EXCEL
PAIN AND SPINE

New Patient Demographics - Please Provide the Following Information:

Date:_____

PATIENT:

Name (Last, First, MI): _____

Social Security Number: _____ Birthdate: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Gender (circle): M / F Age: _____ Height: _____'_____" Weight: _____lbs

Marital Status: (circle one) SINGLE MARRIED WIDOWED SEPARATED DIVORCED

Spouse's Name: _____ Spouse's Phone Number:_____

PHARMACY:

Name: _____

Address: _____

Referring Physician Name: _____ Phone: _____

EMPLOYMENT: (circle one)

EMPLOYED DISABLED RETIRED FULL-TIME STUDENT PART-TIME STUDENT UNEMPLOYED

Patient Employer: _____

Business Address & Phone: _____

INSURANCE:

Do you have medical insurance? (circle) YES NO

PRIMARY INSURANCE NAME: _____ID #: _____

Group #: _____ Subscriber: _____

SECONDARY INSURANCE NAME:_____ID #: _____

Group #: _____ Subscriber: _____

Workers Compensation: (circle) YES NO

Claim #: _____ Adjuster: _____

Phone #: _____ Fax #: _____ Date of Injury: _____

Claims Mailing Address:_____

NEW PATIENT QUESTIONNAIRE

Last Name	First Name	Middle Name	Sex	Date of Birth
_____	_____	_____	_____	_____

Referring Physician: _____

Family Physician: _____

Past Medical History

Diabetes (high blood sugar): Yes No

Bleeding Disorder: Yes No

Cancer: Yes No Type: _____

Other Medical Conditions:

_____

_____

_____

_____

_____

Medication Allergies and Reaction:

_____

_____

_____

_____

_____

Current Medications / Dose / How often taken

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Are you on blood thinners? (Y/N)

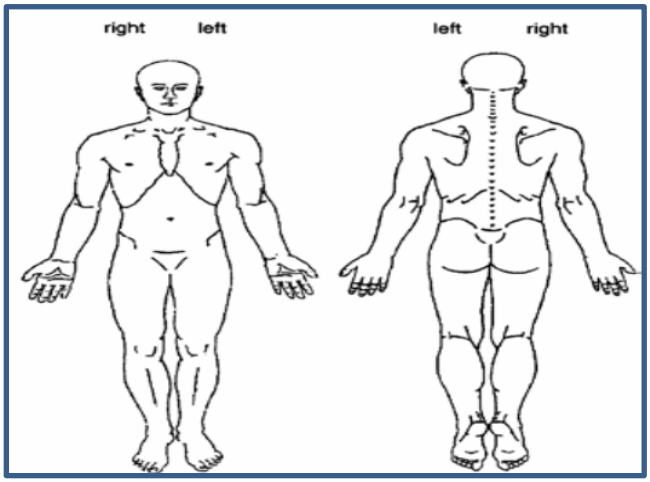
If yes, which one?

_____

When did your pain begin? _____

Was there an inciting event? _____

Shade the locations you have pain:



How would you rate your pain?

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst pain imaginable

What makes your pain **better**? (i.e. sitting, lying down, heat, cold, standing, etc) _____

_____

What makes your pain **worse**? (i.e. movement, walking, bending over, weather, etc) _____

_____

Other Symptoms or Concerns:

_____

_____

_____

_____

_____

NEW PATIENT QUESTIONNAIRE

Last Name	First Name	Middle Name	Sex	Date of Birth
_____	_____	_____	_____	_____

Family History

Circle any of the following that run in your family:

Similar pain	Arthritis	Cancer
Depression	Bleeding disorder	Substance abuse

Social History

Do you use tobacco products? YES / NO

Do you drink alcohol? YES / NO

Do you use illegal drugs? YES / NO

Previous Surgeries and Date of Surgery:

_____

_____

_____

_____

_____

PREVIOUSLY TRIED THERAPIES:

Physical Therapy: YES / NO
If yes where:_____

Chiropractic Care: YES / NO
Massage Therapy: YES / NO
Heat/Ice Pool Therapy: YES / NO
TENS unit: YES / NO
Brace/Orthotic: YES / NO

PREVIOUSLY TRIED PROCEDURES:

Epidural Steroid Injection: YES / NO
Facet joint/medial branch nerve block
Radiofrequency Ablation (RFA): YES / NO
Joint Injections: YES / NO
Trigger point injection: YES / NO
Spinal Cord Stimulation: YES / NO
Surgery: YES / NO

PREVIOUSLY TRIED MEDICATIONS:

Cymbalta/duloxetine: YES / NO
Amitriptyline/Elavil: YES / NO
Nortriptyline/Pamelor: YES / NO
Effexor or Venlafaxine: YES / NO

Membrane Stabilizers
Gabapentin: YES / NO
Lyrica/Pregabalin: YES / NO
Topamax/Topiramate: YES / NO

Muscle Relaxants
Tizanidine/Zanaflex: YES / NO
Flexeril/cyclobenzaprine: YES / NO
Robaxin/Methocarbamol: YES / NO
Baclofen: YES / NO

NSAIDS
Advil/Motrin/Ibuprofen: YES / NO
Celebrex: YES / NO
Mobic/meloxicam: YES / NO
Tylenol/acetaminophen: YES / NO

Opioids
Hydrocodone: YES / NO
oxycodone: YES / NO
tramadol: YES / NO
Butrans/Belbuca: YES / NO
morphine: YES / NO

Any other information you would like for our team to know:

_____

_____

_____

Patient Signature: _____

Date: _____ **Time: _____**

Provider Signature: _____

Date: _____ **Time: _____**

Patient Name: _____ Date: ____/_____/_____

Please answer each question as honestly as possible by putting the corresponding number in the box to the right (ie, if "Seldom" write "1", if "Sometimes" write "2", etc). There are no right or wrong answers.

SCORE	COLOR	Initials of Reviewer

SOAPP®-R

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?					
2. How often have you felt a need for higher doses of medication to treat your pain?					
3. How often have you felt impatient with your doctors?					
4. How often have you felt that things are just too overwhelming that you can't handle them?					
5. How often is there tension in your home?					
6. How often have you counted pain pills to see how many are remaining?					
7. How often have you been concerned that people will judge you for taking pain medication?					
8. How often do you feel bored?					
9. How often have you taken more pain medication than you were supposed to?					
10. How often have you worried about being left alone?					
11. How often have you felt a craving for medication?					
12. How often have others expressed concern over your use of medication?					
13. How often have any of your close friends had a problem with alcohol or drugs?					
14. How often have others told you that you had a bad temper?					
15. How often have you felt consumed by the need to get pain medication?					
16. How often have you run out of pain medication early?					
17. How often have others kept you from getting what you deserve?					
18. How often, in your lifetime, have you had legal problems or been arrested?					
19. How often have you attended an AA or NA meeting?					
20. How often have you been in an argument that was so out of control that someone got hurt?					
21. How often have you been sexually abused?					
22. How often have others suggested that you have a drug or alcohol problem?					
23. How often have you had to borrow pain medications from your family or friends?					
24. How often have you been treated for an alcohol or drug problem?					
Has any relative had a problem with: **(Please circle Y/N for each item below)** Alcohol: Y/N Addiction: Y/N Mental Illness: Y/N					

Green = less than 9	***Yellow = 10-21***	***Red = 22 and over***

Please include any additional information you wish about the above answers. Thank you.

Name:_____

Date of Birth:_____

OSWESTRY PATIENT QUESTIONNAIRE

Instructions: this questionnaire has been designed to give us information as to how your pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you at this time. We realize you may consider 2 of the statements in any section may relate to you, but please mark the box which most closely describes your current condition.

1. PAIN INTENSITY
- ☐ I can tolerate the pain I have without having to use pain killers
- ☐ The pain is bad but I manage without taking pain killers
- ☐ Pain killers give complete relief from pain
- ☐ Pain killers give moderate relief from pain
- ☐ Pain killers give very little relief from pain
- ☐ Pain killers have no effect on the pain and I do not use them

2. PERSONAL CARE (e.g. Washing, Dressing)
- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but manage most of my personal care
- ☐ I need help every day in most aspects of self care
- ☐ I don't get dressed, I was with difficulty and stay in bed

3. LIFTING
- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, i.e. on a table
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift very light weights
- ☐ I cannot lift or carry anything at all

4. WALKING
- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me walking more than one mile
- ☐ Pain prevents me walking more than ½ mile
- ☐ Pain prevents me walking more than ¼ mile
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time and have to crawl to the toilet

5. SITTING
- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than one hour
- ☐ Pain prevents me from sitting more than ½ hour
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

6. STANDING
- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than one hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

7. SLEEPING
- ☐ Pain does not prevent me from sleeping well
- ☐ I can sleep well only by using medication
- ☐ Even when I take medication, I have less than 6 hrs sleep
- ☐ Even when I take medication, I have less than 4 hrs sleep
- ☐ Even when I take medication, I have less than 2 hrs sleep
- ☐ Pain prevents me from sleeping at all

8. SOCIAL LIFE
- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. dancing, etc.
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

9. TRAVELLING
- ☐ I can travel anywhere without extra pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad, but I manage journeys over 2 hours
- ☐ Pain restricts me to journeys of less than 1 hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from traveling except to the doctor or hospital

10. EMPLOYMENT/ HOMEMAKING
- ☐ My normal homemaking/ job activities do not cause pain.
- ☐ My normal homemaking/ job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/ job duties, but pain prevents me from performing more physically stressful activities (e.g. lifting, vacuuming)
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job or homemaking chores.

MEDICAL RECORDS RELEASE FORM

Patient Name:_____

Date of Birth:_____ Phone Number:_____

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that, by initializing this form, I am specifically authorizing the release of this information.

Initials: _____ Date: _____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below:

EXCEL Pain and Spine
Phone: (813) 701-5804
Fax: (813) 291-7615
Documents@excelpainandspine.com
www.excelpainandspine.com

TAMPA: 620 S McDill Ave., Suite B, Tampa, FL 33609
WESLEY CHAPEL: 26851 Tanic Drive, Suite 102, Wesley Chapel, FL 33544
SUN CITY CENTER: 771 Cypress Village Blvd. Sun City Center, FL 33573
WAUCHULA: 326 South 6th Ave Wauchula, FL 33873
ELLENTON: 7032 US-301 North Ellenton, FL 34222
LAKELAND: 1417 Lakeland Hills Blvd Suite 201 Lakeland, FL 33805
DAVENPORT: 2310 North Blvd W Suite A Davenport, FL 33837
WINTER HAVEN: 400 Ave. K SE Suite 9 Winter Haven, FL 33880

I do give permission for these records to be faxed to the above entity. Please forward:

_____ Office Visits _____ Initial History and Physical _____ Imaging Reports

_____ Lab Reports _____ Correspondence _____Insurance Information

Other (please specify):_____

Patient Signature:_____ Date:_____

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Effective date of this notice is November 1, 2020 and will remain in effect until it is amended or replaced by us.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. •

We will consider all reasonable requests and must say "yes" if you tell us you would be in danger if we do not. **Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. •

We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. **Tell us what you want us to do, and we will follow your instructions.** In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we ***never*** share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

• We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

• We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services. **Run our organization**

• We can use and disclose your information to run our organization and contact you when necessary. • We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

• We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work. **Administer your plan**

• We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

• We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues We can share health information about you for certain situations such as:

• Preventing Disease
• Helping with product recalls
• Reporting adverse reactions to medications
• Reporting suspected abuse, neglect, or domestic violence
• Preventing or reducing a serious threat to anyone's health or safety

Do research

• We can use or share your information for health research.

Comply with the law

• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

• We can share health information about you with organ procurement organizations.
• We can share health information with a coroner, medical examiner, or funeral director when an individual dies. **Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

• For workers' compensation claims
• For law enforcement purposes or with a law enforcement official
• With health oversight agencies for activities authorized by law
• For special government functions such as military, national security, and presidential protective services **Respond to lawsuits and legal actions**

• We can share health information about you in response to a court or administrative order, or in response to a subpoena. **Our Responsibilities**

• We are required by law to maintain the privacy and security of your protected health information.
• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. • We must follow the duties and privacy practices described in this notice and give you a copy of it.
• We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

• We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website, and we will mail a copy to you.
• Effective date of this notice is November 1, 2020 and will remain in effect until it is amended or replaced by us.

EXCEL
PAIN AND SPINE

Consent to Medical Treatment

Excel Pain and Spine maintains personnel and facilities in order to assist my physicians in providing me with medical care, and I authorize Excel Pain and Spine providers and personnel to perform on me the care ordered by my physicians. I consent to receive services by telemedicine (using Interactive audio, video, or data communications to carry out consultations, evaluations, screenings, diagnosis, treatment, monitoring or other communications benefiting a patient) if appropriate for my condition, and I understand the risks, benefits and alternatives of doing so, I choose to receive services even if my insurance plan may not cover or continue to cover specific service, including the specific services rendered during the admission. I understand that I have the right to be informed by my providers of the nature and purpose of any proposed operation or procedure and any available alternative methods of treatment together with an explanation of the risks associated with each of them. This form is not a substitute for such explanations, which are the responsibility of my physicians to provide according to the recognized standards of medical practice, and I acknowledge that Excel Pain and Spine and its personnel are not responsible for providing me this information. I understand that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of examinations and or treatments provided by Excel Pain and Spine.

Consent to Recording or Filming

I authorize Excel Pain and Spine, the attending physician, or other Excel Pain and Spine authorized persons to record, photograph or film me for treatment, quality improvement or education purposes. Such recording, filming or photographs will be released only as permitted by law or authorized by me.

Assignment of Insurance Benefits. Patient Financial Responsibility and Credit Report Authorizations

I guarantee payment of all charges made for or on account of the patient. I assign my right and my insurance benefits payments or other payment sources directly to Excel Pain and Spine and/or the physicians providing services in conjunction with Excel Pain and Spine. This assignment includes, but is not limited to, radiology reading, pathology services, emergency room visits or EKG readings. I understand I will receive separate bills for certain Excel Pain and Spine and physician services. I understand I am financially responsible to Excel Pain and Spine and physicians for charges not covered by this insurance assignment, I further understand Excel Pain and Spine can obtain my credit report for collection purposes and I am responsible for any collections, attorney fees and costs. I have provided all Medicare information and insurance cards to Excel Pain and Spine. I agree that in the event benefits paid under this assignment or any other amounts paid by me/us or my/our behalf exceeds the amount due Excel Pain and Spine, my physicians, or those entitles for services in connection with this treatment, and such excess amount may be applied to any other indebtedness that I, my spouse, or any child for whom I am financially responsible, may have with Excel Pain and Spine or any other facility entity related to Excel Pain and Spine.

Authorization to Disclose Information and Privacy Act

I authorize Excel Pain and Spine, and its affiliates to use or disclose my protected health information for the purposes of treatment, payment or healthcare operations. This consent shall cover any of my protected health information that Excel Pain and Spine may maintain or receive. I authorize the release of medical and related information about my treatment to the Professional Standards Review Organization responsible for reviewing the medical care furnished to me. This authorization will expire six years from the date shown below; however, I reserve the right to revoke this authorization at any time by contacting Excel Pain and Spine at 813-701-5804.

Authorization to Release Medical Information

I authorize Excel Pain and Spine and my physicians to disclose any medical information related to my services or treatment to my insurance company, governmental or charitable agencies and their agents, my employer and professional review organizations with whom I may have insurance coverage or who may be assisting in the payment of my bill and my medical care. I also authorize Excel Pain and Spine and my physicians to release any medical information to any licensed physician or medical facility to which I may be referred or transferred for further medical care. In addition, I authorize Excel Pain and Spine and my physicians to release any medical information necessary to prove Excel Pain and Spine's damages in any legal proceeding brought about to enforce any unpaid balance on any of my accounts. This authorization will expire two (2) years from the date shown below, and I understand that I or my legal representative may revoke this authorization at any time, unless legal action has already been taken, or in In the event of my death, the release of medical information is necessary to verify any charges incurred by me.

Authorization to Release Medicare and Medicaid Information

I certify that the information provided by me in applying for payment under Titles V, Will and/or XIX 01 the Social Security Act is correct. I understand that health care services paid for under Medicare, Medicaid and Maternal and Child Health programs are subject to review by professional organizations, which may recommend denial of payment if my medical condition does not warrant continued Excel Pain and Spine care. I authorize Excel Pain and Spine to assist me in the processing of any benefits application, including Medical Assistance, Aid to Families with Dependent Children, or Special Assistance, initiated for the patient within six months of the date of this authorization. Excel Pain and Spine may have access to and copy any records or information to which I would be entitled. The doctrine of informed consent has been explained to me, I acknowledge that this consent is voluntary and that it may be revoked by me at any time except to the extent that action has already been taken in reliance on it. Unless otherwise revoked, this consent shall be valid for one year from the date of authorization, or until final determination of any benefits application as described above, whichever is later.

For Underinsured Patients or Uninsured Patients

I authorize Excel Pain and Spine and its affiliates, to use or disclose my protected healthcare information for the purpose of helping me find a healthcare provider and/or locate a payment source for my visit.

Release of Responsibility/Liability For Valuables

I understand that Excel Pain and Spine has a policy for safekeeping of patient valuables requiring all money, credit cards and/or items of value including jewelry to be given to a family member to hold or leave at home. If I choose not to deposit such items of value with my family member, I absolve Excel Pain and Spine Florida from responsibility for their loss, damage of disappearance.

Payment Guaranty

(Patient and/or responsible party/parties) agree to pay all charges for services rendered by Excel Pain and Spine and my physicians or other providers during treatment related to services provided by Excel Pain and Spine. This guarantee includes charges not covered by my insurance regardless of the reason insurance coverage is denied. I agree to pay the reasonable cost of the attorney services in addition to the unpaid charges. I consent and authorize Excel Pain and Spine and its agents or subcontractors to contact outside sources including for the purpose related to my account, including evaluating and assessing my credit worthiness, my charity eligibility and the viability of collecting any amounts due for treatments I receive, whether at this time or on subsequent visits. I understand and agree that Excel Pain and Spine may assign my accounts as it deems necessary for the purposes of collecting any amounts I owe, including to collection agencies and attorneys. I consent and authorize Excel Pain and Spine and third-party agents of Excel Pain and Spine to contact me at any telephone associated with me, including a wireless number, and to use pre-recorded and/or an automatic dialing service in connection with any communication made to me or related to my account.

I affirm that my signature on this form indicates that I have disclosed any and all current Insurance coverage/s that may pay for this visit. Further, any failure on my part to Identify my insurance/s may result in additional charges for which I will be responsible. My signature also indicates that if I have no insurance coverage I will cooperate and participate in any efforts to help me qualify for any applicable coverage. Failure to do so may render me ineligible for any financial assistance discounts.

I have read the request and authorization in Its entirety and agree to be bound by all the terms and conditions herein. Witness my (our) hand(s) and seal(s) below,

_____. _____

Patient Responsible Party(ies)

_____ _____

Witness Relationship to Patient

****

I have been provided access to Excel Pain and Spine of Privacy Practices

_____

Patient Signature (or authorized representative) Date Time

Excel Pain and Spine Representative_____ Date/Time_____

PATIENT SELF-DETERMINATION QUESTIONNAIRE - YOUR RIGHT TO DECIDE

While you cannot remove all uncertainty about your future health care needs, having an ADVANCE DIRECTIVE in place can give you the peace of mind that comes from making your wishes known in advance. Please let us know if you have any of the following:

1. Declaration to Decline Life Prolonging Procedures (such as do not resuscitate or "DNR")

☐ I have ☐ I have NOT made a Living Will

2. Durable Power of Attorney

☐ I have ☐ I have NOT appointed a Durable Power of Attorney for Health Care Decisions

3. Health Care Surrogate

☐ I have ☐ I have NOT designated a Health Care Surrogate

If you have a living will and/or an assigned health care surrogate, we will gladly make a copy of your documents/will and place it in your chart if you desire.

PATIENT PRIVACY QUESTIONNAIRE

Please list the family members or other persons, if any, whom we **may inform** about your general medical condition and your diagnosis (including treatment, payment and health care operations):

Name: _____ Name: _____

Address: _____ Address:_____

PhoneNumber:_____ PhoneNumber:_____

Relationship: _____ Relationship: _____

Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY:**

Name:_____ Phone#:_____

Name:_____ Phone#:_____

Please indicate your understanding that all correspondence from our office will be sent in a sealed envelope marked "CONFIDENTIAL":

☐ **Check here to indicate that this statement was read.**

Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail? (**Yes) or (No)**

Please print the phone number where you want to receive calls about your appointments: _____

☐ **I am fully aware that a cell phone is not a secure and private line.**

_____ _____
PLEASE *PRINT* PATIENT NAME DATE OF BIRTH

_____ _____
LEGAL REPRESENTATIVE RELATIONSHIP TO PATIENT

_____ _____
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE DATE

PHYSICIAN/PATIENT INFORMED CONSENT AND AGREEMENT FOR LONG-TERM OPIOID/NARCOTIC THERAPY FOR TREATMENT OF CHRONIC PAIN

PATIENT NAME: _____ DOB: _____

You have agreed to or may potentially receive opioid/narcotic therapy for the treatment of chronic pain. You understand that these drugs are very useful but have a potential for misuse and are therefore closely controlled by local, state and federal governments. The goal of this treatment is to: (a) reduce your pain; and (b) improve your level of function in performing your activities of daily living. Our goal is to not initiate or continue opioid therapy whenever possible, but sometimes this may be warranted for more effective pain management.
Alternative therapies and medications have been explained and offered to you. You have chosen opioid/narcotic therapy as one component of treatment.

The use of cigarettes demonstrates a dependence on nicotine. This complicates opioid therapy. If you are a smoker, you have agreed to a smoking cessation program.

You must be aware of the potential side effects and risks of these medications. They are explained below. If you have any questions or concerns during the course of your treatment, you should contact your physician.

If you choose to use these medications, then you must read, understand, agree to, and sign this Agreement. The Agreement will be in effect until: you ask in writing for the Agreement to end, your physician/nurse practitioner/physician assistant (provider) ends the Agreement, and/or you are formally discharged from Excel Pain and Spine.

SIDE EFFECTS

Side effects are normal physical reactions to medications. Common side effects of opioids/narcotics include mood changes, drowsiness, dizziness, constipation, nausea, and confusion. Many of these side effects will resolve over days or weeks. Constipation often persists and may require additional medication. If other side effects persist, different opioids may be tried or they may be discontinued. You should NOT:

a. operate a vehicle or machinery if the medication makes you drowsy;
b. consume ANY alcohol while taking opioids/narcotics; or
c. take any other non-prescribed sedative medication while taking opioids/narcotics.

The effects of alcohol and sedatives are additive with those of opioids/narcotics. If you take these substances in combination with opioids/narcotics, a dangerous situation could result, such as a coma, organ damage or even death. Driving while taking opioids for chronic pain is considered medically acceptable as long as you do not have side effects such as sedation or altered mental status. These side effects usually do not occur while taking opioids/narcotics chronically. However, it is possible that you could be considered DUI if stopped by law enforcement while driving.

Opioid medications have been shown to increase the risk of poor surgical outcomes, increase the risk of motor vehicle collisions, increase the risk of impotence and sexual difficulties, and increase the risk of heart attacks (myocardial infarction), bone fractures, addiction and death.

Constipation is a well-known side effect of opioid therapy and can usually be treated with stool softeners or gentle laxatives. Constipation is a side effect that usually does not go away and requires treatment.

PATIENT'S INITIALS: _____

PATIENT NAME: _____ DOB: _____

RISKS:

DEPENDENCE

Physical dependence is an expected side effect of long-term opioid/narcotic therapy. This means that if you take opioids/narcotics continuously, and then stop them abruptly, you will experience withdrawal syndrome. This syndrome often includes sweating, diarrhea, irritability, sleeplessness, runny nose, tearing, muscle and bone aching, gooseflesh, and dilated pupils. Withdrawal can be life threatening. To prevent these symptoms, the opioid/narcotics should be taken regularly or, if discontinued, reduced gradually under the supervision of your physician.

TOLERANCE

Tolerance to the pain-relieving effect of opioids/narcotics is possible with continued use. This means that more medication is required to achieve the same level of pain control experienced when the opioid/narcotic therapy was initiated. This may occur even though there has been no change in your underlying painful condition. When tolerance does occur, sometimes it requires tapering or discontinuation of the opioid/narcotic. Sometimes tolerance can be treated by substituting a different opioid/narcotic. When initiated, doses of medications must be adjusted to achieve a therapeutic, pain-relieving effect upward adjustments during this period are not viewed as tolerance.

INCREASED PAIN (Hyperalgesia)

The long-term effects of opioids/narcotics on the body's own pain-fighting systems are unknown. Some evidence suggests that opioids/narcotics may interfere with pain modulation, resulting in an increased sensitivity to pain. Sometimes individuals who have been on long-term opioids/narcotics, but who continue to have pain, actually note decreased pain after several weeks off the medications.

ADDICTION

Addiction is a primary, chronic, neurological disease, with genetic, psychosocial, and environmental factors influencing the development and manifestations. It is characterized by behaviors that include one or more of the following: • Impaired control over drug use;

• Compulsive use;

• Continued use despite harm; and/or

• Craving.

Most patients with chronic pain who use long-term opioids/narcotics are able to take medications on a scheduled basis as prescribed, do not seek other drugs when their pain is controlled, and experience improvement in their quality of life as the result of opioid therapy. Therefore, they are NOT addicted. Physical dependence is NOT the same as addiction.

RISK TO UNBORN CHILDREN:

Children born to women who are taking opioids/narcotics on a regular basis will likely be physically dependent at birth. Women of childbearing age should maintain safe and effective birth control while on opioid/narcotic therapy. Should you become pregnant, immediately contact your physician and the medication will be tapered and stopped.

LONG-TERM SIDE EFFECTS:

The long-term effect of opioid/narcotic therapy is not fully known. Most of the long-term effects have been listed above. If you have additional questions regarding the potential long-term effects of opioid/narcotic therapy, please speak with your physician.

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PATIENT NAME: _____ DOB: _____

PRESCRIPTIONS AND USE OF OPIOID/NARCOTIC MEDICATIONS

○ Your medication will be prescribed by your physician for control of pain. Based on your individual needs, you will be provided with enough medication on a monthly basis, two-month basis, or three-month basis. New injuries or pain problems will require reevaluation. Prescriptions for opioids/narcotics will not be . "called in" to the pharmacy.

○ You agree that you must be seen by your physician at a minimum of every three months during the course of your therapy.

○ You agree and understand that increasing your dose without the close supervision of your physician could lead to drug overdose, causing severe sedation, respiratory depression and/or death.

○ You agree and understand that opioid/narcotic medication is strictly prescribed for you, and your opioid/narcotic medication should NEVER be given to others.

○ You agree to fill opioid/narcotic prescriptions at one pharmacy.

○ You agree to secure your opioid/narcotic medications in a safe, locked source to prevent loss or theft. You are responsible for any loss of theft.

○ You agree that lost, stolen or destroyed prescriptions or drugs will not be replaced, and may result in discontinuation of treatment.

○ You agree to obtain opioid/narcotic medication from one prescribing physician or that physician's substitute if your prescribing physician is not available and your prescribing physician has authorized his or her substitute to provide treatment.

○ You agree to submit to an initial examination and evaluation. to routine examination and evaluation on a monthly basis or regular basis (but no less than once every three months), and to examination and evaluation at the direction of your physician.

○ You agree to submit to blood and/or urine testing to monitor the levels of medication or other drugs and any organ side effects. You also agree that other doctors and law enforcement may be notified of the results.

○ You agree NOT to call the physician for refills or replacement medications during evening hours or on weekends/holidays. Medication refill and/or replacement requests will be addressed during regular business hours only.

○ You understand and agree that if you lose your medication or run out early due to overuse, you may experience and go through withdrawal from opioids/narcotics. You further understand and agree that you are solely responsible for your own medications.

○ You agree to bring all prescription medications in their bottles or containers to the office during regularly scheduled visits.

○ You agree to provide a list from your pharmacy detailing all medications received from that pharmacy and to provide updated lists as requested by your physician.

○ For patients taking methadone: Methadone has significant interactions with many other medications. Some of these medications may reduce your body's ability to metabolize methadone, thus INCREASING the methadone in your body, which could be dangerous. Therefore, you MUST notify this office of ALL medications prescribed for ANY condition while taking methadone.

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PATIENT NAME: _____ DOB: _____ DATE: _____

OPIOID/NARCOTIC THERAPY MAY BE DISCONTINUED IF YOU:

• develop progressive tolerance which cannot be managed by changing medications;
• experience unacceptable side effects which cannot be controlled;
• experience diminishing function or poor pain control;
• develop signs of addiction;
• abuse any other controlled substance (this may be determined by random blood/urine testing);
• obtain and or use street drugs (this may be determined by random blood/urine testing);
• increase your medication without the consent of your physician;
• either refuse to stop or resume smoking;
• obtain opiates/narcotics from other physicians or sources;
• fill prescriptions at other pharmacies without explanation;
• sell, give away, or lose medications;
• fail to submit to routine examination and evaluation on a monthly basis or regular basis (but no less than once every three months), or as directed by your physician;
• fail to bring your prescription medications to your regularly scheduled visits;
• fail to submit to blood/urine testing as directed;
• call for refills during evenings, weekends or holidays; or
• violate any of the terms of this agreement.

By signing below, Patient acknowledges and agrees that: (i) I have read and fully understand the Physician/Patient Informed Consent and Agreement for Long-Term Opioid/Narcotic Therapy for the Treatment of Chronic Pain; (ii) I have been given the opportunity to ask questions about the proposed treatment (including no treatment), potential risks, complications, side effects, and benefits; (iii) I knowingly accept and agree to assume the risks of the proposed treatment as presented; and (iv) I agree to abide by the terms of this agreement.

Patient Signature: _____ Date: _____

Print Name: _____

Witness Signature: _____ Date: _____

Print Name: _____

Physician Signature: _____ Date: _____

Print Name: _____