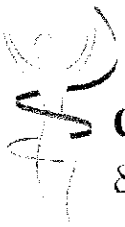

Carolina Pain
& Weight Loss

Carolyn Davis, MSN, FNP-BC
Jennifer McLane, ANP-BC
Amy Heusinger, ANP-BC
Lee-Marie Hinson, MSN-FNP-C
William N Carlson. PA-C
Pain Management Specialists

NEW PATIENT INFORMATION RECORD

Failure to complete this entire form PRIOR to your appointment may result in rescheduling. This information is kept confidential and will be available to your health care team.

PLEASE BRING THIS COMPLETED FORM WITH YOU ON YOUR NEXT VISIT

Today's Date:____/____/_____

Last Name:_____ First:_____ MI:_____

Date of Birth:____/____/_____ Social Security #:_____ Sex:_____ Age:_____

Home Phone: _____ Mobile Phone:_____

Address:_____ City:_____ State:____ Zip:_____

E-mail :_____

Marital Status:_____ Spouse's Name:_____

Referring Physician: _____ **Telephone:** _____

Primary Care Physician: _____ **Telephone:** _____

AUTO/WORK RELATED INJURY DISCLOSURE

Are services you are being treated for today related to an ***automobile accident*** **or** ***work related*** injury?

_____ **YES** _____ **NO**

Patient Signature* _____ Date: _____

****By signing above, you agree to be responsible for all charges your insurance denies as being related to an open worker's compensation or motor vehicle accident claim.***

PHARMACY INFORMATION

Name of Pharmacy_____ Phone_____

BY SIGNING HERE, I ACKNOWLEDGE ALL INFORMATION IS CURRENT AND ACCURATE

Patient Signature: _____ **Date:** _____

- **The pain is described as:** _____

_____

_____

- **The pain is associated with:** (please check those that apply to you)

Decreased function_____ Change in appetite_____ Poor sleep_____
Anger_____ Fatigue_____ Weight gain
Anxiety_____ Headache_____ Depression_____
Blurred vision_____ Numbness_____

- Where was your **MRI** completed at? _____

_____

- **Check off the following medications that you have EVER taken before:**

Morphine _____ Belbuca _____ OxyContin _____
Hydrocodone _____ Butrans patch _____ Dilaudid _____
~~Oxycodone (Percocet)~~ _____ ~~Fentanyl patch~~ _____ ~~Suboxone~~ _____
Oxymorphone _____ Nucynta _____ Tramadol _____

- **Previous Treatment includes:**

Trigger Point Injections_____ Surgery_____
Epidural Injections_____ Chiropractic Adjustments_____

- Please list any **previous pain clinics** that you have been treated at:

Facility Name: **Doctors Name:**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

- Please list all your current medications below (include over-the-counterdrugs)

If you have a list, please hand to the nurse to copy (not front desk). Do not write meds down again!!

MEDICATION NAME	ALLERGIES

- List all **MAJOR Surgeries** which you have had in the past:

Name of Surgery	Hospital/Facility and Year

- Please list any **MAJOR medical history** regarding family members:

Family Member:	Medical History:

Do you have children? ( )yes ( )no

- Do you drink alcohol? ( )yes ( ) no
- Do you ever have suicidal thoughts? ( ) yes ( )no
- Marital Status? ( )Married ( )Single ( )Divorced ( )Widowed
- Work Status? ( )Full Time ( )Part Time ( )Unemployed ( )Retired ( )Disability
- Do you use recreational or illegal substances? ( )yes ( ) no
- Do you smoke tobacco? ( )yes ( ) no
- Have you ever been treated for addiction? ( )yes ( )no ( )Drug ( )Alcohol
    - If yes, where were you treated for this addiction? _____

REVIEW OF SYSTEMS

Cardiovascular:	YES	NO
Chest pain/Angina	___	___
Irregular Heart Beat	___	___
High Blood Pressure	___	___

Gastrointestinal:		
Frequent Constipation	___	___
Frequent Diarrhea	___	___
Heartburn/Indigestion	___	___
Nausea	___	___
Incontinence of stool	___	___

Hematologic:		
Taking blood thinners	___	___
Frequent nose bleeds	___	___
Bleeding problems	___	___

Genitourinary:		
Kidney problems	___	___
Kidney stones	___	___
Problems urinating	___	___
Sexual Problems	___	___

Musculoskeletal:		
Muscle Pain	___	___
Arthritis	___	___
Skin color/temp change	___	___

Constitutional:		
Frequent fevers	___	___
Recent weight loss	___	___
Recent weight gain	___	___
Frequent night sweats	___	___

Allergic/Immunologic:		
Wheezing	___	___
Itching	___	___

Respiratory:	Yes	NO
Current Smoker	___	___
Snoring	___	___
Chronic cough	___	___
Shortness of breath	___	___

Neurological:		
Seizures/Epilepsy	___	___
Numbness	___	___
Weakness	___	___
Headaches	___	___
Dizziness	___	___
Restless legs	___	___

Endocrine:		
Thyroid problems	___	___
Liver problems	___	___
Diabetes	___	___

Emotional/Psychiatric:		
Depression	___	___
Anxiety/Panic	___	___
Irritability	___	___
Suicidal thoughts	___	___

Ophthalmologic:		
Blurred vision	___	___
Eye discharge	___	___

Ears, Nose, Throat:		
Hearing loss	___	___
Bleeding gums	___	___
Problems swallowing	___	___

Integumentary:		
Rash/hives	___	___
Blistering of skin	___	___
Skin Cancer	___	___

SOAPP

Name: _____ Date: _____

The following are some questions given to all patients at Carolina Pain and Weight Loss who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you have mood swings?	0 1 2 3 4
2. How often do you smoke a cigarette within an hour after you wake up?	0 1 2 3 4
3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	0 1 2 3 4
4. How often have any of your close friends had a problem with alcohol or drugs?	0 1 2 3 4
5. How often have others suggested that you have a drug or alcohol problem?	0 1 2 3 4
6. How often have you attended an AA or NA meeting?	0 1 2 3 4
7. How often have you taken medication other than the way that it was prescribed?	0 1 2 3 4
8. How often have you been treated for an alcohol or drug problem?	0 1 2 3 4
9. How often have your medications been lost or stolen?	0 1 2 3 4
10. How often have others expressed concern over your use of medication?	0 1 2 3 4
11. How often have you felt a craving for medication?	0 1 2 3 4
12. How often have you been asked to give a urine screen for substance abuse?	0 1 2 3 4
13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0 1 2 3 4
14. How often, in your lifetime, have you had legal problems or been arrested?	0 1 2 3 4

Carolina Pain
& Weight Loss

Carolyn Davis, FNP-C, MSN
Pain Management Specialist

ACKNOWLEDGEMENT OF POLICIES AND PRIVACY PRACTICES

INSURANCE AUTHORIZATION

I hereby authorization Carolina Pain and Weight Loss to share information with hospitals and physicians, my insurance carriers, worker's compensation companies, attorneys, etc. concerning my illness and treatment.

ASSIGNMENT OF BENEFITS

I hereby assign to Carolina Pain and Weight Loss all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance.

TREATMENT AUTHORIZATION

I hereby authorize Carolina Pain and Weight Loss to render health care to me during my visit.

CONSENT TO USE VIRTUAL MEDICAL SCRIBE

Our microphone-equipped exam rooms allow Virtual Medical Scribe assistants to listen and transcribe your visit into our Electronic Medical Records charting system. This courtesy service provides a more accurate record quickly and helps your provider focus on your well-being.

PRIVACY NOTICE

I have been given the option to review Carolina Pain and Weight Loss "Notice of Privacy Practices" that explains how my personal health information will be used. I am also aware that I may request a copy of the "Notice of Privacy Practices" at any time.

Signature: _____ Date: _____

Witness: _____ Date: _____

Pain Treatment with Opioid Medications: Patient Agreement

I, _____, understand and voluntarily agree that:
(INITIAL each statement)

_____ I will keep (and be on time for) all of my scheduled appointments with the provider and other members of the treatment team.

_____ I understand that the goal of this medicine is to improve my ability to work and function at home and to help my pain as much as possible without causing dangerous side effects.

_____ I will participate in all other types of treatment that I am asked to participate in.

_____ I will keep the medication safe, secure, and out of reach of children. If the medication is lost or stolen, I understand it will not be replaced until my next appointment, and may not be replaced at all.

_____ I will take my medication as instructed and not change the way I take it without first talking to the provider or other members of the treatment team.

_____ I will not call between appointments, at night, or over the weekends looking for refills. I understand that prescriptions will only be filled during scheduled office visits with the treatment team.

_____ I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.

_____ I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

_____ I will not sell this medication or share it with others. I will not take anyone else's medication. I understand that if I do, my treatment will be stopped.

_____ I will sign a release form to let the provider speak to all other doctors or providers that I see.

_____ I will tell the provider all other medications that I take, and make him/her aware right away if I have a prescription for a new medication.

_____ I will use only one pharmacy to get all of my medications: _____
(PHARMACY NAME/PHONE #)

_____ I will not get any opioid pain medication or other medications that can be addictive such as benzodiazepines (Klonopin, Xanax, Valium, etc.) or stimulants (Ritalin, amphetamine, etc.) without telling a member of the treatment team before I fill that prescription.

_____ I will not use illegal/illicit drugs (heroin, cocaine, marijuana, methamphetamine, etc.) I understand that if I do, my treatment may be stopped.

_____ I will comply with the counting of my pills before 4 pm on the day I am called. I understand that I must make sure the office has current contact information in order to reach me, and that any missed pill counts may result in discharge.

____I will keep up-to-date with any bills from the office and tell my provider, or member of the treatment team immediately if I lose my insurance or cannot afford treatment any longer.

____I understand that I may become addicted to this medication. If anyone in my family has a history of drug or alcohol abuse, there is a higher chance of addiction.

____I understand that I may lose my right to treatment in the office if I break any part of this agreement.

Pain Treatment Program Statement

We here at Carolina Pain and Weight Loss are making a commitment to work with you in your efforts to get better. To assist you in this work, we agree that:

We will help you schedule regular appointments for medication refills. If we have to cancel or change your appointment for any reason, we will make sure you have enough medication to last until your next visit.

We will make sure that this treatment is as safe as possible. We will check regularly to make sure you are not having any negative side effects.

We will keep track of your prescriptions and test for drug use regularly to help you feel like you are being well-monitored.

We will help connect you with other forms of treatment to help you with your condition. We will help set treatment goals and monitor your progress in achieving those goals.

We will work with any other doctors or providers you are seeing so that they can treat you safely and effectively.

We will work with your medical insurance providers to make sure you do not go without medication because of paperwork or other things they may ask for.

If you become addicted to these medications, we will help you get treatment and get off of the medications that are causing you problems safely, without getting sick.

Patient Name Printed	Date	Patient Signature

Carolina Pain
& Weight Loss

FINANCIAL POLICY

Thank you for choosing Carolina Pain and Weight Loss for your pain management and weight loss needs. Our main concern is that you receive the proper and optimal care needed to maintain and/or restore your health. We also believe that it is important to understand our financial policies.

Please present your current insurance card at each visit so we can correctly submit your claims in a timely manner to your insurance plan(s). If you do not have your current insurance card at the time of visit, we may need to reschedule your appointment or may ask you to pay for your services in full for that day. If at any time your insurance changes, please notify us immediately of the change to accurately file claims on your behalf. If we cannot verify your current insurance coverage and cannot file the claim in the necessary time period as mandated by your existing insurance plan, you will be responsible for all charges. In the event we do not participate with your insurance plan and it does not have an out-of-network benefit, you may be responsible for payment of all charges.

We participate with most insurance plans and will file the necessary insurance claims on your behalf for in-network insurance plans and most out-of-network plans. Please remembers that insurance is a contract between you, the patient, and your insurance plan(s) and it is ultimately your responsibility to pay the portion of the bill for services rendered that is not paid by your insurance plan(s)(unless otherwise restricted by law or an agreement we, as a network provider, may have with the insurance plan).

Payment is expected at the time of service. Payment will need to include any copayment, deductible and/or coinsurance. Any non-covered services will need to be paid in full on the date of service. Any past due balances will need to be reconciled prior to seeing the provider. Unresolved balances may be placed with an outside collection agency at the discretion of Carolina Pain and Weight Loss. If you do not have insurance coverage at the time of your appointment, payment in full is expected at the time of your visit. For any new self-pay patient without participating insurance coverage, payment in cash will be required at the time of the appointment. For established patients and participating insurance plans, we accept cash, Discover, Visa, MasterCard, American Express and Diners Club International for your convenience.

I agree to abide by the terms of the above financial policy and accept responsibility for any balances not covered by my insurance plan(s). I authorize my insurance plan(s), or any other applicable parties to pay Carolina Pain and Weight Loss and/or provide any information regarding payment of my bill.

_____ _____

Patient Signature Date

_____

Print Name

Carolina Pain
& Weight Loss

MEDICAID-CAROLINA ACCESS WAIVER

I, _____, am aware that I may be financially responsible for any visit(s) at Carolina Pain and Weight Loss for any or all of the reasons listed below:

- If Carolina Pain and Weight Loss cannot verify my Medicaid eligibility coverage at the time of my appointment of it my coverage retroactive terminated after my scheduled appointment.
- For any deductible, co-insurance and/or copayments as specified by Medicaid
- In the event I do not have my Medicaid card as proof of coverage with me at the time of any appointment.
- There is no referral on file allowing me to seek the services of Carolina Pain and Weight Loss.
- Any non-covered service in which Carolina Pain and Weight Loss has given me proper notification that the service is a non-covered benefit.
- Any visit(s) in excess of the legislative annual visit limit for provider visits for the state fiscal year as determined by Medicaid

I have been informed by Carolina Pain and Weight Loss that due to the listed circumstance(s) above, I may be financially responsible for all charges incurred at the time of my visit(s). By deciding to keep my scheduled appointment(s) and seeking the services of Carolina Pain and Weight Loss, I agree to pay any charges related to my appointment- that are not covered by Medicaid within thirty days of receipt of notification from Carolina Pain and Weight Loss for services incurred.

_____ _____

Patient Date

_____ _____

Parent/Legal Guardian Date

_____ _____

Witness Date

PATIENT APPOINTMENT POLICY

Striving to Get You In, Out, and On Your Way

Please take a few minutes to review our no-show policy and sign at the bottom of the form. If you have any questions please let us know.

Definition of a "No-Show" Appointment; Carolina Pain and Weight Loss defines a "No-show" appointment as any scheduled appointment in which the patient either:

- Does not arrive to the appointment
- Cancels with less than 2 hours' notice
- Arrives more than 5 minutes after an appointment time and is consequently unable to be seen

In an attempt to cut down on costs and frustration for everyone, Carolina Pain and Weight Loss has implemented a new appointment policy. It is appreciated that patients call ahead if you will be running late so we can reschedule or offer you a later appointment if available. If you are unable to make the appointment entirely, you will need to call us **no later than 2 hours prior to your appointment time.** In the event that you fail to provide us with the requested 2 hour cancellation notice or miss your appointment altogether (see reasons above), there will be a **$50.00 charge due at the time you reschedule the missed appointment.**

"No-Show" appointment has a significant negative impact on our practice and the healthcare we provide to our patients. When a patient "no-shows" a scheduled appointment it:

- Potentially jeopardizes the health of the "no-showing" patient
- Is unfair (and frustrating) to other patients that would have taken the appointment slot
- Disrespects not only the provider's time, but also the time of the entire staff

Multiple no-shows and excessive cancellations may results in your being discharged.

Always **arrive 15 minutes prior to your scheduled visit.** This allows time for you and our staff to address any insurance, balance or billing questions and or to complete any necessary paperwork before the scheduled visit.

By signing below you acknowledge that you have read and accept the above policies and will adhere to them to the best of your ability aside from extenuating circumstances.

_____ _____ ____/____/____

(patient name printed) (patient signature) (date)

____/____/____

(patient date of birth)

Carolina Pain
& Weight Loss

Patient Update Form

Patient Name_____ **Date of Birth**_____
Address_____
City_____ **State**_____ **Zipcode**_____
Primary Phone_____ **Secondary Phone**_____
Primary Care Doctor_____

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each box that can be given to person/entity listed on the left.
Voice Mail Use ☐ Home # ☐ Cell #	☐ Appointment reminders ☐ Medical Info (including results) ☐ Financial
☐ Spouse (provide name & phone number) Name Phone	☐ Appointment reminders ☐ Medical Info (including results) ☐ Financial
☐ Parent (provide name & phone number) Name Phone	☐ Appointment reminders ☐ Medical Info (including results) ☐ Financial
☐ Other (provide name & phone number) Name Phone	☐ Appointment reminders ☐ Medical Info (including results) ☐ Financial
☐ Email (provide email address)	☐ Appointment reminders ☐ Medical Info (including results) ☐ Financial ☐ Breach notification

I elect to receive email and understand that email may not be sent in an encrypted manner and there is a risk it could be accessed inappropriately.

- I have the right to revoke this authorization at any time.
- I may inspect or copy the PHI to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I authorize the individual(s) listed above to have access to my medical information.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

_____ _____

Patient Signature or Personal Representative **Date**