Welcome to Our Practice

Thank you for choosing River Cities Interventional Pain Specialists as your trusted interventional pain care provider. To better prepare you for your upcoming new patient appointment, we have put together this introductory letter so you are ready for your appointment.

- Please make sure you complete all required new patient paperwork prior to your visit and bring them to your appointment. This information will be used by the provider during your evaluation. Failure to have the forms completed prior to your arrival may result in your appointment being delayed or rescheduled. If possible, you may fax, email, or mail back to our facility. This will help us provide more efficient quality of care for you at the time of service. Our fax number is (318) 797-5844. You may email the completed paperwork back to: consults@rivercities.azalea.phimailbox.com. Our mailing address is: River Cities Interventional Pain Specialists, Attn: New Patient Coordinator, 8731 Park Plaza Drive, Shreveport, LA 71105.
- Please arrive at least 30 minutes prior to your visit and anticipate being at our office for your initial appointment approximately 2-3 hours. You will need to bring any medical records available, including but not limited to: imaging, a photo identification card, a valid health insurance card (or cards), and form of payment for any copay, deductible, or co-insurance as required per your health insurance.
- We require at least 24 hours notice for cancellations and rescheduling of appointments. Failure to do so may result in a no show/cancellation fee.

We appreciate the confidence you have by trusting your care to our team. We look forward to working with you to help manage your chronic pain. Please feel free to reach out to us with any questions that you may have at (318) 797-5848.

Sincerely,

The Office of
River Cities Interventional Pain Specialists

General Office Policies

If you believe your concern is a medical emergency, call 911 or seek immediate medical assistance at the nearest full service emergency room.

Scheduling & Nurse Calls

Reaching our Practice

You can reach our office at (318) 797-5848, during normal office hours of 8am-5pm Monday-Friday. You will be directed to the appropriate personnel for your specific question or concern: Scheduling, Billing, New Patient Coordinator, or Referrals.

Nurse Calls

Your phone call is automatically sent to a nurse when you leave a message with the receptionist. The nurses generally return calls within 48-72 hours, depending on the nature of the call. If your call has not been returned within 72 hours, please call our office at (318) 797-5848 and ask to speak to the practice manager. Please do not make multiple phone calls to the office within the day. You will be asked to make an appointment for issues of general consultation other than medication side effects.

Appointments

When to Arrive for Your Appointment

FOR CLINIC APPOINTMENTS, patients are requested to arrive 15 minutes before their scheduled appointment time and have visit paperwork completed prior to coming. Paperwork can be completed in Patient Portal or printed from the website page Online Forms.

FOR NEW PATIENTS, we ask that you arrive at least 30 minutes prior to your scheduled appointment time and visits generally last 2-3 hours. Please allow time and prepare for a visit of this length on the day of your initial appointment. Please make sure you complete all required new patient paperwork prior to your visit and bring them to your appointment. This information will be used by the provider during your evaluation. Failure to have the forms completed prior to your arrival may result in your appointment being delayed or rescheduled. If possible, you may fax, email, or mail back to our facility.

You can download, print, and complete this paperwork prior to your visit. New Patient Paperwork can be found on our website under the New Patient Information webpage. If you bring your completed paperwork with you, please arrive 15 minutes prior to your scheduled appointment time.

FOR PROCEDURES, patients need to arrive 30 minutes before their scheduled procedure time. It takes time to prepare for your procedure including check-in, changing, taking your vitals, placing your IV, etc. We want to make sure we have enough time to give you truly great care and not rush anything. Absolutely no prescriptions or prescription refills will be given on the day of procedure.

Late Appointments

Our practice strives to provide not only the finest medical care, but also to provide a high level of efficiency and patient service. In order to have adequate office hour coverage, and to keep on schedule during our office hours, please arrive 15 minutes before your scheduled appointment (unless instructed otherwise) and call ahead if you anticipate being late for your appointment. If you arrive past your scheduled appointment time, and you have not completed your visit paperwork prior the appointment, you may have to reschedule for another day. If you need a prescription refill, the receptionist will have a nurse contact you to discuss your prescription refill.

Cancellations & No Shows

Please notify our office no later than 24 hours prior to your scheduled appointment if you cannot be present for your appointment. You may be billed for a missed appointment if you fail to call the office to cancel or reschedule. Following three (3) "no show" appointment cancellations you may not be allowed to reschedule another appointment. Pain medications cannot be called in, so it is imperative to keep scheduled appointments.

Surgery by Other Physicians

You will need to schedule an appointment with our clinic BEFORE undergoing any surgical procedure for any condition that you receive treatment for by this clinic.

Opioid Treatment

If you are receiving narcotics from our office, please remember that you have signed a written agreement to follow certain safeguards. The purpose of the narcotic treatment agreement that you sign is to help us maintain a safe, controlled treatment plan for you. You must remember:

- You are not to receive pain medications from any other physician besides those at River Cities Interventional Pain Specialists. We monitor your pharmacy records periodically and if discovered that you have obtained narcotics from another provider, it will result in a referral for addiction treatment and loss of prescription privileges
- You must use the same pharmacy to fill all of your prescriptions.
- You must take your medication exactly as instructed. Do not change dosage amounts without talking to our office first. If you want to change medications, you must bring un-used medicine with you to your appointment.
- You must keep all regular follow-up appointments.

It is important to make sure that you have enough medication to make it through the weekend or after hours. Medication refills will not be called in or refilled by the provider on call after hours or on weekends.

Forms and Letters

Work Excuses

If you require a work excuse, please ask for it at the time of your appointment. Work excuses are only allowed for the same day of a scheduled appointment or procedure.

Disability Forms

Our requirements for the completion of disability forms or letters are listed below:

- Our office will not initiate long-term disability.
- There will be a charge that must be paid prior to the completion of the form/letter. The charge for most forms is $25.00.
- Ten (10) to fourteen (14) working days will be required for the completion of the form/letter.
- The completion of some forms/letters may require an office visit if additional assessment is required.
- The office will consider continuance of disability forms, first initiated by another provider, subject to review and decided upon by a case-by-case basis.

We reserve the right to refuse to complete a form if it requests information that we do not have as part of your treatment plan.

My signature below verifies that I have read and understand the *General Office Policies* outlined above and that a copy of the policy is available to me upon my request.

Print Patient Name Date of Birth

Patient/Guardian Signature Date

Financial Policy

River Cities Interventional Pain Specialists participates with and accepts most insurance plans. Patients are required to furnish proof of insurance at the time of service**.** As a courtesy to our patients, we will be happy to file the insurance claim(s) for services rendered. If you have questions regarding your insurance, we will try to help. However, questions relating to specific coverage issues must be directed to your insurance company's member services department. Their telephone number should be listed on the back of your insurance card.

Annual deductible amounts will be the obligation of the guarantor. If the patient has met his/her deductible for the current year and can verify this with an Explanation of Benefits from his/her insurance carrier, the remainder of the patient responsibility (such as 20% for most insurance plans) will be due at the time of the visit.

Co-payments for HMO's, PPO's, and other managed care plans must be paid at the time of service. Balance billing patients for their co-pays is a violation of many managed care contracts and will not be allowed. Co-payments will be collected at check-in before the provider sees the patient. If the patient does not have the co-pay at the time of the visit, the patient may reschedule the appointment in order to meet the co-pay requirement.

Monthly statements are generated and mailed to patients/guarantors to make them aware of any outstanding balance after insurance coverage has been exhausted. Any outstanding balance is considered the guarantor's responsibility regardless of insurance coverage.

For your convenience, we accept cash, checks, and most major credit cards. You may also pay your bill online through our website (*shown below*) or your patient portal. Please note that there is a $35.00 service charge for all returned checks and, if a check is returned for insufficient funds, the practice will no longer accept checks for payment from the individual.

We understand that there may be times and circumstances that come up where you are unable to pay your entire bill. In these situations it is very important that you contact our billing office at (318) 797-5848 so a financial representative can assist you in setting up a reasonable payment plan and to keep your account from being sent to a collection agency. The physician and/or practice manager must approve payment plans and discounts. Payment arrangements are understood and agreed upon by the patient and provider prior to services being rendered. An account will be deemed delinquent after 90 days from the date of service or from the date services were denied or paid by the insurance carrier for outstanding balances owed.

If you fail to meet the financial obligations agreed upon in this financial policy or have other payment arrangements made, your outstanding balance will be sent to a collection agency. You will be required to pay your entire balance and any collection agency fees, up to 25% of your account balance, before being scheduled for any further appointments.

If you have billing related questions, please contact our billing office at (318) 797-5848 and select option 3.

ACKNOWLEDGEMENT

I understand that I am responsible for the cost of the medical services rendered and agree to pay any, and all amounts not paid by others within thirty (30) days from the date billed unless I made previous arrangements with my insurance company. I further agree to pay all collection costs including but not limited to court costs, and reasonable attorney's fees, if it becomes necessary to turn this account over to an outside party for collection.

My signature below verifies that I have read and understand the *Financial Policy* outlined above and that a copy of the policy is available to me upon my request.

Print Patient Name	Date of Birth

Patient/Guardian Signature	Date

Patient Portal Guidelines

Our Patient Portal lets established patients communicate more easily with us. The portal is not intended for 'Web Visits' or new problems. Instead, it will make regular communication more flexible. The portal is a voluntary option and is free of charge to all patients. The portal provides you with a much more seamless way to access your health information and contact our office.

Through the portal, you can:

- Update your contact and insurance information
- Check your lab results, medication list, medical history and your visits
- Request your own appointments and prescription refills
- View current and past statements, pay your bill and email billing questions
- Email us securely back and forth

The following will **NOT** be accepted through the Patient Portal:

- Receiving advice on the best course of treatment for your medical problem
  All diagnoses will be made by your provider when you are seen in the clinic for an office visit
- Request for narcotics/controlled medications
- Request for refill for medication not currently being prescribed by a River Cities Interventional Pain Specialists provider

Online communications should never be used for life threatening, emergency communications or urgent requests. As a safeguard, the portal should not be used for pressing issues. If you are experiencing an emergency or have an urgent medical need, call 911 or seek immediate medical assistance at the nearest Urgent Care or Emergency Room.

Reminders for the Patient Portal:

- If you forget your password you may request another one through the patient portal by clicking on the "Forgot Password" link.
- Avoid using a public computer to access the portal.
- The patient portal is provided as a courtesy service for our patients. There is no service fee. However if the patient abuses or misuses the portal we reserve the right to suspend or terminate the patient portal at any time and for any reason.
- You can access the portal day or night, but **we do not have a 24 hour presence** on our end**.** Our hours of operation are 8:00 am - 5:00 pm Monday-Friday. We encourage you to use the web site at any time; however messages are held for us until we return the next business day. Messages are typically handled within 2 business days. If your doctor is out of the office, your request may be held until your doctor returns to the office.

How the Secure Patient Portal Works

A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computer and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect. We will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors:

1) The secure message must reach the correct email address, and
2) Only the correct individual (or someone authorized by that individual) must be able to have access to the message.

Only you can make sure these two factors are present. **It is imperative that our practice has your correct e-mail address and that you inform us of any changes to your e-mail address.**

You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us. You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures regarding the Patient Portal. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, including the Policies and Procedures set forth in the log-in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications.

Secure Email address to use for Patient Portal

_____

My signature below verifies that I have read and understand the *Patient Portal Guidelines* outlined above and that a copy of the policy is available to me upon my request.

_____

Print Patient Name Date of Birth

_____

Patient/Guardian Signature Date

Complete the following if the email address does not belong to the patient. ☐ *Not Applicable*

Name of Parent/Guardian requesting access:

First Name	Middle Initial	Last Name

Relationship to the Patient	Date

Our Patient Portal site may be accessed by two (2) different URL's.

Our Website: www.rivercities.net

Patient Portal direct site: https://app.myhealthspot.com/login?c=141420

Receipt of Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES

River Cities Interventional Pain Specialists, as well as the employees and agents of the Practice, will use and disclose your personal health information to treat you, to receive payment for the care we provide and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care.

We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website and have copies available for distribution.

My signature below acknowledges:

- I have received a copy of the Notice of Privacy Practices.
- I have been informed of my rights and obligations as a patient.
- My understanding of the information contained herein.

I further understand and acknowledge that all references to myself as the patient shall be deemed to apply as if rewritten in their entirety to a dependent for whom I am responsible for and/or who is unable to consent on their behalf.

Print Patient Name	Date of Birth
Patient/Guardian Signature	Date

For Office Use Only		
RCIPS Representative		
Print Name	Signature	Date

Complete this section if you are unable to obtain signature

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices however acknowledgment could not be obtained due to:

☐ Individual refused to sign ☐ Communication barriers prevented obtaining acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other:

Release of Information,
Financial, & Medical Policies

Thank you for choosing River Cities Interventional Pain Specialists as your health care provider. The following is a statement of our Release of Information, Financial, and Medical Policies which we require you to read and sign prior to any treatment.

ASSIGNMENT OF BENEFITS

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to River Cities Interventional Pain Specialists rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

AUTHORIZATION TO RELEASE INFORMATION-For Billing Purposes

I hereby authorize River Cities Interventional Pain Specialists to release medical information to Medicare, my employer's benefits department, or my other insurance company for the sole purpose of obtaining payment for my medical care. I understand that only information pertaining to obtaining payment for my care will be released. I agree that a copy of this release may be used in place of the original.

AUTHORIZATION TO RELEASE INFORMATION-For Coordination of Care

I hereby authorize River Cities Interventional Pain Specialists to release medical information to my referring physician, primary care doctor, case manager, and any other individual involved in my medical care for the sole purpose of facilitating treatment. I understand that my medical information is confidential and that I have a chance to request that my physician not share my medical records with any of the above individuals. Should I choose to exercise this right, I will provide in writing to my physician and any of the individuals involved in my care whom I do not wish to receive my medical records. I agree that a copy of this release may be used in place of the original. I am aware that I may request that this Release of Medical Information may be revoked at any time by providing the physician's office with a dated and signed letter.

PAYMENT FOR MEDICAL SERVICES

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with the billing office. Necessary forms will be completed to file for insurance carrier payments. I hereby assume financial responsibility for all charges incurred for services rendered. I understand that I will be required to pay co-payments, amounts applied to deductibles and balance of bills not paid in accordance with the benefits of my current insurance policy. If I am unable to make payments in full for my medical treatment, I agree to call the billing office and make payment arrangements. I hereby authorize payment for all medical insurance benefits which are payable under the term of my insurance policy to be paid directly to River Cities Interventional Pain Specialists or designates for services rendered. I certify that the information I have reported regarding my insurance coverage is correct. I authorize the doctor's office to verify insurance coverage and benefits allowed in accordance with my insurance company's policy. I understand that it is my full responsibility that any third party which I direct River Cities Interventional Pain Specialists to bill, in the event of non-payment for whatever reasons in accordance with the benefits of my current insurance policy, I will pay immediately. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. In the event that your account is turned over to an outside collection agency, you will be required to pay your entire balance and any collection agency fees, up to 25% of the balance owed and/or all attorney fees and costs incurred to collect the unpaid debt, before being scheduled for any further appointments.

CONSENT TO EXAMINATION AND TREATMENT

By my signature below I attest that I am capable of reading and comprehending this form without assistance, and I have signed the form of my own free will. I agree that I have been made aware of the availability of assistance and/or an interpreter to help me in completing this form.

By my signature below, I hereby authorize the physicians of River Cities Interventional Pain Specialists with the assistance of other health care providers and assistants selected by them, to provide medical care and treatment to me.

Print Patient Name	Date of Birth
Patient/Guardian Signature	Date

For Office Use Only		
RCIPS Representative		
Print Name	Signature	Date

Patient Information Record

(Please Use **BLACK** or **BLUE** Ink Only)

PATIENT DEMOGRAPHICS

Date: _____ Referred by: _____

Name: _____
First M.I. Last

Date of Birth: _____ SSN: _____

Employment Status: ☐ Employed ☐ Retired ☐ Disability Student- ☐ Full time ☐ Part time

Employer: _____

Gender: ☐ Male ☐ Female Marital Status: ☐ S ☐ M ☐ W ☐ D

Ethnicity: ☐ Hispanic or Latino Race: _____

☐ Not Hispanic or Latino

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Communication Needs: _____

Residence Address: _____

_____

_____

Mailing Address: _____

☐ *Check here if the same* _____

_____

Home Phone: _____ Okay to receive phone call reminders?

Work Phone: _____ ☐ Yes ☐ No

Cell Phone: _____

Email Address: _____

EMERGENCY CONTACT *(other than someone living with you)*

Name: _____ Relationship: _____

Home Phone: _____ Alternative Phone: _____

Address City/State/Zip: _____

RESPONSIBLE PARTY ☐ *Check here if same as above*

Name: _____
First M.I. Last

Date of Birth: _____ SSN: _____

Mailing Address: _____

Home Phone: _____ Relationship: _____

Employer: _____ Work Phone: _____

Responsible Party's Spouse's Name *(if applicable):* _____

INSURANCE COVERAGE *Is your illness/injury due to an Auto/Work Accident?* ☐ Yes ☐ No

Primary Insurance Company: _____

Policy Number: _____ Group Number: _____

Employer: _____ Guarantor: _____

Secondary Insurance Company: _____

Policy Number: _____ Group Number: _____

Employer: Guarantor:

Tertiary Insurance Company: _____

Policy Number: _____ Group Number: _____

Employer: _____ Guarantor: _____

PREFERRED PHARMACIES

Name: _____ Telephone: _____

Name: _____ Telephone: _____

Alternative Contacts Form

(Please Use **BLACK** or **BLUE** Ink Only)

We at River Cities Interventional Pain Specialists take your medical confidentiality very seriously. We will not and cannot release information without your written authorization.

This authorization allows our staff members to speak only with an individual(s) you designate in the event you are not available to receive phone calls or you have an adult member that helps coordinate your medical care. You should not designate your doctor.

As part of our Patient Privacy Policy, we will not leave any health information with any other person unless you specifically authorize below:

_____
Signature

I **do not authorize** anyone to receive information regarding my medical care.

_____
Signature

I **authorize** my physician and the employees of River Cities Interventional Pain Specialists to speak with:

Name: Relationship:

Phone Number(s):

☐Appointments ☐Account/Bill ☐Lab Results ☐Test Results ☐Medical Care ☐Treatment

Name: Relationship:

Phone Number(s):

☐Appointments ☐Account/Bill ☐Lab Results ☐Test Results ☐Medical Care ☐Treatment

Name: Relationship:

Phone Number(s):

☐Appointments ☐Account/Bill ☐Lab Results ☐Test Results ☐Medical Care ☐Treatment

Alternate means of contacting me are:

Answering Machine/Voicemail _____

Cell Phone _____

Email _____

Fax Number _____

Other _____

By signing below I understand:

- This authorization will remain in effect unless changed by me while I am a patient at this practice.
- It is my responsibility to notify this office of changes and to complete a new form.
- Any problems and/or questions concerning this form are to be referred to the Privacy Officer.
- That should I desire to revoke this authorization, I will give written notice.

Print Patient Name	Date of Birth
Patient/Guardian Signature	Date

For Office Use Only		
RCIPS Representative		
Print Name	Signature	Date

Medical History & Brief Pain Inventory

(Please Use **BLACK** or **BLUE** Ink Only)

IDENTIFICATION DATA

Name: _____ Date of Birth: _____

Referred by: _____ Today's Date: _____

Gender: ☐ Male ☐ Female

MEDICATION HISTORY

List ALL medications you are currently taking as well as the dosage, frequency, and duration *(prescription, over the counter, herbals, supplements, etc.)*:

_____

_____

_____

_____

_____

ALLERGIES

List any medication you are allergic to and your reaction: ☐ *No Known Allergies*

Medication	Reaction

MEDICAL HISTORY

Please list all surgeries, hospitalizations, and/or serious injuries including date: ☐ *None*

FAMILY HISTORY

List immediate family members who have died *(Father, Mother, etc)*:

_____

_____

Check illnesses immediate family members have had:

☐ Allergies	☐ Asthma	☐ Cancer	☐ High Blood Pressure
☐ Depression	☐ Diabetes	☐ Glaucoma	☐ Hay Fever
☐ Heart Disease	☐ Obesity	☐ Sickle Cell Anemia	☐ Tuberculosis

SOCIAL & WORK HISTORY

Marital Status: ☐ M ☐ Sep ☐ D ☐ W ☐ Single Children: ☐ No ☐ Yes- #Sons:___#Daughters:___

Lives Alone: ☐ Yes ☐ No Do you feel safe in your environment? ☐ Yes ☐ No

Tobacco Usage: ☐ Current ☐ Never ☐ Former Type:_____ #Years: _____

Drinks Alcohol: ☐ Yes ☐ No ☐ Formerly Type: _____ Frequency:_____*(x per wk)*

Drug Use/Abuse: ☐ Yes ☐ No ☐ Formerly Type: _____ Frequency:_____*(x per wk)*

Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Disabled ☐ Retired

Highest Level of Education:

☐ Some High School ☐ High School Diploma/GED ☐ Some College ☐ Associates Degree

☐ Bachelor's Degree ☐ Graduate/Professional Degree ☐ Technical College

Did you stop working because of your pain? ☐ Yes ☐ No

Have you received financial compensation related to your pain? ☐ Yes ☐ No

Are you now bringing a lawsuit because of your pain? ☐ Yes ☐ No

Have you already filed suit for compensation? ☐ Yes ☐ No

Is this visit related to Worker's Compensation? ☐ Yes ☐ No

A. *If so, what was your initial date of injury?*_____

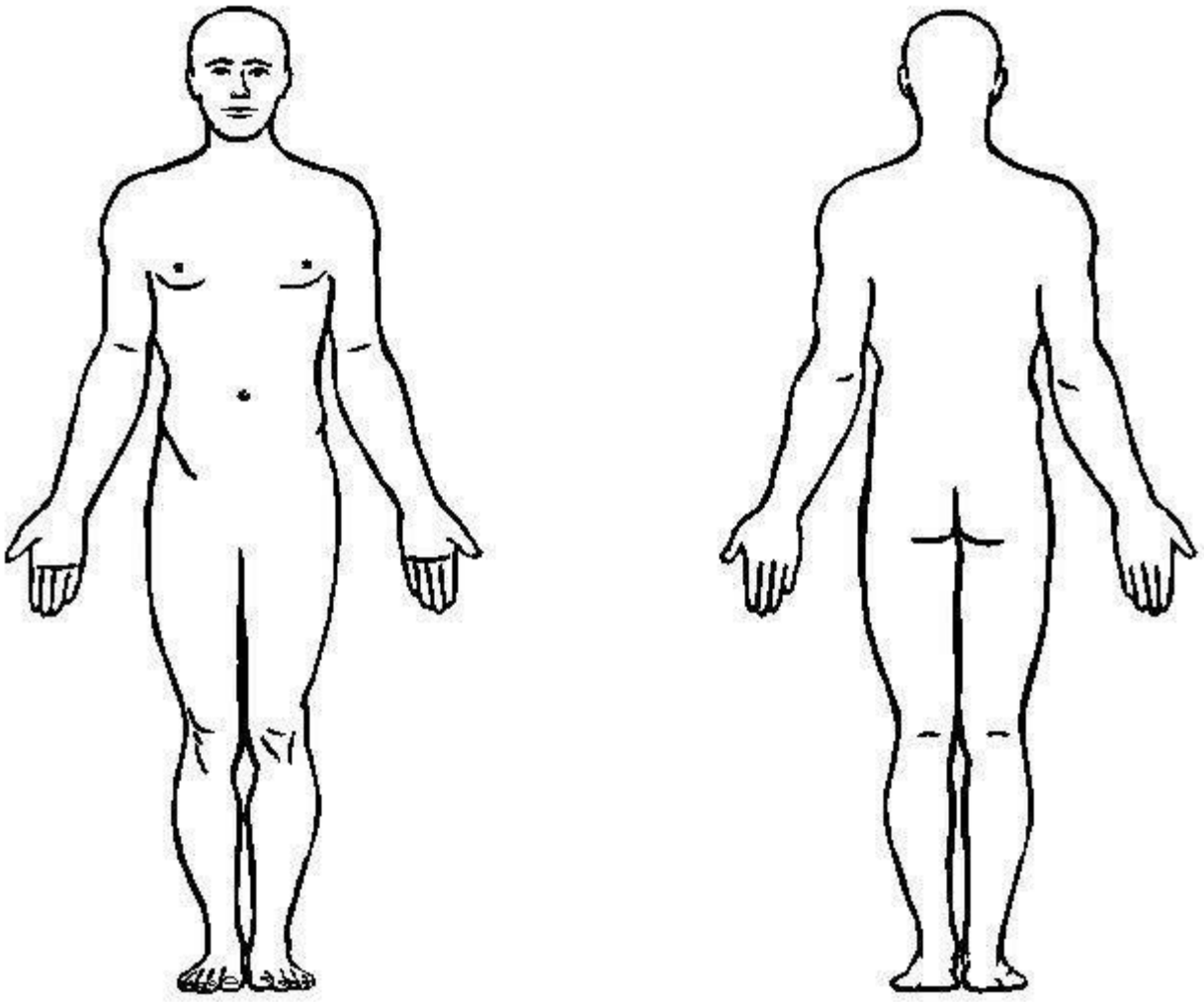
B. *What is the location of your injury?*_____

C. *What is the name and contact information of your case adjuster?*

Name: _____ *Phone Number:* _____

BRIEF PAIN INVENTORY

On the diagram, shade the areas where you feel pain. Put an "X" on the area that hurts the most.



How long has it been since you first learned of your diagnosis?

Current Level of Pain 1 – 10 *(10 is worst)*:

Describe the frequency of your pain:

☐ Intermittent ☐ Constant ☐ Occasional ☐ Rare

Select the words that describe your pain:

☐ Ache ☐ Burning ☐ Deep ☐ Discomforting ☐ Dull ☐ Numbness

☐ Piercing ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Throbbing

What makes your pain worse?

☐ Movement ☐ Sitting ☐ Standing ☐ Stress ☐ Walking ☐ Other: _____

BRIEF PAIN INVENTORY, continued

What relieves your pain?

☐ Exercise ☐ Heat ☐ Ice ☐ Injections ☐ Medication ☐ Physical Therapy ☐ Rest ☐ Sitting

Other methods you use to relieve your pain?

☐ Warm Compress ☐ Cold Compress ☐ Relaxation/Distraction Techniques ☐ Biofeedback

☐ Hypnosis ☐ Other: _____

Rate your pain by choosing the ONE number that best describes your pain at its *worst* last week.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain — *Worst Pain Imaginable*

Rate your pain by choosing the ONE number that best describes your pain at its *least* last week.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain — *Worst Pain Imaginable*

Rate your pain by choosing the ONE number that best describes your pain on *average*.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain — *Worst Pain Imaginable*

In *the past week* how much relief have pain treatments or medications provided?

☐ 0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

No Relief — *Complete Relief*

Considering your pain over *the past week*, choose the number that best describes how it has interfered with your-

General Activity:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — *Completely Interferes*

Mood:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — *Completely Interferes*

Walking Ability:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — *Completely Interferes*

BRIEF PAIN INVENTORY, continued

Normal Work:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — *Completely Interferes*

Relations with Other People:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — *Completely Interferes*

Sleep:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — *Completely Interferes*

Enjoyment of Life:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — *Completely Interferes*

Have you ever had pain due to your present disease? ☐ Yes ☐ No

When you first received your diagnosis, was pain a symptom? ☐ Yes ☐ No ☐ Uncertain

Have you had surgery in the past month? ☐ Yes ☐ No

If YES, what kind? _____

I believe my pain is due to:

The effects of treatment *(ex. Medication, surgery, radiation, prosthetic device)* ☐ Yes ☐ No

My primary disease *(the disease currently being treated and evaluated)* ☐ Yes ☐ No

A medical condition unrelated to my primary disease *(ex. arthritis)* ☐ Yes ☐ No

What treatments or medications are you receiving for your pain?

_____

_____

_____

_____

PAIN MEDICATION

I prefer to take my pain medicine:

☐ On a regular basis ☐ Only when necessary ☐ Do not take medicine

If you take pain medication, how many hours does it take before the pain returns?

☐ 1 hour ☐ 2 hours ☐ 3 hours ☐ Pain medication does not help

☐ 4 hours ☐ 5 to 12 hours ☐ 12+ hours ☐ I do not take pain medication

I take my pain medicine *(in a 24 hour period)*:

☐ Not every day ☐ 1 to 2 times per day ☐ 3 to 4 times per day

☐ 5 to 6 times per day ☐ More than 6 times per day

Do you feel you:

Need a stronger type of pain medication? ☐ Yes ☐ No ☐ Uncertain

Need to take more than what the doctor has prescribed? ☐ Yes ☐ No ☐ Uncertain

Need to receive more information about your pain medication? ☐ Yes ☐ No ☐ Uncertain

Are you concerned that you use too much pain medication? ☐ Yes ☐ No ☐ Uncertain

If yes, why? _____

Do you have side effects from your pain medication? ☐ Yes ☐ No ☐ Uncertain

If yes, which side effects? _____

Medications NOT prescribed by my doctor that I take for pain are:

_____

REVIEW OF SYSTEMS

Please list the date of your last: Tetanus Shot _____

Dental Exam _____ Chest X-Ray _____ EKG _____

Please check the box if your medical history includes any of the symptoms below

EYE, EAR, NOSE, THROAT

Ear Infection ☐
Eye Problems ☐
Hay Fever ☐
Hearing Loss ☐

GASTROINTESTINAL

Change in Bowel Habits ☐
Jaundice *(hepatitis)* ☐
Rectal Bleeding ☐
Stomach Pain ☐
Ulcers ☐

REVIEW OF SYSTEMS, continued

CARDIO-RESPIRATORY

- Activity Limitation ☐
- Asthma ☐
- Congestive Heart Failure ☐
- Cough *(if chronic)* ☐
- Pacemaker/Defibrillator ☐
- Pneumonia ☐
- Rheumatic Fever ☐
- Trouble Breathing ☐

GENITO-URINARY

- Difficulty Starting Stream ☐
- Kidney Disease ☐
- Night Time Urination ☐
- Urinary Infection ☐

SKELETAL

- Arthritis ☐
- Back Problems ☐
- Joint Pain/Swelling ☐
- Neck Pain/Stiffness ☐

NEURO-MUSCULAR

- Disorientation ☐
- Migraine/Headaches ☐
- Multiple Sclerosis ☐
- Muscle Pain ☐
- Numbness ☐
- Paralysis ☐
- Seizures/Epilepsy ☐
- Speech ☐
- Stroke ☐
- Tingling ☐
- Tremors ☐
- Weakness ☐

ENDOCRINE

- Diabetes ☐
- Hyperlipidemia ☐
- Recent Wt. Gain/Loss *(#10)* ☐
- Thyroid Problems ☐

HEMATOLOGIC

- Anemia ☐
- Bleeding Tendencies ☐
- Sickle Cell Disease ☐
- Thrombophlebitis/Blood Clot ☐

VASCULAR

- Arteriosclerosis ☐
- Coronary Artery Disease ☐
- Hypertension ☐
- Peripheral Artery Disease ☐
- Peripheral Vascular Disease ☐

RHEUMATOLOGY

- Ankylosing Spondylitis ☐
- Fibromyalgia ☐
- Osteoarthritis ☐
- Osteoporosis ☐
- Polymyalgia Rheumatica ☐
- Psoriatic Arthritis ☐
- Rheumatoid Arthritis ☐
- Systemic Lupus Erythematosus ☐

OTHER

- Cancer ☐
- Mental/Emotional Problems ☐
- V.D. History ☐

REVIEW OF SYSTEMS, continued

WOMEN ONLY

☐ Irregular Periods ☐ Abnormal Flow ☐ PID/Pelvic Pain ☐ Breast Disease

Last Menstrual Period *(date)*: _____ Last Pelvic/Pap Smear *(date)*: _____

Birth Control? *If so, what type:* _____ #Pregnancies: _____ #Births: _____

Electronic Prescribing & Refill Policy

CONSENT FOR ELECTRONIC PRESCRIBING

River Cities Interventional Pain Specialists is enrolled in an electronic prescribing program. This program is meant to help our providers with understanding what medications our patients are currently using and to give them the best possible treatment.

By signing this form, you are consenting to allow River Cities Interventional Pain Specialists to retrieve electronic prescribing information from other providers through the Sure Scripts database.

I agree that River Cities Interventional Pain Specialists may request and use my prescribing medication history from other healthcare providers.

Print Patient Name _____ Date of Birth _____

Patient/Guardian Signature _____ Date of Consent _____

Primary Pharmacy Name: _____

Address: _____

Phone Number: _____

Secondary Pharmacy Name: _____

Address: _____

Phone Number: _____

PRESCRIPTION REFILL REQUESTS

We require a 48 hour notice for all prescription refill requests. Prescriptions will only be refilled during normal business hours and may require an appointment. No prescriptions will be filled during weekends, holidays, or after hours. It is your responsibility to make sure you have a sufficient amount of medications.

Please be prepared to provide the following information when calling:

- Your Name & Telephone Number
- Pharmacy Name & Telephone Number
- Medication Name & Strength

_____

Initial Today's Date

Agreement on Controlled Substances Therapy for Chronic Pain Treatment

Developed by the American Academy of Pain Medicine

The purpose of this agreement is to create an understanding regarding controlled substances (a type of medication that is regulated by states and the Federal government) that may benefit your chronic pain symptoms. My goal is to treat you safely with these potent medications and also to prevent abuse of or addiction to these medications.

Medications such as opioids (narcotic analgesics), benzodiazepine tranquilizers, barbiturate sedatives, and muscle relaxants such as Soma (carisoprodol), that may be useful in managing pain, can be problematic in several ways. These medications have "street value" and potential for abuse. Although these medications may be prescribed with the goal of improving your comfort and functionality, their medical use is also associated with the risk of serious adverse effects such as development of an addiction disorder or a relapse in a person with a prior addiction history. The extent of this risk is uncertain, but it is known to be higher in certain vulnerable patients. My goal is to have you take the lowest possible dose of medication that is reasonably effective in managing your pain and improving your function, and when possible, have it tapered and eventually discontinued, while at the same time monitoring and managing these potential risks.

Because these medications have the potential for abuse or diversion (i.e. sharing, trading or selling to ANYONE other than whose name is on the prescription), strict accountability is necessary for both medical safety and legal reasons. Therefore, the following policies are agreed to by you, the patient, to help me keep you safe and to provide you with good care.

1. You must get a prescription for all controlled substances from the physician whose name appears below or, during his or her absence, by the covering physician, unless specific written authorization is obtained for an exception. *(Multiple sources can lead to untoward medication interactions or poor coordination of treatment)*
2. You must obtain all controlled substances from the same pharmacy. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:

   Pharmacy: _____ Phone: _____

3. You must inform our office of any new medications or medical conditions and of any adverse effects you experience from any of the medications that you take.
4. You must give the prescribing physician permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability and coordinating your care.
5. You may not share, sell or otherwise permit others to have access to these medications. You must take all medications exactly as prescribed, unless you develop side effects. If you develop side effects, you must consult with your doctor or local emergency providers.
6. You must not stop these medications abruptly or without consulting the prescribing physician, as an abstinence/withdrawal syndrome may develop.
7. You must agree that your urine may be tested for controlled substances before initiation of therapy and that random urine follow up testing may be done. You must cooperate in such testing, and you must agree that the presence of unauthorized substances, illicit substances or absence of prescribed medications may prompt referral for assessment for addictive disorder and possible tapering and discontinuation of the controlled substances immediately or in the future.
8. You will not give your prescriptions or bottles of these medications to anyone else. These substances may be sought by other individuals with chemical dependency and should be closely safeguarded. You will take the highest degree of care with your medications and prescriptions. You will not leave them where others might see or otherwise have access to them.

9. You must bring original containers of medication to each office visit.
10. You must keep all controlled substances in a secure area. Since the medications may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.
11. You must exercise extreme caution when taking these medications and driving or operating heavy machinery. The use of these medications may induce drowsiness or change your mental abilities, thereby making it unsafe to drive or operate heavy machinery. The effects of these medications are particularly problematic during any dose changes. If you are the slightest bit impaired, you must refrain from these activities.
12. You must discuss the long-term use of controlled substances with your physician. Prolonged opioid use can be associated with serious health risks. You need to understand these risks.
13. You must agree that medications will not be replaced if they are lost, flushed down the toilet, destroyed, left on an airplane, etc. If your medication has been stolen and you complete a police report regarding the theft and present that report to the prescribing physician, an exception may be made at the discretion of your treating physician.
14. You must agree that early refills will not be given.
15. You understand that prescriptions may be issued early only if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date.
16. You agree that, if the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.
17. You agree that failure to adhere to these policies may result in tapering and cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.
18. You agree that prescription renewals are contingent on keeping scheduled appointments. Do not phone for prescriptions after hours or on weekends. If you receive any controlled substances in an ER, you must report that incident to your prescriber, in writing, within 48 hours.
19. You recognize that any medical treatment is a trial, and that continued prescription is contingent on evidence of benefit and improved functionality.
20. You acknowledge that the risks and potential benefits of therapy with controlled substances have been explained to you and that you have had the opportunity to ask any questions that you may have.

BY SIGNING BELOW:

You understand and agree that failure to adhere to these policies will be considered noncompliance and may result in cessation of opioid prescribing by your physician and possible dismissal from this clinic.

You affirm that you have full right and power to sign and be bound by this agreement. You further affirm that you have been given the opportunity to ask any questions you may have and that you have read, understand, and accept all of its terms.

Physician Signature	Patient Signature
Today's Date	Patient Name *(Printed)*
	Today's Date