Southern Pain Institute
Pain Management, EMG/NCS and IME
Anna-Louise O. Molette, M.D.

Patient Registration

Name ____________________ **Date of Birth** __________ **Male Female**
Address ____________________ **Social Security Number** ____-____-____
____________________ **Race:** □ Asian □ African American □ Caucasian □ Hispanic
____________________ □ Native American Language __________

Home Phone ( ) __________ **Email** ____________________

Insurance Provider __________ **Insurance ID #** ____________________
Insurance Group # ____________________
Name on Insurance Card __________ **If not patient what is relationship** ______
Address of Insured if different from patient ____________________
____
____

Insured's place of Employment ____________________ **Work Phone ( )** ______
Are you REGISTERED DISABLED? □ Yes □ No

I ____________________, Authorize the release of any medical or other information necessary to process this case or claim. I request and authorize payment of medical or government benefits to my treating physician here who accepts assignment. I authorize any treatment, procedure, or lab work deemed necessary by the treating physician or staff. ***I agree to be personally responsible for any and all charges (including, but not limited, no show and same day cancellation fees) regardless of whether they are paid by an insurance company. I also agree to pay any court cost associated with the collection of my account balance.***

You were Referred by Dr. ______________ **Phone ( )** ____-______________
Your Primary Care Physician (PCP) ______________ **Phone ( )** _____-_______
PCP address ______________ **City/State** ______________

Emergency Contact Person ______________ **Phone ( )** _____- ______________

____________________ ______________
Signature of Patient **Date**

____________________ ______________
Signature of Patient Representative/Guardian **Date**

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Pain Management, EMG/NCV and IME

Name__________________________ **Date** ______________

List **All** Current Medications

Name Strength (mg) Quantity

1.____
2.____
3.____
4.____
5.____
6.____
7.____
8.____
9.____
10._______________________________________
11._______________________________________
12._______________________________________
13._______________________________________
14._______________________________________
15._______________________________________

Allergies: ***(Please list all allergies. If you are not allergic to anything please write that you are not allergic to anything.)***

*1.*____________________
*2.*____________________
*3.*____________________
*4.*____________________

Name_____________________________________ Date ____________________

My complaint today is ____
The problem started ____
How did the problem start? ____

1. **What makes the problem worse?** ☐Exercise ☐Walking ☐Bending ☐Sitting ☐Standing ☐Twisting ☐Lifting ☐Sneezing/Coughing ☐Repetitive use ☐Other ________________________

2. **What makes the problem better?** ☐Lying ☐Sitting ☐Standing ☐Waling ☐Manipulation ☐Therapy ☐Pain Pills ☐Muscle Relaxers ☐Injections ☐Anti-inflammatory ☐Other __________

3. **Please check the type of pain**: ☐Sharp ☐Dull ☐Aching ☐Nagging ☐Boring ☐Numb ☐Tingling

4. **How long does the pain last?** _____ what is the intensity? (0 least- 10 most) ___**What treatments have you had for this problem?** ☐Medication ☐Surgery ☐ Injections ☐Other

5. **Surgical History related to your pain**__________ (Year) _________(Year) did surgery help? ___

6. **List other medical problems/surgeries**:___________, ____________, ____________, _________, __________,___________,____________, ____________

7. **Have you had any psychiatric illness**? ____If yes, what is the diagnosis? Are you seeing a psychologist or psychiatrist? ___If yes, what is his/her name? ____________________________

8. **Are you working now**? __ What is your occupation? ___________How may hours per day do you work? __________Do you plan on changing jobs in the next 5-6 months? ____________

9. **Are you disabled**?_____ Are you able to take care of yourself? __ If no, what is the name and relationship of your caregiver?________ Are you married? __How many children? __ages?____

Name_______________________________________ Date ____________________

10. **Are there any substance abuse issues in the household**? ___ If yes please explain _____________

11. **Do you smoke cigarettes or use tobacco of any form now**? ___ If no did you ever smoke cigarettes or use tobacco of any form? ___ if yes, when did you stop? How many packs did/do you smoke a day? ___ How many years? _______

12. Which medications have you used? (Check all that apply) ☐**Fentanyl patches** ☐**Percocet** ☐**Hydrocodone** ☐**Oxycontin** ☐**Morphine** ☐**Robaxin** ☐**Ambien** ☐**Benadryl** ☐**Ms-contin** ☐**Elavil** ☐**Gabapentin** ☐**Lidoderm patches** ☐ **Tramadol** ☐**Lortab** ☐ **Savella** ☐**Cymbalta** ☐**Soma** ☐ **Xanax** ☐**Motrin** ☐ **Other** ______

13. Which of the following drugs or substances, if any have you used in the past? (Check all that apply) Next to each drug or substance that you have checked, indicate if you used it occasionally ("O"), frequently ("F"), or continuously ("C")

☐**Alcohol** ____☐**Barbituates**____ ☐ **Cocaine**_____ ☐**Heroin**_____
☐ **Amphetamines**_____ ☐**Marijuana**_____ ☐**Other**______

14. Are you presently using any of the drug or stubstances below? ? (Check all that apply) Next to each drug or substance that you have checked, indicate if you used it occasionally ("O"), frequently ("F"), or continuously ("C")

☐**Alcohol** ____☐**Barbituates**____ ☐ **Cocaine**_____ ☐**Heroin**_____
☐ **Amphetamines**_____ ☐**Marijuana**_____ ☐**Other**______

15. **Have you had any of the following studies**? __ If yes please provide the date of the study.
☐Diagnostic X-rays _____☐Emg(nerve study) _____☐ MRI/CT ______ ☐other
_____ __________

16. **Have you had any physical therapy for the problem**?__ If yes did it help?__Are you doing a home exercise program? ___ Have you been hospitalized for the problem? _____
17. **What are your treatment goals**?
____

Name: ______________________ Date: ____________

Pain Drawing

SOME PM&R PHYSICIANS HAVE THEIR PATIENTS COMPLETE A PAIN DRAWING SO THEY CAN UNDERSTAND THE LOCATION AND INTENSITY OF THEIR PAIN.

Instructions: Mark these drawings according to where you hurt (if the right side of your neck hurts, mark the drawing on the right side of the neck, etc.). Please indicate which sensations you feel by referring to the key below.

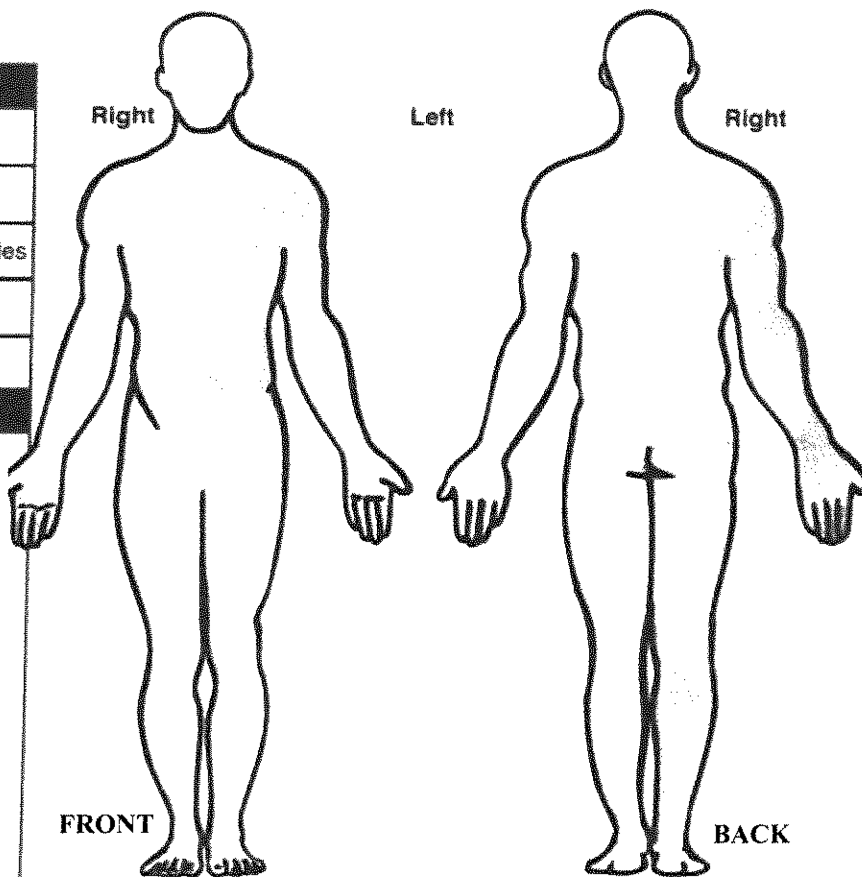
☐ RIGHT HANDED

☐ LEFT HANDED

KEY	
//////	Stabbing
XXXX	Burning
0000	Pins & Needles
====	Numbness
ΔΔΔ	Aching

PAIN LEVEL

- 0 No Pain at all
- 1 Mild pain; You are aware of it but it does not bother you.
- 2 Pain you can tolerate without meds
- 3 Moderate pain requiring meds to tolerate
- 4-5 More severe; begin to feel anti social
- 6 Severe pain
- 7-9 Intensely severe
- 10 Most severe pain/ Burning alive/ Contemplating suicide



CIRCLE YOUR CURRENT PAIN LEVEL

0 1 2 3 4 5 6 7 8 9 10

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REVIEW OF SYSTEMS:

Please check any of the following you may be experiencing:

__Fevers or chills
__Night sweats
__Nausea or Vomiting
__Constipation
__Chest Pain
__Shortness of Breath
__Cough
__Headaches
__Changes in Urination
__Blurry Vision
__Weakness

Medication Questionnaire:

Please complete at each visit:

When was the last time you took your pain medication?

____

Are you taking your pain medication as prescribed? YES/ NO/ SOMETIMES

Is your pain medication helpful? YES / NO / SOMETIMES

Do you exercise on a regular basis? YES / NO

PAIN CONTRACT

The following is an agreement between the Treating Physician prescribing Opioids and/or medications with strong potential for dependence and his/her Patient. Dismissal from the program can be immediate if the contract is broken in any aspect or if the responsible Physician deems it appropriate. Any dismissal from the program will be explained by the treating Physician to the Patient, Referring Provider, Pharmacy, and Sponsoring insurance company as appropriate. Southern Pain Institute & Co. believes the rules and guidelines to be appropriate for the being included in the pain management program. They are intended to help only. They are also believed to be vital, and very much fair. **I may receive Opioids and/or medications with dependence potential while actively participating in this program ONLY if I follow the rules listed below**:

(please initial)

___**01.** I will use the medication only as prescribed by the Southern Pain Institute Physician. **I will not** alter any dosage until I have contacted the prescribing physician and received approval to do so.

___**02.** I will receive my pain medication only from a Southern Pain Institute Physician. If I receive any prescribed medication outside the Southern Pain Institute physician or associate, with respect to pain management, my Treatment Will Be **TERMINATED.**

___**03.** The physician prescribing the medication reserves the right to decrease or discontinue the medication at any time strictly at his or her own discretion. An appropriate detoxification program will be recommended if deemed necessary.

___**04.** I agree to use only one pharmacy to receive my pain medications. If I change pharmacies, I will inform Southern Pain Institute. If my home address changes, I will contact Southern Pain Institute and report the new address.

___**05.** I will notify other health providers as well as emergency room providers that I am signed into a pain management program prior to taking any outside pain medication prescriptions.

___**06.** I understand that I am **required** to bring **ANY/ALL** MEDICATIONS prescribed to me by Southern Pain Institute to any and every visit to Southern Pain Institute. I can be discharged from the program if **I miss a scheduled appointment**

___**07.** Refills will be obtained every thirty days or as otherwise agreed. Refills will be made at time of scheduled appointment or by calling the designated refill line a **MINIMUM** of 7 days **BEFORE** running out of medication.

___**08.** I may be allowed (**upon discretion**) one replacement prescription refill for lost, stolen, or missing prescription or medication. After this one replacement, I will only be able to obtain a refill at the usual scheduled time. Furthermore, I will not only notify the physician immediately, but also the local police of the missing medication or prescription. A copy of the police report will be sent to the prescribing physician. A second loss will be immediately treated as a breach of contract and I can be released from the care of the pharmacological management of my conditions/symptoms by the attending physician.

___**09.** I understand that combining other medications with Opioids may cause drowsiness, intoxication, or death. Some of these medications are tranquilizers (downers), stimulants (uppers), diet pills, sleeping pills, alcohol or other street drugs.

___**10.** I understand that if I use more of any of the medications prescribed, sell, let other people use, collect, or obtain them and it is not authorized by Southern Pain Institute; Southern Pain Institute may refuse to continue to prescribe medication of potential dependence therapy. A referral to and addiction treatment center may be made; a medication change may occur.

___**11.** I understand that I must be seen by my pain management physician regularly. This requires a scheduled visit to the clinic. Refills **<u>will not</u>** be made if I do not keep **ANY** appointment. My response to therapy will be evaluated at each visit

___**12.** I understand psychological evaluation and/or follow-up may be required by Southern Pain Institute for Opioid maintenance.

___**13.** I understand that I may be given a **SUPERVISED** urine or blood drug screening test, to check if I am following rules.

___**14.** I must notify my Southern Pain Institute physician of any changes in pain status and of any dosage or schedule changes in the administration of the prescribed medication made by myself or other provider.

___**15.** PROFANITY, VOICE RAISING, THREATS, and other EXAGERATED BEHAVIOR (Directed toward Physician/ Staff or other patients on premises) will be grounds for IMMEDIATE DISCHARGE.

___16. I WILL NOTIFY THE PHYSICIAN IF I AM PREGNANT.

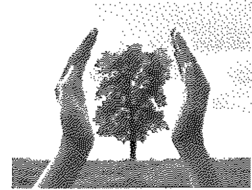
I HAVE READ THE ABOVE CONTRACT AND UNDERSTAND THE RULES REGARDING PRESCRIBING AND USE OF PAIN MANAGEMENT MEDICATIONS. I AGREE TO COMPLY WITH THIS PROGRAM. I ALSO AGREE TO TESTING AND DETOXIFICATION IF NECESSARY. _____ **Chronic Narcotic use carries risk of DEPENDENCE, TOLERANCE, ADDICTION, AND OTHER MEDICAL SIDE EFFECTS.**

Patient Signature______________________________ **Date**____________

Witness Signature______________________ Date_______ Physician Signature________________ Date_______

REQUESTS FOR MEDICATION CAN ONLY BE MADE AT 615.459.3206 FAX 615.459.6525
Remember call 7 days <u>BEFORE</u> you are Due!!!!!

Pharmacy________________________ **Phone # (   )** ______________**Address**____________________________________



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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided the Southern Pain Institute (SPI) Notice of Privacy Practices ("Notice"):

It tells me how (SPI) will use my health information for the purposes of my treatment, payment for my treatment, and SPI's healthcare operations.

The notice also explains in more detail how SPI may use and share my health information for other than treatment, payment, and healthcare operations.

SPI will also use and share my health information as required/permitted by law.

CONSENT FOR TREATMENT

The following information is to be completed by the patient or the patient's legally authorized parent, guardian or representative:

I consent to medical treatment for myself or for the patient for whom I am the legally authorized representative. I understand that Southern Pain Institute will share patient health information according to federal and state law regarding treatment, payment, and operative procedures.

I understand that the patient is responsible for all charges incurred, regardless of the patient's insurance status. The patient agrees to pay for services rendered as the patient incurs the charges. I authorize my insurance provider to pay Southern Pain Institute for services rendered.

Printed Legal Name of Patient: _______________Signature_________________

Patient's Date of Birth: _____ Today's date _______

Southern Pain Institute
Pain Management, EMG/NCS and IME
Dr. Anna-Louise O. Molette
739 President Place Suite 220
Smyrna Tennessee 37167
P: 615.459.3244
F: 615.459.6525

Authorization to Release Medical Records

I ____________________________ hereby authorize _____________________________ to disclose my medical records to Southern Pain Institute.

Patient's Name __________________ Dob ___________
Address ______________________________________
____
____

Phone # ____
Purpose of Disclosure □ **Evaluation and Treatment** □ **Other**

Information to be disclosed to the following person/organization:
Southern Pain Institute
739 President Place, Suite 220
Smyrna, Tennessee 37167
P: 615.459.3244
F: 615.459.6525

I agree and understand that sensitive information (HIV records, urine screens, etc) may be released to Southern Pain for treatment within a pain management clinic.

Specific Information ____

Use of copies: **A copy of this authorization may be utilized with the same effectiveness as an original until ______________ (expiration date) or until it is revoked by the undersigned.**

Signature of Patient or Guardian____

Date ____________________