Advanced Pain Center, PA
801 N Jackson
Odessa, TX 79761
Tel: 432-333-5200 Fax: 432-333-1800

PATIENT REGISTRATION

Patient Name _____ SS# _____

Address _____ City _____ State _____ Zip _____

Phone (Home): _____ (Work) _____(Mobile)_____

Date of Birth _____ Sex: Male _____ Female _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Employer _____ Occupation _____

Ethnicity Hispanic ___ Not Hispanic ___Unknown___. Preferred Language _____

Race American Indian ___, Asian ___, Black ___, Pacific Islander ____, White ____, Other Race___

INSURANCE INFORMATION

PRIMARY INSURED

Name of Insured _____

Insurance Company _____

Co-Pay _____ Deductible _____

SECONDARY INSURED

Name of Insured _____

Insurance Company _____

Co-Pay _____ Deductible _____

RESPONSIBLE PARTY

Name _____ Relationship _____

SS# _____ DOB: _____

Employer: _____ Phone: _____ Work: _____

EMERGENCY CONTACT: Name _____ Phone: _____

NEW PATIENT INITIAL EVALUATION FORM

Name:_____**Age**_____**Sex**: M / F

Referring Physician: _____

Primary Care Physician: _____

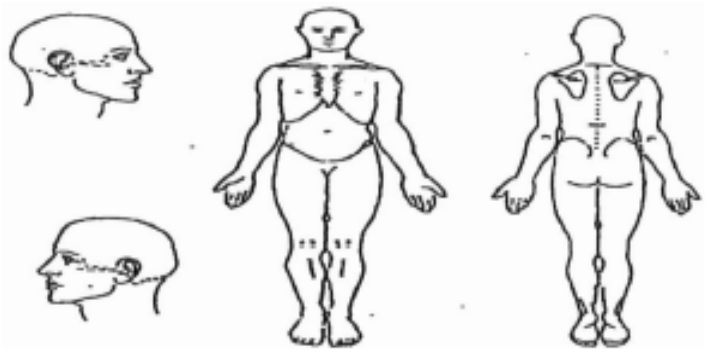
How did you learn about our clinic? _____

1. **Chief Complaint**: _____

Please circle area of pain: Head Neck Rt. Shoulder Lt. Shoulder Rt. Arm Lt. Arm Rt. Hand

Lt. Hand Mid Back Low Back Rt. Hip Lt. Hip Rt. Leg Lt. Leg Lt. Knee Rt. Knee Rt. Foot Lt. Foot

On the body chart, please shade area of pain:



Is the pain (circle one) Constant / Intermittent?

Do any of these words describe your pain? (Circle those that apply) Burning – Splitting – Cramping –

Shooting – Dull – Crushing – Sore – Throbbing – Stabbing – Stinging – Numb – Pins & Needles

On a scale of 0- 10, with 10 being extreme pain and 0 being no pain, please rate your lowest and highest levels of pain:

0 1 2 3 4 5 6 7 8 9 10

2. **History of Current Pain**

How long have you had pain? (Circle one) Days / Weeks / Months / Years

Did your pain begin with a specific event, or did it "Come out of the blue?"_____

What makes your pain better?

What makes your pain worse? _____

Has the pain changed in the last 4 weeks? Y / N

Please list any interventions you have tried to ease this pain problem: (Circle those that apply)

Chiropractics- Shots-Biofeedback-Massage-TENS Unit- Physical Therapy- Epidural Injections-

Acupuncture- Facet Injections- Any other injections- Steroid/ Cortisone Therapy-
Other_____

Have you seen any other physicians for this pain? Y / N

What is / are the name(s) of the physicians(s) you has seen regarding this pain?

Specialty Physician Name Approximate Date Seen

Neurosurgeon: _____

Orthopedics: _____

Pain: _____

Psychiatrist/Psychologist: _____

General health Questions

Do you have difficulty swallowing? Do you have any fever? Y / N

Do you have any weakness? Y / N If so where? _____

Do you have any numbness? Y / N If so where? _____

Are there any changes in bowel and / or bladder function? Y / N
Do you have difficulty with constipation? Y / N

Do you sleep well? Y / N How many hours of sleep do you get a night? _____

Are you depressed? Y / N Have you had any weight loss? Y / N How many lbs? _____

How quickly was the weight lost? _____Days _____Weeks _____Months

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3. Past Medical- Surgical History:

Please circle any illnesses you have been diagnosed with: (Circle all that apply)

Diabetes- Heart Attack/Pacemaker- Coronary artery disease- Hypertension- Blood Disorders-

Thyroid Problems (hypo/hyper) - COPD / asthma/ bronchitis - Cancer- Stroke- Skin

Disease- Migraine/ Headaches- Seizure/Epilepsy- Eye problems- Allergies- Neurological disorders (MS,

Parkinson, etc) - Autoimmune Diseases- PVD (poor circulation in feet) - Other (Please explain any one circled),
_____

Have you ever been diagnosed and/or treated for a psychiatric or psychological disorder? Y / N

What were the diagnoses? _____

Please list all of your surgeries with the hospital and year in which they were performed:

_____

_____

_____

What Diagnostic Tests have you had done for your condition:

Test	**Area Tested**	**Date**	**Where At?**
X-ray			
CT Scan			
MRI			
Bone Scan			
EMG			
Mylogram			
Any Other Tests			

4. Allergies: Please List any medications allergies and your reactions to that medication:

_____

5. Current Medications:

Please list your **pain medications** you are currently taking with their dosage/amount:

_____

_____

_____

How long have you been taking these medications? _____

By what percent do your medications diminish your pain? _____%

Are there any side effects from your pain medications? Y / N
Describe the side effects:_____

Do you take your pain medications as prescribed? Y / N

Please list all your other current prescription medications with dosage and any Over-the-Counter meds:

_____

_____

_____

Are you currently on "Blood Thinners?" Y / N. **Name them**

Please List all medications you have taken in the past for you pain:

_____

_____

_____

6. Social Functional History:

Are you (circle those that apply) Single – Married- Divorced – Widow/Widower – Remarried

List all the people who live with you

_____

How many children do you have? _____

What is your highest level of education? _____

Are you currently (circle one) Employed- Unemployed- Retired

Has your pain caused you to miss days from work? Y/ N NA

Are you on Disability? Y / N NA

What is your occupation/ What was your occupation? _____

Do you need the help of another person to:

To get into and/or our out of bed? Y / N	**To help you get dressed/undressed? Y / N**
To get into and /or out of a chair? Y / N	**To help you prepared your meals? Y / N**
To use the toilet? Y / N	**To do your grocery shopping? Y / N**
To bathe or shower? Y / N	**To walk? Y / N**

Do you use a ? (circle all that apply) Cane- Walker- Crutches- Wheelchair- Braces (back or body)

Are you currently involved in any lawsuits? Y / N

Do you use tobacco products (circle all that apply) Cigarettes- Cigars- Chew- Snuff
How much a day? _____

Do you drink Alcoholic beverages? Y / N How much? _____Day _____Week _____Month

Do you use recreational drugs/street drugs/illegal drugs including Marijuana? Y / N
Used in the last month? _____

Do you have a regular exercise program? Y / N If yes what? _____

Please list your Hobbies or things you like to do for Fun and Relaxation:

_____

Have you ever been physically abused? Y / N Have you ever been sexually abused? Y / N

7. Family History

Family Medical History	Mother	Father	Brothers	Sisters
Cancer				
Heart Disease				
Hypertension				
Stroke				
Addiction				
Alcoholism				
Anxiety Disorder				
Bleeding Tendency				
Depression				
Diabetes				
Glaucoma				
Sickle Cell Anemia				

ADVANCED PAIN CENTER, P.A.

CHRONIC PAIN TREATMENT AGREEMENT

Patient Name: _____ Date of Birth _____

I understand that the purpose of this Agreement is to prevent misunderstandings about my treatment and certain medications I may be taking for pain management. This is to help both me and my physician to comply with the laws regarding controlled medications.

1. I understand that this Agreement is essential to the trust and confidence necessary in a physician/patient relationship and that my physician undertakes to treat me based on this Agreement.
2. I understand that if I break any term of this Agreement, my physician will stop prescribing these pain-control medications and has the right to discharge me from the Pain Center. In this case, my physician shall provide me with a thirty (30) day prescription of medicine (provided medication was not already obtained from another
provider(s)), and any scheduled appointments or emergency appointments during that thirty (30) day period).
3. I understand that these medications may have side effects and specific issues of developing tolerance, dependence, habitation, addiction and withdrawal problems and I will undergo any recommended laboratory studies including random urine or blood testing and regular follow up visits required to keep the regimen as safe as possible.
4. I understand that these medications are being used to reduce the intensity of my pain and improve my function and ability to work, and not simply feel good
5. I will not use any illegal controlled substances, including marijuana, cocaine, etc. I certify that I am not undergoing treatment for substance dependence or abuse and that I am not currently abusing illicit or prescription drugs. **I will not share, sell, or trade my medication with anyone.**
6. I will not attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medicines from any other physician unless previously discussed, documented and agreed upon with Advanced Pain Center's physician. I understand that it is violation of Federal and State laws to do so and that Advanced Pain Center may discontinue any prescription of narcotic/opioid medications and discharge me from the clinic.
7. I certify that I am not pregnant and will notify the physician immediately if I become pregnant. I have realized that it is my responsibility to keep myself and others from harm, including the safety of my driving. If there is any question of impairment of my ability to safely perform any activity including driving, I will not attempt to do so.
8. I will safeguard my medications from loss or theft. I understand that lost or stolen medication will not be replaced and that a police report must be filed for the theft and a copy provided to Advance Pain Center.

9. I agree that refills of my prescriptions for pain medication shall be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends and that I will not alter the dose of the medication.
10. I agree to use only the following pharmacy:

Pharmacy Name: _____
Pharmacy Address: _____
Pharmacy Phone: _____

If for any reason I am unable to fill my prescription at this designated pharmacy, I agree to notify Advanced Pain Center. I authorize Advanced Pain Center and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize my physician to provide a copy of this Agreement to my pharmacy or any other healthcare provider from whom I seek care. I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting healthcare operations of the practice. I further authorize Advanced Pain Centers access to my medical records at any other healthcare facility, institution or clinic where I seek care while I am a patient of Advanced Pain Centers.
11. I will bring all unused prescriptions at any time requested by my provider. I understand that I may have to consent to random urine or other drug tests for medications at the physician's request.
12. I agree to allow the physician to communicate with the referring physician, primary care physician, and any pharmacists regarding my use of controlled substances.
13. I understand that I must keep all follow-up appointments as recommended by my physician and that failure to comply may cause discontinuation of narcotic/opioid prescriptions and discharge from the clinic.
14. I understand that I must adhere to the Treatment Policies of the practice and that the benefit of the narcotic/opioid medication will be evaluated periodically using the following criteria: degree of pain relief; increase in general functioning; increase in exercise activities; completion of rehabilitation program; return to work status; and maintenance of employment.
16. I agree to the terms of this Agreement that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

Patient Signature: _____ Date: _____

Printed Patient Name: _____

Physician Signature: _____

Witnessed By: (Office Staff)_____

Printed Witness Name: _____

ADVANCED PAIN CENTER, PA.
TREATMENT POLICIES

Thank you for choosing Advanced Pain Center for your chronic pain care. We are committed to the treatment of your condition. In order to provide your care, we require both treatment and financial compliance. Your clear understanding of our policies is important to our professional relationship.

NARCOTIC/OPIOID ADMINISTRATION

Because your condition may require the dispensing of narcotic substances, we require you to sign a treatment agreement with us. This agreement outlines the conditions under which treatment is provided. This agreement is required of all patients and is signed at the time of your first service. We may also ask you to sign updated versions of this agreement from time to time.

FINANCIAL POLICY

If your insurance plan requires a copayment, it is payable at time of service. If you present without the copayment, we reserve the right not to see you. We are happy to bill your primary insurance company directly if a copy of both sides of your insurance card is provided at time of service as well as all required demographic information necessary to file your claim. If you fail to provide the necessary demographic information to file your claim, you will be responsible for payment in full at time of service. If payment is not received from your insurance company in ninety days, you will be expected to assist in the resolution of the open claim. It is in your best interests to ensure that the correct insurance information is provided at time of service.

If you have HMO coverage it is your responsibility to obtain the necessary referral for your visit or procedure and forward a copy of this referral to our office prior to your visit or procedure. Self pay patients are required to pay in full at time of service. We will discount our fees for self pay patients only if payment is made at time of service. We accept cash, check, money order, Master Card and Visa. If for any reason a payment is dishonored by your bank, there will be a $40.00 service fee added to your bill and you will be required to pay by cash, certified check , money order or credit card for all future services.

OFFICE POLICIES

DEMOGRAPHICS

All patients are required to provide the necessary demographic information in order for us to provide care and bill for our services. You are required to notify us when any demographic information changes. You are required to provide a copy of your insurance card if your coverage changes. You are required to sign a Patient Information form and medical records release annually.

PRIVACY

A copy of our complete privacy policy is provided to you at time of your initial visit. This policy explains your rights including your right to see and copy your records, to limit disclosure of your protected health information, and to request an amendment to your record. You may revoke in writing any consent for release of your health care information, except to the extent the Practice has already made disclosures with your prior consent. Because of the privacy regulations we are not at liberty to discuss your treatment with anyone unless you specifically designate your permission to do so. If you wish to allow access to your protected health information to any individual, ask our receptionist for an Access to Medical Records form. By signing this release, you allow us to discuss your care with the specified individual(s).

APPOINTMENTS
We attempt to contact our patients in advance of their appointments to remind them of the time and date. Please be sure to provide a telephone number where you may be reached. If you have voice mail on your contact telephone number, our staff will leave a message including the time, date and location of your appointment. We ask that you make your next appointment at time of service. Timely follow up appointments are a requirement of your care and we reserve the right to discharge you if you continually call at the last minute or fail to keep your regularly scheduled appointments. We require 24 hours notice if you intend to cancel your appointment. Should you cancel, reschedule, or no show for an appointment twice without 24 hours notice you will be required to hold your next appointment with a credit card. If you cancel this appointment for any reason, your credit card will be charged and you will be discharged from the practice for failure to uphold your treatment agreement.

PSYCHOLOGICAL EVALUATIONS
Because of the nature of our treatment, there may be occasions when the physician determines that a psychological evaluation is necessary. For example, many healthcare plans require evaluations prior to intrathecal pump or dorsal column stimulator placements. We reserve the right to discontinue care if you fail to obtain an evaluation as requested.

STAFF
We require our staff to address our patients with professionalism and we ask our patients to do the same. If at any time our staff feels that your tone or language is offensive or abusive, we expect them to terminate the conversation immediately and notify the Practice Administrator. We will document your record and if it happens again you will be discharged from the practice.

COMPLAINTS
If for any reason you are unhappy with the care provided by Advanced Pain Center, PA, we ask that you submit a written explanation of your concerns to: Compliance Officer, Advanced Pain Center, PA., 801 N Jackson , Odessa, TX 79761. This allows our Compliance Officer to research the matter and respond to your concerns in writing within thirty days. If for any reason additional time is needed, our Compliance Officer will contact you regarding the delay. We are committed to providing the best possible treatment and ask your cooperation in following our policies.

I ACKNOWLEDGE RECEIPT OF A COPY OF THE PRACTICE'S NOTICE OF PRIVACY POLICIES.
I READ AND UNDERSTAND THE ABOVE POLICIES AND AGREE TO ABIDE BY THEM. I FURTHER UNDERSTAND THAT FAILURE TO DO SO MAY RESULT IN MY DISCHARGE FROM THE PRACTICE.

_____ _____ _____
Patient Name (PRINT) Patient Signature Date

ADVANCED PAIN CENTERS, PA. (Fax No 432-333-1800)
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____Date of Birth: _____

I, the undersigned, authorize you to furnish a copy of the my medical records including lab results, progress notes, radiology reports, operative notes and other documents pertaining to my medical evaluation to Advanced Pain Center, PA.

I authorize the release of these medical records to Advanced Pain Centers from all physicians, relevant healthcare facilities and diagnostic centers involved in the course of my treatment.

I authorize Advanced Pain Center to release my medical records regarding their treatment to relevant healthcare providers, facilities and diagnostic centers involved in the course of my treatment. I specifically consent to the disclosure of records to Advanced Pain Centers that may contain alcohol/drug or substance abuse information. I specifically consent to the disclosure of these records by Advanced Pain Center to relevant healthcare providers, healthcare facilities and diagnostic centers involved in my treatment. **_____(Initials)**

I specifically consent to the disclosure of records to Advanced Pain Center that may contain HIV test results or diagnoses and AIDs and AIDs related conditions. I specifically consent to the disclosure of these records by Advanced Pain Center to relevant healthcare providers, healthcare facilities and diagnostic centers involved in my treatment. **_____(Initials)**

I specifically consent to the disclosure of records that contain mental health information. I specifically consent to the disclosure of these records by Advanced Pain Centers to relevant healthcare providers, healthcare facilities and diagnostic centers involved in my treatment. **_____(Initials)**

If not previously revoked, this authorization will expire TWELVE (12 months) from the date of my signature or as otherwise specified by date, event or condition(s) as follows:

_____ _____
Signature Date

_____
Witness Signature (Office Staff)

Advanced Pain Center

Refill Policy

Refill Request's must be called in 3 days prior to due date and meds will be sent on the day they are due.

By signing this I understand and agree that if I need a refill on any medication, I need to call the office 3 days in advance so that it will give the doctor ample time to either refill the medication or notify me if it cannot be refilled.

_____ _____

Print Patient Name Date

_____

Signature

New Patient Questionnaire

Please check the appropriate boxes

Constitutional Symptoms

Weight Loss	No _____	Yes_____	
Appetite	Normal_____	Loss_____	Increased _____
Fatigue	No _____	Yes _____	
Physical Strength	Normal _____	Loss _____	Improved_____

Heent

Deafness/Hearing Loss	No_____	Yes _____
Dizziness	No _____	Yes _____
Headache	No_____	Yes _____
Smelling Sense Change	No _____	Yes _____

Eyes

Corrective Lenses/Contacts	No_____	Yes _____
Change in vision	No_____	Yes _____

Cardiovascular

Chest pain/Angina	No _____	Yes _____
High Blood Pressure	No _____	Yes _____
Heart Attack	No _____	Yes _____

Respiratory

Shortness of Breath	No _____	Yes _____
Asthma	No _____	Yes _____
COPD/Emphysema	No _____	Yes _____

Gastrointestinal

Gastroesophageal Reflux Disorder	No_____	Yes_____
Nausea	No _____	Yes_____
Diarrhea	No_____	Yes _____
Bloating	No _____	Yes _____
Constipation	No_____	Yes _____

Genitourinary

Blood in Urine	No_____	Yes_____
Kidney Stones	No_____	Yes_____
Difficulty in Urination	No_____	Yes_____

SKIN

Rashes/Scars/Masses No_____ Yes_____

Musculoskeletal

Abnormal Joints No _____ Yes _____
Fractures No _____ Yes _____
Arthritis No _____ Yes _____
Joint Swelling No_____ Yes _____
Limitation of Joint Movemen No_____ Yes _____
Muscle Wasting No_____ Yes_____
Muscle Weakness No _____ Yes _____
Muscle Pain or Tenderness No _____ Yes _____
Night Cramps No _____ Yes _____
Atrophy No _____ Yes _____
Posture Abnormalities No _____ Yes_____

Neurological

Gait Disturbance No _____ Yes_____
Stroke No _____ Yes_____
Blackouts No _____ Yes_____
Epilepsy/Seizures No_____ Yes_____
Headaches No _____ Yes _____
Incoordination No _____ Yes _____
Memory Loss No_____ Yes_____
Involuntary Movements No _____ Yes_____
Spasticity No_____ Yes _____

Psychological

Depression No_____ Yes _____
Anxiety No_____ Yes _____
Sleeping Difficulty No_____ Yes _____

Endocrine

Thyroid No _____ Yes _____
Diabetes No _____ Type I _____ Type II _____
Intolerance None _____ Heat _____ Cold _____
Polyuria No _____ Yes _____

Hematologic

Bleeding Disorder No _____ Yes _____
Anemia No _____ Yes _____
Easily Bruised No _____ Yes _____

PLEASE READ CAREFULLY
AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "Patient/Guardian" shall be understood to mean _____.

"Physician" shall be understood to mean Sai Gundlapalli, MD, MPH and Advanced Pain Center, PA.

I understand that I am entering into a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by the Physician, I, the Patient/Guardian, agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against the Physician.

Should I initiate or pursue a meritorious medical malpractice claim against Physician, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Medical Specialties in the same specialty as the Physician. Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be members in good standing of the American Board of Anesthesiology with subspecialty certification in Pain Management

I agree the expert(s) will be obligated to adhere to the guidelines or code of conduct defined by the American Board of Anesthesiology and that the expert(s) will be obligated to fully consent to formal review of conduct by such society and its members.

I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions.

In further consideration, Physician also agrees to exactly the same above-referenced stipulations.

Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting or refuting evidence of a frivolous or meritless claim.

Patient/guardian and Physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other dependents.

Physician and Patient/guardian agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery or any other theory of recovery.

Patient/guardian and Physician acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physician's reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief.

Patient/guardian acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

_____	_____
Sai Gundlapalli, MD, MPH	Patient/Guardian
_____	_____
Effective from Date of Treatment:	Date of Signature