Columbia Pain Management, P.C.
1010 10th Street
Hood River, OR 97031
541-386-9500 (office) 541-386-9540 (fax)

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Mr./Mrs./Miss/Ms._____,

Welcome to Columbia Pain Management. Your appointment has been scheduled for _____, 2016 check in at _____am/pm.

Enclosed you will find a financial agreement/medical release form, medical history forms, and a copy of our privacy policy. **These forms must be completed and brought with you to your appointment**. If these forms are not completed, your appointment will be rescheduled. You will also need to bring any medical insurance cards or claim number information.

Our office hours are Monday-Wednesday and Friday 8 am to 5 pm and Thursday 8:00 am to 6:45 pm. When our office is closed, you may call the office phone number and leave a message.

We have a 24 hr cancellation policy. If you cancel this first appointment with less than 24hours notice, you will not be rescheduled. If you are being seen on a continuing basis and cancel an appointment with less than 24 hours notice, you will be charged **$50.00.**

We do require co-payments, deductibles and non-covered charges to be paid at the time of service. Your appointment will be rescheduled if required payments are not brought with you.

Columbia Pain Management has a policy of collecting a UDS (urine sample) on all new patients to assist the provider with your overall pain management plan. This is now considered standard of care in cases where patients are, or may be, provided pain medication for non-malignant pain. Refusal to provide a urine sample will limit our therapeutic options for your pain management treatment.

If you have any questions, please call our office. We look forward to meeting you.

Sincerely,

The Staff of Columbia Pain Management, P.C.

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541-386-9500 Fax 541-386-9540

Personal Information

Name_____ Male___ Female___ Phone Number_____

Mailing address_____ Work Number_____

_____ Cell Number _____

Physical address _____ Date of Birth_____/_____/_____

(if different) _____

Social Security Number_____-_____-_____ Spouse's Name_____

Patient's Chief Complaint_____

Primary Care Physician_____ Allergies _____

Emergency Contact (relative):_____ Phone: _____

Emergency Contact (non-relative): _____ Phone: _____

Email address_____

Pharmacy_____ Phone_____

How did you hear about us? _____

Primary Insurance Information

Insurance plan_____

Policy Number_____ Group Number_____

Ins Phone Number_____ Policy Holder Name_____

Insurance pre-authorization information_____

_____

Secondary Insurance Information

Insurance plan_____

Policy Number_____ Group Number_____

Ins Phone Number_____ Policy Holder Name_____

Insurance pre-authorization information_____

_____

Date: _____Patient Signature: _____

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Medical Information Release

I give permission for my medical information to be released to/or discussed with:

Name Relationship to Patient

_____

_____

_____

I understand that I can change this at any time.

Printed Name of Patient: _____

Signature: _____ Date: _____

Chart Photo Release

I give my permission for Columbia Pain Management to take a photograph of me to keep in my chart.

Printed Name of Patient: _____

Signature: _____ Date: _____

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Financial Policies & Agreement

Payment/Insurance Policy

In an effort to keep medical costs down while maintaining a high level of professional care, our financial policy is **payment due at time of service**. We collect copayments, coinsurance, and applicable deductible amounts at the time of service. Once insurance reimbursement is received your account will be adjusted in accordance with what your insurance company deems as your financial responsibility.

We file insurance claims as a courtesy to our patients when the patient provides us with **current** information. If for any reason your insurance coverage changes and we are not notified of such change then you will be responsible for the charges associated with your care. Your insurance company will not accept back dated claims.

We do not process secondary insurance claims except for those associated with Medicare, as required by law. We will provide you with a receipt, upon request, to assist you in filing any secondary insurance claims.

Please be aware that your insurance company may determine that services provided are not covered under your particular benefit plan. Any verbal verification of benefits or coverage is never a guarantee of payment. If your insurance company has not paid for services in full within 60 days, you will be billed for the balance

All statements are due and payable upon receipt. We will be happy to discuss a payment plan for unexpected and large expenses. Our office accepts cash, checks, debit cards, VISA, MasterCard, Discover, and American Express.

Cancellation Policy

We work very diligently to be able to see all of our patients in a timely manner, and as such missed appointments leave us with a hole in providing care to other patients. Therefore we have a “Missed Appointment Policy” which states that appointments not cancelled with 24 hours minimum advanced notice will be charged a fee of $50. We do, as a courtesy to our patients, attempt to confirm appointments, but this service does not resolve the patient of informing our office of the need to cancel an appointment.

Statement of Financial Responsibility/Assignment of Insurance Benefits

By signing below, I acknowledge primary responsibility for the payment of service to Columbia Pain Management. I request my claims be filed to my insurance carrier and I authorize payment of service directly to the provider. I allow the release of medical information by mail, fax, or telephone, to the insurance carrier, or case manager, when the information is requested to process claims.

Release of Information to Other Health Care Providers

By signing below, I authorize Columbia Pain Management, PC to release my medical records to my other health care providers and I authorize my other providers to release medical records to Columbia Pain Management, PC, for the purposes of a managed treatment plan and/or continuity of care. The type of information to be disclosed may include: history and physical, medications, therapy, lab/pathology/imaging reports, clinician notes, problem list, operative reports). I understand that I can change this authorization at any time. I understand that I any changes must be in writing.

Release of Restricted Medical Information

By initialing below, I authorize disclosure of the following information:

_____ Drug/Alcohol Addiction Program Records _____ Psychotherapy/Mental Health Program Notes

Disclosure of above information is limited to the following:

Treatment dates of: _____

Duration: This authorization shall begin immediately and remain in effect until written notice is given.

X_____ _____ _____

Signature of Patient or Responsible Party Date of birth Date

_____

Printed Name of Patient or Responsible Party

I have received notice of privacy policies _____ (initial here)

PATIENT NAME:_____ **DATE:**_____

For Office Use Only:

D.O.B._____ **Age:**_____ **Gender: [ ] male [ ] female**

Referring Physician:_____

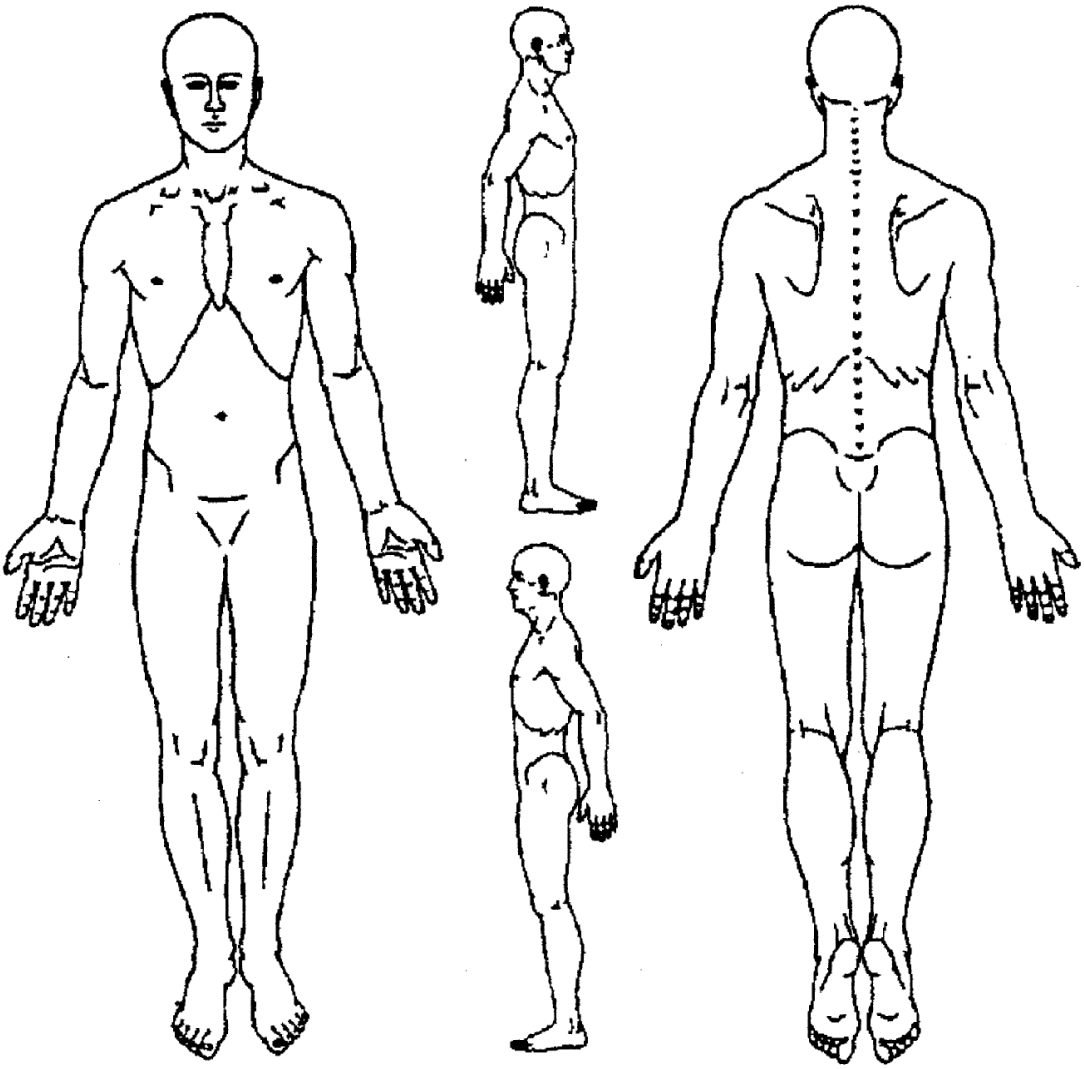
Reason for Referral:_____

Numerical Pain Rating Now:_____

Please Draw Your Pain

xxxxx Burning 00000 Aching ##### Pins and Needles = = = = = Numbness

Please use Black Ink



PAIN QUESTIONNAIRE

History of Present of Illness:

Please choose the statement that best describes your pain:

[ ] my pain is mostly in my back

[ ] my pain is mostly in my leg or legs

[ ] my pain is mostly in my neck

[ ] my pain is mostly in my neck or arms

[ ] my pain is everywhere

[ ] my pain is _____

When did your pain start?

If this is a motor vehicle crash or work related injury, what is the date of injury?

How did your pain start?

What makes your pain worse?

What makes your pain better?

Do you notice other symptoms that accompany your pain?

Do you feel depressed?

Have you lost control of your bowel movements or your bladder?

Are your arms or hands weak since your pain started? [ ] Yes [ ] No

Are your legs weak since your pain started? [ ] Yes [ ] No

Pain Education:

Do you feel you have a good understanding of what is causing your pain?

Do you feel there are factors other than physical causes that contribute/sustain your pain?

Do you feel you have the ability to change your pain?

Have you participated in Pain Education, Meditation, Guided Imagery, Biofeedback or other Mind/Body treatments to assist with pain?

Previous Work-up:

Please check below the tests that have been done to explore the cause of your pain. Please indicate which doctor ordered the test and when & where it was performed.

[ ] CT or MRI scans

[ ] Blood tests (arthritis, diabetes, liver)

[ ] Nerve conduction tests

[ ] Discography (pressurizing discs)

[ ] X-rays

[ ] Bone Scan

[ ] Bone density test

Indicate below what other specialists you seen for this pain problem. Include names if possible:

[ ] Other pain specialist:

[ ] Surgeon (neurosurgeon or orthopedic surgeon):

[ ] Rheumatologist (arthritis doctor):

[ ] Neurologist (nerve doctor):

[ ] Chiropractor:

[ ] Headache specialist:

[ ] Oncologist (cancer doctor):

[ ] Occupational Medicine/Company doctor:

[ ] Psychiatrist or psychologist:

[ ] Other:

Previous Treatments:

What other treatments have been tried for your pain? Please check those that apply

[ ] Physical therapy
[ ] Spinal manipulation/massage
[ ] Nerve Blocks
[ ] Implanted pain pump
[ ] Botox/phenol injections
[ ] Epidural injections
[ ] Acupuncture
[ ] Spinal Cord Stimulator
[ ] Vertebroplasty/kyphoplasty
[ ] Trigger point injections

Surgeries for Index Pain:

Did you have surgery for your pain? [ ] Yes [ ] No

Please list your surgeries, dates, and surgeon here:

_____

_____

_____

Did the surgery help? [ ] Yes [ ] No

Additional Narrative:

Is there any aspect of your pain problem that you feel has been overlooked or not addressed by other doctors? If yes, describe below:

_____

_____

_____

Ancillary Database:

Did you bring outside records or films for me to review? [ ] Yes [ ] No

Past Medical History:

What other medical problems do you have?

1. 4.

2. 5.

3. 6.

Additional Surgeries:

What other surgeries have you had? (Please indicate year performed)

_____

_____

_____

Medications:

Please List your current medications

1. 6.

2. 7.

3. 8.

4. 9.

5. *10*.

Other Medications Trialed for Pain:

What other medications have been tried for your pain?

1. 5.

2. 6.

3. 7.

4. 8.

For Office Use Only:

Allergies: Have you ever had an allergic reaction to a medication? [ ] Yes [ ] No

If so, what medication and what reaction?

Social History:

Please indicate how often, if ever, you engage in any of the following activities:

[ ] Smoke cigarettes, pipe, or nicotine chew (number per day: _____)

[ ] Drink coffee, Tea, Cola or soda with Caffeine (total number of cups per day: _____)

[ ] Drink Alcohol Beers per day_____
Wine (glasses) per day_____
Mixed Drinks or hard liquor per day _____

Do any first degree relatives (mother, father, brother, sister, children) have a history of addiction to alcohol, medication or drugs? [ ] Yes [ ] No

Do you have a personal history of addiction to alcohol, medications, or drugs?

[ ] Yes [ ] No

If yes, have you had treatment for addiction or chemical dependency

[ ] Yes [ ] No

Exercise:

How often do you exercise in an activity that is at least *moderately intense* for you:

[ ] Daily [ ] Every other day [ ] 2 times/week
[ ] Weekly [ ] Monthly

Type of exercise: _____

Activities of Daily Living: (see pain outcome profile as well)

Have you fallen because of poor balance, passing out, or weakness?
[ ] Yes [ ] No

Do you use a mobility device such as a walker, cane, motorized scooter or wheelchair?
[ ] Yes [ ] No

Type of mobility of device: _____

Do you have any difficulty caring for yourself that has not been covered in another part of the intake paperwork? if so, please explain.

_____

_____

_____

Vocational:

Are you currently employed and working? [ ] Yes [ ] No

If yes,

Name of company:_____

Job title:_____

How long:_____

Is this a work-related pain issue or injury? [ ] Yes [ ] No

If yes, what is your accepted condition?

If yes, are you interested in returning to your previous job?

If yes, do you currently have restrictions or did your doctor put you on light duty?

Are you receiving medical disability benefits or worker's compensation time loss?
[ ] Yes [ ] No

Do you think that you can do your job with the level of pain you usually have now?
[ ] Yes [ ] No

Family/Community:

Are you married? [ ] Yes [ ] No

Do you have children? [ ] Yes [ ] No

Do you have active hobbies? [ ] Yes [ ] No

What do you do for enjoyment?

What clubs or organizations do you belong to?

Spiritual activities (church, meditation, etc.):

Family Medical History:

Is there a history in your blood relatives of the following problems? If so, who?

[ ] Depression

[ ] Suicide

[ ] Fibromyalgia

[ ] Irritable bowel syndrome (IBS)

[ ] Disabling Headaches

[ ] Chronic pain

[ ] Disabling arthritis

[ ] Severe mental illness

[ ] Alcoholism or drug addiction

Review of systems:

Are you having any of these symptoms? Please check those that apply

[ ] Recent fevers (last 3 months)
[ ] tiredness
[ ] swollen feet or hands
[ ] rash
[ ] blurred vision
[ ] double vision
[ ] heart problems
[ ] lung problems
[ ] hepatitis
[ ] liver disease
[ ] incontinence of stool
[ ] constipation
[ ] stomach ulcers
[ ] black or bloody stools
[ ] incontinence of urine
[ ] kidney disease
[ ] falling down
[ ] joint swelling
[ ] localized weakness
[ ] difficulty walking
[ ] muscle shrinkage
[ ] morning stiffness
[ ] depression
[ ] nervousness
[ ] sleeping difficulties
[ ] bleeding disorder
[ ] thyroid problem
[ ] are you pregnant?
[ ] date of last period if still menstruating
_____

For Office Use Only:

Exam:

Weight: _____ Height:_____

BP: _____ P:_____

Columbia Pain Management, PC
Notice of Privacy Policies

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

Introduction

At Columbia Pain Management, PC, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective 01/01/03, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Columbia Pain Management, PC, a record of your visit is made. Typically, this record contains your symptoms, examinations and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Columbia Pain Management, PC, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522 and,
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our responsibilities

Columbia Pain Management, PC, is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with the respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate your reasonable requests to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For more Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer. If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The OCR address is: **Office for Civil Rights,** U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, DC 20201.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use health information for treatment.
For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

We will use your health information for payment.
For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.
For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.
Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.