VITAL PAIN CENTER

NEW PATIENT INFORMATION

PATIENT NAME:_____ DOB:_____ AGE: _____
ADDRESS: _____ CITY:_____ STATE:____ ZIP:_____
PHONE:_____ SS #: _____ MARTIAL STATUS: _____
REFERRING DOCTOR: _____ PHONE: _____
PRIMARY CARE DOCTOR: _____ PHONE: _____

YOUR PHARMACY AND THEIR PHONE NUMBER ARE REQUIRED TO OBTAIN PRESCRIPTIONS:
PHARMACY: _____ PHONE: _____
ADDRESS: _____

DO YOU HAVE SEPERATE PRESCRIPTION COVERAGE? YES or NO if yes, complete below
COMPANY: _____ ID#:_____
IS THIS A MAIL ORDER ONLY PHARMACY PLAN? YES or NO PHONE #_____

INSURANCE INFORMATION

IF THIS IS A WORKERS COMP or AUTO ACCIDENT CLAIM – SEE FRONT DESK FOR A DIFFERENT FORM.

PRIMARY INSURANCE: _____ PHONE:_____
ID #:_____ GROUP #:_____

PLEASE READ AND SIGN BELOW

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNEMENT OF BENEFIT: I authorize the release of any medical information necessary to process this claim, I hereby authorize Vital Pain Center to apply for benefits on my behalf of covered services, request that payments from my insurance company be made directly to Vital Pain Center. I understand that I am responsible for payments to this office within the stated policy. I permit a copy of this authorization to be used in place of the original.

X_____ DATE: _____

VITAL PAIN CENTER (THE PRACTICE) - in general, any information that is about the healthcare you receive, your health or payment for that care is considered confidential and protected by our office. We may need to use your protected health information to carry out treatment, payment, healthcare operations and/or other purposes. Our notice of privacy provides a more complete description of permitted uses and disclosures.

PLEASE SIGN BELOW TO ACKNOWLEDGE THAT YOU HAVE *RECEIVED OR DECLINED A COPY* OF OUR NOTICE OF PRIVACY PRACTICES (HIPAA).

I DECLINED A COPY: _____ DATE:_____

I RECEIVED A COPY: _____ DATE:_____

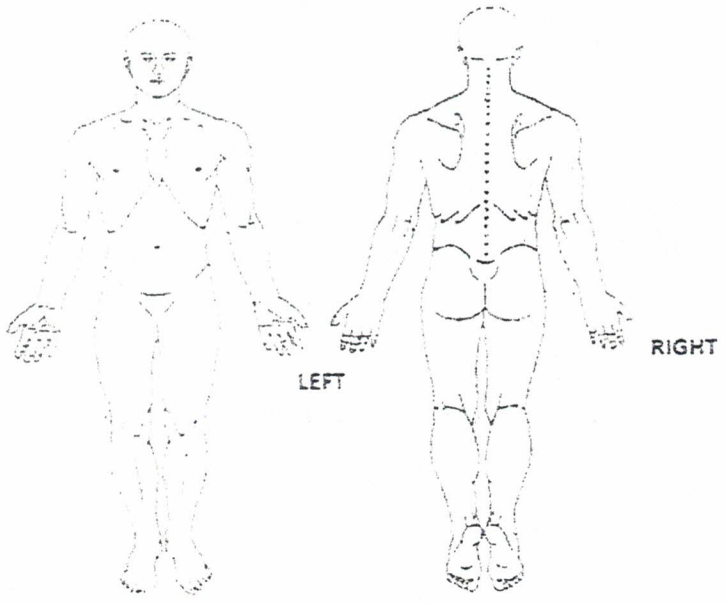
VITAL PAIN CENTER – NEW PATIENT QUESTIONAIRRE

NAME: _____ TODAY'S DATE: _____

BIRTHDAY: _____

HEIGHT: _____

WEIGHT: _____



MARK WHERE YOUR PAIN IS LOCATED ON THE IMAGE

1) Past and Current **MEDICAL HISTORY:** _____

_____

2) Past and Current **INJURIES:** _____

3) Past **SURGERIES:** _____

4) Past or Present **PSYCHIATRIC PROBLEMS:** _____

5) ALLERGIC TO - **CONTRAST ?** YES or NO

6) ALLERGIC TO - **LATEX ?** YES or NO

7) Do You Take **BLOOD THINNERS?** YES or NO (READ BELOW)

- If YES – Which Blood Thinners Do You Take? _____

8) Any **BLEEDING DISORDERS?** YES or NO If YES, Explain: _____

FAMILY HISTORY - Does Your Family Have Any of The Listed Conditions Below?

WRITE WHO HAS WHAT BELOW EACH CONDITION: *Mother, Father, Sister, Brother, Etc.*

( ) Bleeding Disorder | ( ) Cancer | ( ) Heart Attack | ( ) Pain

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SOCIAL HISTORY:

1) Do You **SMOKE TOBACCO?** YES or NO

2) Do You **DRINK ALCOHOL?** YES or NO IF YES, How Often: _____

3) **Tried or Currently Using STREET DRUGS?** YES or NO *IF YES, COMPLETE BELOW*

Name of Drug Used: _____ Amount: _____ When: _____

MEDICATION

List *ALL* **PAIN MEDICATION** you have **TRIED** in the **PAST:** _____

_____

CURRENT MEDICATIONS: _____

_____

ALLERGIES: _____

PAIN HISTORY

1) **Rate Your Pain From 1-10** (*1 being no pain – **10** being extreme pain*) ....

Pain Right **NOW** : _____/ **10** At Its **WORST** : _____/ **10** At Its **LEAST** : _____/ **10**

2) How **OFTEN** Do You Have Pain? ( ) Constant ( ) Most of the Time ( ) Occasionally ( ) Rarely

3) Does Your Pain **AFFECT SLEEP?** ( ) Always ( ) Most of the Time ( ) Occasionally ( ) Rarely

4) **How Does Your Pain *FEEL*?** ( ) Achy ( ) Burning ( ) Sharp ( ) Stabbing ( ) Throbbing

5) **Do You Have Any of These?** ( ) Numbness ( ) Itching ( ) Tingling ( ) Weakness

6) Does Your Pain ***RADIATE*** to Other Parts of Your Body? **YES** or **NO**

If *YES*, List Where: _____

7) How Did Your Pain ***BEGIN*?** ( ) Work Accident ( ) Auto Accident ( ) After Surgery ( ) OTHER

***Explain*:** _____ ***When Did Pain Begin*?** _____

8) What Makes Your Pain Feel **BETTER?** _____

9) What Makes Your Pain Feel **WORSE?** _____

10) Are You Interested in **MEDICAL MARIJUANA?** YES **or** NO **or** UNSURE

WHAT TREATMENTS HAVE YOU TRIED IN THE PAST?

( ) Acupuncture ( ) Exercise ( ) Chiropractor ( ) Injections ( ) Pain Clinic ( ) TENS

( ) Physical Therapy – IF YES, When: _____ For How Long: _____

( ) NSAIDS – IF YES, What *NSAIDS* Have You Tried? _____

Signature of Person Completing This Form: _____

Relationship to Patient: _____

NAME: _____ DOB: _____

CONTROLLED SUBSTANCE AGREEMENT

Your treatment plan requires the use of controlled substances.

For this reason, you must agree to sign and follow the policies below that Dr. Rivero-Becerra has determined to be necessary to initiate and continue treatment requiring prescriptions of controlled substances to manage your pain.

YOUR TREATMENT AT VITAL PAIN CENTER WILL STOP IF YOU ARE NON-COMPLIANT WITH THE BELOW POLICIES:

1. I agree to obtain **ALL** controlled substances **SOLELY** from Dr. Rivero-Becerra.
2. ALL controlled substance prescriptions will be obtained from ONE pharmacy – below is my chosen pharmacy:

PHARMACY NAME: _____

3. I agree to allow Dr. Rivero-Becerra and his staff to communicate with any health professional providing my healthcare, any pharmacist and any legal authority regarding my use of controlled substances.
4. I agree to take the medication **AS PRESCRIBED**. Treatment will be stopped if medications are taken more often or in a higher dose than prescribed.
5. You may **NOT** sell, share or otherwise permit others to have access to these medications – all medication should be kept in a secure and safe location.
6. Since these drugs may be harmful or lethal to a person who is **NOT** tolerant to their effects, especially a child, you **MUST** keep them out of reach of such people.
7. I agree to keep **ALL** scheduled appointments at Vital Pain Center. **NO** medication will be ordered if appointments are missed. **YOU MUST BE ON TIME TO ALL APPOINTMENTS OR YOU MAY BE ASKED TO RESCHEDULE.**
8. I understand that NO allowances will be made for lost or stolen prescriptions. NO early refills will be granted. **RANDOM PILL COUNTS MAY BE REQUIRED AND YOUR COOPERATION IS NECESSARY.**
9. Unannounced observed urine and/or serum toxicology screens may be required and your cooperation is required. Presence of unauthorized substances **OR** non-presence of the prescribed medication may result in termination of treatment and a referral for assessment for addictive disorder.
10. I certify that I am **NOT PREGNANT**. Pregnancy may warrant discontinuation of chronic opioid therapy at the discretion of Dr. Rivero-Becerra. If I become pregnant, I agree to notify Dr. Rivero-Becerra as soon as possible.
11. I understand that **ANY** medical treatment is initially a trial and the continued prescriptions are determined by evidence of improvement in both pain control and overall functioning abilities.
12. I understand that this mode of treatment will be **STOPPED** if I develop a rapid tolerance or loss of effectiveness from the prescribed medication. If I develop side effects that are significant in the view of Dr. Rivero, my functional activities decrease, or if I break any terms of this contract.
13. I understand that these drugs should **NOT** be stopped abruptly as an abstinence syndrome will likely develop.
14. ALL unwanted, unused, or intolerable controlled medication **MUST BE RETURNED TO VITAL PAIN CENTER.** If you are unsure if your medication is controlled, call the office.

I HAVE READ AND SIGNED THE FORM LISTING THE RISK INVOLVED WITH THE USE OF A CONTROLLED SUBSTANCE FOR MANAGEMENT OF CHRONIC PAIN. I AFFIRM THAT I HAVE THE FULL RIGHT AND POWER TO SIGN AND BE BOUND TO THIS AGREEMENT AND THAT I HAVE READ, UNDERSTOOD, AND ACCEPTED ALL OF ITS TERMS.

_____ DATE: _____

(PATIENT NAME – PRINTED)

_____ _____

(PATIENT SIGNATURE) **(WITNESS)**

HIPAA PRIVACY AUTHORIZATION FORM

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION.

(REQUIRED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT, 45 C.F.R. PARTS 130 AND 164)

1. **AUTHORIZATION:** I AUTHORIZE *VITAL PAIN CENTER* TO USE AND DISCLOSE THE PROTECTED HEALTH INFORMATION TO:
   - WRITE THE NAME OF OTHER **HEALTHCARE PROVIDERS** WE ARE PERMITTED TO SHARE YOUR TREATMENT WITH *
     IF WE ARE NOT TO SHARE WITH ANYONE - WRITE NONE

     _____
   - WRITE THE NAME OF **ANY FAMILY MEMBERS** WE ARE PERMITTED TO SHARE YOUR TREATMENT WITH *
     IF WE ARE NOT TO SHARE WITH ANYONE - WRITE NONE

     _____

2. **EFFECTIVE PERIOD:** THIS AUTHORIZATION COVERS THE TIME PERIOD AS FOLLOWING:
   (START DATE) _____ TO **(END DATE):**_____
   OR - ***ALL*** PAST AND FUTURE RECORDS _____ (NO EXPIRATION)

3. **EXTENT OF AUTHORIZATION:** *CHECK ONE OF THE FOLLOWING BELOW*

   _____ I AUTHORIZE THE RELEASE OF MY COMPLETE MEDICAL RECORDS.
   INCLUDING: MENTAL HEALTH, COMMUNICABLE DISEASE, HIV/AIDS, DRUGS & ALCOHOL.

   _____ I AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS - WITH THE **EXCEPTION** OF...
   _____ MENTAL HEALTH _____ HIV/AIDS _____ DRUGS & ALCOHOL

4. THIS MEDICAL INFORMATION MAY BE USED BY THE PERSON(S) I AUTHORIZE TO RECEIVE THIS INFORMATION FOR MEDICAL TREATMENT, CONSULTATION, BILLING AND CLAIMS, APPOINTMENTS, MEDICATIONS, AND OTHER PURPOSES AS I MAY DIRECT.

5. I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION, IN WRITING, AT ANYTIME. I UNDERSTAND THAT A REVOCATION IS NOT EFFECTIVE TO THE EXTENT THAT ANY PERSON(S) OR ENTITY THAT HAS ALREADY ACTED IN RELIANCE ON MY AUTHORIZATION – OR IF MY AUTHORIZATION WAS OBTAINED AS A CONDITION OF OBTAINING INSURANCE COVERAGE AND THE INSURER HAS A LEGAL RIGHT TO CONTEST THEM.

6. I UNDERSTAND THAT MY TREATMENT, PAYMENT, ENROLLMENT, OR ELIGIBILITY FOR BENEFITS WILL NOT BE CONDITIONED ON WHETHER I SIGN THIS AUTHORIZATION.

7. I UNDERSTAND THAT INFORMATION USED OR DISCLOSED PURSUIT TO THIS AUTHORIZATION MAY BE DISCLOSED BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY FEDERAL OR STATE LAW.

X _____ DATE: _____

PRINTED NAME: _____ **RELATIONSHIP TO PATIENT:** _____

VITAL PAIN CENTER- OPIOID RISK AGREEMENT

NAME: _____(printed clearly) DOB: _____

The use of _____ (name of medication), may cause addiction and is only

One part of the treatment for _____(DX codes for condition).

1. The goals of this medicine are:

( ) to improve my ability to work and function at home

( ) to help my condition as much as possible without causing dangerous side effects

2. I have been told that:

1. If I drink alcohol or use street drugs, I may not be able to think clearly and I could become sleepy and risk Personal injury.
2. I may get addicted to this medication
3. If I or anyone in my family has a history of drug or alcohol problems, I am at a higher risk for addiction.
4. If I need to stop this medicine, I must do it slowly or I may get very sick.

3. The duration of this medication is undetermined at this time:

Dr. Rivero- Becerra will see me monthly to assess my current medication for any changes, decrease needs, or discontinuation of the medication based on my condition and treatment for my chronic pain condition.

4. If the patient is taking benzodiazepines- Dr. Rivero does not prescribe those medication and can not stop, adjust or develop a taper plan for such medicines. The ordering physician must do so.

5. If authorization is required for my medication:

The office staff will attach the most recent available urine drug test, current office note, most recent PDMP report, a therapy note if applicable, and controlled substance agreement, along with any additional documentation necessary to approve my mediation.

X_____(patient signature)

X_____(witness signature)

X_____(Physician signature)

Vital Pain Center, LLC

PATIENT NAME_____DATE_____

OPIOD RISK TOOL

Instructions: Circle the appropriate box

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Total Score (circle one): L = 0-1 M = 3-7 H = 8 or Higher

VITAL PAIN CENTER, LLC 363 VANADIUM RD STE 106 PITTSBURGH, PA 15243

QUALITATIVE/PRELIM URINE DRUG SCREEN LAB REQUISITION

Patient Information:

_____

First and Last Name **Date of Birth**

By signing below, I consent to provide an unadulterated specimen that is my own.

X_____

Patient Signature **Date**

_____

Ordering Provider: JORGE RIVERO-BECERRA, MD

Collection Date and Time: _____ Collector Initials: _____

Urine Temp Acceptable ✓ YES _____ NO

LAB ORDER:

I am ordering qualitative (presumptive) urine drug testing including validity testing.

Perform qualitative UDS on the following substance:

6-Acetylmorphine	Benzodiazepine	Fentanyl
Buprenorphine	Cocaine	Creatinine
Opiates	Oxycodone	Tramadol
EDDP		

_____

Signature of Ordering Provider Date of Order: