Colorado Springs Pain Consultants

Patient Name: _____

Last First Middle Initial

Gender: M F Other:_____ Date of Birth:_____ Preferred Language:_____

Social Security Number:_____—_____—_____ Marital Status: Single / Married / Divorced / Widowed

Race/Ethnicity: Latino or Hispanic / American Indian or Alaska Native / Asian / African American / Native Hawaiian or Other Pacific Islander / Caucasian / Decline to Specify

Mobile Number : _____ Home : _____ Work:_____

Email Address:_____ Would you like us to send you appointment reminders via email? Y / N Preferred method of communication: Mobile / Home / Work

Can we leave a confidential voicemail message on the preferred number you have chosen? Y / N

Who else can we speak to about your care? _____

Is there any person/s we should NOT speak to about your care? _____

Patient Address (Include Apt #,City,& Zip) :_____

_____

Primary Insurance Company: _____Relationship to Guarantor: _____

Guarantor Name: _____

Last First Middle Initial

Guarantor Date of Birth: _____ Guarantor Gender: M / F / Other:_____

Guarantor Social Security _____—_____—_____

Secondary Insurance Company: _____Relationship to Guarantor:_____

Guarantor Name: _____

Last First Middle Initial

Guarantor Date of Birth: _____ Guarantor Gender: M / F / Other:_____

Guarantor Social Security _____—_____—_____

Workman's Comp Insurance Company: _____ Date of Injury:_____

Adjuster:_____

Name Phone Number Fax Number

Claims Address: _____

Prescription Insurance Company: _____ Policy Number:_____

Phone Number:_____

Preferred Pharmacy: _____

Name Address City State Zip

Colorado Springs Pain Consultants

Patient Name:_____

Date of Birth:_____

Have you been in a motor vehicle accident within the past two years? Y / N If yes, date:_____

Prescription History— May we:

_____Retrieve all of your prescription history

_____ Only prescription history with current provider

_____ Do NOT retrieve prescription history

Emergency Contact: _____

First Last Phone Number

Relationship to Emergency Contact: _____

Primary Care Provider : _____

Name Phone Number

_____

Address City State Zip

Orthopedic Provider :_____

Name Phone Number

_____

Address City State Zip

Neurologist Provider : _____

Name Phone Number

_____

Address City State Zip

Rheumatologist : _____

Provider Name Phone Number

_____

Address City State Zip

Other: _____

Name Phone Number

_____

Address City State Zip

Colorado Springs Pain Consultants

Patient Name_____

Date of Birth _____

Social History

Smoking Status: Never / Former / Current everyday / Heavy tobacco / Current some days / Light

How many packs per day? _____ Duration/ How often:_____

Alcohol use: Y / N How often:_____

Caffeine: Y / N How often:_____

Marijuana: Y / N How often:_____

Have you been issued a medical Marijuana card (If yes, please provide a copy)? Y / N

Work Status:_____

Surgical History

Surgery	Year	Doctor

Medication History

Medication Failed	Year	Prescribing Doctor

Past Medical History (Please list all past major medical issues i.e. Anemia, Stroke, Cancer etc.)

_____

_____

_____

_____

Ongoing Medical Problems (Please list all major ongoing medical issues i.e. Hypertension, Diabetes, Rheumatoid Arthritis etc.)

_____

_____

_____

Colorado Springs Pain Consultants

Patient Name_____

Date of Birth _____

Spinal Cord Stimulator: Trial: Y / N Year:_____ Permanent Implant: Y / N Year:_____

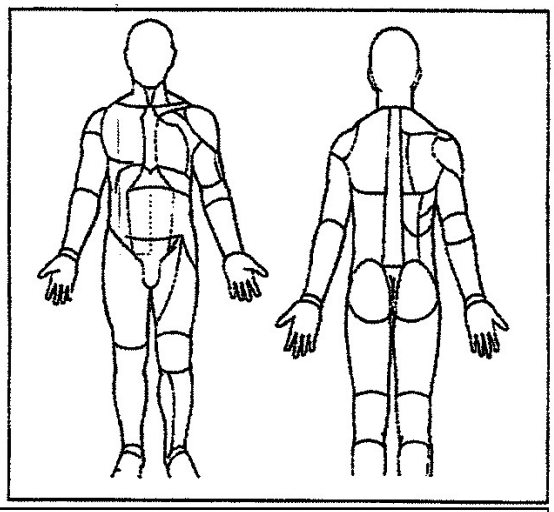
Family History

Relation	Status	Diagnosis/ Cause of Death
Mother	Alive & Well/ Deceased	
Father	Alive & Well/ Deceased	
Brother	Alive & Well/ Deceased	
Sister	Alive & Well/ Deceased	

Have you been to any previous pain management? Y / N

If yes, name of physician (s): _____

In the diagram to the right, please shade the areas of your pain:



Reason for Visit (Location of Pain):_____

When did pain begin?:_____

On a scale of 0-10, with 10 being the most painful:

What is your pain level today?: _____

What is your range of pain in the past month?:_____

Duration of pain (How long does it last):_____

What aggravates your pain?:_____

What relieves your pain?:_____

Medication	Dosage	Frequency

Allergy	Reaction

Colorado Springs Pain Consultants

Patient Name:_____

Date of Birth:_____

O.R.T.

Please select your gender

- ☐ Male
- ☐ Female

Do you have a family history of substance abuse? Check all that apply

- ☐ Alcohol
- ☐ Illegal Drugs
- ☐ Prescription Medications

Do you have a personal history of substance abuse? Check all that apply

- ☐ Alcohol
- ☐ Illegal Drugs
- ☐ Prescription Medications

Is your current age 16-45 years old?

- ☐ Yes
- ☐ No

Do you have a history of preadolescence sexual abuse?

- ☐ Yes
- ☐ No

Have you been diagnosed with any of the following Psychological diseases? Check all that apply

- ☐ Attention Deficit Disorder
- ☐ Bipolar
- ☐ Schizophrenia
- ☐ Obsessive Compulsive Disorder
- ☐ PTSD
- ☐ Depression

Webster LR, Webster R. Predicting aberrant behaviors in Opioid treated patients: preliminary validation of the ORT.

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Opioid Agreement

Patient Name_____

Date of Birth_____

Initials

_____ Colorado Springs Pain Consultants providers will be the only providers to prescribe controlled substances for pain.

_____ Abusive, unprofessional, uncontrolled, aberrant behavior results in an automatic dismissal.

_____ Patient must be seen for regular office visits to receive a medication refill. No early refills.

_____ Medications filled partially at the pharmacy are final, providers are not responsible for writing prescriptions to complete the original script.

_____ It is understood that you may not receive medications during your first office visit.

_____ Prescriptions will not be written/electronically sent at/from any of the surgery centers during a procedure visit.

_____ It is understood that prescriptions will not be filled out of state.

_____ The safety of all prescriptions/medications are the patients responsibility and prescriptions/medications that are lost, misplaced, destroyed, or stolen will not be replaced.

_____ It is understood that no refills will be made after hours, on weekends or on holidays.

_____ It is understood that changes will not be made to medications in between office visits.

_____ Patient will make arrangements prior to traveling regarding medications.

_____ Other classifications of medications may be prescribed to assist in pain management and limit opiate use.

_____ Other therapies may be ordered to assist in pain management such as nerve blocks, TENS Unit, physical or occupational therapy, psychological counseling as appropriate to the diagnosis.

_____ It is understood that no trustworthy patient-provider relationship can be had with a patient that abuses illegal drugs or alcohol. "Street Drugs" such as cocaine, heroin, amphetamines, ecstasy, etc. are in and out of themselves dangerous. Mixed with some of the medications often used in pain management, the combination could be lethal.

_____ It is understood that periodically the patient will be subject to a urine test, when requested by the provider, to determine compliance with therapy. Urine tests are tested for the presence of the prescribed medications as well as several other medications and illegal substances.

_____ It is understood that if a urine sample results are positive for illegal substances it will result in a dismissal from the practice.

_____ The patient has the right to refuse such random or periodic urine testing. Colorado Springs Pain Consultants reserves the right to end the patient-provider relationship with a patient that refuses to comply.

_____ It is understood there is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substances.

_____ It is understood that each patient using Medical Marijuana must obtain or show proof of a red card that is valid and issued by the state of Colorado.

_____ It is understood that providers will not prescribe any psychological or benzodiazepine medications.

_____ It is understood that Colorado Springs Pain Consultants will only treat chronic pain and the patient must seek medical care for all other issues with a primary care provider.

_____ It is understood that the patient will communicate fully with the provider about the character and intensity of their pain, the effect of the pain on their daily life, and how well the medication/procedure is helping to relieve the pain.

_____ It is assured the patient will not share their medication with anyone nor take/use any controlled opioid medications that are not prescribed to them.

_____ Patient will not attempt to obtain any controlled medications, including opioid pain medications and controlled stimulants from any other provider outside of Colorado Springs Pain Consultants. Dental procedures and scheduled surgeries will be handled by the servicing provider until care Is released from that provider.

_____ Patient authorizes the provider and pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this states Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of pain medication.

_____ Patient authorizes the provider to provide a copy of this contract to their pharmacy, primary care provider and local emergency room. Patient agrees to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

_____ It is understood that the provider will be checking the Prescription Drug Monitoring Program website throughout the treatment period to verify the patient is receiving controlled substances from only one prescriber and only one pharmacy.

_____ It is understood that the patient will use medications at a rate no greater than the prescribed rate and that use of medications at a greater rate will result in dismissal.

_____ It is understood that this contract is essential to the trust and confidence necessary in a patient-provider relationship and that my provider undertakes to treat me based on this contract.

_____ It is understood that if the patient is in violation of this contract it will result in automatic dismissal.

I have read all of the above, asked questions, and understand the agreement. If I violate the agreement, I understand the provider may discontinue this form of treatment.

_____ _____

Patient Signature Date

_____ _____

Provider Signature Date

Colorado Springs Pain Consultants

Patient Name_____

Date of Birth_____

Consent for Chronic Opioid Therapy

Colorado Springs Pain Consultants providers and allied health professionals are prescribing opioid medications, sometimes called narcotic analgesics to me for pain management. This decision was made because my condition is serious or other treatments have not helped my pain.

I am aware that the use if such medication has certain risks associated with it, including but not limited to, sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and possibility that the medication will not provide complete pain relief.

I am aware of the possible risks and benefits of other types of treatments that do not involve the use of opioids. I will tell my provider about all other medications 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 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 his/herself.

I am aware that certain medications such as Nalbuphine (Nubain), Pentazocaine (Talwin), Buprenorphine (Buprenex), and Butorphanol (Stadol) may reverse the action of the medication I am using for pain control. Taking any of these medications while I am taking my pain medications can cause symptoms like a bad flu, called withdrawal syndrome. I agree to not take any of these medications and to tell any other provider that I am taking an opioid as my pain medication and cannot take any of the medications listed above.

I am aware that addiction is defined as the use of a medication even if it causes harm, having cravings for a medication, feeling the need to use a medication and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medication is high. I am aware that the development of addiction has been reported in medical journals and is much more common in a person who has family or personal history of addiction. I agree to tell my provider my complete and honest personal medication 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 medications for a long time. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medication 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 analgesia (inability to feel pain) does not seem to be an issue 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 provider to choose another form of treatment.

MALES ONLY: 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 primary care physician may check my blood to see if my testosterone level is normal.

FEMALES ONLY: If I plan to become pregnant or believe that I have become pregnant while taking this pain medication, I will immediately call my obstetric physician and this office to inform them. I am aware my provider will not prescribe me opioids shall I become pregnant.

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

Patient Signature	Date
Provider Signature	Date

Colorado Springs
Pain Consultants

Authorization for Release of Medical Records

Patient's Name:_____ Date of Birth:_____

I authorize release of my health information records to Colorado Springs Pain Consultants to enable a comprehensive review of my medical care. I authorize the following physician offices, clinics, hospitals, other health care providers, pharmacies and legal offices to provide copies of my health information to:

Colorado Springs Pain Consultants

3920 N. Union Blvd. Ste. 220, Colorado Springs, CO 80907

Phone: 719-375-5400 Fax: 719-434-7474

(List of all facilities, clinics, and offices from which information will be requested)

Physician Offices (List all physicians you have seen in the past two years)

	Physician Name	Address	Phone Number
1.			
2.			
3.			
4.			

Hospital and Other Facilities (For surgeries/procedures, MRI/CT Scans and any Lab and X-Ray reports)

	Facility Name	Address	Phone Number
1.			
2.			
3.			
4.			

Restrictions:

_____ There are NO restrictions on the information that can be released.

_____ The following information CAN NOT be released: _____

Duration: This authorization shall be effective immediately. I understand This authorization to release medical records will become invalid when I am no longer a patient if Colorado Springs Pain Consultants. I understand I have the right to revoke this authorization at any time by sending written notification to the Privacy/Compliance Officer at the above listed address.

_____ _____

Signature of patient or personal representative Date

(PLEASE PRINT) Name of patient or personal representative:_____

(PLEASE PRINT) If personal representative, describe authority:_____

Colorado Springs
Pain Consultants

Acknowledgement of Receipt of Privacy Notice

Patient Name_____

Date of Birth_____

I acknowledge that I have received the attached Privacy Notice.

_____ _____

Patient or Personal Representative Signature Date

_____

Printed Patient Name

If Personal Representative's signature appears above, please describe authority:_____

I, _____, give consent for Colorado Springs Pain Consultants, LLC. to retrieve my prescription history.

_____

Signature

_____

Date

3920 N. Union Blvd Ste 220 Colorado Springs, CO 80907 Office: 719.375.5400 Fax: 719.434.7474

www.cspainconsultants.com

Colorado Springs Pain Consultants

Patient Name_____

Date of Birth_____

Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for Colorado Springs Pain Consultants to furnish medical care and treatment to myself, considered necessary and proper in diagnosing or treating his/her physical condition.

Patient/Responsible Party _____ Date _____

In the event of cancellation of an office visit or procedure within less than 24 hours notice, a fee of $50 will be charged for an office visit and $150 for a procedure.

Benefit Assignment/Release of Information

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers to Colorado Springs Pain Consultants. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Information Privacy: Colorado Springs Pain Consultants will use and disclose your personal health information to treat you, to receive payment for the care we provide and for other health care operations. Health care operations generally include those activities we perform to improve the quality off care. We have prepared a detailed Notice of Privacy Practices to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, and have copies available for distribution. The undersigned acknowledges receipt of this information.

Patient/Responsible Party _____ Date_____

Financial Policy Statement

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made due to policy termination you will be responsible for the amount refunded to your insurance company. We reserve the right to assess a finance charge of 18% annually for balances carried over an extended period of time. Benefits and eligibility are verified prior to your visit as a courtesy and as a result, we are not responsible for incorrect information provided by your insurance company as it relates to co-pay or benefit plan limitations. Your policy must be in effect at the time of service and subject to individual plan limitations and exclusions as mandated by your plan. An authorization is not guarantee of payment. If any payment is made directly you for services billed by us, you recognize an obligation to promptly submit same to Colorado Springs Pain Consultants.

Patient Authorizations

- By my signature below, I hereby authorize Colorado Springs Pain Consultants and the providers, staff, and hospitals associated with Colorado Springs Pain Consultants to release medical and other information acquired in the course of my examination and/or treatment (with the exceptions stipulated below) to the necessary insurance companies, third party payers, and/or other physicians or healthcare entities required to participate in my care.

- I understand that I must check one, none, or more of the following types of health information to indicate that I authorize that information type to be released to the necessary insurance companies, third party payers, and/or other physicians and/or healthcare entities required to participate in my care.

  By checking the following lines, the health information I authorize to be released may NOT include the following:

  _____ Diagnosis, evaluation, and/or treatment for alcohol and/or drug abuse.

  _____ Records of HTLV-III or HIV testing (AIDS test) result, diagnosis, and/or treatment.

  _____ Psychiatric and/or psychological records, or evaluation and/or treatment for mental, physical, and/or emotional illness, including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans, and/or evaluations.

- By my signature below, I hereby authorize assignment of financial benefits directly to Colorado Springs Pain Consultants and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this agreement.
- By my signature below, I authorize Colorado Springs Pain Consultants personnel to communicate by mail and/or answering machine message according to the information I have provided in my patient registration information.

The above may not apply for patients that are considered Worker's Compensation; however, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services.

*I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fess.

I UNDERSTAND MY RESPONSIBILTY FOR THE PAYMENT OF MY ACCOUNT

_____ _____

Patient/ Responsible Party Date

_____ _____

Provider Signature Date