausea	
Vomiting	
Constipation	
Diarrhea	

Increased frequency of urination	
Incontinence	
Diabetes	

Trouble seeing	
Eye pain	
Double vision	
Loss of hearing	

Rash	
Fatigue	
Night Sweats	
Weight change	

Anxiety	
Depression	
Bipolar disorder	

DEMOGRAPHICS

Today's Date:_____

Patient Name:_____ Date of Birth:_____
Last First M.I

Soc Sec#:_____-_____-_____ Drivers Lic#:_____ Marital Status:_____

Language: English:_____ Other:_____ Race:_____ Ethnic Group:_____

Physical Address:_____ City:_____

State:_____ Zip Code:_____

Mailing Address:_____ City:_____

State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____

Email Address:_____ Ok to Leave a Detailed Message? Yes_____ or No__

Employer:_____ Employer Phone:_____

Emergency Contact:_____ Relationship:_____

Phone:_____

Referring Provider:_____ Phone:_____

Primary Care Provider:_____ Phone:_____

Pharmacy Name:_____ City:_____ Phone:_____

INSURANCE INFARMATION

Patient's Name:_____

Primary Insurance:_____

Address:_____City:_____State:_____Zip Code:_____

Phone:_____Subscriber Name:_____

Date of Birth:_____Subscriber ID:_____Group Number:_____

Secondary Insurance:_____

Address:_____City:_____State:_____Zip Code:_____

Phone:_____Subscriber Name:_____

Date of Birth:_____Subscriber ID:_____Group Number:_____

Work Comp Insurance Name:_____

MVA Insurance Name:_____

Address:_____City:_____State:_____Zip Code:_____

Phone:_____Employer at Time of Injury:_____

Claim#:_____Date of Injury:_____

Adjustor Name:_____Phone:_____

FINANCIAL POLICY

Please be assured that everyone in this practice provides medical care in the highest quality possible to all our patients, in an atmosphere of caring, trust and mutual respect.

Your complete understanding of your financial responsibilities is essential; the following is our financial policy that all patients are required to read and sign prior to seeing a healthcare provider. Please let us know if you need any clarification on our payment policies.

Please present to the office with a form of payment to meet your financial obligations to your insurance provider and to your healthcare provider. We accept cash, debit card, check, MasterCard, Visa, Discover and American Express.

You are responsible for all copays, coinsurance, deductibles, and non-covered services. We are obliged to collect your copay at the time of service per your insurance company. Please understand that we cannot waive deductibles, coinsurances or copays that are required by your insurance. Patient portion of payment is due at time of service unless prior arrangements have been made with the business office.

We accept assignment with most major insurance companies and participating provider plans. However, please note:

1. Your insurance policy is a contract between you, your employer and the insurance company. Our relationship is with you, not your insurance carrier.
2. All charges are your responsibility whether your insurance company pays or not (to the extent of insurance contractual obligation).
3. Returned checks will be subject to any bank fees charged to our office, in addition to a service fee, and will be billed to you.
4. Unpaid balances are subject to collections process.

We understand that temporary financial problems may affect timely payment of your balance. Balances not paid within 90 days will be turned over to an outside collections agency, unless prior payment arrangements have been made with our business office. Patients turned over to a collection agency will also cease to be patients of Pain Specialists of Southern Oregon.

Due to the hardship imposed on the practice and other patients, scheduled appointments that are missed, cancelled and /or rescheduled with less than 24 hours' notice will result in a fee and may also result in discharge from the practice. The fee for missed appointments is determined based on the level of hardship it imposed on the practice. This fee will not be covered by your insurance and must be paid prior to you seeing the healthcare provider.

Prescriptions provided outside of an office visit due to missed, cancelled and/or rescheduled appointments are subject to a fee and payment will be required at the time prescription is provided.

I have read and understand Pain Specialists of Southern Oregon's "Financial Policy" as described above.

Patient Signature/Authorized Signature Date

Printed Name of Patient / Printed Name of Authorized Signer Relationship to patient if not patient

Authorization to Release and Assign Insurance Benefits: I authorize release of any information required to act on any insurance claim and permit photocopy or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to Pain Specialists of Southern Oregon the medical and/or surgical benefits I am entitled from my insurance company and/or Medicare. This authorization is in effect for all future claims until I choose to revoke it in writing.

Patient Signature/Authorized Signature Relationship to patient if not patient Date

NOTICE OF PRIVACY PRACTICE

I understand that Pain Specialists of Southern Oregon (referred to below as "This Practice") will. use and disclose health information about me.

I understand that my health. information may include information created and received by the practice; may be in the form of written, electronic records or spoken words; and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

I understand and agree that This Practice may use and disclose my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This ˜written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such

Patient Signature:_____ Date:_____

_____

Representative Signature Relationship Date

RELEASE OF INFORMATION

I,_____, hereby authorize
Patient Name

Pain Specialists of Southern Oregon to release information about my:

- □ Medical Information
- □ Billing Information
- □ Appointment Information
- □ Other:_____

*Required by Pain Specialists of Southern Oregon:

*Referring Provider:_____
Name

*Primary Care Provider:_____
Name

If requested by:

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

Patient Signature:_____ Date:_____

Representative Signature	Relationship	Date

ADVANCED CARE

Do you have a health care proxy in the event you are unable to make your own medical decisions?

☐ Yes

☐ No

Designee's Name:_____ Phone Number:_____

Do you have a living will?

☐ Yes

☐ No

Which statement best reflects your wishes on advanced care recommendations?

☐ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.

☐ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.

☐ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

Patient Signature:_____ Date:_____

_____

Representative Signature Relationship Date

CONSENT TO OBTAIN EXTERNAL PRESCRIPTIONHISTORY

By signing below, **I** authorize Pain Specialists of Southern Oregon and its affiliated providers to view my external prescription history.

I understand that prescription history from other unaffiliated medical providers, insurance companies and pharmacy benefit managers may be viewable by my providers and staff at Pain Specialists of Southern Oregon, and it may include prescriptions over several years.

My signature certifies that **I** have read and understood the scope of my consent and that **I** authorize the access to my prescription history.

Patient Signature:_____ Date of Birth:_____

Printed Patient Name:_____ Date:_____

_____

Representative Signature Relationship Date

Witness Signature:_____ Date:_____

Witness Printed Name:_____