General Information

Your initial visit at Pain Care Consultants will be with one of our Board Certified pain management physicians. After visiting with the physician, you will receive a comprehensive treatment plan. We use a multidisciplinary approach to treat pain, so your plan may include diagnostic/therapeutic procedures, physical therapy, psychological evaluation/treatment, medication management, lab tests, and/or radiological examinations. For your convenience, we offer a majority of these treatments at many of our office locations.

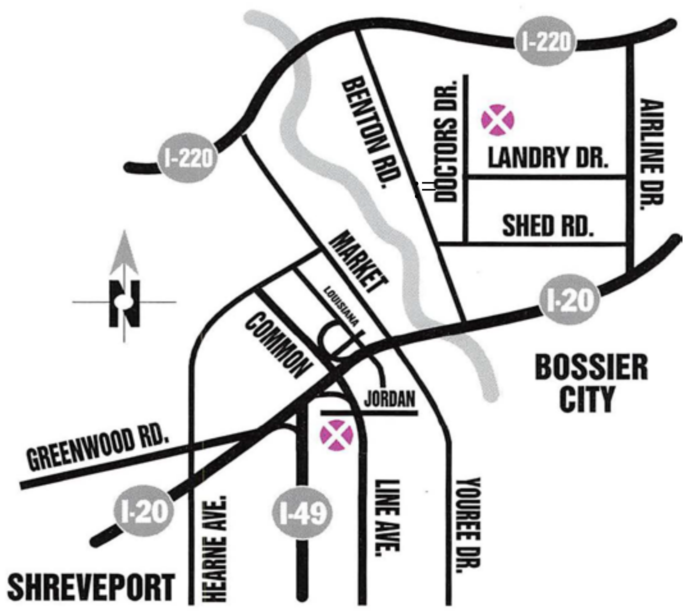
DIAGNOSTIC/THERAPEUTIC PROCEDURES
Depending on your situation, your physician may prescribe an injection that may be used for diagnosis and/or treatment. The details of the injection will be explained by your medical provider and through educational materials.

PHYSICAL THERAPY
Through exercise, massage, and stretching, physical therapy can increase your strength, improve the movement of your joints, decrease your pain, and improve your function.

PSYCHOLOGICAL EVALUATION/TREATMENT
Behavioral Health therapists working with patients that suffer with chronic pain are not trying to decide whether a patient's pain is real or imaginary. We understand that we cannot visualize pain and that it is real to the person that suffers with it every day. Pain can affect multiple parts of your life, including your ability to participate in your hobbies or job, interact with your family members, or even perform simple household chores. This can lead to significant frustration and possibly even depression. Behavioral Health therapists can help with these problems by using psychology-based treatment approaches that can reverse some of these effects of pain. Our goal is to help you regain the life you had before you started experiencing pain.

MEDICATION MANAGEMENT
All medications have the potential for side effects and may require multiple adjustments to find the best dosage that reduces your pain while minimizing side effects. These adjustments will typically take place during your office visits.

Directions



1534 Elizabeth Avenue Location:

1-20 Eastbound- From 1-20 take Line Ave. exit and merge right onto Line Ave. Turn right on Jordan St. then left on Elizabeth Ave. Take the second entrance on the right into the parking lot. Patient drop off is at the tower entrance under the breezeway on your left side. Office is located on the 2nd floor in Suite 201. You may park in the front or go through the breezeway and park in the back parking lot.

1-20 Westbound- Take Common St. exit and veer right in circle. Turn right onto Louisiana Ave. right on Fairfield and left onto Line Ave. Go under I-20 and continue uphill to Jordan. Turn right on Jordan St. then left on Elizabeth Ave. Take the second entrance on the right into parking lot. Patient drop off is at the tower entrance under the breezeway on your left side. Office is located on the 2nd floor in Suite 201. You may park in the front or go through the breezeway and park in the back parking lot.

2005 Landry Drive Location:

1-20 Eastbound- From 1-20. take Airline Drive Exit. Turn left on Airline Drive under 1-20 heading North for approximately 1 mile to Airline Drive and Shed Road through the intersection and turn onto the first street on the left which is Landry Drive.

1-20 Westbound- From 1-20. take Airline Drive Exit. Turn right and go approximately 1 mile to Airline Drive and Shed Road through the intersection and turn onto the first street on the left which is Landry Drive.

1-220- Take Airline Drive Exit. Drive South on Airline Drive for approximately 3 miles. Go over railroad tracks and turn onto the first street on the right which is Landry Drive.

1534 Elizabeth Avenue, Suite 201 • Shreveport, LA 71101
318/629-5505 (Phone) • 318/629-5506 (Fax)
www.paincarela.com

OFFICE POLICIES

Emergencies

If you feel you have a life-threatening emergency, dial 911 or go to your nearest emergency facility.

Calls to the Office

If you have any questions or concerns, please feel free to contact our office. Someone will return your call as soon as possible, usually within 24 hours. Many times we return calls at the end of the day. If the matter is an emergency and cannot wait until the end of the day for a response, please let us know when you call.

Financial Policy

Please read our financial policy that is enclosed with your New Patient Forms. For more information, you can contact our office at 318-629-5505.

Insurance

- We will bill your insurance company for services rendered. You are responsible for any amount that your insurance company does not pay, or co-pay if you are in an HMO or PPO. Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. You are responsible for the full amount if your insurance fails to pay promptly.
- Not all of our physicians are members of HMO and PPO plans. Please be sure to ask in advance if the doctor you are about to see belongs to your particular insurance plans. If your insurance company sends you payment for services, you are responsible for forwarding it to our office.
- We are participating providers for Medicare. We will file your Medicare and secondary insurance. If you do not have a secondary insurance carrier, we must bill you for the 20% of the Medicare allowable. You will be billed for any procedure not covered by Medicare.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Cancellation of Appointments

We understand that circumstances can occur that make it necessary for you to cancel or reschedule an appointment. Please contact us at least 24 ahead of time, if you need to cancel or reschedule your appointment. Our policy is to charge for missed appointments at the rate of a normal office visit. Regardless if you have private insurance or Workers' Compensation, you will be responsible for this charge at the time of your next visit.

Prescriptions
Refills for prescriptions will require an office visit. Be sure to bring a list of your medications to all office visits.

- **Medications WILL NOT be renewed over the phone from your pharmacy**
- **There will be NO PHONE-IN REFILLS**
- **You MUST PICK UP a prescription in the office**
- **Patients MUST OBTAIN ALL PRESCRIPTIONS before leaving the office**
- **We DO NOT DEAL WITH MAIL-IN PHARMACIES – If you MUST USE A MAIL-IN PHARMACY for NON-CONTROLLED MEDICATIONS, you MUST DEAL WITH THEM YOURSELF.**
- **You MUST obtain opioid (pain) medication locally**
- **We are not responsible if the actions of the pharmacy result in your running out of medication.**

Medical Records
Copies of records or requests for transfer of records to other physicians must be done in writing. Please contact our medical records department at (318) 629-5505 or fax requests to (318) 629-5506. As a courtesy to our patients, we do not charge CURRENT patients or physician offices for medical records requests.

Any other entity requesting medical records will be subject to costs as the following rate: $1 per page for the first 25 pages, $.50 for pages 26-500 and $.25 per page thereafter and a handling charge of $7.50. These reasonable cost limitations were set forth by the Louisiana Revised Statues 40:1299.96. This charge is payable in advance when the forms are submitted to us for completion.

Please allow five (5) working days to complete requests.

Medical Forms
There will be a $25 charge per form and this charge is payable when the forms are submitted to us for completion. For FMLA and disabilities forms, these are completed on a case by case basis.

At least seven working days are necessary to complete paperwork. Medical forms CANNOT be completed on the days you are seen by one of our physicians.

Musculoskeletal Institute of Louisiana

Orthopedic Specialists of Louisiana • Pain Care Consultants

Patient Registration Form

Date ________________

Patient Information

Name:____ Social Security Number: ____________________

Street Address: __________________________________ Date of Birth:____________________ Age: ________

City/State/Zip:___________________________________ Gender: ☐Male ☐Female

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed Email: ______________________________

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino Race: ______________________________

Preferred Language: ☐English ☐Spanish ☐Other ________ Communication Needs: ____________________

Preferred Phone: ______________________________ ☐Home ☐Mobile ☐Work

Secondary Phone: ______________________________ ☐Home ☐Mobile ☐Work

Employer:____________________________________ Occupation:______________________________

Emergency Contact Name: ________________________ Phone:________________Relationship: __________

Primary Insurance Plan

Payer (e.g. BC/BS): ____________________________ Plan Number:______________________________

Policy/I.D. Number:____________________________ Group Number:_____________________________

Secondary Insurance Plan (if any)

Payer (e.g. BC/BS):____________________________Plan Number: ______________________________

Policy/I.D. Number:____________________________Group Number: _____________________________

Workers Compensation Claim Information

Is your visit today a Work Related Injury? ☐Yes ☐No If **Yes** have you reported to your employer? ☐Yes ☐No

Employer: __________________________________ Phone Number: ______________________________

Third Party Liabilty (MVA or Slip & Fall)

Is your visit today related to a MVA or Slip & Fall? ☐Yes ☐No If **Yes** have you contacted an attorney? ☐Yes ☐No

Attorney Name: ______________________________ Date of Accident: ____________________________

Referral

Referring Physician: __________________________ Primary Care Physician: ______________________

Medicaid/Medicaid Replacement

Please be advised that Musculoskeletal Institute of Louisiana (d/b/a Orthopedic Specialists of Louisiana and Pain Care Consultants) is **NOT** a participating provider in the MEDICAID/MEDICAID REPLACEMENT programs and Musculoskeletal Institute of Louisiana **WILL NOT** file MEDICAID/MEDICAID REPLACEMENT. If you request treatment by one of our physicians, you must agree to be personally responsible for payment IN FULL for all charges related to your treatment.

I agree that Musculoskeletal Institute of Louisiana, LLC may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

I Hereby Authorize Musculoskeletal Institute of Louisiana, LLC to release any medical information and/or medical records maintained at this clinic as needed to my insurance company, to the social security administration or carriers, to my attorney, or to the attorney responsible for the payment for medical services or evaluation to be provided. I permit a copy of this authorization to be used in place of the original. I hereby assign to the facility listed above all Insurance Company or Medicare reimbursements for medical and/or surgical expenses. Regulations pertaining to Medicare assignment of benefits apply. I have been given a copy of the Notice of Private Practices of Musculoskeletal Institute of Louisiana, LLC.

I have been informed that Musculoskeletal Institute of Louisiana, LLC is NOT a participating provider in MEDICAID/MEDICAID REPLACEMENT programs and that Musculoskeletal Institute of Louisiana WILL NOT file MEDICAID/MEDICAID REPLACEMENT.

____ ____________________

Signature (Patient or Responsible Party) Date

Musculoskeletal Institute of Louisiana

Orthopedic Specialists of Louisiana • Pain Care Consultants

FINANCIAL POLICY and CONTRACT WITH PATIENT

Thank you for choosing us as your health care provider. We are committed to providing our patients with the best treatment possible. We hope that you understand that our credit and collection policies are a necessary part of assuring the financial resources needed to maintain this vital health care facility for our patients and community.

Our charges for your care are considered to be the usual and customary charges in line with what other specialists in this geographical area charge their patients. You are responsible for payment of your bill in full, regardless of your insurance company's determination of usual and customary charges for this area. The only exceptions for this are if you are covered by Medicare or you are covered by a PPO or HMO for which we are a provider of services.

STATEMENT OF RESPONSIBILITY

By signing below, I hereby enter into a contract with MUSCULOSKELETAL INSTITUTE OF LOUISIANA, LLC, for the furnishing of medical and/or surgical procedures for illness or injury. I understand that I am contractually responsible for the total bill incurred as a result of treatment received. Although I may have insurance coverage, I understand that this is an agreement between me and my insurance carrier to pay certain amounts for my medical care. The obligation to pay my doctor bill is an obligation by me to my doctor. I am totally responsible for payment of my doctor bill in full. This is regardless of the status of any pending insurance claim or the insurance company's determination of usual and customary rates or amount of assignment. I accept full responsibility for payment of the account, and depending upon the circumstances, I may be expected to pay in full at time of service. I hereby acknowledge that I should coordinate personally with my health insurance carrier. I hereby grant MUSCULOSKELETAL INSTITUTE OF LOUISIANA, LLC, its agents and attorneys the right to disclose my confidential health care information for purposes of collection of my bill through contact with any third party or through a lawsuit.

In the event that I am covered by a managed care PPO or HMO for which my doctor is a provider of services, I understand that the clinic will accept the allowable charges and will write off any amount that is disallowed by insurance. **I accept responsibility for payment of my co-pay and/or deductible at time of service, any allowable amount not paid by insurance, and/or treatment my policy does not cover.** I understand that you do accept assignment on Medicare and I will not owe any disallows that are written off of my account. **However, I understand that I am responsible for my deductible, co-pay and any charges not covered by Medicare.**

If I am here as the result of a liability claim, I understand that my doctor cannot wait for settlement of my claim in order to be paid and that payment is due at the time services are rendered. My attorney and/or insurance carrier will be provided with an itemized statement for my reimbursement.

If I am here as the result of an on the job injury and my workman's compensation claim is denied, I understand that I am personally responsible for payment of the bill in full.

In the event that credit is extended to me, I understand that any bill rendered by MUSCULOSKSLETAL INSTITUTE OF LOUISIANA, LLC is due and payable upon receipt of statement. If payment in full creates a financial hardship, the clinic will consider an extended payment plan arrangement. I also understand that I may pay my bill in full at any time by cash, check, or any major credit card. **There is a fee (currently $25) for any checks returned by the bank**. In the event of default in the payment of any amount due and this account is turned over to an agency or attorney for collection or legal action, **I hereby agree to be held liable for my outstanding balance plus, attorney fees of 25% of my balance over 30 days in arrears if the account is forwarded to collection, and all court costs, and judicial interest.** I, the undersigned, have read and understand this contract, and hereby agree to the terms herein.

Date: ________________ Signature: ____

PATIENT/RESPONSIBLE PARTY

ASSIGNMENT OF BENEFITS/AUTHORITY TO RELEASE INFORMATION

I have this date, assigned to MUSCULOSKELETAL INSTITUTE OF LOUISIANA, LLC the benefits due me under my existing policy or policies of insurance. I understand, in so far as they are necessary to cover such expenses, that the above assignment of insurance is accepted by MUSCULOSKELETAL INSTITUTE OF LOUISIANA, LLC as a convenience to me. Said company is hereby given my consent to file claims on said policy and to do such other actions as it deems necessary in connection therewith so as to promptly obtain payment to the company, direct, and without payment to me.

I authorize the release of all medical records to the referring and family physicians, to my insurance carrier, and/or my attorney at law. I allow fax transmittal of my records, if necessary.

Date: ________________ Signature: ____

PATIENT

____ ____

PARENT/GUARDIAN RELATIONSHIP TO PATIENT

Musculoskeletal Institute of Louisiana

Orthopedic Specialists of Louisiana • Pain Care Consultants

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize Musculoskeletal Institute of Louisiana to use or disclose the following protected health information (PHI) from the medical records of the patient listed below:

Patient Name: ____ DOB: _____________________________

Patient Address: ____

Home Phone: ___________________________ Work: _________________________ Mobile: ____________________________

☐ I will pick up copies of my records ☐ Mail copies of my records to the individual noted below

☐ Fax my records to: ______________________ ☐ Provide my records in electronic form

Information is to be disclosed by	And is to be provided to:
Name:	Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:

Purpose of request: ☐ Patient's Request ☐ Dispute ☐ Legal ☐ Referral ☐ Other: ___________________

Information to be disclosed from my health record: *(check appropriate box(es))*

☐ Only the period of events from _______________ to _______________

☐ Recent Progress Notes ☐ Pathology/ Lab Reports ☐ X-Ray Reports/Films ☐ EMG Report

☐ Billing Records ☐ Operative Report ☐ Entire Health Record *(Excludes Psychotherapy Notes)

☐ Other: ____

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment Referral ☐ HIV/AIDS-related Treatment

☐ Mental Health *(Other than Psychotherapy Notes)*

☐ Psychotherapy Notes (If Checking this box, no other boxes may be checked. A separate Authorization to Release/Request for an individual's Health Information must be completed to obtain additional records.)

I understand (Please Initial):

____ I understand that this authorization will expire two years from my last date of service visit. A photocopy of this form will be considered as valid as the original

____ I have the right to revoke this Authorization in writing at any time to Musculoskeletal Institute of Louisiana and the revocation will not apply to information already retained, used, or disclosed in response to this Authorization.

____ **In order to release sensitive information regarding Alcohol/Drug Abuse Treatment/Referral, HIV/AIDS-Related Treatment, Mental Health (other than psychotherapy notes), I must check the appropriate box or boxes. In order to authorize the use or disclosure of Psychotherapy Notes I must only check this specific box on this form. Authorizations for the use or disclosure of other health record information may not be made in conjunction with authorizations pertaining to Psychotherapy Notes. If this box is checked with other boxes, another authorization will be required to authorize the use or disclosure of Psychotherapy Notes Only.**

____ My health care and payment for my health care will not be affected if I do not sign this form.

____ The information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

By signing below, I acknowledge that I have read and understand this Authorization (*a copy of the signed form will be given to you)*

____ ______________________________ __________________

Signature of Patient, Parent or Legal Representative Relationship to Patient Date

Effective Date: October 1, 2001

Reviewed/Revised Date: July 7, 2020

PAIN CARE CONSULTANTS
Prathima Anandi, M.D.
Rama Letchuman, M.D. Kathleen Majors, M.D.
Matthew Mosura, M.D. Ross B. Nelson III, M.D.
Board Certified in Pain Management

CHRONIC NARCOTIC TREATMENT AGREEMENT

WARNING

Narcotics are dangerous drugs.

They can cause very serious side effects and complications including addiction, disability, and death.

I UNDERSTAND AND AGREE TO THE FOLLOWING

That this chronic narcotic treatment agreement relates to my use of any and all medication(s) for chronic pain prescribed by my physician. I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). **Therefore, medication(s) will only be provided so long as I follow the rules specified in this Agreement.**

My physician may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior:

I, ____ (print name), agree to the following:

- I understand that the use of narcotic analgesics (pain medicine) for treatment of pain other than cancer pain is controversial and not routine. Other alternatives have either been tried or offered and are unacceptable to me.
- I will not obtain any other narcotics or other controlled substances from other physicians or dentists including narcotic cough medications, tranquilizers, sleeping pills or sedatives **without prior approval of my pain doctor**. I understand that my surgeon/dentist will not be writing outpatient prescriptions, but rather my pain doctor will be writing my pain prescriptions after surgery, and I need to inform my pain doctor so that my medications can be adjusted after surgery.
- **I WILL NOT OBTAIN OR SEEK NARCOTICS FROM ANYONE OTHER THAN PAIN CARE CONSULTANTS (DRS. ANANDI, LETCHUMAN, MAJORS OR NELSON). I WILL NOT INCREASE, DECREASE, STOP OR ALTER MY DOSE OF NARCOTICS WITHOUT PRIOR APPROVAL OF PAIN CARE CONSULTANTS. I UNDERSTAND THAT INCREASING MY DOSE OF NARCOTIC UNAUTHORIZED OR OBTAINING NARCOTIC PRESCRIPTIONS OUTSIDE OF THIS OFFICE WILL RESULT IN DISCHARGE FROM THIS PAIN PROGRAM.**
- I agree to have Drs. Anandi, Letchuman, Majors, and Nelson obtain my pharmacy records, psychiatric records and medical records.
- I understand that I must notify Drs. Anandi, Letchuman, Majors, and Nelson of any criminal indictment or arrest. I give permission for Drs. Anandi, Letchuman, Majors, and Nelson to obtain information and records regarding criminal indictments, arrests and convictions. I understand that withholding information of past or current criminal charges or convictions will result in discharge from pain management.
- All prescriptions for narcotic medications will be in written form and given to me in the office during follow-up visits. No such medications will be called in by phone.
- I must get my medications from one of the two pharmacies that I have listed and I must notify you if I change pharmacies at any time.

Pharmacy Name: ____ **Phone** ____________________________

Pharmacy Name: ____ **Phone** ____________________________

1534 Elizabeth Avenue, Suite 201 • Shreveport, LA 71101
318/629-5505 (Phone) • 318/629-5506 (Fax)
www.paincarela.com

- **AS PER STATE REGULATIONS, I UNDERSTAND THAT I MUST KEEP MY FOLLOW-UP OFFICE APPOINTMENTS, MINIMUM OF EVERY 3 MONTHS. IT IS MY RESPONSIBILITY TO KEEP MY OFFICE VISIT APPOINTMENTS. MY DOCTOR MAY REQUEST MORE FREQUENT VISITS AND I AGREE TO BE SEEN AS SCHEDULED.**
- I will submit to drug testing on a random basis. If unprescribed drugs are found in my blood, saliva or urine, or excessive levels of prescribed drugs are found, or if prescribed drugs are not found in expected amounts, all medications will be discontinued as per my doctor's instructions and I will have to find another physician to treat my pain.
- I agree to undergo psychological and/or psychiatric evaluation, including psychometric testing. This will be used to determine my suitability for chronic narcotic, invasive, or other treatment for my pain.
- I understand that operating any type of automobile, other vehicle, machinery, or any potentially hazardous device may be dangerous while taking narcotics. Therefore I will exercise extreme caution when undertaking such tasks. I will not perform any potentially hazardous task while taking narcotics. Because narcotics can decrease mental function, I will not make any important decisions or commitments without consulting responsible and trusted advisors while taking narcotics.
- I understand that it is illegal for me to transport narcotics in any container other than my original prescription bottle. I will keep my narcotics locked up in a safe to prevent loss or theft. I will remove only the amount of medicine for my immediate use to prevent loss of the entire stock. If my medication is lost or stolen, I will contact Pain Care Consultants as soon as possible. **I UNDERSTAND THAT LOST OR STOLEN MEDICATIONS OR PRESCRIPTIONS WILL NOT BE REPLACED.**
- I will not give away any of my medication, loan my medication or sell my medication. I understand that doing any of the above is illegal and a violation of federal and state drug laws and also a violation of our office narcotic treatment agreement and will result in immediate discharge from the pain management program.
- I agree to actively participate in physical therapy, counseling. **or any other forms of treatment** as recommended by my physician.
- **IF MY PAIN IS NOT <u>WELL CONTROLLED</u> WITH NARCOTICS, I UNDERSTAND THAT THE NARCOTICS WILL BE DISCONTINUED AS PER MY DOCTOR'S INSTRUCTIONS.**
- **I UNDERSTAND THAT STOPPING A LONG-ACTING NARCOTIC MEDICTION SUDDENLY CAN RESULT IN WITHDRAWAL, HEART ATTACK, STROKE, SEIZURE, PERMANENT DAMAGE, DISABILITY OR DEATH.**
- I understand I am not to use **<u>Alcohol</u>**, **<u>Marijuana</u>**, or any other **<u>Illegal Street Drugs</u>** while taking narcotic medication. If I do it may result in coma or death.
- I must always have a working phone number on file so we can reach you, if my number changes for any reason I must notify the office immediately.
- I understand if anyone from the office calls me and wants me to come in I must be able to report to the clinic within 24 hours to bring medications for evaluation and for labs.

I hereby certify that I have read this form or have had it read to me, that I understand all of it, and that I have had a chance to have all of my questions answered to my satisfaction. By voluntarily signing this form, I agree and accept the responsibilities associated with this type of therapy. I also understand that failure to comply with the above regulations may result in the immediate discontinuation of the controlled substances that have been prescribed, as well as possible discharge from the program. I understand that this Agreement contains the entire agreement of the parties and supersedes and replaces all prior agreements between the parties and such other agreements shall be null and void and of no further force or effect. I also understand that this document is self renewable, on a yearly basis. I agree that should I decide to terminate this agreement, I will do so in writing. This agreement will go into effect when pain medications are prescribed by this program or its affiliates.

Patient: ________________________________(Signature) Physician: ____________________________

Witness: ____ Date: ______________________________

Authorization to Release Information Concerning Your Care

We at **Musculoskeletal Institute of Louisiana** take your medical confidentiality very seriously. We will not and cannot release information without your written authorization.

This authorization allows our staff members to speak only with an individual(s) you designate in the event you are not available to receive phone calls or you have an adult member that helps coordinate your medical care. You should not designate your doctor.

As part of our Patient Privacy Policy, we will not leave any health information with any other person unless you specifically authorize below.

❑ **I do not authorize anyone to receive information regarding my medical care.**

Per my request, release the following information on myself: (Check each that apply)

❑ Appointments ❑ Account/Bill ❑ Lab/Test Results ❑ Medical Care/Treatment

Person: ______________________________ Relationship: ______________________________
Phone number(s): ____

Person: ______________________________ Relationship: ______________________________
Phone number(s): ____

Person: ______________________________ Relationship: ______________________________
Phone number(s): ____

<u>This will not include copies of your medical records. If you wish someone else to pick up a copy of your medical records, please fill out our Authorization to Use or Disclose Protected Health Information Form</u>

Medical History and Consent for Treatment

I certify that the information I have supplied is accurate, complete and true.

I authorize ***Pain Care Consultants*** and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

I give my consent for ***Pain Care Consultants*** to retrieve and review my medication history. I understand that this will become part of my medical record.

I acknowledge that I have had the opportunity to review ***Musculoskeletal Institute of Louisiana*** Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I authorize **Pain Care Consultants** to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize ***Pain Care Consultants*** to release any information required in obtaining procedure authorization or the processing of any insurance claims.

I understand that ***Pain Care Consultants*** will not release my Protected Health Information to any other party (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at its facility and on its website.

Print Name: ______________________________ Date of Birth: ______________________

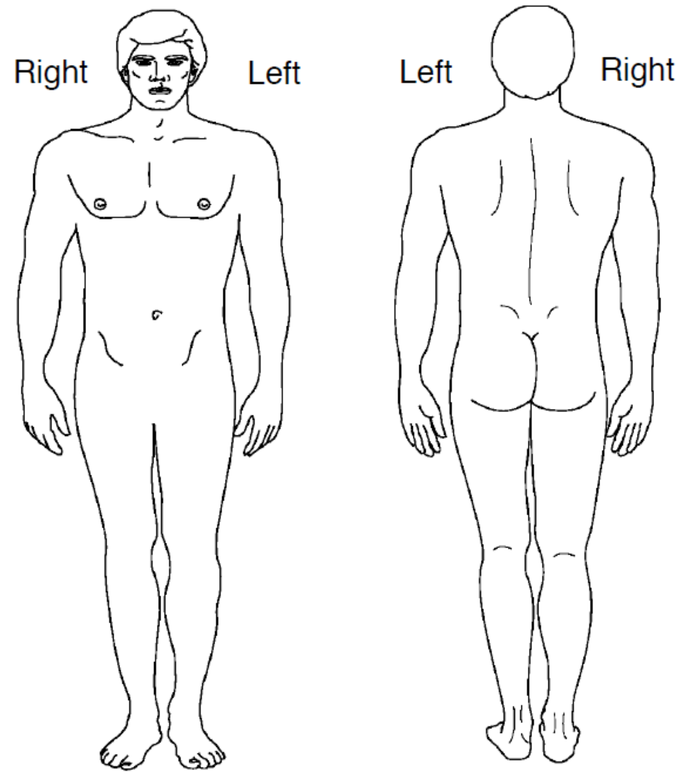
Signature: ______________________________ Date: ______________________

Patient Name:____ Date: _______________________

Location of Pain

Use this diagram to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms:

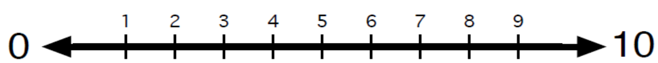
"N" = numbness
"S" = stabbing
"B" = burning
"P" = pins and needles
"A" = aching



Where is your worst area of pain located? ______________________

Does this pain radiate? If so, where? __________________________

Please list any additional areas of pain: ________________________



Rate Your Pain (0 = None and 10 = Worst pain imaginable)

_______ What number on the pain scale (0-10) best describes your pain **right now**?

_______ What number on the pain scale (0-10) best describes your **worst pain**?

_______ What number on the pain scale (0-10) best describes your **least pain**?

_______ What number on the pain scale (0-10) best describes your **average pain over the last month**?

In the last 24 hours rate how your pain has interfered with you (0= Does not interfere and 10= Completely interferes):

_______ General Activity

_______ Mood

_______ Walking Ability

_______ Normal Work

_______ Relationships with people

_______ Sleep

_______ Enjoyment of life

Onset of Symptoms

Approximately when did this pain begin? Date: _________________________

What caused your current pain episode?

❑ Accident at work ❑ Following surgery ❑ Pain "just began" ❑ Accident at home ❑ Cancer
❑ Motor Vehicle Accident ❑ Other:____

How did your current pain episode begin? ❑ Gradually ❑ Suddenly

Since your pain began, how has it changed? ❑ Decreased ❑ Increased ❑ Stayed the same

Describe the event that caused your pain ____

____

____

____

Patient Name:____ Date: _______________________

Pain Description

How often does your pain occur? ❑ Continuously ❑ 1-2 times a day ❑ 1-2 times a month ❑ Almost all the time
❑ Several times a week ❑ Less than once a month ❑ Several times a day ❑ Less than 3-4 times /month

When is your pain at its worst? ❑ Mornings ❑ During the day ❑ Evenings ❑ Middle of the night
❑ Progressively worsens throughout the day ❑ No changes – it's inconsistent or always the same

What word best describes the frequency of your pain? ❑ Constant ❑ Intermittent

Check all of the following that describe your pain:
❑ Aching ❑ Band-like ❑ Burning / Hot ❑ Cramping ❑ Deep ❑ Dull
❑ Muscle Spasm, Tightness ❑ Numb ❑ Piercing ❑ Pressure ❑ Shooting ❑ Shock-like
❑ Stabbing / Sharp ❑ Squeezing ❑ Throbbing ❑ Tiring / Exhausting ❑ Tingling / Pins and Needles

Are you having trouble sleeping? ❑ Yes ❑ No **Average number of hours of sleep per night:** ________ **hours**
Difficulty falling asleep ❑ Yes ❑ No **Difficulty staying asleep** ❑ Yes ❑ No

If you have NECK and/or ARM pain:
Is the pain in your arm(s)
❑ Worse than your neck
❑ Same as your neck
❑ Less than your neck

Please divide your pain:
Neck pain ________**%**
Arm pain ________**%**
The total should be 100%

If you have BACK and/or LEG pain:
Is the pain in your leg(s)
❑ Worse than your back
❑ Same as your back
❑ Less than your back

Please divide your pain:
Ba**ck pain** ________**%**
Leg **pain** ________**%**
The total should be 100%

How long can you sit? ____________________ **minutes.** **How long can you stand**? ____________________ **minutes**
How long can you drive/ride in car? ____________________ **minutes.**
How far can you walk? ____________________**minutes or** ____________________**miles**

What Makes Your Pain Better, Worse or No Change (Check All That Apply)

	Better	No Change	Worse		Better	No Change	Worse
Bending/Stooping				Coughing/Sneezing			
Driving				Relaxation			
Sitting				Heat			
Standing				Cold			
Lying Flat				Lifting			
Lying Sideways				Stress/Anxiety			
Twisting				Sleep			
Walking				Physical Activity			
Walking UP Stairs				Cold Weather			
Walking DOWN Stairs				Damp Weather			
Work Duties				Pain Medications			
Sexual Activity				Other____________________			

Patient Name:____ Date: _______________________

Pain Treatment History

HOW DO THE FOLLOWING TREATMENTS IMPACT YOUR PAIN? * IF YOU HAVEN'T TRIED IT, LEAVE THE ROW BLANK *****

Treatment	No Relief	Temp Relief	Excellent Relief	DATE(S)? (ok to approximate)
Acupuncture				
Biofeedback				
Chiropractic				
Epidural Steroid Injection ❑ Cervical ❑Thoracic ❑ Lumbar				
Exercise Program				
Facet Joint Injection/Medial Branch Blocks ❑ Cervical ❑Thoracic ❑ Lumbar				
Heat (Heating Pad; Hot Bath)				
Hypnosis				
Ice Packs				
Joint Injections:				
Massage				
Meditation				
Nerve Blocks:				
Physical Therapy				
Psychological Therapy				
Radiofrequency Ablation:				
Relaxation Therapy				
Spinal Cord Stimulator: ❑ Trial ❑ Permanent Implant				
Stretching				
TENS Unit				
Traction				
Trigger Point Injection(s)				

❑ I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS

Please describe any further details regarding previous pain treatments: ____

____

Diagnostic Tests and Imaging

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

❑ MRI of the ________________________________ Date: ______________ Facility: ___________________

❑ X-ray of the _______________________________ Date: ______________ Facility: ___________________

❑ CT scan of the _____________________________ Date: ______________ Facility: ___________________

❑ EMG/NCV study of the _______________________ Date: ______________ Facility: ___________________

❑ Other diagnostic testing: ____

❑ I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS.

Physicians You Have Seen For Your Pain

Physician	Date	Treatment

Patient Name:____ Date: _________________________

Past Medical History

	Yes	No	Notes
Aids			
Alzheimer Disease			
Anxiety			
Amputation			
Arterial Insufficiency			
Asthma			
Bladder or Kidney Infection			
Blood Disorders			
Brain Tumor			
Cancer (List Specific Type)			
Colon Trouble			
COPD			
Depression			
Diabetes			
Fibromyalgia			
Gastroesophageal Reflux Disease (GERD)			
Glaucoma			
Gout			
Gynecology Problems (Specify)			
Headache (Other than migraine)			
Heart Disease			
Hiatal Hernia			
High Blood Pressure			
History of Blood Transfusion			
Kidney Disease			
Liver Disease			
Migraine Headache			
Mental Disorder (not depression or schizophrenia)			
Neuropathy			
Osteoarthritis			
Osteoporosis			
Polio			
Positive HIV Test			
Prostate Trouble			
PTSD			
Rheumatic Fever			
Rheumatoid Arthritis			
Schizophrenia			
Seizure (Epilepsy)			
Shingles			
Sinus Trouble			
Stomach Ulcers			
Stroke			
Thyroid Problem			
Whiplash (Neck Injury)			

Other medical history please list: ____
____
____

Patient Name:______________________________ Date: ______________

Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the date.

Surgery	Date

❑ I HAVE NEVER HAD ANY SURGICAL PROCEDURES.

Anesthesia History

Have you ever had any adverse reactions to anesthesia? ❑ Yes ❑ No

If yes, which type of anesthesia did you have problems with? (Please check all that apply)

❑ Local anesthesia ❑ Epidural ❑ General Anesthesia ❑ IV Sedation

Has a family member ever had any adverse reactions to anesthesia? ❑ Yes ❑ No

If yes, which type of anesthesia did you have problems with? (Please check all that apply)

❑ Local anesthesia ❑ Epidural ❑ General Anesthesia ❑ IV Sedation

Current Medications

Please indicate which (if any) of the following blood-thinners you are taking:

❑Aggrenox ❑ Coumadin / Warfarin ❑ Effient ❑Lovenox ❑ Plavix ❑ Pletal ❑ Pradaxa

❑ Prasugrel ❑ Ticlid ❑ Other ______________________________

Please list *all* medications you are currently taking. Attach an additional sheet, if required.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

Allergies

Do you have any known drug allergies? ❑Yes ❑No **If Yes, please select below the medications you are allergic to.**

❑ Penicillin ❑ Tetracycline ❑ Sulfa ❑ Morphine ❑ Erythromycin ❑ Codeine

❑ Radiographic Dyes ❑ Other ______________________________

What type of response did you have? ______________________________

Topical Allergies: ❑ Iodine/Betadine ❑ Latex ❑ Tape **Are you allergic to shellfish**? ❑Yes ❑No

Patient Name:____ Date: _______________________

Social History

Are you capable of becoming pregnant? ❑ Yes ❑No **If so, are you currently pregnant**? ❑ Yes ❑No

Who do you live with? ❑ Alone ❑ Spouse ❑ Parents ❑ Roommate ❑ Other: ________________________________

Highest level of education: ❑ Grammar school ❑ High School ❑ College ❑ Post-graduate

Tobacco Use: ❑ Has Never Used Tobacco ❑ Current Tobacco User - Packs Per Day_______ I have smoked for ________ years.

❑ Former Tobacco User - How many years did you smoke _________________

Alcohol Use: ❑ Never Drinks Alcohol ❑ Current Alcoholism ❑ History of Alcoholism ❑ Drinks Alcohol Socially

❑ Daily Limited Use - How many drinks per day? _________________________

Have you ever gotten a DWI (DUI)? ❑ Yes ❑No **If Yes date(s), explain** ____

Illegal Drug Use: ❑ Denies Any Illegal Drug Use ❑ Currently Using Illegal Drugs (Which: __________________________________)

❑ Currently Uses Marijuana ❑ Currently Using Someone Else's Prescription Medications

❑ Formerly Used Illegal Drugs (not currently using) (Which: ____)

Have you ever abused prescription medications? ❑ Yes ❑No (Which: ____)

Are there any substance abuse issues in your household? ❑ Yes ❑No

Have you ever been arrested? ❑ Yes ❑No **If Yes date(s), explain** ____

____

Do you cry often? ❑ Yes ❑No **Do you feel depressed**? ❑ Yes ❑No

Have you ever attempted suicide? ❑ Yes ❑No **If Yes date(s), explain** ____

____

Do you currently have thoughts of suicide? ❑ Yes ❑No

Family History

Mark all appropriate diagnoses as they pertain to your immediate family (mother, father, sister, brother, children) only.

❑ Alcoholism ❑ Arthritis ❑ Cancer-Type_______________________________ ❑ Colitis

❑ Diabetes ❑ Drug Abuse ❑ Heart Disease ❑ High Blood Pressure ❑ High Cholesterol

❑ Kidney Problems ❑ Migraine Headache ❑ Rheumatoid Arthritis ❑ Schizophrenia ❑ Seizures

❑ Stroke ❑ Other medical problems: ____

❑ I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY. ❑ I AM ADOPTED (No Medical History Available).

Review of Symptoms

Mark the following symptoms that you currently suffer from. Note: Diagnosed conditions/Diseases should be noted under Past Medical History, above.

Constitutional: ❑ Abnormal Bleeding ❑ Chills ❑ Difficulty Sleeping ❑ Easy Bruising ❑ Excessive Sweating ❑ Excessive Thirst ❑ Fatigue ❑ Fever ❑ Insomnia ❑ Low Sex Drive ❑ Night Sweats ❑ Swollen / Tender Lymph Nodes ❑ Unexplained Weight Gain ❑ Unexplained Weight Loss

Skin: ❑ Blisters ❑ Changes in Moles ❑ Discoloration ❑ Rashes ❑ Sores

Head/Ears/Eyes, Nose/Throat: ❑ Dental Problems ❑ Earaches ❑ Hearing Problems ❑ Nosebleeds ❑ Recurrent Sore Throats ❑ Ringing in the Ears ❑ Sinus Problems ❑ Visual Changes

Cardiovascular: ❑ Bleeding Disorder ❑ Chest Pain ❑ Deep Vein Thrombosis ❑ Fainting ❑ High Blood Pressure ❑ Irregular Heartbeat ❑ Lightheadedness ❑ Shortness of Breath During Sleep ❑ Swelling in the Feet

Respiratory: ❑ Cough ❑ Wheezing ❑ Pulmonary Embolism ❑ Short of Breath on Exertion ❑ Short of Breath at Rest

Gastrointestinal: ❑ Abdominal Cramps ❑ Acid Reflux ❑ Constipation ❑ Coffee Ground Appearance in Vomit ❑ Dark & Tarry Stools ❑ Diarrhea ❑ Hernia ❑ Vomiting

Musculoskeletal: ❑ Back Pain ❑ Joint Pain ❑ Joint Stiffness ❑ Joint Swelling ❑ Muscle Spasms ❑ Neck Pain

Genitourinary/Nephrology: ❑ Blood in Urine ❑ Painful Urination ❑ Decreased Urine Flow/Frequency/Volume ❑ Flank Pain

Neurological: ❑ Tremors ❑ Dizziness ❑ Headaches ❑ Numbness/Tingling ❑ Seizures ❑ Instability When Walking

Psychiatric: ❑ Depressed Mood ❑ Feeling Anxious ❑ Stress Problems ❑ Suicidal Thoughts ❑ Suicidal Planning

Musculoskeletal Institute of Louisiana

Orthopedic Specialists of Louisiana • Pain Care Consultants

Disclosure of Financial Interest
As required by R.S. 37:1744 and LAC 46:XLV.4211-4215

Louisiana law requires physicians and other health care providers to make certain disclosures to a patient when they refer a patient to another health care provider or facility in which the physician has a significant financial interest.

Our physicians have a financial interest in these facilities:

Specialists Hospital Shreveport
Specialists Outpatient Therapy
1500 Line Avenue, Suite 206
Shreveport, LA 71101
318-213-3800

The nature and extent of each physician's interest is that they are one of multiple physicians who own an interest in the facility to which a patient may be referred for the purpose of surgical procedure, pain management procedure, physical therapy evaluation and treatment or prescriptive needs.

Patient Acknowledgement

By signing this Disclosure of Financial Interest, you acknowledge that you have read and understand the foregoing notice and understand that your physician has an ownership interest in above mentioned facilities.

__________________________________ __________________________________

Patient/Personal Representative Signature Date Signed

__________________________________ __________________________________

Please Print Patient's Name Date of Birth

____

Relationship to Patient if Personal Rep.