Colorado Springs Pain Consultants

Name: _____

Date of Birth: _____

Patient Information

Patient Name: _____ (Last / First / M.)

Mailing Address (incl. city & zip): _____

Permanent Address (incl. city & zip): _____

Phone: Work: _____ Ext: _____ Home: _____ Cell: _____

Date of Birth: _____ Age: _____

SSN: _____ Marital Status: Single / Divorced / Married / Widowed

Gender: Male / Female Race: _____ Ethnicity: Hispanic or Latino/Not Hispanic or Latino

Current Employer: _____ Occupation: _____

(If workers' comp, indicate employer where accident occurred)

Employer Address: _____

Date of Injury/Accident/Illness: _____ If Injury (please circle specific): Auto / Work Comp

Case Manager Name: _____ Case Manager Phone: _____

Case Manager Fax: _____ Case #: _____

Closest friend or relative not living with you: _____

Address/Phone: _____

Emergency Contact: _____

Address/Phone: _____

Insurance Information

Primary Insurance Company: _____

Subscriber's Relationship to Patient: SELF SPOUSE PARENT OTHER

Spouse Name: _____ (Last / First / M.)

Spouse's Employer: _____ Telephone # _____

Spouse SSN: _____ Spouse Date of Birth: _____

Secondary Insurance Company: _____

Third Insurance, if applicable: _____

Preferred Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____

Referral Information (Please tell us how you were referred to our practice)

Referring Physician/Physician Name and Phone number: _____

Health Plan Provider List _____

Other Source _____

(W/C Adjuster, Case Manager, Zoc Doc, Demand Force, Website, Friend etc)

****** Please present this form and all insurance ID cards to the receptionist at this time. ******

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Office: 719.375.5400 • Fax: 719.434.7474
www.cspainconsultants.com

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Name: _____

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Have you been to any previous pain management (circle one)? Yes No

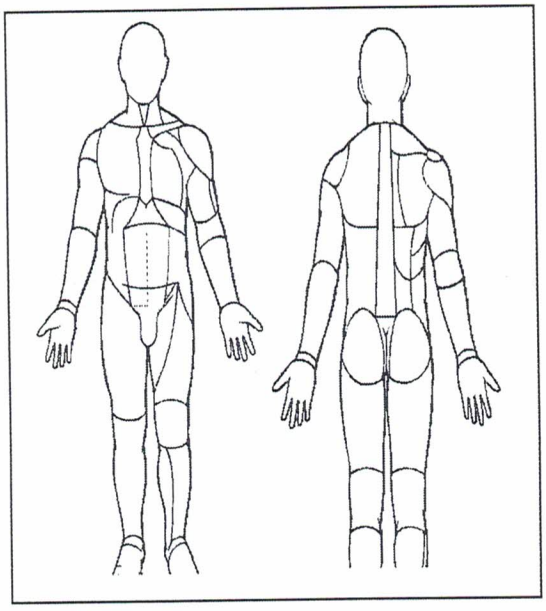
If yes, name of physician(s): _____

Work Status: ____ Regular Duty ____ Light Duty (Restrictions): _____

____ Off Work (date last worked): _____ ____ Retired (year retired): _____

Disabled (since): _____ If disabled, by what doctor: _____

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



Reason for Visit (Location of Pain): _____

Onset of pain (when did pain begin): _____

Severity of Pain (on a scale of 0-10, with 0 being the most painful): _____

Pain Scale: From 0 - 10 what is your pain level today? _____
(No Pain) **0 1 2 3 4 5 6 7 8 9 10** (Worst Pain)

What is your range of pain in the past month? _____
(No Pain) **0 1 2 3 4 5 6 7 8 9 10** (Worst Pain)

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

What aggravates your pain: _____

What relieves your pain: _____

Medications you are presently taking (Include all over the counter and prescribed medications):

Medication Name	Dosage	Frequency

Allergy	Reaction

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Have you been issued a medical Marijuana card (if yes, please provide a copy)? Yes_____ No_____

Height: _____ Weight: _____

Review of Symptoms:

Constitutional ☐ All neg

Neg	Pos	
○	○	Chills
○	○	Fatigue
○	○	Fever
○	○	Malaise
○	○	Night sweats
○	○	Weight gain
○	○	Weight loss
○	○	Other:

HEENT ☐ All neg

Neg	Pos	
○	○	Ear drainage
○	○	Ear pain
○	○	Eye discharge
○	○	Eye pain
○	○	Hearing loss
○	○	Nasal drainage
○	○	Sinus pressure
○	○	Sore throat
○	○	Visual changes
○	○	Other:

Respiratory ☐ All neg

Neg	Pos	
○	○	Chronic cough
○	○	Cough
○	○	Known TB exposure
○	○	Shortness of breath
○	○	Wheezing
○	○	Other:

Cardiovascular ☐ All neg

Neg	Pos	
○	○	Chest pain
○	○	Claudication
○	○	Edema
○	○	Palpitations
○	○	Other:

Gastrointestinal ☐ All neg

Neg	Pos	
○	○	Abdominal pain
○	○	Blood in stools
○	○	Change in stools
○	○	Constipation
○	○	Diarrhea
○	○	Heartburn
○	○	Loss of appetite
○	○	Nausea
○	○	Vomiting
○	○	Other:

Genitourinary ☐ All neg

Neg	Pos	
○	○	Dysuria
○	○	Hematuria
○	○	Polyuria
○	○	Urinary frequency
○	○	Urinary incontinence
○	○	Urinary retention
○	○	Other:

Reproductive ☐ All neg

Neg	Pos	
○	○	Abnormal Pap
○	○	Dysmenorrhea
○	○	Dyspareunia
○	○	Hot flashes
○	○	Irregular menses
○	○	Vaginal discharge
○	○	Other:

Integumentary ☐ All neg

Neg	Pos	
○	○	Breast discharge
○	○	Breast lump
○	○	Brittle hair
○	○	Brittle nails
○	○	Hair loss
○	○	Hirsutism
○	○	Hives
○	○	Pruritis
○	○	Mole changes
○	○	Rash
○	○	Skin lesion
○	○	Other:

Musculoskeletal ☐ All neg

Neg	Pos	
○	○	Back pain
○	○	Joint pain
○	○	Joint swelling
○	○	Muscle weakness
○	○	Neck pain
○	○	Other:

Hematologic / Lymphatic ☐ All neg

Neg	Pos	
○	○	Easy bleeding
○	○	Easy bruising
○	○	Lymphadenopathy
○	○	Other:

Immunologic ☐ All neg

Neg	Pos	
○	○	Contact allergy
○	○	Environmental allergies
○	○	Food allergies
○	○	Seasonal allergies
○	○	Other:

ⓘ ☐ All others negative

Reproductive ☐ All neg

Neg	Pos	
○	○	Erectile dysfunction
○	○	Penile discharge
○	○	Sexual dysfunction
○	○	Other:

Psychiatric ☐ All neg

Neg	Pos	
○	○	Anxiety
○	○	Depression
○	○	Insomnia
○	○	Other:

Musculoskeletal ☐ All neg

Neg	Pos	
○	○	Back pain
○	○	Joint pain
○	○	Joint swelling
○	○	Muscle weakness
○	○	Neck pain

Neurological ☐ All neg

Neg	Pos	
○	○	Dizziness
○	○	Extremity numbness
○	○	Extremity weakness
○	○	Gait disturbance
○	○	Headache

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Name: _____

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Past Medical History:

- ☐ Anemia
- ☐ Angina
- ☐ Arrhythmia
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Blood clots
- ☐ Brain tumor
- ☐ Cerebrovascular accident
- ☐ Cirrhosis
- ☐ Colon cancer
- ☐ Congestive heart failure
- ☐ COPD
- ☐ Coronary artery disease
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Hepatitis C
- ☐ HIV/AIDS
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Kidney failure
- ☐ Liver disease
- ☐ Lung cancer
- ☐ Migraine headaches
- ☐ Multiple Sclerosis
- ☐ Parkinson's disease
- ☐ Peripheral nerve disorder
- ☐ Renal disease
- ☐ Rheumatoid arthritis
- ☐ Seizure disorder
- ☐ Spinal cord tumor
- ☐ Thyroid disease
- ☐ Tremor

Gender Specific:

- ☐ Breast cancer

Past Surgical History:

☐ Anesthesia reaction		☐ Carpal tunnel release		☐ Knee replacement		**Gender Specific:**	
☐ Aneurysm clipping/resection		☐ Cataract extraction		☐ Laminectomy		☐ Cesarean section	
☐ Angioplasty with stent		☐ Cerebral shunt		☐ LASIK		☐ D and C	
☐ Angioplasty		☐ Cholecystectomy		☐ Muscle biopsy		☐ Hysterectomy	
☐ Appendectomy		☐ Colectomy		☐ ORIF		☐ Mastectomy	
☐ Arthroscopy knee		☐ Colostomy		☐ Pacemaker		☐ Myomectomy	
☐ Arthrodesis		☐ Discectomy		☐ Small bowel resection		☐ Reduction mammoplasty	
☐ Back surgery		☐ Gastric bypass		☐ Spinal infusion pump		☐ TAH / BSO	
☐ CABG		☐ Hernia repair		☐ Thyroidectomy		☐ Vaginal hysterectomy	
☐ Carotid endarterectomy		☐ Hip replacement		☐ Tonsillectomy			

Other Past Medical and/or Surgical History:

System:	Disease:	Year:	Management:	Year:	Outcome:

Spinal Cord Stimulator (if yes, when): Trial: Y / N Year: _____ Permanent Implant: Y / N Year: _____

Morphine Pump (if yes, when): Trial: Y / N Year: _____ Permanent Implant: Y/N Year: _____

Family History:

Relation	Status	Diagnosis (cause of death y/n?)	Relation	Status	Diagnosis (cause of death y/n?
Mother	Alive & Well/Deceased		Sister	Alive & Well/Deceased	
Father	Alive & Well/Deceased		Brother	Alive & Well/Deceased	

Patient History:

Tobacco usage: current ____ former ____ never ____ type _____ units/day _____ years used _____

Alcohol usage: no ____ yes ____ formerly ____ Caffeine usage: no _____ yes _____

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CONSENT FOR CHRONIC OPIOID THERAPY

Colorado Springs Pain Consultants *physicians and allied health professionals are prescribing Opioid medicine, 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 of such medicine has certain risks associated with it, including but not limited to, sleepines or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowin of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and possibility that the medicine will not provide complete pain relief.

I am aware about the possible risks and benefits of other types of treatments that do not involve the use of Opioids. I will tell my physician about all other medicines and treatments that I am receiving. I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include, but are not limited to: Using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for his/herself.

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

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

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

I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain; however, it has been seen and may occur to me. If it occurs, increasing doses may not always help, and may cause unacceptable side effects. Tolerance or failure to respond well to Opioids may cause my physician 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 physician family 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 medicine, I will immediately call my obstetric physician and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medicines, the baby will be physically dependent on Opioids. I am awar that the use of Opioids is not generally associated with a risk of birth defects.

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However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an Opioid.

Summary of Guidelines for prescribed Opiates:

1. The patient must provide copies of reports from previous and concurrent treating physicians
2. The patient must provide CSPC accurate patient address and phone number and keep us up to date of any changes in their personal information.
3. Colorado Springs Pain Consultants physicians and allied health professionals will be the only providers to prescribe controlled substances for pain.
4. The patient must provide us with the name and phone number of the pharmacy that the patient is using and keep us up to date with any changes.
5. The patient must be seen for regular office visits to receive a medication refill. Prescriptions will be written for a 30-day supply and will not be filled earlier than one (1) month.
6. The safety of the patient's medication is the patient's responsibility.
7. The patient is responsible for all prescriptions/medications given and must understand that is the prescriptions/medications are lost, misplaced or destroyed; the prescriptions/medications **cannot be replaced.**
8. **No refills will be made after hours, on weekends or on holidays.** The patient will need to notify the office for a refill at least three (3) days in advance.
9. Other classifications of medications may be prescribed to assist in pain management and limit opiate use.
10. Other therapies may be ordered to assist in pain management such as nerve blocks, TENS, physical or occupational therapy, psychological counseling as appropriate to the diagnosis.
11. The patient understands that no trustworthy patient-doctor relationship can be had with a patient that abuses illegal drugs. "Street Drugs" such as marijuana, cocaine, amphetamines, etc. are in and out of themselves dangerous. Mixed with some of the medicines often used in pain management, the combination could be lethal.
12. We will periodically check the patient's urine for compliance with therapy. The urine will be tested for the presence of the prescribed drugs as well as several other drugs, including illegal drugs.
13. The patient understands that if we find a urine sample that contains illegal substances, we may end the patient - doctor relationship.
14. The patient has the right to refuse such random or periodic urine testing. Colorado Springs Pain Consultan reserves the right to end the patient - doctor relationship on a patient that refuses to comply with our urine drug testing policy.

The patient authorizes any physician office, hospital or clinic to provide full details of medical history and treatmer to CSPC for the use of continuity of care by completing a medical release form up to date.

Any breach of these guidelines may result in the patient being discharged from the practice of Colorado Springs Pai Consultants.

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

_____ _____

Patient signature Date

_____ _____

Witness printed name and signature Date

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Name: _____

Date of Birth: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____ **Date of birth:** _____

Email address (provide only if you would like electronic copy of records): _____

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
4105 Briargate Pkwy, Suite 235, Colorado Springs, CO 80920
Phone: (719) 375-5400 Fax: (719) 434-7474

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

PHYSICIAN OFFICES (please list all physicians you have seen in the past two years)

	Physician's Name	Address	Phone Number
1.			
2.			
3.			

PHARMACY (please provide an updated list of all pharmacies that you have used in the past two years)

	Pharmacy Name	Address	Phone Number
1.			
2.			
3.			

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.			

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 of **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

Name: _____

Date of Birth: _____

CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give my consent for CSPC to furnish medical care and treatment to myself, _____ considered necessary and proper in diagnosing or treating his/her physical and mental condition

Patient/Guardian/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 maior medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payors 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: CSPC 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 of care. W 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/Guardian/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 terminatior you will be responsible for the amount of money 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 a guarantee of payment. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to **CSPC.**

Patient Authorizations

- By my signature below, I hereby authorize Colorado Springs Pain Consultants and the physicians, 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 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 one or more of the following boxes, the health information I authorize to be released may include any of 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, includir narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatmen 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 assignment.
- By my signature below, I authorize Colorado Springs Pain Consultants personnel to communication by mail, answering machine message, and/or email according to the information I have provided in my patient registration information.

The above may not apply for those 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 fo all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.**

I UNDERSTAND MY RESPONSIBILTY FOR THE PAYMENT OF MY ACCOUNT:

_____ _____

Patient/Guardian/Responsible Party Date Witness printed name and signature Date

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