

# THE PAIN CENTER

## RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, \_\_\_\_\_, have reviewed/received a copy of

Patient Name

**THE PAIN CENTER** \_\_\_\_\_ 's Notice of Privacy Practices.

Practice Name

\_\_\_\_\_  
Signature of Patient / Guardian

\_\_\_\_\_  
Date

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### OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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PLEASE PRINT

DATE: \_\_\_\_\_

LAST NAME:		FIRST NAME:	M.I.
LOCAL ADDRESS:		PHONE NUMBER: (    )	CELL NUMBER: (    )
CITY:		STATE:	ZIP:
PERMANENT ADDRESS:			
CITY:		STATE:	ZIP:
DATE OF BIRTH: /   /	SEX: M / F	MARITAL STATUS: S M W D	SOCIAL SECURITY # -   -
HEALTH INSURANCE: [   ]	AUTO INSURANCE: [   ]	WORKERS COMP: [   ]	L.O.P. [   ]
PRIMARY INSURANCE:		SECONDARY INSURANCE:	
COMPANY ADDRESS:		COMPANY ADDRESS:	
POLICY NUMBER:		POLICY NUMBER:	
GROUP NUMBER:		GROUP NUMBER:	
SUBSCRIBERS NAME AND DATE OF BIRTH:		SUBSCRIBERS NAME AND DATE OF BIRTH:	
NAME OF EMPLOYER:		PHONE NUMBER: (    )	
PRIMARY PHYSICIAN:		PHONE NUMBER: (    )	
NAME OF SPOUSE / NEAREST RELATIVE:		RELATIONSHIP:	PHONE NUMBER: (    )
IS THIS TREATMENT THE RESULT OF AN ACCIDENT? YES                      NO		IF YES, WHERE DID THE ACCIDENT OCCUR? WORK                      HOME                      OTHER	
DATE OF ACCIDENT: /   /	NAME OF PERSON TO CONTACT CONCERNING ACCIDENT:		PHONE NUMBER: (    )

**ASSIGNMENT OF BENEFITS:**

**CONSENT FOR TREATMENT:** I, the undersigned, on behalf of the patient whose name appears above, hereby consent and authorize all diagnostic and therapeutic treatment considered necessary or advisable in the judgment of the attending physician.

**INSURANCE BENEFITS:** I hereby authorize \_\_\_\_\_ to release any information acquired in the course of my examination and/or treatment to the Social Security Administration & HealthCare Financing Administration or its intermediaries or carriers, any information needed for Medicare or other insurance claims. I permit a copy of this authorization to be used in place of the original and I request payment of medical insurance either to myself or to the party who accepts assignment. This is a lifetime authorization. I agree to pay in full for all medical service rendered by \_\_\_\_\_. If I fail to pay my charges, I agree to pay the cost of collection, including reasonable attorney fees and costs.

**AUTHORIZATION TO RELEASE INFORMATION:**

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY HEALTH INSURANCE CLAIM FORMS.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**RELEASE & ASSIGNMENT FOR MEDICARE AND AUTOMATIC CROSS – OVERS (MEDIGAP)**

Those who have Medicare only and/or a supplement that does not cross over directly from Medicare please sign 1<sup>st</sup> release only.

Those who have Medicare and a supplement that automatically cross-over, please sign both releases below.

**LONGTERM RELEASE & ASSIGNMENT**

I hereby authorize payment to \_\_\_\_\_ of benefits due to me from my Insurance company otherwise payable to me if assignment is accepted.

I further authorize the release of any medical information required by my insurance carrier(s). A copy of this authorization may be used in lieu of the original.

I authorize any holder of medical or other information about me to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request payment of medical insurance benefits either to myself or the party who accepts assignment.

PATIENT'S NAME (Please Print) \_\_\_\_\_ DATE \_\_\_\_\_

PATIENT'S SIGNATURE \_\_\_\_\_ MEDICARE# \_\_\_\_\_

**RELEASE AND ASSIGNMENT**

TO: \_\_\_\_\_

GROUP # \_\_\_\_\_ ID. # \_\_\_\_\_

INSURANCE CO. ADDRESS: \_\_\_\_\_

I hereby authorize Dr. \_\_\_\_\_ to release to your company or its representative, my information including the diagnosis and the records of my treatment or examination rendered to me during the period of such Medical or Surgical care.

I also authorize and request your company to pay directly to the above named doctor the amount due me in my pending claim for Medical or surgical treatment services, by reason of such treatment or services rendered to:

PATIENT: \_\_\_\_\_

I understand I am financially responsible for charges not covered by this authorization.

SIGNATURE OF INSURED: \_\_\_\_\_

## THE PAIN CENTER QUESTIONNAIRE

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Occupation \_\_\_\_\_ Education \_\_\_\_\_

Marital Status \_\_\_\_\_ Spouse' Name \_\_\_\_\_

List Children and their Ages \_\_\_\_\_  
\_\_\_\_\_

1. Are you allergic to any drugs? \_\_\_\_\_
2. Do you have a history of Asthma, Diabetes, Hypertension, Heart Attack, Vascular Disease or any other disease? If so, please explain \_\_\_\_\_  
\_\_\_\_\_
3. Do you have TB or chronic cough? \_\_\_\_\_
4. Have you ever had surgery? ( ) Yes ( ) No  
If yes what kind of surgery \_\_\_\_\_  
\_\_\_\_\_
5. Where is your pain located? (shade in the body illustration attached to the questionnaire)
6. How long have you had this pain? \_\_\_\_\_
7. What diagnosis or medical explanation have you received for your pain? \_\_\_\_\_  
\_\_\_\_\_
8. Are there any other symptoms that accompany your pain? \_\_\_\_\_  
\_\_\_\_\_
9. In your own words, describe your pain (sharp, dull, aching, burning, etc.) \_\_\_\_\_  
\_\_\_\_\_
10. What factors seem to aggravate your pain? \_\_\_\_\_  
\_\_\_\_\_

11. What factors seem to relieve your pain? \_\_\_\_\_  
\_\_\_\_\_
12. What medications do you take for pain relief? \_\_\_\_\_  
\_\_\_\_\_
13. How long have you been taking this medication? \_\_\_\_\_
14. Does this medication relieve your pain? ( ) Completely ( ) Not at all ( ) Somewhat
15. Have you ever been a patient in a hospital for diagnosis or treatment of your pain?  
( ) Yes ( ) No If yes, Name of hospital \_\_\_\_\_  
Date and Year \_\_\_\_\_
16. Have you ever had acupuncture or nerve block treatments for your pain? ( ) Yes ( ) No  
If yes, Date and Year \_\_\_\_\_ By whom? \_\_\_\_\_  
Result of treatment? \_\_\_\_\_
17. Does pain prevent you from performing any of your usual work, social or family duties?  
( ) Yes ( ) No If yes, Name them \_\_\_\_\_  
\_\_\_\_\_
18. Do you receive workman's compensation or other benefits?  
( ) Yes ( ) No ( ) Still Waiting
19. Is there a lawsuit involved? ( ) Yes ( ) No
20. Have you attempted to return to work?  
( ) Yes ( ) No ( ) Fulltime ( ) Part time ( ) Does not apply
21. Have you ever had Psychiatric/Psychological treatment for any condition or problem?  
( ) Yes ( ) No
22. Do you consider yourself to be a sickly person? ( ) Yes ( ) No
23. Do you have trouble falling asleep? ( ) Never ( ) Sometimes ( ) Usually ( ) Always

24. Do you have any objections to our obtaining records of your hospitalization, diagnosis or from any hospital or physicians you have listed on this questionnaire? ( ) Yes ( ) No
25. As part of your overall medical evaluation and treatment, you will participate in a pain management assessment. This process is designed to assist the treatment team in identifying those areas which contribute to and impact upon your pain experience. The goal is to assist you in recognizing resources which will empower you to manage and cope with life disruptions associated with your pain and enhance your quality of life.

Using the scale below, please indicate the severity of life disruption caused by your pain.

0	1	2	3
No Disruption	Mild	Moderate	Extreme

- |                            |                                |
|----------------------------|--------------------------------|
| a) Family/Marital _____    | f) Recreational Activity _____ |
| b) Mood _____              | g) Sleep _____                 |
| c) Social Activities _____ | h) Appetite _____              |
| d) Sexual Activity _____   | i) Work _____                  |
| e) Mobility _____          | j) Financial _____             |

26. How much of your day is disrupted by needing to deal with your pain?

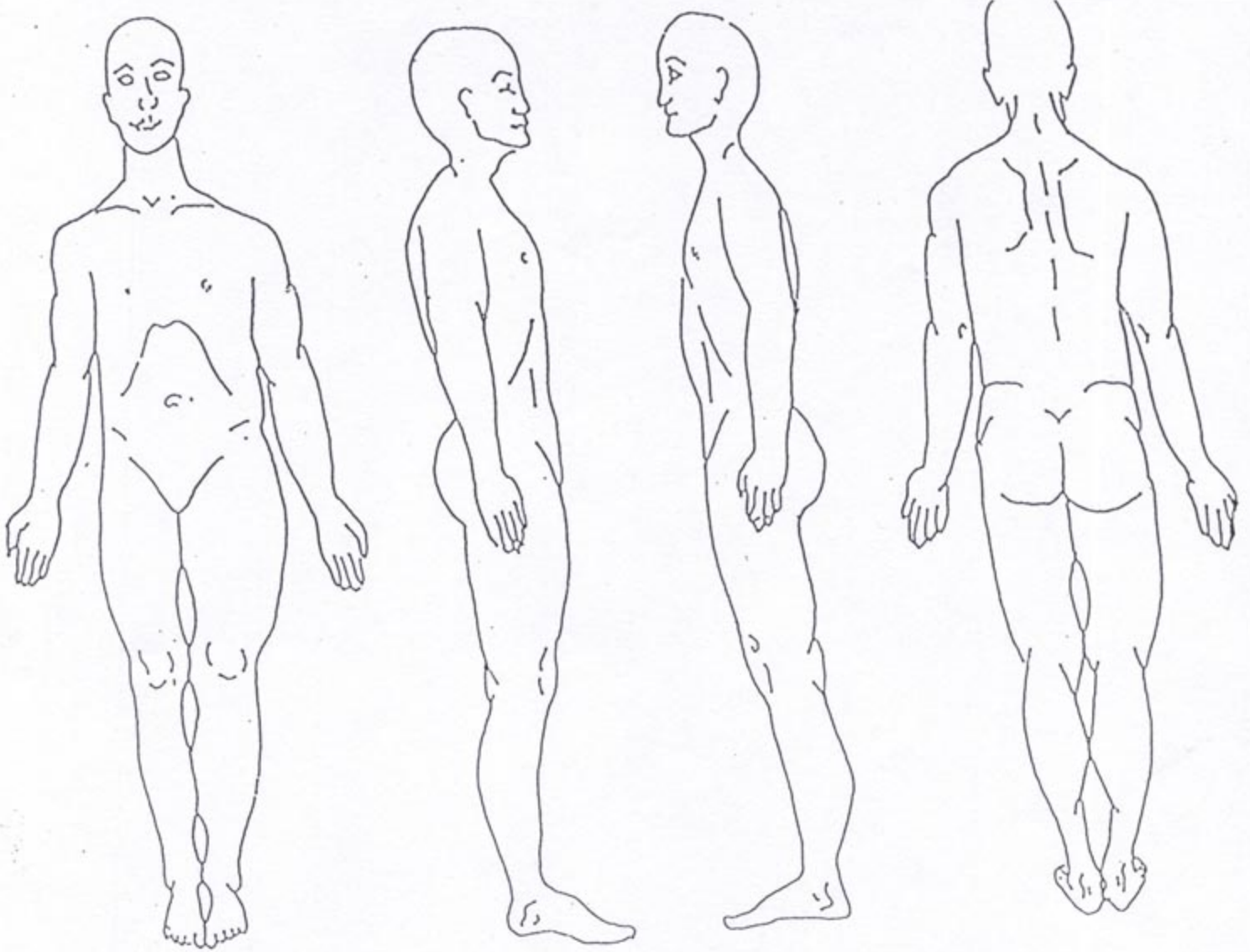
\_\_\_\_\_ Hours per day

27. Does your family understand the pain you are experiencing? \_\_\_\_\_

28. What changes have you noticed within your family as a result of your pain? \_\_\_\_\_

29. What indications have you noticed that let you know your family is having trouble coping with your pain? \_\_\_\_\_





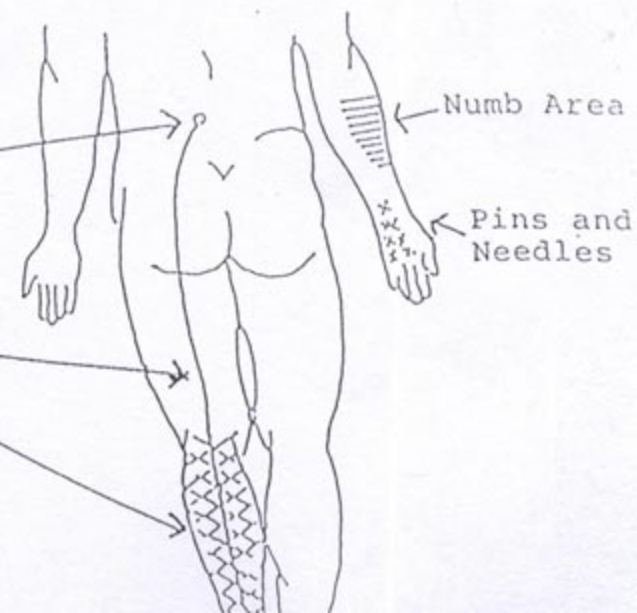
Mark on the drawings ABOVE, where your pain is with a SOLID circle. If your pain starts at a spot and travels elsewhere, draw a line from that point to where it ends. If your pain is in the whole area then SHADE in that area. Mark any numb areas with HORIZONTAL LINES and any pins and needles with X's.

EXAMPLE ONLY - DO NOT WRITE ON THIS DIAGRAM

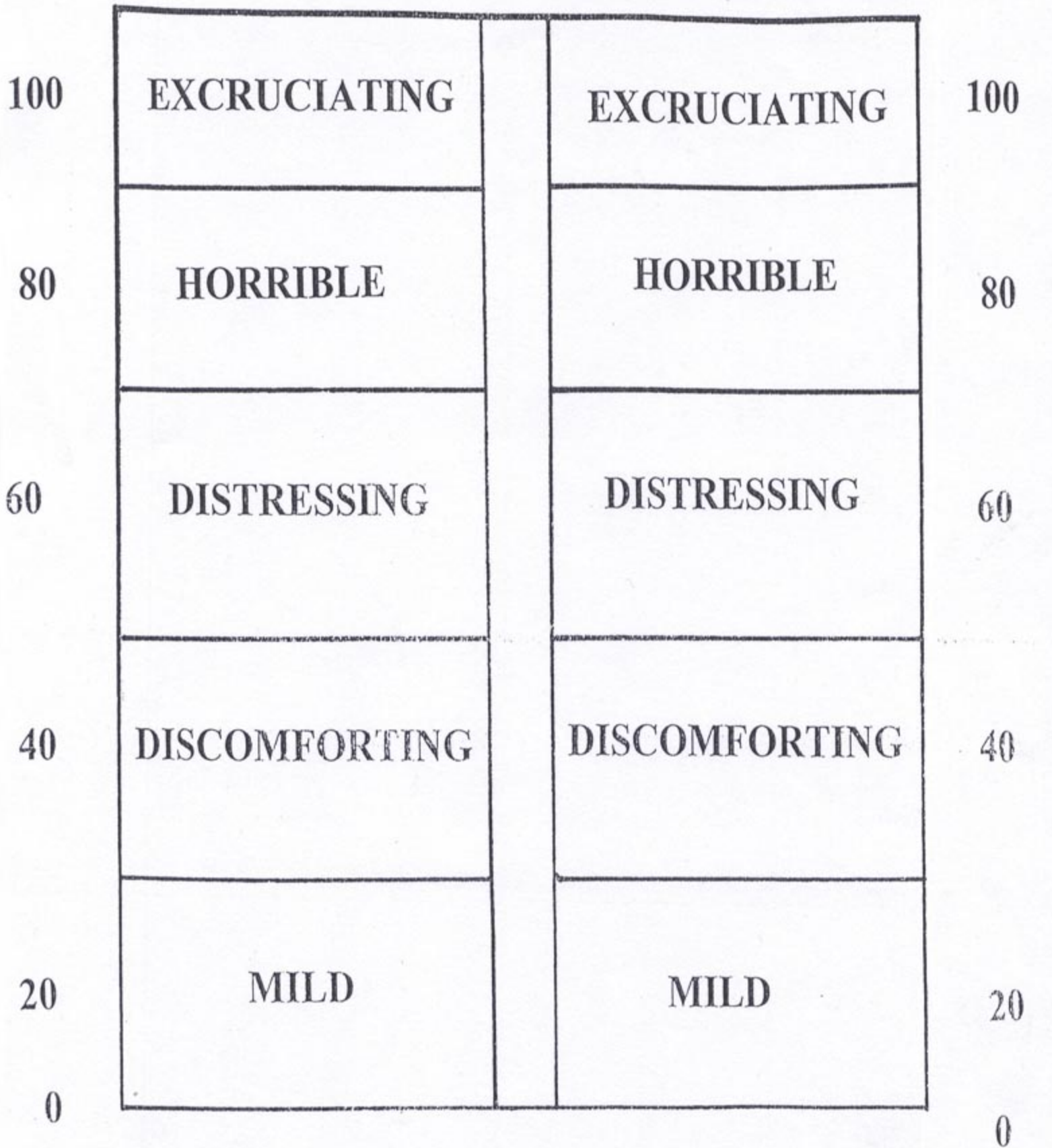
Pain begins to the left of midline in the small of the back.

Pain travels to heel.

The entire back of the lower leg hurts.



# YOUR PAIN METER



BEFORE  
YOUR  
FIRST  
VISIT

AFTER  
YOUR  
LAST  
VISIT

TODAY

