Patient Evaluation

Date: _____ Patient Name: _____ DOB: _____

Address: _____ Phone: _____ Email: _____

First/last name of your Referring Provider: _____ **First/last name of your Primary Care Provider:** _____

If you are a Female, please tell us your pregnancy status: ☐ Hysterectomy ☐ Post-Menopausal ☐ Uterine or Endometrial Ablation
☐ Child-Bearing Age-No Contraception ☐ Child-Bearing Age-Birth Control Medication ☐ Child-Bearing Age-Other Contraception

Where is the location of your pain: _____

When did your pain first begin, please tell us month and year if known? mm/yyyy: _____

What is the main cause of your pain? ☐ Unknown ☐ Normal aging ☐ Fall ☐ Sporting accident ☐ Motor vehicle accident

Is the cause of your pain work related? ☐ No ☐ Yes _____

Are you here due to a specific injury at work or accident? ☐ Y ☐ N Explain: _____

Do you have an attorney for an injury or accident you sustained? ☐ No ☐ Yes **Have you filed for Workers' Compensation benefits?** ☐ No ☐ Yes

Do you have, or have you ever, filed for workers' compensation benefits? ☐ No ☐ Yes **Are there any legal issues involving your pain?** ☐ No ☐ Yes

What is the frequency of your pain? ☐ Constant ☐ Fluctuating but always present ☐ Fluctuating but usually present ☐ Fluctuating and rarely present

What best describes your pain? ☐ Aching ☐ Burning ☐ Cramping ☐ Dull ☐ Numb ☐ Sharp ☐ Stabbing ☐ Stinging ☐ Throbbing ☐ Tingling

What is your pain level most of the time? ☐ 0 - No Pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Unbearable Pain

What makes your pain worse? ☐ Bending or stooping ☐ Changing from sitting to standing ☐ Sitting ☐ Lifting or carrying heavy loads
☐ Lifting or carrying small loads ☐ Lying on back ☐ Lying on side ☐ Twisting ☐ Walking ☐ Nothing

What makes your pain better? ☐ Lying on side ☐ Lying on back ☐ Sitting ☐ Standing ☐ Walking ☐ Stretching ☐ Exercise ☐ Medications
☐ Changing Positions ☐ Heat and Ice ☐ Nothing

What does your pain interfere with? ☐ Daily Chores ☐ Employment ☐ Exercise ☐ Grooming ☐ House Chores ☐ Mood ☐ Sleep ☐ Relationships
☐ Walking ☐ Nothing

Have you had any of these Imaging/Tests to assist in the evaluation of your pain? MRI: ☐ No ☐ Yes **CT Scan:** ☐ No ☐ Yes **X Ray:** ☐ No ☐ Yes
EMG/Nerve Conduction: ☐ No ☐ Yes

Have you ever had Genetic Testing done? ☐ No ☐ Yes

Have you had any of the following to assist in the evaluation of your pain?
☐ Blood work completed in the past year ☐ Drug Screening ☐ Bone Scan ☐ Bone Density
☐ Vascular Studies ☐ Functional Capacity Evaluation ☐ Depression Screening

Have you had any of the following to assist with treatment of your pain?
☐ Spinal Injections ☐ Joint Injections ☐ Trigger Point Injections ☐ Brace ☐ Tens Unit
☐ Physical Therapy ☐ Chiropractic Therapy ☐ Aquatic Therapy ☐ Surgical Evaluation
☐ Surgery ☐ Spinal Cord Stimulator ☐ Spinal Traction ☐ Cane ☐ Walker
☐ Exercise Program ☐ Weight loss Program ☐ Intrathecal Pain Pump ☐ None

Previous Pain Clinic: _____

Do you smoke? How much? _____ How long? _____

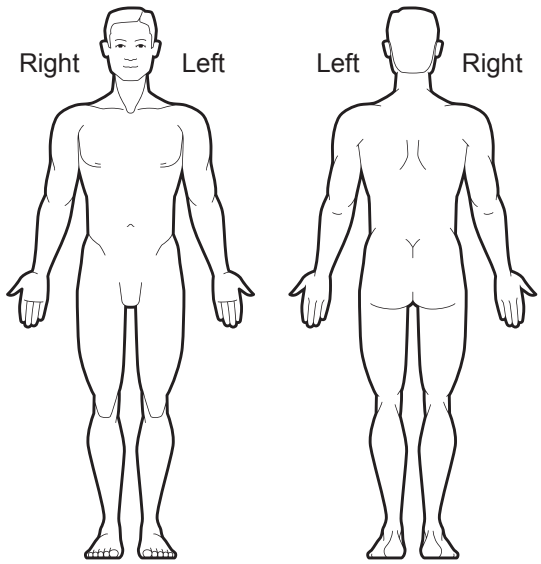
Do you drink? How much? _____

Do you use illicit drugs? What? _____ Last time you used? _____

Have you ever been to drug or alcohol rehab? Where? _____

When? _____

Draw in the location of your pain below:



INSURANCE INFORMATION:

Name Of Primary Insurance Company: _____

Phone: (_____) _____ Address: _____ City, State, Zip: _____

Insured Name: _____ SS#: _____ Relationship: _____

Policy#: _____ Group #: _____ DOB: ____/____/____ Referral Required ☐ Y ☐ N

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History

Date: _____ Patient Name: _____ DOB: _____

Address: _____ Phone: _____ Email: _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (Add additional page if needed).

MEDICATION	DOSAGE	INSTRUCTIONS

EDUCATION

Educational Level _____

CURRENT EMPLOYMENT

Date, place and type of last job _____

Patient Authorization for Use and Disclosure of Protected Health Information

The Pain Management Group will not disclose your medical records ("PHI" or Protected Health Information) to any party without your signed consent, except as stipulated in our Notice of Privacy Policies and Practices. This form authorizes us to release your medical records to the parties indicated by you.

Your Name: _____ Date of Birth: _____

AUTHORIZED PARTIES

By signing below, I authorize The Pain Management Group, its agents and employees **("Provider")**, to use and/or disclose any and all of my protected health information of any kind and description to the following party or parties **("Recipients"):**

PARTY	**RELATIONSHIP TO YOU**
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION INCLUDING HIV & AIDS RELATED INFORMATION AND SUBSTANCE ABUSE INFORMATION

I understand that neither Provider nor Recipient may condition any treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization. In addition, I understand that Recipient may re-disclose the Records and that the Records may no longer be protected by the Federal privacy regulations.

I acknowledge and agree that the protected health information authorized to be disclosed under this Authorization may include records for drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases and communicable disease-related information.

With respect to any communicable disease-related information protected by State confidentiality rules and disclosed under this Authorization, Recipient is prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by applicable law.

Further, with respect to any drug or alcohol abuse treatment information disclosed under this Authorization, this information has been disclosed from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rule prohibit the recipient of this information from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

RIGHT OF REFUSAL

I acknowledge that I have had the opportunity to review The Pain Management Group's Notice of Privacy Policies and Practices, which is displayed for public inspection at this facility and on its website at www.ThePainManagementGroup.com.

The Pain Management Group's Notice of Privacy Policies and Procedures describes how my protected health information may be used and disclosed, and how I may access my health records.

I understand I have the right to refuse to sign this authorization and that I do not have to sign this authorization to receive treatment at The Pain Management Group. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Health Insurance Portability and Accountability Act (HIPAA). I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer whose address is listed below:

PRIVACY OFFICER
Ryan D. Brown
Mailing Address: 28 White Bridge Pike, Suite 111, Nashville, Tennessee 37205
Telephone: 615.986.6153
Fax: 615.234.1515
Email: Ryan.Brown@OurAdvancedHEALTH.com

EXPIRATION

This Authorization will remain effective until the expiration date specified below or, if no date is set forth below, for as long as the Patient is a Patient of the Provider. A photocopy of this Authorization will be considered effective and valid as the original.

Date authorization expires (if any): _____

PATIENT'S SIGNATURE

_____ _____

Signature of Patient or Legal Guardian **Today's Date**

_____

Relationship to Patient

Narcotic Management Agreement

This is our Narcotic Contract and Opioid Consent Form. Please read and INITIAL next to each understood statement. If you do not understand or do not agree with any statement, do not initial. Leave it blank and we can discuss it at your initial visit. If you have any questions, please call 615-941-8501.

INITIAL

_____ I accept admission into The Pain Management Group's service under the care of David E. Fritz, MD, Bradley C. Hill, DO, Daniel J. McHugh, MD, Timothy H. Miller, MD, and John Welker, MD for treatment of chronic pain including the use of narcotic medication as indicated under my treatment plan.

_____ I understand that using narcotics can be habit forming and acknowledge that such medications have certain risks including but not limited to physical dependence, addiction, tolerance to pain relief, sleepiness, constipation, nausea, itchy allergic reaction, slow breathing, and even death.

_____ I will not operate heavy equipment or drive while taking my medications until the side effects are known. I am aware my reflexes and reaction time may be slowed, even if I am unaware of it.

_____ I will control my usage of narcotic medications as directed by the attending physician. **There are no exceptions.** If medication is inadequate for your pain level, you **must** call before adjusting dosage.

_____ I acknowledge that the use of **ANY** illegal substances will not be tolerated.

_____ I agree to follow instructions ordered by the attending physician and/or physician's assistant or nurse practitioner which may include participation in pain management instructions/class, psychological counseling, exercise, physical therapy, injection therapy, non-narcotic therapy, imaging studies, referrals, diagnostic testing, etc.

_____ I agree not to seek any narcotic/pain medication from any other physicians other than The Pain Management Group. I will inform my other physicians of this narcotic agreement and request they coordinate any and all narcotic/pain medication with The Pain Management Group.

_____ I will tell my doctor about other medications and treatments I am receiving.

_____ Prescriptions for the amount and type of narcotic/pain medication established in my plan of care will be e-scribed to my pharmacy. If the pharmacy does not accept e-scripts, they will be printed and handed to me. I understand that I am responsible for my medication.

_____ **Lost, Stolen, or Misplaced Medication Will Not Be Replaced for any Reason.**

_____ I agree that the attending physician can call me in for a pill count at any time, **and all controlled substances must be brought to each office visit.**

_____ I will manage my medication to prevent shortage prior to the scheduled refill date and will schedule appointments with The Pain Management Group for re-evaluation prior to being out of medication. **Repeated phone calls to obtain additional medication will not be tolerated and may result in my discharge from this clinic.**

_____ I give permission to The Pain Management Group to obtain urine and/or blood drug screening at random as deemed necessary.

_____ I give The Pain Management Group permission to share information, as needed with appropriate drug and law enforcement agencies if deemed appropriate or necessary by my physician.

_____ I agree to use a single pharmacy for my narcotic/pain medications: **Pharmacy:** _____ **Phone:** _____

_____ I agree to take any pharmacy problems to the pharmacy and not to The Pain Management Group.

_____ **Renewal or Refill of Narcotics/Pain Medication Will Not Be Called to a Pharmacy without an office visit; There are No Exceptions.**

_____ I am aware other medication such as nalbuphine (Nubain™), pentazocine (Talwin™), buprenorphine (Suboxone™), and butorphanol (Stadol™) may reverse the actions of my medications, causing withdrawl symptoms.

_____ I will be honest with my provider about my past medical history, family history, and personal drug history to prevent harm to myself.

_____ I am aware that tolerance to narcotic medications can occur and increasing doses of medications may not help and may cause unacceptable side effects.

_____ I am aware that long-term narcotic use can result in low testosterone levels.

_____ I agree that if I become pregnant or plan to become pregnant I will inform my OB/GYN of all medications I am taking. Narcotic medications and treatment may be suspended during pregnancy to prevent any birth defects.

_____ Narcotic medication may affect my mood, sexual desire and performance, physical performance, and stamina.

_____ I acknowledge that use of alcoholic beverages with a positive result on urine drug screens, will result in discontinuation of pain medications if detected on more than 2 occasions. Combining alcohol with opioids can lead to overdose and in some cases death.

_____ I acknowledge that the use of CBD products can result in a positive result for THC (marijuana) with urine drug screening. I acknowledge that I will be required to discontinue the use of any CBD product that results in a positive THC (marijuana) result. I further acknowledge that THC (marijuana) is considered an illegal substance in the state of Tennessee, and that the presence of THC (marijuana) in my urine drug screen can result in discontinuation of opiate medications.

The GOAL of our personalized care plan is to restore a healthy and active lifestyle that increases the ability to function, decreases pain and safely and conservatively utilizes opioid therapy, when warranted. We confirm the patient has a legitimate indication for continued treatment with opiates for severe, chronic, intractable pain.

I, _____, affirm, by my signature below, that I have read and understand the rules and goals for narcotic control. I agree to abide by the rules of the Narcotic Management Agreement. I fully understand if I breach any portion of this agreement, it is grounds for **immediate discharge** from any and all physicians of The Pain Management Group. I have agreed to attach my electronic signature to this agreement.

Patient Name (please print): _____ Patient Signature: _____ Date: _____

PMG Medical Professional: _____ Date: _____

EXTERNAL RX HISTORY CONSENT:

In order to maintain an accurate and up to date medical record we request permission to query outside resources for a list of your medications.

Signature of Patient or Responsible Party _____ Date: _____ /_____ /_____

Consent for Chronic Opioid Therapy

_____ (Provider Full Name), _____ (Sup Provider Full Name) and/or his associates is prescribing opioid medicine, sometimes called narcotic analgesics, to me for my pain diagnosis.

I am aware that the use of such medicine has certain risks and possible effects associated with it, including but not limited to: physical dependence, addiction, tolerance to pain relief, the possibility that the medicine will not provide complete pain relief, sleepiness or drowsiness, constipation, nausea, vomiting, itching, allergic reaction, slowing of breathing (respiratory depression), and death.

I am aware of the possible risks and benefits of other types of treatment that do not involve the use of opioids. The other treatments discussed may include injection therapies, imaging studies, referrals, physical therapy and other treatments as deemed appropriate by provider.

I will tell my doctor about all other medicines and treatments that I am receiving.

I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include, but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself.

I am aware that certain other medicines such as nalbuphine (Nubain™), pentazocine (Talwin™), buprenorphine (Buprenex™), and butorphanol (Stadol™), may reverse the action of the medicine I am using for pain control. Taking any of these other medications while I am taking my pain medicines can cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of these medications and to tell any other doctors that I am taking an opioid as my pain medicine and cannot take any of the medicines listed above.

I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine is very low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge.

I understand that physical dependence is a normal, expected result of using these medicines for a long period of time. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine use is markedly decreased, stopped, or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening.

I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain, however, it has been seen and may occur to me. If it occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment.

If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medicines, the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

I have read this form or have had it read to me. I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give my consent for the treatment of my pain with opioid pain medicines.

☐ **FEMALE** Signature: _____ Date: _____

I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

I have read this form or have had it read to me. I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give my consent for the treatment of my pain with opioid pain medicines.

☐ **MALE** Signature: _____ Date: _____

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Patient Financial Policy

This is an agreement between The Pain Management Group, as creditor, and the Patient/Debtor named on this form and indicated by patient/debtor signature below.

In this agreement the words "you", "your" and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us" and "our" refer to The Pain Management Group. By executing this agreement, you are agreeing to pay for all services that are rendered.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. A copy of your signed financial agreement will be provided to you.

HEALTH INSURANCE - It is YOUR responsibility to:

- Ensure we have been provided with the most current insurance information relative to filing your claim including insurance card, ID number, employer, birth date and patient address. This information will be located on our patient registration form.
- Ensure we are contracted with your insurance carrier to receive maximum benefits.
- Pay your co-payment or patient portion at the time of service.
- Inform us of any insurance changes made after this signed agreement/date of service. Insurance carriers have specific timely filing guidelines and pre-authorization requirements for certain services. If revised insurance information is not provided to us within your insurances' timely filing limits, you will be required to pay for services in full. If prior authorization was required for services already received and your claim is denied for lack of authorization, you will be required to pay for services in full.
- Contact your insurance company if no correspondence is received by you within 45 days of the date of service.

It is OUR responsibility to:

- Submit a claim to your health insurance carrier based on the information provided by the patient/debtor at the time of service or as updated information is provided.
- Provide your health insurance carrier with information necessary to determine benefits. This may include medical records and/or a copy of your insurance card.
- Provide MVA patients a courtesy health insurance claim form for their records upon request.

PAYMENT OPTIONS: Per our contracted agreement with your insurance carrier, we are required to collect your co-payment on the day of service. If you do not have insurance, you are required to pay for treatment at the time of service unless other arrangements have been formally made. A separate self-pay financial agreement will be provided to you.

- **Balances under $50 are due at the time of service. For balances greater than $50, an additional 10% of the total amount is due at the time of service.**

We accept the following: Cash or Credit Card ***(Visa, MasterCard, Discover, American Express)***

PENDING APPROVALS FOR SERVICES: In the event we are unable to obtain approval for services and you wish to proceed, we will not bill your insurance. Services will be reduced to the in-network insurance allowable amount and will apply to the patient's responsibility.

_____ Initials

Patient and/or Debtor Signature: _____ Date _____/_____/_____

Additional financial explanations are continued on the back side of this page

PAIN MANAGEMENT Group pmg | Advanced HEALTH

ThePainManagementGroup.com ▪ 615.941.8501 ▪ Fax: 615.941.8102

Antioch ▪ Centennial ▪ Clarksville ▪ Cookeville ▪ Cool Springs ▪ Gallatin ▪ Hendersonville ▪ Midtown ▪ Mt. Juliet ▪ Murfreesboro

DAVID E. FRITZ, MD | BRADLEY C. HILL, DO | DANIEL J. MCHUGH, MD | TIMOTHY H. MILLER, MD | JOHN WELKER, MD

WORKERS' COMPENSATION INJURIES: Written approval/authorization by your employer and/or workers' compensation carrier prior to your initial visit is needed. We will contact your case manager and/or supervisor to confirm your workers' compensation injury. If this claim is denied, for any reason by your employer or your employer's workers' compensation carrier, you will be responsible for payment in full. If denial is made by workers' compensation, health insurance can be filed for these denied services and you will be held responsible for the account.

MOTOR VEHICLE ACCIDENTS (MVA's) – Yes, I was involved in a MVA on _____/_____/_____. Unless prior agreement has been reached or I am a Medicare recipient, my **health insurance** will be filed for services related to this accident. In the event I do not provide insurance information upon initial visit, I understand insurance denials may occur depending on type of service(s) received or carrier specific filing requirements. I agree, as the patient or patient's guardian, I am ultimately responsible for all balance(s) due to this facility and/or its physician(s) for services rendered regardless of insurance denial(s) or unfavorable case outcomes. If I have chosen an attorney to oversee my case, this financial agreement will serve as a Letter of Protection to my attorney. I further understand my account may be handled by an outside entity that specializes in attorney lien accounts at the facilities discretion.

_____ Yes, I have chosen to retain an attorney. Signed: _____ Date: _____/_____/_____

Attorney Name: _____ Phone: _____

BILLING INFORMATION

STATEMENTS: A statement of account will be provided to you if insurance has paid leaving a patient portion, denied or no response is received. Due to the type of service we provide, you may receive billing from more than one practice, otherwise known as split billing. The balance on your statement is due and payable within 30 days of receipt unless other arrangements are made with our billing department. The statement will be sent to the address provided at the time of service. In the event your mailing address changes after your service date and your account has not been paid in full, you are required to notify our billing office of this change by email at Billing@OurAdvancedHEALTH.com or call 615.239.2018. In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child at time of service will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, court documentation is required for any guarantor address changes, otherwise, it is the authorizing/custodial parent's responsibility to collect from the other parent. Any account with a credit balance of less than <$5.00> will not be refunded without specific request from the patient/debtor.

DELINQUENT ACCOUNTS: We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If you fail to pay on time and we refer your account(s) to a third party for collection, a collection fee will be assessed and will be due at the time of the referral to the third party. The fee will be calculated at the maximum percentage permitted by applicable law, not to exceed 18 percent. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.

CONSENT TO CONTACT: I grant permission and consent to AdvancedHEALTH and its agents, assignees, and contractors (which may include third party debt collectors for past due obligations): (1) to contact me by phone at any number associated with me, if provided by me or another person on my behalf; (2) to leave messages for me and include in any such messages amounts owed by me; (3) to send me text message or emails using any email address I provided or any phone number associated with me, if provided by me or another person on my behalf; and (4) to use prerecorded/artificial voice messages and/or an automated telephone dialing system (an auto dialer) as defined by the Telephone Consumer Protection Act in connection with any communications made to me as provided herein or any related scheduled services and my account. I understand that my refusal to provide the consent described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services.

WAIVER OF CONFIDENTIALITY: You understand if your account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

MEDICAL RECORDS: You will be required to request in writing or sign a medical authorization form for the release of your medical records to any organization or physician. We charge a **$20 flat rate** for 1-5 pages plus .50 per additional page and postage.

- If age 18 years and over, you should contain documentation of whether a medical advance directive has been executed for Medicaid/Medicare members. A copy should be on file within the office.
- Please notify the office if you have a Living Will or Power of Attorney.

Authorization For Release Of Protected Health Information (PHI)

SECTION A: This section must be completed for all Authorizations for Release or Right to Access

Patient Name: _____ DOB: _____ SSN: _____

Requestor's Name / Address / Phone No. (Who is receiving PHI):

_____

_____

_____

Recipient's Name / Address / Phone No. (Who receives this form)

_____

_____

_____

Patient Address: _____

This authorization will expire on the following Date: _____/_____/_____

Purpose of Disclosure: _____

SECTION B: DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED

Is this request for psychotherapy notes? ☐ **YES**, then this is the only item you may request on this authorization.
YOU MUST SUBMIT another authorization for other items below. ☐ **NO, then you may check as many items below as you need.**

DESCRIPTION	DATE(S)	DESCRIPTION	DATE(S)	DESCRIPTION	DATE(S)
☐ All PHI in Psychotherapy Medical Record		☐ Laboratory		☐ Demographics	
☐ All PHI in Medical Record		☐ Imaging/Radiology		☐ Itemized Bill	
☐ History & Physical		☐ Pathology		☐ Claim Form	
☐ All Progress Notes		☐ Operative Notes		☐ Other:	
☐ Discharge Summary					

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV or AIDS results, testing or information. _____ (Initial)

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I will receive a copy of this form after I sign it.

SECTION C: SIGNATURES

I have read the above and authorize the disclosure of the protected health information as stated

_____ _____
Signature of Patient/Guardian/Patient Representative DATE:

_____ _____
Print Name of Patient's Guardian/Representative Relationship to the Patient

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Revised 10.29.2025

Medication

Date: _____ Patient Name: _____ DOB: _____

Please check all medications that you have previously tried.

NEUROPATHIC MEDICATIONS		
☐ Gabapentin (Neurontin)	☐ Lamotrigine (Lamictal)	☐ Levetiracetam (Keppra)
☐ Oxcarbazepine (Trileptal)	☐ Pregabalin (Lyrica)	☐ Tiagabine (Gabitril)
☐ Topiramate (Topamax)	☐ Valproic Acid	☐ Zonisamide (Zonegran)
ANALGESICS		
☐ Tramadol (Ultram)	☐ Fentanyl	☐ Oxycodone (Percocet)
☐ Oxymorphone (Opana)	☐ Meperidine (Demerol)	☐ Codeine
☐ Morphine	☐ Tapental (Nucynta)	☐ Hydrocodone (Lortab)
☐ Buprenorphine (Butrans patch)	☐ Suboxone	☐ Hydromorphone (Dilaudid)
☐ Methadone (Dolophine)		
NSAIDs		
☐ Flurbiprofen (ansaid)	☐ Diclofenac + Misoprostol (Arthrotec)	
☐ Aspirin	☐ Celecoxib (Celebrex)	☐ Sulindac (Clinoril)
☐ Oxaprozin (Daypro)	☐ Salsalate (Disalcid)	☐ Diflunisal (Dolobid)
☐ Piroxicam (Feldene)	☐ Indomethacin (Indocin)	☐ Naproxen (Naprosyn)
☐ Etodolac (Lodine)	☐ Meclofenamate (Meclomen)	☐ Fenoprofen (Nalfon)
☐ Meloxicam (Mobic)	☐ Ibuprofen (Motrin)	☐ Rofecoxib (Vioxx)
☐ Ketoprofen (Oruvail)	☐ Tolmetin (Tolectin)	☐ Diclofenac (Voltaren)
☐ Choline Magnesium Trisalicylate (Trilisate)	☐ Nabumetone (Relafin)	
MUSCLE RELAXERS		
☐ Baclofen (Lioresal)	☐ Carisoprodol (Soma)	☐ Chlorzoxazone (Parafon forte)
☐ Cyclobenzaprine (Flexeril)	☐ Metaxalone (Skelaxin))	☐ Orphenadrine (Norflex)
☐ Tizanidine (Zanaflex)	☐ Methocarbamol (Robaxin)	
ANTI-DEPRESSANTS		
☐ Fluoxetine (Prozac)	☐ Paroxetine (Paxil)	☐ Duloxetine (Cymbalta)
☐ Sertraline (Zoloft)	☐ Citalopram (Celexa)	☐ Venlafaxine (Effexor)
☐ Escitalopram (Lexapro)	☐ Trazodone	☐ Amitriptyline (Elavil)
☐ Nortriptyline (Pamelor)	☐ Bupropion (Wellbutrin)	☐ Mirtazapine (Remeron)
☐ Doxepin (Sinequan)	☐ Milnacipran (Savella)	
ANXIETY/SLEEP AIDS		
☐ Lorazepam (Ativan)	☐ Clonazepam (Klonopin)	☐ Alprazolam (Xanax)
☐ Diazepam (Valium)	☐ Temazepam (Restoril)	☐ Zolpidem (Ambien)
☐ Eszopiclone (Lunesta)	☐ Zaleplon (Sonata)	
HEADACHE TREATMENT		
☐ Frovatriptan (Frova)	☐ Naratriptan (Amerge)	☐ Rizatriptan (Maxalt)
☐ Sumatriptan (Imitrex)	☐ Zolmitriptan (Zomig)	☐ Fioricet
☐ Fioricet with Codeine	☐ Butorphanol (Stadol)	☐ Erenumab (Aimovig)
OSTEOPOROSIS		
☐ Estrogen	☐ Risedronate (Actonel)	☐ Pamidronic Acid (Aredia)
☐ Etidronate (Didronel)	☐ Raloxifene (Evista)	☐ Teriparatide (Forteo)
☐ Alendronate (Fosamax)	☐ Calcitonin (Miacalcin)	☐ Ibandronate (Boniva)
OTHER		
☐ Acetaminophen (Tylenol)	☐ Lidocaine	☐ Pramipexole (Mirapex)
☐ Ropinirole (Requip)		

Have you tried any Over the Counter Medications such as BioFreeze, Icy Hot, Bengay, Aspercreme? ☐ No ☐ Yes

Have you ever tried Prescription Creams such as EMLA Cream, Voltaren Gel, etc for your pain? ☐ No ☐ Yes

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History

PAST MEDICAL HISTORY No Known Medical Problems ☐

- ☐ Adrenal Disorders
- ☐ Alcohol Abuse
- ☐ Anxiety Disorder
- ☐ Asthma
- ☐ Bipolar Disorder, Nos
- ☐ Breast Disorders
- ☐ Cancer, place (please specify) _____
- ☐ Constipation
- ☐ Congestive Heart Failure
- ☐ Coronary Heart Disease
- ☐ Crohn's Disease
- ☐ Cystitis
- ☐ Depression
- ☐ Diabetes Mellitus
- ☐ DVT
- ☐ Emphysema
- ☐ Epilepsy & Seizures
- ☐ Fatty Liver
- ☐ Fibromyalgia
- ☐ Gastric Ulcer
- ☐ Glaucoma
- ☐ Gum & Periodontal Disease
- ☐ Gynecologic Disorders
- ☐ Headache
- ☐ Head Injury
- ☐ Heart Attack
- ☐ Hepatitis B Virus (Serum)
- ☐ Hepatitis C Virus
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV Infection
- ☐ Irritable Bowel Syndrome
- ☐ Multiple Sclerosis
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Pancreatitis
- ☐ Peripheral Vascular Disease
- ☐ Prostate Disorders
- ☐ Reflux (GERD)
- ☐ Renal Insufficiency
- ☐ Renal Failure
- ☐ Rheumatoid Arthritis
- ☐ Skin Disorders
- ☐ Sleep Disorder
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Disorders
- ☐ TIA (mini stroke)
- ☐ Underweight
- ☐ Misc: _____ _____ _____

PAST SURGICAL HISTORY No Known Surgery ☐

- ☐ Abdominal Surgery
- ☐ Angioplasty
- ☐ Appendectomy
- ☐ Breast Surgery
- ☐ Bladder Surgery
- ☐ Cervical Fusion
- ☐ Cesarean Section
- ☐ Cholecystectomy (gallbladder)
- ☐ Digestive System Surgery
- ☐ Ear Surgery
- ☐ Endarterectomy
- ☐ Eye Surgery
- ☐ Gastric Surgery
- ☐ Heart Surgery
- ☐ Hysterectomy
- ☐ Kidney Surgery
- ☐ Liver Surgery
- ☐ Oral Surgery
- ☐ Prostate Surgery
- ☐ Skin Surgery
- ☐ Surgery for Aneurysm Repair
- ☐ Throat Surgery
- ☐ Thyroid Surgery
- ☐ Tonsillectomy
- ☐ Tubal Ligation
- ☐ Thoracic Fusion
- ☐ Vertebro/kyphoplasty
- ☐ Lower Back Surgery
- ☐ Right Shoulder Surgery
- ☐ Left Shoulder Surgery
- ☐ Right Wrist Surgery
- ☐ Left Wrist Surgery
- ☐ Right Hand Surgery
- ☐ Left Hand Surgery
- ☐ Right Hip Surgery
- ☐ Left Hip Surgery
- ☐ Right Knee Surgery
- ☐ Left Knee Surgery
- ☐ Ankle Surgery
- ☐ Misc: _____

SOCIAL HISTORY

MARITAL STATUS

- ☐ Never Married
- ☐ Engaged
- ☐ Married
- ☐ Remarried
- ☐ Single
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

LIVING SITUATION

- ☐ Living Homebound
- ☐ Living with Parents
- ☐ Living with Relatives ***(not parents)***
- ☐ Living alone - no help available
- ☐ Living alone - help available
- ☐ Living with Adult Children
- ☐ Living Independently with Spouse
- ☐ Living with a Friend
- ☐ Living with Family

WORK STATUS

- ☐ Working Full-Time
- ☐ Working Part-Time
- ☐ Applying For Disability Comp
- ☐ Currently On Partial Disability
- ☐ Retired
- ☐ Unemployed
- ☐ Never Substantially Employed
- ☐ Currently on Permanent Disability

Family History

☐ FAMILY HISTORY UPDATED DATE: _____ ☐ FAMILY HISTORY (free text): _____

	FAMILY	FATHER	MOTHER	BROTHER	SISTER
Denies significant illness	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐
Anxiety Disorder	☐	☐	☐	☐	☐
Bleeding Problems	☐	☐	☐	☐	☐
Cancer, NOS	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Diabetes Mellitus	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐	☐
Lupus	☐	☐	☐	☐	☐
Mental (Psych) Disorder	☐	☐	☐	☐	☐
Migraine Headache	☐	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐	☐
Progressive Muscular Dystrophy	☐	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐	☐
Seizure Disorder	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Thyroid Disorders	☐	☐	☐	☐	☐

Symptom Review

CONSTITUTIONAL

Fever (as symptom) ☐Y ☐N
Chills (as symptom) ☐Y ☐N
Recent weight gain (_____ lbs) reported ☐Y ☐N
Recent weight loss (_____ lbs) reported ☐Y ☐N

EYES

Vision Problems ☐Y ☐N

ENT

Loss of Hearing ☐Y ☐N

CARDIOVASCULAR

Chest Pain or Discomfort ☐Y ☐N

RESPIRATORY

Shortness of Breath ☐Y ☐N

PSYCH

Anxiety ☐Y ☐N
Poor Sleep ☐Y ☐N
Depression ☐Y ☐N

GI

Nausea ☐Y ☐N
Vomiting ☐Y ☐N
Diarrhea ☐Y ☐N
Constipation ☐Y ☐N

GU

Urinary Loss of Control ☐Y ☐N
Date of Last Menstruation: _____ ☐Y ☐N
Pregnancy ☐Y ☐N

SKIN

Rash ☐Y ☐N

NEUROLOGIC

Frequent Falls While Walking ☐Y ☐N

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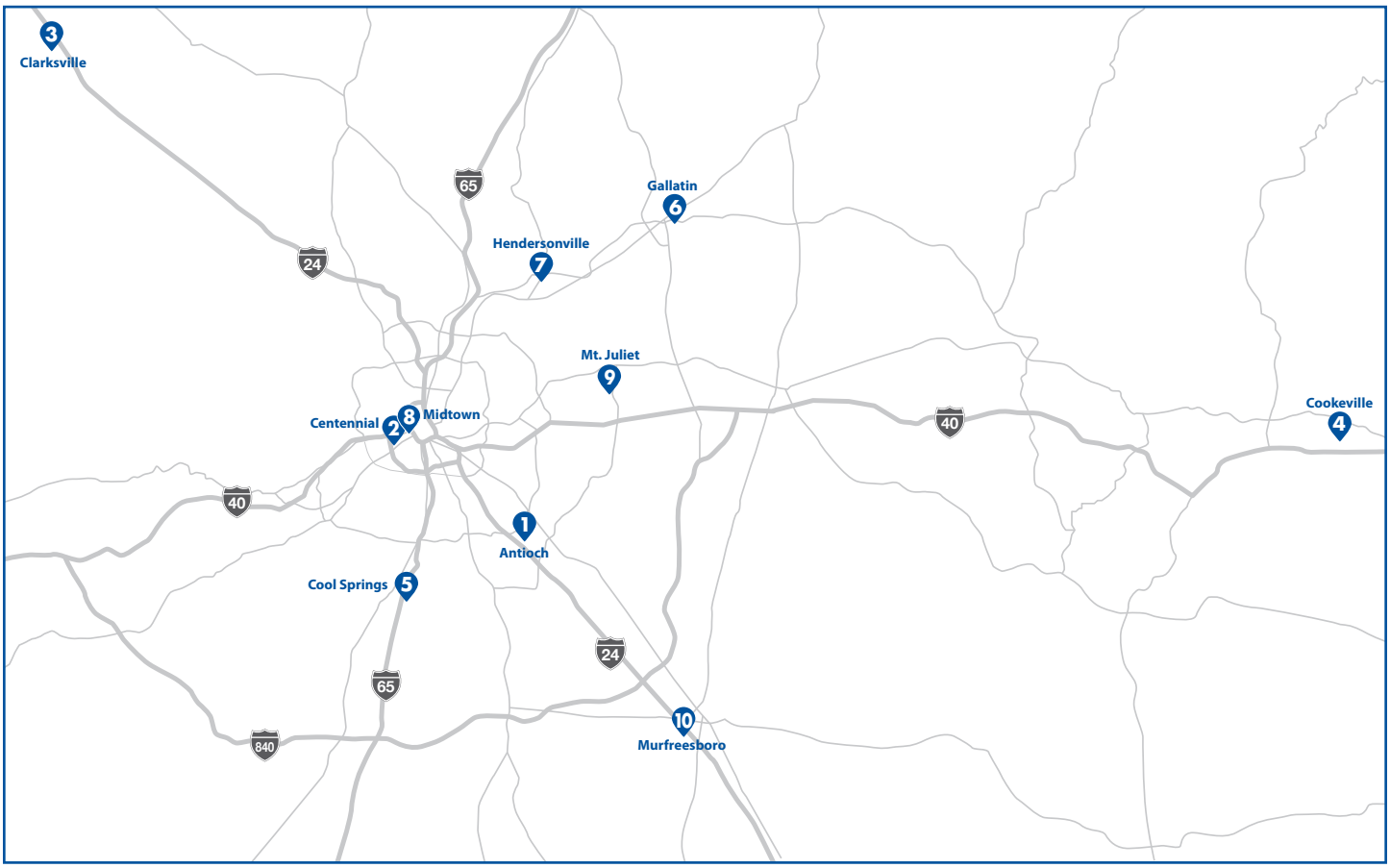

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