Dear New Patient,

Thank you for choosing Shaw Pain Clinic for your pain management needs. We look forward to seeing you at your upcoming appointment! Please take a moment to review the following information to ensure a smooth transition into our group.

We have enclosed our new patient paperwork packet for you to complete prior to your appointment. You will also find a records release authorization form, please fill this out so that we can obtain your records from any previous doctor. If you have had diagnostic imaging done, please ensure we have copies of the reports prior to your visit. **Please return the completed new patient packet to our office at least a week prior to your new patient appointment to save time during your initial visit with us.**

Our office will attempt to confirm your appointment with you via text and/or phone call 2-3 business days prior to your appointment. It is important that you confirm your appointment with us. Shaw Pain Clinic requires a 24 hour notice if you need to cancel or reschedule your appointment, or you will incur a no show fee of $100.00 and cannot be rescheduled until this is paid.

Your specific appointment details are outlined below. If you have any questions leading up to your appointment, Please don't hesitate to call us at (830) 220-5007.

We welcome you to Shaw Pain Clinic and look forward to serving you!

Sincerely,
Shaw Pain Clinic Staff

Patient Name:		
Appointment Date:	**Arrival Time:**	**Appointment Time:**
Your appointment is at the following location: **503 E FM 1431, Ste 201** **Marble Falls, TX 78654** **In order for our provider to see all of our patients in a timely manner, if you arrive beyond your appointed **ARRIVAL TIME**, you may be asked to reschedule your appointment.*		

J. Kaleb Shaw, MD
503 E FM 1431, Ste 201 | Marble Falls, TX 78654
Phone: (830) 220-5007 | Fax: (830) 220-5009

PATIENT REGISTRATION FORM

Registration forms are required to be updated on an annual basis
(Please print or write legibly)

Patient Information

□ Mr. □ Mrs. □ Ms. □ Jr. □ Sr. □ Other_____________
Patient's Name (Last)___________________ (First)__________________ (Middle)_________________
(as it appears on your insurance card)
Preferred Name ____
Marital Status □ Married □ Single □ Divorced □ Legally Separated □ Widowed □ Other____________
Social Security Number _____-____-______ □ Female □ Male Date of Birth____/_____/_____
E-Mail Address____
Phone Numbers Cell_____________ Home_______________ Work__________________
Mailing Address___________________________________ City, State__________________ Zip_______
Physical Address__________________________________ City, State__________________ Zip________
Employment Status □ Employed □ Student □ Retired □ Self Employed □ Unemployed □ Disabled
Employer____
Patient Relationship to Responsible Party____

Primary Insurance Information

Provide your insurance card to the receptionist at check-in
Name of Insured___________________________________ Patient Relationship to Insured__________
Insured Employer Name____
Insurance Company/Phone Number___________________________ | (_______) _______-__________
Insurance Claims Address________________________________ City, State______________ Zip_______
Subscriber ID (Policy Number)_________________________________ Group Number_______________
Effective Date___________________ Term Date___________________
Policy Holder's Date of Birth_________________________ Social Security Number_____-____-_______

Secondary Insurance Information

Provide your insurance card to the receptionist at check-in
Name of Insured___________________________________ Patient Relationship to Insured__________
Insured Employer Name____
Insurance Company/Phone Number___________________________ | (_______) _______-__________
Insurance Claims Address________________________________ City, State______________ Zip_______
Subscriber ID (Policy Number)_________________________________ Group Number_______________
Effective Date___________________ Term Date___________________
Policy Holder's Date of Birth_________________________ Social Security Number_____-____-_______

Assignment and Authorization of Benefits for Patients with Insurance

I hereby assign all medical and /or surgical benefits, to which I am entitled, including Medicare, private insurance, and other plans to Shaw Pain Clinic, PLLC. I understand that I am financially responsible for all charges, co-payments, co-insurance and deductibles. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical record. I authorize insurance claims filed and benefits assigned. I agree that the information supplied on this form is accurate and up to date to the best of my knowledge.

____ ______________________________
Patient Signature Date

____ ______________________________
Printed Patient Name Date of Birth

GENERAL CONSENT FOR CARE AND TREATMENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). The consent will remain fully effective until it is revoked in writing.

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. You have the right at any time to discontinue services.

I voluntarily request a Shaw Pain Clinic physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at Shaw Pain Clinic, PLLC. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

______________________________________	______________________________________
Signature of Patient	Date
______________________________________	______________________________________
Printed name of Patient	Date

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name:___________________________________ Date of Birth:_____________________

- I authorization **Shaw Pain Clinic, PLLC** to release information from my medical record, as described in this form.
- Many of our patients allow family members to call and discuss medical information, request prescription refills, medical records, results of tests, pick up forms, etc. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have any of your medical information released to family members, you must sign this form. Signing this form will only give consent to release said information to the individuals indicated below.

_____________________________________ __________________ _______________________
Name Relationship Phone Number

_____________________________________ __________________ _______________________
Name Relationship Phone Number

Check all that apply to the above names:

□ Regarding appointment, time & date □ Discuss lab results □ Discuss imaging results
□ Pick up prescriptions □ Pick up forms □ Discuss medical care
□ Discuss billing information

RIGHT TO REVOKE: *I understand that I can withdraw at any time by giving written notice stating my intent to TERMINATE this authorization to* ***Shaw Pain Clinic, PLLC 503 E FM 1431, Ste 201 Marble Falls TX, 78654.*** *I understand that prior actions taken in reliance on this authorization by entities that had permission to access my Medical Record will not be affected.*

SIGNATURE AUTHORIZATION: *I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop release of Medical Record that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code 181.154(c) and/or 45 C.F.R. 164.502(a)(1). I understand that information released pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.*

____ _______________________
Patient Signature Date

____ _______________________
Legally Authorized Representative Relationship to Patient

____ _______________________
Witness Date

FINANCIAL POLICY

Patient's Name:_______________________________ Date of Birth:___________________________

Thank you for choosing **Shaw Pain Clinic, PLLC** as your health care provider. The following is our Financial Policy. If you have any questions or concerns about our payment policies, please do not hesitate to ask our front office personnel. We ask that all patients read and sign our Financial Policy prior to seeing a medical care provider.

Patient's portion of payment, including co-pay, deductible, and/or balance on account is due at the time services are rendered unless prior arrangements have been made with the office. We accept assignment with most major insurance companies and participating provider plans. However, you must understand that:

___ 1. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance carrier. We verify your benefits as a courtesy and do not guarantee coverage or payment.
___ 2. All charges are your responsibility whether your insurance company pays or not.
___ 3. Fees for services, along with unpaid deductibles and co-payments, are due at the time of treatment.
___ 4. If the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier to request prompt payment. Please inform our office of the carrier's response.
___ 5. Returned checks will be subject to a $25.00 collection charge. If the check is not picked up within 10 days, the check may be turned over to law enforcement.
___ 6. Completion of forms is subject to a $25.00 charge.
___ 7. No show or cancellations without 24 hour notice are subject to a $50.00 charge. **Appointment will not be allowed to reschedule until this charge is paid in full.**
___ 8. Unpaid balances over 90 days may be subject to collections via small claims court, attorney, and/or collection agency with applicable collection fees. All collection fees are the responsibility of the patient.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Authorization to Release and Assign Insurance Benefits: I authorize release of **ANY** medical information, including substance abuse, mental health, and HIV/AIDS records, required to act on **ANY** medical insurance claim and permit photographic or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to **Shaw Pain Clinic, PLLC** the medical and/or surgical benefits I am entitled from my insurance company(s) and/or Medicare.

This authorization is in effect for all future claims, until I choose to revoke it in writing. I, the undersigned, understand and agree to the above Financial Policy. I understand that I am financially responsible for all charges incurred for my medical treatment. I have had the opportunity to ask and have my questions answered to my satisfaction.
I have received or been offered and declined a copy of the Privacy Practices. I have had the opportunity to have any questions answered to my satisfaction regarding the privacy practices of the clinic.

Patient Signature____ Date____________________

Printed Name____

Relationship to patient_______________________________ Authorized Witness____________________

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the release of your Medical Records.

Patient Name: ____________________________________ DOB: ______________________________
Phone Number:___________________________________ Email Address:_____________________

RELEASE INFO TO:
Name: Dr. Jerod Kaleb Shaw
Address: 503 E FM 1431, Ste 201
City, State: Marble Falls Zip: 78654
Phone: 830-220-5007
Fax: 830-220-5009

OBTAIN INFO FROM:
Name:__________________________________
Address:________________________________
City, State:____________________ Zip:______
Phone:________________________________
Fax:___________________________________

Reason for Disclosure (please circle one):

Treatment/Continuing Care	Personal Use	Billing/Claims
Insurance	Legal Purposes	Disability Determination
School	Unemployment	Other:____________________________

What information can be disclosed? *Complete the following by indicating those items that you want disclosed. If entire Medical Record is to be released, then check only the first line.*

□ Entire Record	□ History/Physical Exam	□ Past/Present Medication	□ Lab Results
□ Physcians Orders	□ Patient Allergies	□ Operative Reports	□ Consultations
□ Progress Notes	□ Diagnostic Test Reports	□ Billing Information	□ Radiololgy

Your initials are required to <u>NOT</u> release the following information:

____ Mental Health Records (Excluding Psychotherapy Notes) ____ Genetic Information/Results
____ Drug, Alcohol, or Substance Abuse Records ____ HIV/AIDS test results/treatment

<u>RIGHT TO REVOKE:</u> *I understand that I can withdraw at any time by giving written notice stating my intent to TERMINATE this authorization to* ***Shaw Pain Clinic: 503 E FM 1431, Ste 201 Marble Falls, TX 78654.*** *I understand that prior actions taken in reliance on this authorization by entities that had permission to access my Medical Record will not be affected.*

<u>SIGNATURE AUTHORIZATION</u>: *I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop release of Medical Record that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code 181.154(c) and/or 45 C.F.R. 164.502(a)(1). I understand that information released pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.*

____ ________________________________
Patient Signature Date

____ ________________________________
Legally Authorized Representative Relationship to Patient

____ ________________________________
Witness Signature Date

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT
AS REQUIRED BY THE TEXAS MEDICAL BOARD
REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9 CHAPTER 170
4th Edition: Developed by the Texas Pain Society, August 2017 (www. texaspain.org)

NAME OF PATIENT: _________________________________DATE:______________________

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug(s) after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to use the drug(s) recommended to you by me, as your physician, For the purposed of this agreement the use of the word “physician” is defined to include not only my physician but also my physician’s authorized associates, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat my condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician (name at bottom of agreement) to treat my condition which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent for my physician to administer or write prescription(s) for dangerous and/or controlled drugs (medications) as an element in the treatment of my chronic pain.

It has been explained to me that these medication(s) include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT HAVE BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT (THIS IS SOMETIMES REFERRED TO AS “OFF-LABEL” PRESCRIBING). MY DOCTOR WILL EXPLAIN HIS TREATMENT PLAN(S) FOR ME AND DOCUMENT IT IN MY MEDICAL CHART.

I HAVE BEEN INFORMED AND understand that I will undergo medical tests and examinations before and during my treatment. Those tests include random unannounced checks (urine, blood, saliva, or any other testing when it is deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances or absence of authorized substances may result in my being discharged from your care.

<u>For female patients only:</u>
____ To the best of my knowledge **I am not pregnant.**
____ If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment. I accept that it is **MY responsibility** to inform my physician immediately if I become pregnant.
____ **If I am pregnant or am uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY.**

All of the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo/fetus/baby.

<u>I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING:</u> Constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension(low blood pressure), arrhythmias(irregular heartbeat), insomnia, depression, impairment of reasoning and judgement, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. 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 times 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 himself or herself.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medication(s) for the treatment of my chronic pain.

The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and functional life. I realize that I may have a chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored specifically for me. I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time and that I will notify my physician of any discontinued use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

I understand that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of medication(s) to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

PAIN MANAGEMENT AGREEMENT:
I UNDERSTAND AND AGREE TO THE FOLLOWING:

That this pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called 'narcotics, painkillers', and other prescription medications, etc.) 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 am aware that all controlled substance prescriptions are now being monitored by the Texas State Board of Pharmacy and that information will be accessed by my physician each time a prescription is written.
____ My progress will be periodically reviewed and, if the medication(s) are not improving my function and quality of life, the **medication(s) may be discontinued.**
____ I will **disclose** to my physician **all medication(s)** that I take at any time, prescribed by any physician.
____ I will use the medication(s) **exactly as directed by my physician.**
____ I agree **not to** share, sell or otherwise permit others, including my family and friends, to have access to these medication(s).
____I will **not allow or assist in the misuse/diversion of my medication; nor will I give or sell them** to anyone else.
____ All medication(s) must be obtained at **one pharmacy, where possible**. Should the need arise to change pharmacies, my physician must be informed. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my physician to release my medical records to my pharmacist as needed
____ My pain management physician will manage the chronic pain symptoms. All other health related issues must be managed by my primary care physician.
____ I understand that my medication(s) will be refilled on a regular basis, Understand that my prescription(s) and my medication(s) are exactly like money. **If either are lost or stolen, they may NOT BE REPLACED.**
____ Refill(s) **will not be ordered before the scheduled refill date.** However, early refill(s) are allowed when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.
____ I will receive controlled substance medication(s) **only from ONE physician** unless it is for an emergency or the medication(s) that is being prescribed by another physician is approved by my physician. Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.

____ If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then **my physician may try alternative medication(s) or may taper me off all medication(s).** I will not hold my physician liable for problems caused by the discontinuance of medication(s).

____ **I agree to submit to urine and / or blood screens** to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substances(s), such as marijuana, speed, cocaine, etc., treatment for chronic pain may be terminated. Also, a consult with, or referral to, an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an addictionologist or a physician who specialized in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.

____ I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize **that my active participation** in the management of my pain is extremely important. I agree to **actively participate in all aspects of the pain management program** recommended by my physician to achieve increased function and improved quality of life.

____ I agree that I **shall inform any doctor** who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.

____ I hereby give my physician **permission to** discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s). I give my pain physician permission to obtain any and all medical records necessary to diagnose and treat my painful conditions.

____ I must take the medication(s) as instructed by my physician. **Any unauthorized increase** in the dose of medication(s) may be viewed as a cause for discontinuation of treatment.

____ I just **keep all follow-up appointments** as recommended by my physician or my treatment may be discontinued.

____ I understand many prescription medication for chronic pain produce serious side effects including drowsiness, dizziness, and confusion. Alcohol will enhance all of these side effects and should be discontinued before starting these medications.

I certify and agree to the following:

____ 1) I am **not currently using illegal drugs or abusing prescription medication(s)** and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

____ 2) I have **never been involved** in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.)

____ 3) **No guarantee or assurance has been made** as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved I consent to chronic pain treatment, since I realized that it provides me an opportunity to lead a more productive and active life.

____ 4) I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain.

I fully understand the explanations regarding the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.

____ 5) If I become a patient in this clinic and receive controlled substances to control my pain, this pain management agreement supersedes any other agreement that I may have signed in the past.

____

Name and contact information for pharmacy

_______________________________________ _______________________________________

Patient Signature Physician Signature (*or Appropriately Authorized Assistant*)

____

Date

New Patient Intake Form

Your completed intake paperwork helps our physicians and other providers get to you know and your medical history better. We rely on its accuracy and completeness to provide you with the best possible care. Please inquire at our front desk or call (830) 220-5007 if you have any question on how to complete any section on this form.

Patient Information

Today's date: ____

Your name: __________________________________Date of Birth: ____________ Age: ____________

Referring Physician: ___________________________Primary Care Physician: _____________________

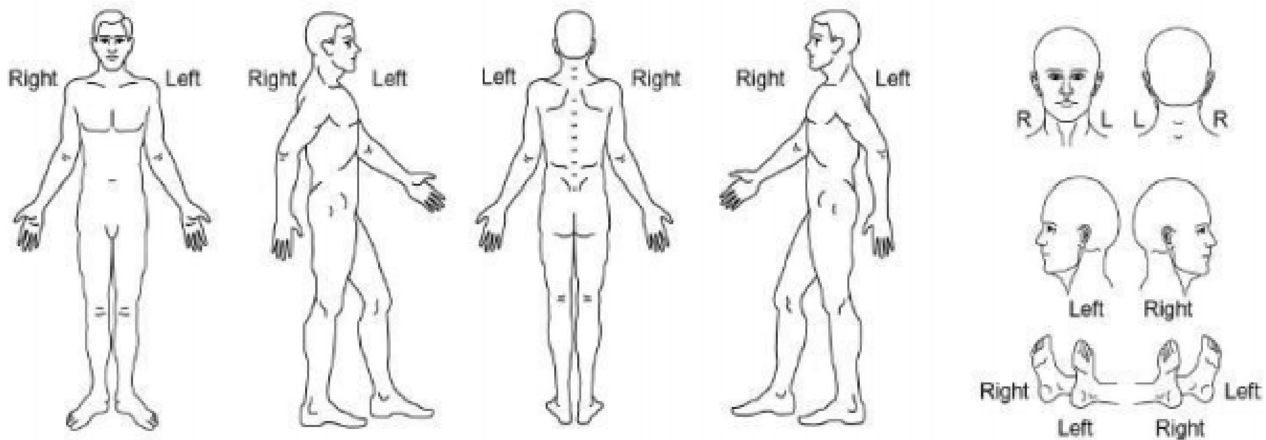
Pain History

Chief Complaint (Reason for your visit today)? ____

Does this pain radiate? If so where? ____

Please list any additional areas of pain: ____

Use this diagram to indicate the area of your pain. Please highlight PINK for pain / BLUE for numbness or tingling.



Onset of Symptoms

Approximately, when did this pain begin?____

What caused your current pain episode? ____

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

Since your pain began, how has it changed? ☐ Improved ☐ Worsened ☐ Stayed the same

TO BE COMPLETED BY OFFICE PERSONNEL

Vitals

BP:______/_______ P:________ Ht:_________ Wt:__________ BMI:___________

Allergies:____

Current Medications:____

____

____

Last O/V:___________ Type of O/V:____________ Today VAS:____________ Last VAS:______________

Last Procedure:_____________ Type of Procedure:__________________________ % of Relief:________

Provider Notes

Plan/Orders

____
J. Kaleb Shaw, MD

____
Date

Pain Description

Describe the character of your pain (eg: dull, stabbing, throbbing, etc):

____

What time of day is your pain at its worst?

____

How often does the pain occur?

☐ Constant ☐ Changes in severity but always present ☐ Intermittent (comes and goes)

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now_______________ The Best It Gets_______________ The Worst It Gets_______________

What other factors worsen or affect your pain?

____

What other factors relieve your pain?

____

Are there any associated symptoms? (eg: numbness/tingling/weakness/incontinence, etc)

____

What are the goals you wish to achieve with Pain Management? ______________________________

____

Diagnostic Testing and Imaging

☐MRI of the: ___________________________________ Facility:____________________Date: _________

☐X-Ray of the: __________________________________Facility:____________________Date: _________

☐CT Scan of the_________________________________ Facility:____________________Date: _________

☐EMG/NCV study of the: _________________________ Facility:____________________Date: _________

☐Other Diagnostic Testing: _______________________Facility:____________________Date: _________

☐ I have not had ANY diagnostic tests for my current pain complaint

Please mark all of the following treatments you have had for pain relief:

	No Change	**Worsened Pain**	**Helped Pain**
Spine Surgery	☐	☐	☐
Physical Therapy	☐	☐	☐
Chiropractic Care	☐	☐	☐
Psychological Therapy	☐	☐	☐
Brace Support	☐	☐	☐
Acupuncture	☐	☐	☐
Hot / Cold Packs	☐	☐	☐
Massage Therapy	☐	☐	☐
TENS Unit	☐	☐	☐

Interventional Pain Treatment History

□ Epidural Steroid Injection – (circle all levels that apply) Cervical / Thoracic / Lumbar

□ Joint Injection – Joint(s):____

□ Medial Branch Blocks/Facet Injections – (circle all levels that apply) Cervical / Thoracic / Lumbar

□ Nerve Blocks – Area/Nerve(s):____

□ Radiofrequency Nerve Ablation – (circle all levels that apply) Cervical / Thoracic / Lumbar

□ Spinal Cord Stimulator – Trial Only/Permanent Implant____________________________________

□ Trigger Point Injections – Where?____

□ Vertebroplasty / Kyphoplasty – Level(s):____

□ Other:____

Which of these procedures listed above have helped your pain?______________________________

____

Please list the names of other Pain Physicians you have seen in the past:

____

Mark the following physicians or specialists you have consulted for your current pain problem(s):

□ Acupuncturist ___________________________ □ Neurosurgeon__________________________________

□ Psychiatrist/Psychologist_________________ □ Chiropractor___________________________________

□ Orthopedic Surgeon_____________________ □ Rheumatologist_________________________________

□ Internist________________________________ □ Physical Therapist______________________________

□ Neurologist_____________________________ □ Other____

Past Medical History

Please mark the following conditions/diseases that you have been treated for in the past:

Cancer/Oncology

☐ Cancer – Type _______________
☐ Cancer – Type________________
☐ Cancer – Type________________

Cardiovascular/Hematologic

☐ Anemia
☐ Heart Attack
☐ Coronary Artery Disease
☐ High Blood Pressure
☐ Peripheral Vascular Disease
☐ Stoke/TIA
☐ Heart Valve Disorders
☐ Presence of stent/pacemaker/ defibrillator

Gastrointestinal

☐ GERD (Acid Reflux)
☐ Gastrointestinal Bleeding
☐ Stomach Ulcers
☐ IBS/Crohns Disease

Urological

☐ Chronic Kidney Disease
☐ Kidney Stones
☐ Urinary Incontinence
☐ Dialysis

Neurological

☐ Multiple Sclerosis
☐ Peripheral Neuropathy
☐ Seizures
☐ Balance Disorder
☐ Head Injury
☐ Headaches
☐ Migraines

ENT

☐ Glaucoma
☐ Vertigo
☐ Hearing Problems
☐ Nosebleeds

Respiratory

☐ Asthma
☐ Bronchitis/Pneumonia
☐ Emphysema/COPD

Musculoskeletal/Rheumatologic

☐ Bursitis
☐ Carpal Tunnel Syndrome
☐ Fibromyalgia
☐ Osteoarthritis
☐ Osteoporosis
☐ Rheumatoid Arthritis
☐ Chronic Joint Pains

Psychological

☐ Depression
☐ Anxiety
☐ Schizophrenia
☐ Bipolar Disorder
☐ ADD/ADHD
☐ PTSD

Endocrinology

☐ Diabetes – Type_____________
☐ Hyperthyroidism
☐ Hypothyroidism

Other Diagnosed Conditions

☐ ____________________________
☐ ____________________________
☐ ____________________________
☐ ____________________________

Past Surgical History

Please list any surgical procedures you have had done in the past, including date:

1) ____ Date?______________________________
2) ____ Date?______________________________
3) ____ Date?______________________________
4) ____ Date?______________________________
5) ____ Date?______________________________

□ I have **never** had any surgical procedures performed.

Family History

Please mark all appropriate diagnoses as they pertain to your parents and siblings:

□ Arthritis □ Cancer □ Diabetes
□ Headaches /Migraines □ High Blood Pressure □ Kidney Problems
□ Liver Problems □ Osteoporosis □ Rheumatoid Arthritis
□ Seizures □ Stroke
□ Other Medical Problems:____
□ I have no significant family medical history

Social History

Occupation:__________________________________ When was the last time you worked?_____________

Check which ones applies: □ Temporary Disability □ Permanent Disability □ Retired □ Unemployed

Who is in your current household?____

Alcohol Use:

□ Social use □ Daily use of alcohol □ Never □ History of alcoholism □ Current alcoholism

Tobacco Use:

□ Current use □ Former user □ Never used

□ Packs per day?_______ How many years? _______ □ Quit Date:_________

Illegal Drug Use:

□ Denies any illegal drug use □ Currently uses illegal drugs □ Formerly used illegal drugs

Have you ever abused narcotic or prescription medications? □ Yes □ No

Current Medications

Are you currently taking any blood thinners or anti-coagulants? □ Yes □ No
If YES, which one? □ Aspirin □ Plavix □ Coumadin □ Eliquis □ Xarelto □ Aggrenox □ Other_________
Who is the prescribing physician?____

Please list all medications you are currently taking, including vitamins. Attach an additional sheet or medication list if required:

Medication Name	**Dose**	**Frequency**
1)________________________________	____________________	____________________
2)________________________________	____________________	____________________
3)________________________________	____________________	____________________
4)________________________________	____________________	____________________
5)________________________________	____________________	____________________
6)________________________________	____________________	____________________
7)________________________________	____________________	____________________
8)________________________________	____________________	____________________
9)________________________________	____________________	____________________
10)_______________________________	____________________	____________________

Please list all past pain medications that you have been on at any point for your current pain complaints?

Medication Name	**Dose**	**Frequency**
1)________________________________	____________________	____________________
2)________________________________	____________________	____________________
3)________________________________	____________________	____________________
4)________________________________	____________________	____________________
5)________________________________	____________________	____________________

Only if any of your medications cause constipations, please answer these questions. If not, you can skip this section.

On average, how often do you have a bowel movement?
(Please check one)
□ More than 3 times per day
□ 2 to 3 times per day
□ Once per day
□ 2 to 3 times per week
□ Less than once per week

Allergies

Do you have any drug/medication allergies? ◻ Yes ◻ No
If so, please list all medications that you are allergic to:

Medication Name	**Allergic Reaction**
1)___________________________________	___________________________
2)___________________________________	___________________________
3)___________________________________	___________________________
4)___________________________________	___________________________
5)___________________________________	___________________________

Topical Allergies: ◻ Latex ◻ Iodine ◻ Tape ◻ IV Contrast

Review of Systems

Mark the following symptoms that you currently suffer from:

Constitutional: ☐Fevers ☐Chills ☐Sweats ☐Weakness ☐Fatigue ☐Decreased Activity ☐Malaise ☐Unexplained weight gain ☐Unexplained weight loss ☐Low sex drive ☐Difficulty sleeping

Eyes: ☐Blurriness ☐Double vision ☐Visual disturbance ☐Pain

Ears/Nose/Throat/Neck: ☐Hearing problems ☐Ear pain ☐Sinus problems ☐Sore throat ☐Nosebleeds

Respiratory: ☐Shortness of breath ☐Cough ☐Sputum production ☐Wheezing

Cardiovascular: ☐Chest pain ☐Palpitations ☐Swelling in feet ☐Shortness of breath during sleep ☐Bleeding disorder ☐Blood clots ☐Fainting

Gastrointestinal: ☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation ☐Heartburn ☐Abdominal pain

Genitourinary/Nephrology: ☐Painful urination ☐Blood in urine ☐Change in urine stream ☐Unusual discharge ☐Flank pain ☐Urinary incontinence

Musculoskeletal: ☐Back pain ☐Neck pain ☐Joint pain ☐Muscle pain ☐Muscle cramp ☐ Muscle spasm ☐Gait disturbances ☐Joint stiffness ☐Joint swelling ☐Trauma

Integumentary: ☐Rash ☐Itching ☐Lesions ☐Bruising

Neurological: ☐Abnormal balance ☐Confusion ☐Numbness ☐Tingling ☐Dizziness ☐Headaches ☐Loss of coordination ☐Memory loss ☐Seizures ☐Tinnitus ☐Tremors ☐Vertigo

Psychiatric: ☐Feeling anxious ☐Depressed mood ☐Suicidal thoughts ☐Hallucinations ☐Stress problems ☐Suicidal planning ☐Thoughts of harming others

SLEEP DISORDER RISK ASSESSMENT

□ Please check here if you have already been diagnosed with sleep apnea and are currently undergoing treatment. If this is the case, it is not necessary for you to complete remainder of this survey. Thank you!

What is Sleep Apnea?
Sleep apnea is the most common form of Sleep Disordered Breathing (SDB). It refers to a variety of breathing difficulties a person may experience while sleeping.

The symptoms listed in the checklist on this form describe many of the symptoms of sleep apnea. Often it is a sleep partner who recognizes these signs, and the patient is unaware of his or her unusual or irregular breathing during sleep. Some people with sleep apnea may stop and restart breathing hundreds of times in a single night.

What are the Risk Factors Associated with SDB?
Sleep apnea and snoring increase the risk for high blood pressure, heart failure, stroke, automobile and work-related accidents, and other affects of not getting enough sleep.

80% of uncontrolled high blood pressure patients suffer from Sleep Disordered Breathing (SDB).
58% of chronic pain patient's suffer from SDB.
50% of heart failure patients suffer from SDB.
45% of high blood pressure patients suffer from SDB.
30% of heart disease patients suffer from SDB.

How is SDB treated?
The good news is that SDB is easily treated. A number of treatment options are available that will improve quality of life.

Nearly half of all Americans suffer from sleep disorders. Please take this survey to help identify your risk.

□ I have had a sleep study within the past 5 years or I am currently being treated for sleep apnea. If you checked the above box, you do not need to complete the remainder of this sleep survey.
□ I snore or I have been told I snore.
□ I have been told I stop breathing when I sleep or sometimes I wake up snoring, gasping or choking.
□ I have trouble staying asleep at night.
□ I feel fatigued during the day.
□ I feel sleepy or fall asleep at times during the day.
□ My quality of sleep is poor and I don't feel refreshed upon awakening.
□ I have been diagnosed with any of these: high blood pressure, atrial fibrillation or congestive heart failure.

If you have questions or concerns about a sleep disorder, please discuss during your visit.

TOTAL NUMBER OF BOXES CHECKED: _________

NOTICE OF PRIVACY PRACTICES

Effective Date: December 1st, 2019

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the office by dialing the main office number.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by the facility, whether made by facility personnel, agents of the facility, or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your health information created in the doctor's office or clinic.

Our Responsibilities
We are required by law to maintain the privacy of your health information, provide you a description of our privacy practices, and to notify you following a breach of unsecured protected health information. We will abide by the terms of this notice.

Uses and Disclosures
How we may use and disclose Health Information about you.

The following categories describe examples of the way we use and disclose health information:

For Treatment: We may use health information about you to provide you treatment or services. We may disclose health information about you to doctors, nurses, technicians, medical students, or other facility personnel who are involved in taking care of you at the facility. For example: a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Different departments of the facility also may share health information about you in order to coordinate the different things you may need, such as prescriptions, lab work, meals, and x-rays.

We may also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you're discharged from this facility.

For Payment: We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information about your surgery so they will pay us or reimburse you for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it.

For Health Care Operations: Members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve. For example, we may combine health information about many patients to evaluate the need for new services or treatment. We may disclose information to doctors, nurses, and other students for educational purposes. And we may combine health information we have with that of other facilities to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy.

We may also use and disclose health information:
- To remind you that you have an appointment for medical care;
- To assess your satisfaction with our services;
- To tell you about possible treatment alternatives;
- To tell you about health–related benefits or services;
- For population based activities relating to improving health or reducing health care costs;
- For conducting training programs or reviewing competence of health care professionals

When disclosing information, primarily appointment reminders and billing/collections efforts, we may leave messages on your answering machine/voice mail.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include our laboratory testing. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, business associates are required by federal law to appropriately safeguard your information.

Individuals Involved in Your Care or Payment for Your Care and/or Notification Purposes: We may release health information about you to a friend or family member who is involved in your medical care or who helps pay for your care or to notify, or assist in the notification of (including identifying or locating), a family member, your personal representative, or another person responsible for your care of your location and general condition. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort in order to assist with the provision of this notice.

Future Communications: We may communicate to you via newsletters, mail outs or other means regarding treatment options, health related information, disease-management programs, wellness programs, research projects, or other community based initiatives or activities our facility is participating in.

Organized Health Care Arrangement: This facility and its medical staff members have organized and are presenting you this document as a joint notice. Information will be shared as necessary to carry out treatment, payment and health care operations. Physicians and caregivers may have access to protected health information in their offices to assist in reviewing past treatment as it may affect treatment at the time.

Health Information Exchange/Regional Health Information Organization: Federal and state laws may permit us to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share your health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of your health records; decreasing the time needed to access your information; aggregating and comparing your information for quality improvement purposes; and such other purposes as may be permitted by law.

As required by law. We may disclose information when required to do so by law.

As permitted by law, we may also use and disclose health information for the following types of entities,
including but not limited to:
Food and Drug Administration
Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
Correctional Institutions
Workers Compensation Agents
Organ and Tissue Donation Organizations
Military Command Authorities
Health Oversight Agencies
Funeral Directors and Coroners
National Security and Intelligence Agencies
Protective Services for the President and Others
A person or persons able to prevent or lessen a serious threat to health or safety

Law Enforcement: We may disclose health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

For Judicial or Administrative Proceedings: We may disclose protected health information as permitted by law in connection with judicial or administrative proceedings, such as in response to a court order, search warrant or subpoena.

Authorization Required: We must obtain your written authorization in order to use or disclose psychotherapy notes, use or disclose your protected health information for marketing purposes, or to sell your protected health information.

State-Specific Requirements: Many states have requirements for reporting including population-based activities relating to improving health or reducing health care costs. Some states have separate privacy laws that may apply additional legal requirements. If the state privacy laws are more stringent than federal privacy laws, the state law preempts the federal law.

Your Health Information Rights
Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the **Right to:**

◊ **Inspect and Copy:** You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the facility will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

◊ **Amend:** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the facility. Any request for an amendment must be sent in writing to our office.

We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

◊ **An Accounting of Disclosures:** You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment or health care operations where an authorization was not required.

◊ **Request Restrictions:** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. Any request for a restriction must be sent in writing to our office.

We are required to agree to your request only if 1) except as otherwise required by law, the disclosure is to your health plan and the purpose is related to payment or health care operations (and not treatment purposes), and 2) your information pertains solely to health care services for which you have paid in full. **For other requests, we are not required to agree.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

◊ **<u>Request Confidential Communications:</u>** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work instead of your home. The facility will grant reasonable requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.

◊ **<u>A Paper Copy of This Notice:</u>** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

If the facility has a website you may print or view a copy of the notice by clicking on the Notice of Privacy Practices link.

To exercise any of your rights, please obtain the required forms from the Privacy Official and submit your request in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the facility and on our website and include the effective date. In addition, each time you register at or are admitted to the facility for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the facility by following the process outlined in the facility's Patient Rights documentation. You may also file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

<u>You will not be penalized for filing a complaint.</u>

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us permission to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provided to you.