Comprehensive Pain Care, P.C.

Date: _____ Status: (circle one) Minor Single Married Widow(er) Divorced Separated

Patient Name: _____ SSN: _____

Date of Birth: _____ ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Email Address: _____

Employer Name/Address: _____

Work Phone: _____

Spouse Name: _____ SSN: _____ Birthdate: _____

Primary Care Physician: _____ Referring: _____

Primary Insurance, Name/Address: _____

ID and Group #: _____ Relation to Patient: _____

Secondary Insurance, Name/Address: _____

ID and Group #: _____ Relation to Patient: _____

Please list three (3) people that we could contact in the event of an emergency:

1. _____ Ph# _____ Relationship: _____
2. _____ Ph# _____ Relationship: _____
3. _____ Ph# _____ Relationship: _____

Pharmacy: _____

Pharmacy Phone Number: _____

I understand that I am responsible for checking with my insurance regarding any pre-certification and referral requirements.

Authorization for Release of Information
And Payment of Benefits

Comprehensive Pain Care, P.C.

770-421-8080 • Fax: 770-421-9566

I hereby authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse, and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for any health care related utilization review or quality assurance activities.

I hereby assign and authorize payment to the above state office of all medical and/or surgical benefits, including major medical benefits, to which I am entitled to under any insurance policy or policies, under self-insurance program, or any other benefit plan.

I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to the above stated office by any insurance policy, self-insurance program or other benefit plan.

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

Print patient name and date of birth: _____

_____ _____

Signature of person providing the authorization — Date

_____ _____

Relationship to patient if not patient — Reason patient unable to sign

PROTECTING YOUR HEALTH INFORMATION

What you need to know about the Health Insurance Portability and Accountability Act

Identify theft. Credit card fraud. Computer viruses. Concern for the privacy and security of personal information has never been greater. Our concern for the safety and security of your personal healthcare information has never been taken more seriously.

While we have always gone to great lengths to ensure the privacy of your personal health information, we will soon be getting additional help from the Federal government in the form of new regulations. These regulations will help standardize privacy and security requirements across the country and across all different type of healthcare organizations.

New Regulations Passed-
These regulations are part of the Healthcare Insurance Portability and Accountability Act, HIPAA for short. HIPAA does three primary things:

1. It helps standardize and simplify the way healthcare organizations exchange electronic healthcare data.
2. It provides consumers with additional protections for getting and maintaining health insurance coverage, although, it does not guarantee coverage.
3. It creates new security rules to ensure the safety and privacy of individual health information and medical recor s.

HIPAA Ensures the Privacy and Security of Individual Health Information-
Currently, individual state laws govern the use and disclosure of this information, creating many inconsistencies and gaps in the way you health information is protected. HIPAA sets minimum security and privacy standards for healthcare organizations to follow. If a state has more stringent privacy and security laws, then those would be followed instead. In addition, HIPAA sets heavy penalties for violations of these standards and the misuse of personal health information.

Defining Individual Health Information-
Every time you go to see a doctor, or admitted to the hospital, fill a prescription or send a claim to an insurance company, a record is made of your confidential health information. This type of information is referred to as individually identifiable health information and is the type of information regulated by HIPAA. It can be in any formation-electronic, paper or oral.

Healthcare organizations that collect and manage this type of information and are therefore covered by these regulations including physicians, physical therapists, mental health professionals, dentists, chiropractors, optometrists, podiatrists, and others; hospitals, health plans, employers, healthcare clearinghouses such as claims processors; and other healthcare organizations who conduct administrative and financial transactions.

Added Control over Health Information-
Under HIPAA, you have new rights to understand and control how you health information is used:

- **Right to Education-Healthcare providers and health plans are required to provide you with a clear written explanation of how they intend to use and disclose your information.**
- **Right to Access Medical Records-You have the right to see and get copies of your medical records, request changes and receive a history of non-routine disclosures of your personal health information.**
- **Right of Consent-Healthcare providers are required to obtain prior consent before sharing personal health information for purposes other than treatment, payment and healthcare operations.**
- **Right to Rec urse-You have the right to file a formal complaint if you believe that violations of the regulations were made.**

In general, HIPAA tries to find a balance between protecting your privacy and allowing the appropriate flow of information between healthcare providers that is necessary for you to access care and receive quality healthcare services.

The following websites may also contain helpful information on HIPAA:

American Medical Association-http://www.ama-assn.org/
American Dental Association-http://www.ada.org/
American Chiropractic Association-http://www.amerchiro.org/
American Optometric Association-http://www.aoanet.org/
American Podiatric Medical Association-http://www.apma.org/
American Academy of Opthalmology-http://www.aao.org/

Comprehensive Pain Care, P.C.
833 Campbell Hill Street, Suite 112
Marietta, GA 30060
P: 770-421-8080 F: 770-421-9566

Date: _____

I have been given the HIPAA Pamphlet regarding the protection of my medical records.

At the time of my original visit at this office, I received the patient handbook.

I understand that if I should have any questions regarding my medical records, the protection thereof and/or any issues of concern, I may speak to the office manager.

Patient Name: _____
(Please Print)

Signature: _____

Date: _____

Comprehensive Pain Care, P.C.
Pain and Addiction Patient Information
Medical History

Name (Please Print): _____ Date: _____

Date of Birth: _____ Age: _____ Sex: ___ Male ___ Female

For Office Use:
Date:_____ BP:_____/_____ P:_____ R:_____ T:_____ Ht:_____ Wt:_____

Which of the following conditions are you currently being treated or have been treated for in the past (please check all that apply):
___Heart Disease (Explain):_____
___High Blood Pressure ___Low Blood Pressure ___Peripheral Vascular Disease
___Lung Disease ___Asthma ___COPD/Emphysema ___Pulmonary Emboli (Blood Colts)
___Liver Problems/Hepatitis ___Reflux (GERD) ___Ulcer ___Chronic Pancreatitis
___Colitis ___Arthritis ___Fibromyalgia ___Lupus ___Psoriasis ___HIV
___Kidney/Bladder Disorder ___Interstitial Cystitis (IC) ___Diabetes
___Thyroid Disorder ___Sleep Apnea ___Restless Leg Syndrome
___Spine Disease (Explain):_____
___Stroke ___Seizures ___Headaches/Migraines ___Peripheral Neuropathy
___Carpel Tunnel Syndrome ___Other Neurological Problems:_____
___Cancer: Type/Location:_____ Treatment:_____
___Anemia ___Bleeding/Clotting Problems ___Eye Disorder/Glaucoma ___ENT Problems
___Depression ___Anxiety ___Bipolar Disorder ___Schizophrenia
___Attention Deficit Disorder(ADD/ADHD) ___Other Psychiatric Disorder:_____
___ Other Medical Disorder(Please Describe):_____
_____
For women of childbearing potential: Are you pregnant or could you be pregnant?___Yes ___No
If yes, please provide your due date:_____
List form of birth control:_____ ___Hysterectomy ___Tubal Ligation
Medication or other Allergies: ___Yes ___No
Please list any allergies:
_____
Please list your past surgeries with date:
_____
_____

Have you ever been hospitalized (other than for surgeries mentioned above)? ___ Yes ___ No
If yes, what for?_____
Do you currently smoke, dip or chew tobacco? ___Yes ___No
If n
o, have you in the past? ___Yes ___No How much for how long? _____
How much alcohol, beer, or wine do you drink in a week?_____
If none, have you drank in the past? ___Yes ___No If yes, How much per week?_____
Does any member of your family (including children and parents) have any history of drug or alcohol abuse or addiction? ___Yes ___No If yes, explain:_____
_____
Describe your **current** drug or alcohol use (include drug/amount, date/time last used and route— oral, nasal, smoked or injected):
_____
_____
_____
_____

What drugs have you abused in the **past**? (Check all that apply.)
___ Alcohol ___Marijuana ___Cocaine ___Methamphetamine ___Amphetamine ___Heroin
___Pain Pills ___Oxycodone ___Hydrocodone ___Dilaudid ___Morphine
___Soma ___Xanax ___Valium ___Methadone ___Buprenorphine (Suboxone) ___Fiorinal
___Barbiturates ___Sleeping Pills ___K2/Spice (Synthetic Marijuana)
___Bath Salts (Synthetic Cathinones/Khat) ___ GHB ___Ketamine ___Rohypnol
___MDMA (Ecstasy, Molly) ___Hallucinogens (LSD, Salvia, PCP) ___Inhalants (Huffing)
___Anabolic Steroids ___Dextromethorphan
___Other (list):_____

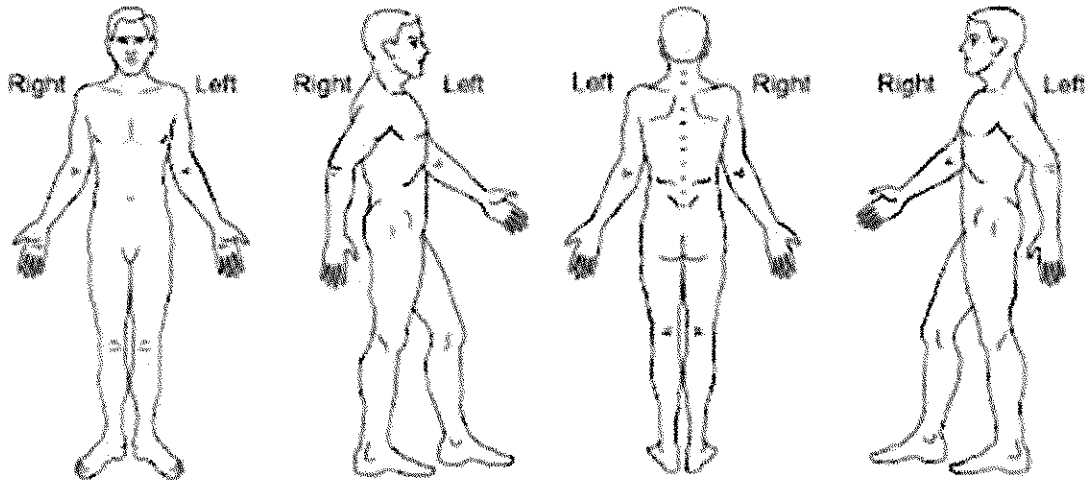
Current Physicians (include name and phone number):
Primary Care Physician: _____
Psychiatrist: _____
Clinical Psychologist and/or Counselor:_____
Specialty Physicians (Ortho, Neuro, Cardiac, etc.):
_____
_____

Past Physicians/Programs seen for Pain or Addiction Treatment:_____
_____

Current Domestic Situation (Check One): ___Single ___Married ___Widowed ___Divorced
Children: ___Yes ___No (ages_____)
With whom do you live?_____
Are there any alcohol or drug abuse issues in the household? ___Yes ___No
If yes, explain:_____
Current or last job:_____How many years employed?_____
Are you presently involved in a lawsuit? ___Yes ___No
If yes, explain:_____
Where is your worse pain located?_____
Does your pain radiate or travel? (Explain)_____
Check the words that describe your pain:
___Arching ___Throbbing ___Shooting ___Stabbing ___Gnawing ___Intermittent
___Sharp ___Tender ___Burning ___Exhausting ___Tiring ___Continuous
___Penetrating ___Nagging ___Numb ___Miserable ___Unbearable
Rate your pain using a scale where 0 = no pain and 10 = the worst pain that you can possibly imagine:
Your pain at its worst during the last month: _____
Your pain at its least during the last month: _____
Your pain on average during the last month: _____
Your pain as it is right now: _____
When and how did your pain problem start?_____
_____
As far as you know, what is the cause of your pain (i.e. the diagnosis)? _____
_____
List what tests and studies have been done and date(X-rays, MRI, etc.): _____
_____
What sort of things make this pain feel better (for example: heat, rest, medicine)? _____
_____

What sort of things make this pain feel worse (for example: walking, standing, lifting)? _____
_____

List any activities you want or need to do that your pain interferes with significantly?_____
_____
What has been the most effective non-drug treatment for your pain?_____
What has been the most effective medication for your pain?_____
Have you felt very anxious or depressed because of your pain?_____
Have you felt very anxious or depressed because of your drug use?_____



On the diagram above, shade the area(s) where you feel pain. Please be as exact as possible.

Check all the statements which apply to your use of pain medications.

_____My pain medication does not help at all.
_____My pain medication provides some relief but not enough to be considered meaningful.
_____My pain medication helps and definitely improves my quality of life.
_____My pain medication helps but I have difficulty controlling my use of it.
_____I have run out of pain medication early more than once.
_____I use my pain medication to help me feel better when I am anxious or sad.
_____I have obtained pain medication from multiple doctors at the same time.
_____I have obtained pain medications from illegal or street sources.
_____I have obtained pain medications from friends or family.
_____I sometimes feel guilty about my use of pain medications.
_____My friends or family have been critical of my use of pain medications.
_____My friends or family have told me that I act differently when I take my pain medications.
_____My friends or family have told me that sometimes I slur my speech or act intoxicated when I take my pain medications.
_____I have dozed off at inappropriate times (during meals, while driving, at the movies) because of my pain medications.
_____I have been in trouble with the law or at work because of my pain medications.
_____My doctor has told me that I may have a problem with my pain medications.
(Why?_____)

To my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient (or legal guardian):

Signature _____ Date _____

Comprehensive Pain Care, P.C.

833 Campbell Hill Street, Suite 112
Marietta, Georgia 30060
Tel: 770-421-8080
Fax: 770-421-9566

Date _____

I _____ give permission for Dr. Donald Taylor and staff to speak with the following:

_____

_____

_____

Regarding any information pertaining to my medical treatment.

Patient Name: _____
(please print)

Patient Signature: _____

Comprehensive Pain Care, PC
833 Campbell Hill Street, Suite 112 Marietta, Georgia 30060
Phone: 770-421-8080 Fax: 770-421-9566

Protecting Your Medicines At Home

Today, the abuse of prescription medicines is more widespread than the abuse of traditional street drugs, excluding marijuana. In fact, the number of people who abuse prescription medicines is approximately three times the number of people who abuse cocaine[1]. Thus we all need to be vigilant in protecting our own medicines from abuse.

The most commonly abused medicines are opioid pain relievers, sedatives, and stimulants. Abusers obtain these drugs by fraud and by theft. Fraud includes *forging prescriptions* and *faking illnesses* in order to trick doctors into writing prescriptions. Thieves not only burglarize pharmacies, they also steal from individual patients, such as yourself.

Sometimes this person is a family member or caregiver-someone you would never suspect. Here are some steps you can take to:

Protecting Your Medicines

- **Do not share your medicines with anyone.**
- **Lock medicines and medical supplies, such as syringes, in a locking cabinet and secure the key.**
- **Always store medicines in a cool, dry place protected from light.**
- **Do not store prescriptions drugs in the bathroom medicine cabinet. A bathroom is hot and Humid; bathroom medicine cabinets are rarely locked.**
- **Do not store medicines in the glove compartment of your car or in the kitchen cabinets. Here, too, heat and moisture degrade medicines and may make them unsafe.**
- **Keep medicines out of direct sunlight and away from a radiator or heating duct.**
- **Make sure all bottles are tightly closed.**
- **Do not store medicines inside purses, coat pockets, nightstands, or other locations easily accessed by others.**
- **Store all medicines in their original containers with the original labels intact.**
- **Do not store medicines in the refrigerator or freezer unless directed by your pharmacist.**

Protecting Yourself

- **Never take medicine in the dark. Always turn the light on and wear your glasses if Required for reading.**
- **Read the label each time to check the dosage before opening the bottle.**
- **Examine the medicine itself before taking it. Check for capsules or tablets that differ from the others in the bottle.**
- **If the appearance or the odor of the medicine has changed, check with your pharmacist**

before taking it.

- Follow the directions carefully. Special instructions, such as " Do not take with grapefruit" or " Take two hours before or after meals, " are given because they affect how the medicine works or how it affects your body.
- Never use medicines after they have expired. Expiration dates are listed with EXP and a date. If only a month and year are listed, the medicine can be used until the last day of that month; that is , "EXP 9/2019" means the medicine can be taken until the last day of September 2019.
- Inspect your medicine storage cabinet at least once a year. Ask yourself these questions:

Do I need the medicine?
Is it in its original container with the label firmly attached?
Is there an expiration date on the label?
Are my doctors and my pharmacist aware of all the medicines I am taking?

Protecting Your Loved Ones

Each year accidental poisonings from medicines and household chemicals kill about 30 children and prompt more than 1 million calls to the nation's Poison Control Centers. The number to reach your Poison Control Center is **1-800-222-1222**.

- Avoid taking medicines in front of children. Children like to imitate grown-ups.
- Use child-resistant packaging on your medicines whenever possible-it saves lives.
- Replace child-resistant caps securely after each use.
- Never call medicine " candy," call it " medicine."
- Do not discard any medicines, including patches, in the wastebasket where children can find them.
- If you are giving medicine to a loved one, check the label every time you give it.
- Keep track of doses to ensure that you are correctly following the directions on the bottle label.

*If you ever suspect that anyone has stolen your prescription medicine, report it to your local police department. You may save the thief from tragedy... you may even save a life.

[1]Substance Abuse & Mental Health Services Administration, 2008 National Survey on Drug Use and Health.
Information in this document was obtained from Educational Services by Purdue Pharma L.P, Stanfod, CT 06901-3431

Comprehensive Pain Care, PC
833 Campbell Hill Street, Suite 112, Marietta, Georgia 30060
Phone: 770-421-8080 Fax: 770-421-9566

I, _____, have read and understand my
(Print Name)
responsibilities as listed in the "Protecting Your Medicines at Home" document.

_____ _____
Signature Date

Comprehensive Pain Care, PC
833 Campbell Hill Street, Suite 112, Marietta, Georgia 30060

FINANCIAL POLICY:

We are committed to meeting your healthcare needs at Comprehensive Pain Care, PC. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner, we ask that you adhere to the following guidelines.

1. Payment is expected at the time of service.

2. We will file your insurance for you if we are a participating provider of your plan. However, you will be responsible for any and all services in excess of your insurance limits as well as all non-covered services.

3. All co-payments and deductibles are due at the time of service.

4. If we are not participating providers of your plan, full payment is due at the time of service, unless prior arrangements have been made. At your request we will give you complete forms that will be accepted by your insurance company for reimbursement.

We will mail you a monthly billing statement for any outstanding balances. If arrangements need to be made you must contact the billing manager prior to your next appointment.

I acknowledge that I understand and accept this financial policy.

_____ _____

Signature Date

Principles of Medical Practice

At Comprehensive Pain Care, P.C. we are dedicated to providing the best medical care possible. We feel that the practice of pain medicine (algology) requires unique characteristics of the physicians, nurses, psychologists, counselors and other caregivers that choose to devote themselves to this difficult area of healthcare. We all feel strongly that our patients deserve the best possible care. To that end, our physicians have developed a set of principles to guide our practice. We feel that it is our duty to adopt such guidelines to protect our patients from the many harmful influences that can impede their care in today's healthcare environment. The following standards define what we consider to be the essentials of honorable business conduct for physicians and other healthcare practitioners. Our physicians follow these principles and expect all employees of the Practice for Pain Medicine to adopt similar standards. (Parts of this set of standards were adopted from the American Medical Association's "Principle of Medical Ethics".)

1. A physician must be dedicated to providing competent medical series with compassion and respect for human dignity.

2. A physician shall openly tell the patient about appropriate treatment options, answer questions about medical risks and give the patient the current and accurate medical facts needed to make informed decisions about treatment.

3. A physician shall provide patients with information about other physicians and medical resources when this will benefit the patients.

4. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficit in character or competence, or who engage in fraud or deception.

5. A physician shall practice within all confines of the law; but shall also recognize a responsibility to seek changes in those laws that are contrary to the best interest of their patients.

6. A physician shall respect the rights of patients, colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

7. A physician shall respect the rights of patients, staff and colleagues to have an office environment free from sexual or racially motivated harassment. Any sexually oriented activity between the staff and patients is unethical and will not be tolerated.

8. A physician shall care for patients without regard to sex, race, creed, color, sexual orientation or previous condition of servitude.

9. A physician shall continue to study; continually learn how to apply advanced scientific knowledge to the care of their patients.

10. A physician shall, except in cases of emergency, be free to choose to whom they deliver medical services.

11. A physician shall recognize their responsibility to participate in activities contributing to an improved community.

12. A physician shall recognize their own responsibility to their own and to their families' physical, mental and spiritual health.

13. A physician shall at times, for personal renewal and/or professional education, need to be away from his practice. During this time, the physician will arrange for appropriate coverage for his patients.

If you think that our physicians or staff is not adhering to these principles, if there is any concern that you have not been treated with compassion, dignity and respect, or if you feel in any way harassed or subjected to unethical treatment, please report your concerns to our practice manager immediately.

Date: _____

Signature: _____

Opioid Risk Tool: Patient Form

(including point values to determine risk scoring total)

NAME:
DATE:

Mark each box that applies.

	Female	Male
1. Family History of Substance Abuse:		
Alcohol	☐	☐
Illegal drugs	☐	☐
Prescription drugs	☐	☐
2. Personal History of Substance Abuse:		
Alcohol	☐	☐
Illegal drugs	☐	☐
Prescription drugs	☐	☐
3. Age (mark box if between 16 and 45)	☐	☐
4. History of Preadolescent Sexual Abuse	☐	☐
5. Psychological Disease		
Attention deficit disorder, obsessive-compulsive disorder, bipolar, schizophrenia	☐	☐
Depression	☐	☐

Scoring Totals _____ _____