PATIENT DEMOGRAPHICS

Patient Last Name _____ First _____ Middle Initial _____

Patient Email Address

_____

Address

_____

City _____ State _____ Zip Code _____

Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____

Patient DOB _____/_____/_____ Age _____ Patient Sex: ◯ Male ◯ Female

Race: ☐ American Indian ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or other Pacific Islander ☐ Patient Refusal

Preferred Language: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient Refusal

Social Security Number _____-_____-_____

Marital Status ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Other

Primary Care Physician _____ Phone # (_____) _____-_____

Referring Physician _____ Phone # (_____) _____-_____

Emergency Contact _____ Phone # (_____) _____-_____

Name of Employer

_____

Occupation

_____

Is this visit related to an on the job injury? ☐ No ☐ Yes

If Yes, Date of Injury:

_____

Is this visit related to an automobile accident? ☐ No ☐ Yes

If Yes, Date of Accident:

_____

Insurance Company **(if auto or work comp)**

_____

Phone # (_____) _____-_____Policy #

_____

Are you currently working with an Attorney at this time? ☐ No ☐ Yes

If Yes: ☐ Personal Injury ☐ Workman's Compensation Claim #

_____

Attorney Name

_____

Address

_____

City _____ State _____ Zip Code

_____

Phone (_____) _____-_____ Fax (_____) _____-_____

RESPONSIBLE PARTY'S BILLING INFORMATION
(IF MINOR OR SIGNED OVER POWER OF ATTORNEY)

Last Name _____ First Name

_____

Address

_____

City _____ State _____ Zip Code _____

Home Phone (____) ____-_____ Cell Phone (____) ____-_____

Social Security Number ____-____-_____ Responsible Party's DOB ____/____/____

Relationship to Patient

_____

PRIMARY INSURANCE INFORMATION

Insurance Company _____ Subscriber# _____

Employer Sponsoring Plan

_____

Insured DOB ____/____/____ Insured Name

_____

SECONDARY INSURANCE INFORMATION

Insurance Company _____ Subscriber # _____

Employer Sponsoring Plan

_____

Insured DOB ____/____/____ Insured Name

_____

Financial Arrangements and Insurance

We are committed to providing you with the best possible care. If you have health insurance, we will help you receive your maximum allowable benefits. To achieve this we need your assistance, and understanding of our payment policy. Please always bring your current insurance card with you to all appointments. We will collect your co-payment at the time of service, if you cannot pay your co-pay at the time of service, your appointment will need to be rescheduled.

We participate with Medicare. We accept Medicare assignment and will bill Medicare for you. If you have supplemental insurance please bring that information with you to your appointment. You may be responsible for a portion of your charges such as Medicare deductible and co-insurance.

If you belong to an insurance which requires a referral from your Primary care physician, please bring the referral with you to your appointment. We must have a current referral before you can be seen. If you do not bring a current referral with you to your appointment, your appointment will have to be rescheduled.

If you are being treated for a work-related injury, injuries occurring from an automobile accident, or a third-party liability (for example, injured on the property of another person), we must have approval from your adjuster prior to seeing you. We will also need the following information; name of your insurance carrier, their address, and phone number, your adjusters name, your claim number, and the date of your injury/accident.

If your claim is denied by workmen’s compensation, auto insurance, or third-party liability, you will be responsible for the entire bill for services. If the automobile insurance fails to pay for 100 percent of the billed charges, you will be held responsible for any amount the insurance does not cover. Returned checks and balances older than 30 days are subject to additional collection fees you will be assessed a $20.00 fee on any returned check. In addition to collection and legal fees (13-21-109 C.R.S.). Charges may also be made for broken appointments and appointments cancelled without 24 hours advance notice.

If payments are not paid as agreed and your account is placed for collection, you agree to pay all reasonable costs of collection, including but not limited to; attorney fees, court costs, and interest at 18% per annum from the date of service.

We will gladly discuss your proposed treatment, and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of “U.C.R” which is defined as “usual, customary, and reasonable” fees, for this region. Thus our fees are considered usual, customary, and reasonable by most companies.

   This statement does not apply to companies who reimburse based on an arbitrary “schedule” of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as health care, providers our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or are uncertain regarding you insurance coverage, PLEASE don’t hesitate to ask us. We are here to help you

I have read and understand the above financial policy and agree to abide by the policy as stated.

_____

Printed patient name

_____ _____

Patient or representative signature Date

CONSENT TO PAYMENT

I understand that responsibility for payment of medical services in this office for my dependents is mine; due and payable at the time of services are rendered unless financial arrangements have been made. I understand that I am responsible for all costs of collection including attorney fees, collection fees and court costs. I understand that any unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly). **Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance.** I also assign all benefits to Colorado Pain Consultants, PLLC. I authorize the submission of claims without obtaining my signature on each and every claim submitted. I give my authorization and consent for treatment after having a full explanation of proposed treatment, alternatives, and risks by my doctor. I have been advised of my privacy rights as provided by the Healthcare Information Portability and Accountability Act of 1996. I hereby authorize this Colorado Pain Consultants, PLLC and its employees, agents and assignees to contact me via e-mail, text messaging and to my cellular devices.

Late for Scheduled Appointments

We understand that delays can happen, however we must try to keep the other patients and providers on time. If a patient is past their scheduled time it is up to the discretion of the provider if the appointment is to be reschedule.

Initials: _____

Cancellation/No Show Policy for Office Appointment

We understand that there are times when you must miss an appointment due to emergencies. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment book. If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company.

Initials: _____

Cancellation/No Show Policy for Injection Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment book. If an appointment is not cancelled at least 24 hours in advance you will be charged a one hundred and fifty dollar ($150) fee; this will not be covered by your insurance company.

Initials: _____

CPC POLICY ON MARIJUANA/THC/ALCOHOL/TOBACCO

Due to government policies and safety reasons, opioids, benzodiazepines, or any controlled substances cannot be prescribed if you are consuming marijuana/THC.

Initials: _____

Alcohol is not allowed as it can create adverse effects which can lead to death while taking opioids or any other controlled substances.

Initials: _____

Smoking any tobacco products will not be permitted. Recent research shows that nicotine makes people more sensitive to pain. If you are a current smoker, you and your doctor will agree upon a time frame to cease all smoking.

Initials:

_____

All patients are required to do a drug screen if their doctors prescribe opioids or any other controlled substances. Your screening may take place during an appointment, or you may be randomly called to our office to supply a sample. It is also possible to be called in for random pill counts. Failure to comply is an automatic dismissal from Colorado Pain Consultants.

Initials: _____

Patient's Signature:

_____

Date: _____/_____/_____

NEW PATIENT INTAKE FORM

Your completed intake paperwork helps our physicians and other providers get to know you 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 (303) 792-2959 if you have any question on how to complete any section on this form.

Name:

_____

Date: _____/_____/_____

Patient Information

Chief Complaint (Reason for your visit today)?

_____

Does this pain radiate? If so where?

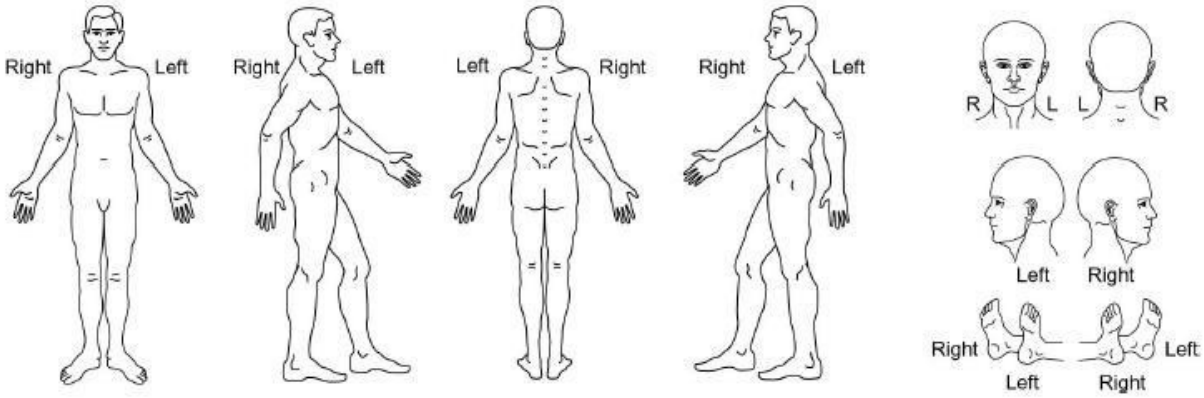
_____

Please list any additional areas of pain:

_____

_____

Use this diagram to indicate the area of your pain. Mark the location with an "X"



PAIN HISTORY

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

Was this caused by an accident? If so, please list if this is auto/work related and describe nature of accident:

_____

_____

Pain Description

Check all of the following that describe your pain:

☐ Dull/Aching ☐ Hot/Burning ☐ Shooting ☐ Stabbing/Sharp

☐ Cramping ☐ Numbness ☐ Spasming ☐ Throbbing

☐ Squeezing ☐ Tightness ☐ Tingling/Pins and Needles

Where is your pain worst?

☐ Morning ☐ Daytime ☐ Evening ☐ Middle of the Night ☐ Always the same

How often does the pain occur?

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

If pain is "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 _____

Mark the effect each of the following have on your pain level (please check all boxes that best describes your pain):

	Increase	Decrease	No change
Bending Backward	1 ☐	2 ☐	3 ☐
Bending Forward	1 ☐	2 ☐	3 ☐
Changes in Weather	1 ☐	2 ☐	3 ☐
Climbing Stairs	1 ☐	2 ☐	3 ☐
Coughing/Sneezing	1 ☐	2 ☐	3 ☐
Driving	1 ☐	2 ☐	3 ☐
Lifting objects	1 ☐	2 ☐	3 ☐
Looking upward	1 ☐	2 ☐	3 ☐
Looking downward	1 ☐	2 ☐	3 ☐
Going from sitting to standing	1 ☐	2 ☐	3 ☐
Sitting	1 ☐	2 ☐	3 ☐
Standing	1 ☐	2 ☐	3 ☐
Walking	1 ☐	2 ☐	3 ☐

What is the most comfortable position you can get into?

_____

_____

What other factors worsen or affect your pain which is not mentioned above?

_____

_____

_____

ASSOCIATED SYMPTOMS

	No	Yes	Comments
Numbness/Tingling	◯	◯	
Weakness in the arm/leg	◯	◯	
Balance Problems	◯	◯	_____
Bladder Incontinence	◯	◯	
Bowel Incontinence	◯	◯	
Joint Swelling/ Stiffness	◯	◯	_____
Fever/ Chills	◯	◯	

Please mark all of the following treatments you have used for pain relief: Please check the box that most reflects your treatment

1 -No change 2 -Worsened Pain 3 -Helped Pain 4 -Not Done

Spine Surgery	1 ☐	2 ☐	3 ☐	4 ☐

Physical Therapy	1 ☐	2 ☐	3 ☐	4 ☐
Chiropractic Care	1 ☐	2 ☐	3 ☐	4 ☐
Massage Therapy	1 ☐	2 ☐	3 ☐	4 ☐
Psychological Therapy	1 ☐	2 ☐	3 ☐	4 ☐
Brace Support	1 ☐	2 ☐	3 ☐	4 ☐
Acupuncture	1 ☐	2 ☐	3 ☐	4 ☐
Hot Packs/Heat	1 ☐	2 ☐	3 ☐	4 ☐
Ice Packs/Cold	1 ☐	2 ☐	3 ☐	4 ☐
Medications	1 ☐	2 ☐	3 ☐	4 ☐
TENS Unit	1 ☐	2 ☐	3 ☐	4 ☐

Other_____

_

Interventional Pain Treatment History

☐ Epidural Steroid Injection:

(Check all that apply) ☐ Cervical ☐ Thoracic ☐ Lumbar

☐ Joint Injections- Joint(s) _____

☐ Medial Branch Blocks/Facet Injections:

(Check all that apply) ☐ Cervical ☐ Thoracic ☐ Lumbar

☐ MILD (Minimally Invasive Lumbar Decompression- _____

☐ Nerve Blocks- Area/Nerve(s) - _____

☐ Radiofrequency Nerve Ablation:

(Check all 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 with your pain?

_____

Diagnostics Test and Imaging

Mark all of the following test that you have had related to your current pain complaints:

☐ MRI of the: _____ Date: _____/_____/_____

☐X-Ray of the: _____ Date: _____/_____/_____

☐CT Scan of the: _____ Date: _____/_____/_____

☐EMG/NCV study of the: _____ Date: _____/_____/_____

☐Other Diagnostic Testing: _____ Date: _____/_____/_____

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

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

☐Acupuncturist ☐Neurosurgeon ☐Psychiatrist/Psychologist

☐Chiropractor ☐Orthopedic Surgeon ☐Rheumatologist

☐Internist ☐Physical Therapist ☐Neurologist

☐Other

Have you ever been abused physically, emotionally or sexually? ◯Yes ◯No

If Yes, please explain?

_____

Have you ever been treated for a psychological disorder (depression, anxiety, bipolar disorder, etc.)? ◯Yes ◯No

If Yes, please explain?

_____

Have you ever been addicted to alcohol or drugs? ◯Yes ◯No

If Yes, what type and for how long?

_____

Have any of your family members been addicted to alcohol or drugs? ◯Yes ◯No

If Yes, who and what type?

_____

Please check if you suffer from the following:

☐ Poor Sleep ☐ Decreased Concentration

☐ Changes in appetite ☐ Decreased Sex Drive

☐ Decreased Interests ☐ Suicidal Thoughts

☐ Guilt (about being in pain) ☐ No Hope for the Future

☐ Decreased Energy

MEDICAL HISTORY

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

_____

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

General Medical

☐ Cancer- Type_____
☐ Diabetes- Type_____

Cardiovascular/Hematologic

☐ Anemia
☐ Heart Attack
☐ Coronary Artery Disease
☐ High Blood Pressure
☐ Peripheral Vascular Disease
☐ Stroke/TIA
☐ Heart Valve Disorder

Gastrointestinal

☐ GERD (Acid Reflux)
☐ Gastrointestinal Bleeding
☐ Stomach Ulcers
☐ Constipation

Urological

☐ Chronic Kidney Disease
☐ Kidney Stones
☐ Urinary Incontinence

Head/Ears/Eyes/Nose/Throat

☐ Headaches
☐ Migraines
☐ Head Injury
☐ Hyper/Hypo Thyroid
☐ Glaucoma

Respiratory

☐ Asthma
☐ Bronchitis/Pneumonia
☐ Emphysema/COPD

Musculoskeletal/Rheumatologic

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

Other Diagnosed Conditions

_____
_____
_____

☐ Dialysis _____

Neuropsychological

☐ Multiple Sclerosis ☐ Depression ☐ Bipolar Disorder

☐ Peripheral Neuropathy ☐ Anxiety ☐ Schizophrenia

☐ Seizures ☐ Obsessive Compulsive Disorder (OCD)

Past Surgical History

Please list all 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.

Current Medication

Are you currently taking any blood thinners or anti-coagulants? ◯ Yes ◯ No

If Yes, which ones:

☐ Aspirin ☐ Plavix ☐ Coumadin ☐ Lovenox ☐ Dabigatem ☐ Aggrenox

☐ Xaralto ☐ Other:

_____

Please list all medications you are currently taking including vitamins. Attach additional sheet 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) _____ _____

_____

Allergies

Do you have any drug/medication allergies? ◯ Yes ◯ No

If so, please list all medications you are allergic to:

	Medication Name	**Allergic Reaction**
1)	_____	
	_____	
2)	_____	
	_____	
3)	_____	
	_____	
4)	_____	
	_____	
5)	_____	
	_____	

FAMILY HISTORY

Mark all appropriate diagnoses as they pertain to your first degree relatives:

☐ Arthritis	☐ Cancer	☐ Diabetes
☐ Headaches/Migraines	☐ High Blood Pressure	☐ Kidney Problems
☐ Liver problems	☐ Osteoporosis	☐ Rheumatoid Arthritis
☐ Seizures	☐ Stroke/TIA	

☐ Other Medical problems:

SOCIAL HISTORY

Occupation:

_____

Working Status:

☐ Full Time ☐ Part-time ☐ Restricted Duty ☐ Disabled ☐ Retired

☐ Homemaker ☐ Unemployed

Marital Status:

☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Other

Are you currently under workman's compensation? ◯ Yes ◯ No

Is there an ongoing lawsuit related to your visit today? ◯ Yes ◯ No

Alcohol Use:

☐ Social Use ☐ History of Alcoholism ☐ Current Alcoholism

☐ Daily use of alcohol ☐ Never

Tobacco Use:

☐ Current User ☐ Former User ☐ Never used

☐ Packs per day ☐ How many years? _____ ☐ Date you quit _____/_____/_____

Illegal Drug Use:

☐ Denies any illegal drug use ☐ Currently uses Illegal drugs

☐ Formerly used illegal drugs (Not currently using) ☐ Marijuana/cTHC

Have you ever abused Narcotic or Prescription medications? ◯ Yes ◯ No

REVIEW OF SYSTEMS

Mark the following symptoms that you currently suffer from:

Constitutional:

☐ Chills ☐ Fever ☐ Difficulty sleeping
☐ Easy Bruising ☐ Night Sweats ☐ Fatigue
☐ Insomnia ☐ Low sex drive ☐ Tremors
☐ Weakness ☐ Unexplained weight gain ☐ Unexplained weight loss

Eyes:

☐ Recent vision changes

Ear/Nose/Throat/Neck:

☐ Dental Problems ☐ Earaches ☐ Hearing problems
☐ Nosebleeds ☐ Sinus Problems ☐ Nosebleeds

Cardiovascular:

☐ Chest Pain ☐ Blood Clots ☐ Shortness of breath
☐ Fainting ☐ Palpitations ☐ Swelling in feet

Respiratory:

☐ Cough ☐ Wheezing ☐ Shortness of Breath

Gastrointestinal:

☐ Constipation ☐ Acid Reflux ☐ Abdominal Cramps
☐ Diarrhea ☐ Nausea/Vomiting ☐ Hernia

Musculoskeletal:

☐ Back Pain ☐ Joint Pain ☐ Joint Stiffness
☐ Joint Swelling ☐ Muscle Spasms ☐ Neck Pain

Genitourinary/Nephrology:

☐ Flank Pain ☐ Blood in Urine ☐ Painful Urination
☐ Decreased Urine Flow/Frequency/Volume

Neurological:

☐ Dizziness ☐ Headaches ☐ Tremors

☐ Numbness/Tingling

Psychiatric:

☐ Depressed Mood ☐ Feeling Anxious ☐ Stress Problems

☐ Suicidal Thoughts ☐ Suicidal Planning ☐ Thoughts of Harming Others

☐ All other review of systems negative

Reviewer:

_____

PHARMACY INFORMATION

I agree to use only _____ pharmacy for all my medications given to me by Colorado Pain Consultants, PLLC.

My pharmacy is located at _____ and their phone number is (_____) _____-_____.

My pharmacy fax number is (_____) _____-_____.

It is my responsibility to notify my pharmacy that I am under a narcotic agreement with Colorado Pain Consultants, PLLC.

If I change my pharmacy for any reason, I agree to notify Colorado Pain Consultants, PLLC. I must put in writing at my next visit the name, address, phone number and fax number of the new pharmacy I have chosen to use.

- I will also advise my new pharmacy of my prior pharmacy's name and address.
- I agree **NOT** to use multiple pharmacies as this is a violation to my narcotics agreement.
- I will bring all prescription bottles to all my appointments and upon request by my provider.

Patient's name:

_____

Date of Birth: _____/_____/_____

Patient’s Signature:

_____

PATIENTS RIGHTS

- Patients are treated with respect, consideration and dignity.
- Patients are provided appropriate privacy. Patients have the right to privacy of any information or treatment concerning his/her own medical care. Patients have the right to be informed of any person other than routine personnel that would be observing or participating in his/her treatment.
- Patients have the right to know the person or persons responsible for coordinating his/her care.
- Patient disclosures and records are treated confidentially, and except when required by law, patients are given the opportunity to approve or refuse their release.
- Patients are provided, to degree known, complete information concerning their diagnosis, treatment and prognosis. When it is medically inadvisable to give such information to a patient the information is provided to a person designated by the patients or to a legally authorized person.
- Patients have the right to receive from his/her physician enough information so that he/she may understand the procedure or treatment being received in order to sign the informed consent.
- Patients have the right to refuse treatment and to be informed of the consequences of his/her actions. Patients are given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.
- Patients have the right to know if any research will be done during his/her treatment and have the right to refuse.
- Patients have the right to expect quality of care and service from the facility.
- Patient have the right to be informed of mechanism by which he/she will have continuing health care following if discharged from Colorado Pain Consultants, PLLC.

- Patients have the right to know services that are provided by Colorado Pain Consultants, PLLC.
- Patients have the right to know methods for expressing grievances and suggestions to Colorado Pain Consultants, PLLC.
- Patient has the right to information concerning the instruction to which he/she may have to be transferred. The institution to which the patient is being transferred must give approval prior to transfer.

Patient's Signature:

_____

Date: _____/_____/_____