# Welcome!

ANA PAIN MANAGEMENT, P.C.

**Anand C. Thakur, MD**
**42645 Garfield Road Ste 103**
**Clinton Township, Michigan 48038**
**Phone: 586-286-7246 Fax: 586-329-4751**

Thank you for choosing ANA Pain Management for your healthcare needs.

## GETTING READY FOR YOUR VISIT

On your first visit, please bring any relevant medical records, X-rays, CT or MRI scans, medication bottles and other medical information related to the problem for which you are being seen.

Please complete the attached questionnaire **before** your appointment. It is confidential and will become part of your medical record. It asks for information about your current problems, and past medical history. This form will give your doctor a better understanding of your problem and will allow him to spend more time discussing treatment plans with you.

We value you as a patient and are providing the following information about clinic policies to assist us in delivering your healthcare needs.

**It is your responsibility to obtain any HMO health insurance referrals that may be needed for your visit.** This will include all the Medicaid and Blue Care Network plans**. If we do not receive your referral within 24 hours of the date of your appointment, we will need to reschedule your appointment. Co-Pays are your responsibility as dictated by most insurance policies and will be collected prior to seeing the physician.**

**If you are being treated for a work or auto related injury, the patient must provide ANA Pain Management with a written authorization from your employer or the auto insurance company handling your case. It should contain the following information: authorization to be treated by our physician, name and address of the facility our office is send all claims pertaining to the patient's treatment, the claim number, the date of injury, and attorney's name representing your case and/or the adjuster's name, address and phone number. If this is not received by your scheduled appointment date, we will reschedule your appointment to another day and time. If the auto claim becomes settled but the account has an outstanding balance after the settlement, the patient will be responsible for remaining balance.**

## CANCELLATION POLICY

We have established the follow policies to provide every patient with care as quickly as possible, as we know your time is valuable.

**Consult/New patient appointment:** As a new patient, we will allow you to reschedule your consult appointment one time. After two cancellations and/or no-shows, you will not be allowed to reschedule with our office.

**Existing Patients:** Once you have become a patient of the office, we ask that you make your appointments carefully to ensure you are able to keep them. After three cancellations and/or no-shows you may be discharged from the office. This is based on Dr. Thakur reviewing your case.

**There will be a $75.00 charge for cancelations without rescheduling, or $150.00 for no call/no show. Procedure cancelations are $200.00.**

## LATE POLICY

If you arrive past the indicated "**Arrival Time"** on your enclosed letter, you may be asked to reschedule. We ask that you arrive 10-15 minutes before your scheduled appointment time to allow time for registration.

If you arrive 15 minutes past your appointment time you may be asked to reschedule.

## PRESCRIPTION DRUGS

Please be aware that we may **not** be able to provide you with medications. If you have been prescribed a medication by another physician, it is the responsibility of that physician to continue providing you with that medication unless otherwise stated by Dr. Thakur and he does chose to take over the care of your opioid pain medications.

We also ask that you bring all pill bottles for the medications you are currently taking to your visit. Dr. Thakur will determine the best possible treatment plan for you, but this may not include the continuation of current prescriptions.

## PHYSCIAN PHONE CALLS

When calling the office to speak with Dr. Thakur or another member of the office we will do our best to return your phone call within 48 hours. Since we are not an Urgent care clinic, if you have an emergency we advise that you go to your nearest emergency room.

Sincerely,

Dr. Anand C. Thakur and Staff

ANA PAIN MANAGEMENT, P.C.

# New Patient Form

**Date_____**

**Patient's Name**_____
**First** **Middle** **Last**

**Date of Birth**_____

**Social Security number** _____-_____-_____ **PLEASE COMPLETE**

**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

**Do you have a DNR:** ☐ Yes ☐ No

**E-Mail Address**_____

**Patient Street Address**_____

**City** _____ **State** _____ **Zip Code** _____

**Telephone Number** _____

**How would you prefer to be contacted?** ☐ E-Mail ☐ Phone ☐ Mail

**Primary Care Doctor: Name** _____ **Phone** _____

**Treating Doctor:** **Name** _____**Phone** _____

**Referring Doctor:** **Name** _____**Phone** _____

**Medicare requires us to ask the following:**

**Race:** ☐ Asian ☐Hispanic ☐ African American ☐ Caucasian ☐Declined
**Language:** ☐ English ☐ Spanish ☐ Sign Language ☐ Other ☐ Declined
**Ethnicity:** ☐ Latino/Hispanic ☐ Not Latino/Hispanic ☐ Decline

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**Employer / School Name** _____

**Occupation** _____

**Years Employed** _____ ☐ Full Time ☐ Part time

**Employer's Street Address** _____

**City** _____ **State** _____ **Zip Code** _____

**Telephone Number** _____

**Spouse / Parent Name** _____

**Relationship to patient?** ☐ Spouse ☐ Parent ☐ Other _____

**Street Address** _____

**City** _____**State**_____ **Zip Code** _____

**Telephone Number** _____

**Nearest relative, not living with you?** _____**Relationship?** _____

**Street Address** _____

**City** _____ **State**_____ **Zip Code** _____

**Telephone Number**_____

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**Is this related to a motor vehicle accident?** ☐ Yes ☐ No

Date of accident _____ Claim Number _____

Adjuster's Name _____Phone_____

Address _____

Is the Claim still open? ☐ Yes ☐ No If so, Date Closed _____

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**Is this related to a worker's compensation accident?** ☐ Yes ☐ No

Date of accident _____ Claim Number _____

Adjuster's Name _____Phone_____

Address _____

Is the Claim still open? ☐ Yes ☐ No If so, Date Closed _____

ANA PAIN MANAGEMENT, P.C.

**Primary Insurance Company Name**_____

**Street Address**_____

**City**_____ **State**_____**Zip Code**_____

**Policy Type:** ☐ Individual ☐ Cobra ☐ Group ☐ HMO ☐ PPO

**ID Number**_____

**Group Number or Name**_____

**Policy Holder's Name**_____
First Middle Last

**Social Security Number** _____ - _____ - _____**Birthday**_____

**Relationship to patient?** ☐ Self ☐ Spouse ☐ Parent

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**Secondary Insurance Company Name**_____

**Street Address**_____

**City**_____ **State**_____**Zip Code**_____

**Policy Type:** ☐ Individual ☐ Cobra ☐ Group ☐ HMO ☐ PPO

**ID Number**_____

**Group Number or Name**_____

**Policy Holder's Name**_____
First Middle Last

**Social Security Number** _____ - _____ - _____

**Relationship to patient?** ☐ Self ☐ Spouse ☐ Parent

_____ _____ _____
Patient Name (print) Patient/Guardian Signature Date

ANA PAIN MANAGEMENT, P.C.

# HIPAA AUTHORIZATION

For use or disclosure of health care information

By signing this form, I, _____, authorize ANA Pain Management the use and disclosure of my health information as described below:

**You can disclose my health information as describe below:**

____leave message on my answering machine
____leave message with spouse
____leave message with anyone who answers phone
____can fax information to my home
____can fax information to my work place
____can mail information to my home
____can mail information to my work place

**You can leave message confirming appointments as described below:**

____leave message on my answering machine
____leave message with spouse
____leave message with anyone who answers phone

**Name of person/persons authorized to receive any information or pick up prescriptions/letters:**
_____

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I understand that I have the right to revoke this authorization in writing at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do sin in writing and send it to:

ANA Pain Management
42645 Garfield Road, Ste 103
Clinton Township, MI 48038

_____
Patient Name (print)

_____ _____
Patient Signature Date

ANA PAIN MANAGEMENT, P.C.

# Assignment of Benefits

**Assignment of Benefits**
I hereby assign payment directly to accepting the assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. I understand that I am financially responsible for the charges not covered by my insurance company or for any and all charges which the insurance carrier declines to pay. It is further agreed that my credit balance resulting from payment of insurance or other sources may be applied to any other accounts owed to said physician(s) by the insured or his/her family.

**Release of Information**
The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician(s) or to the patient or to the Health Care Financing Administration and/or the patient's attorney for all or part of the physician(s) charges including but not limited to patient insurance companies, worker's compensation carries, welfare funds or the patient's employer if it is a worker's compensation case.

**Lifetime Authorization**
Medicare and Medicaid Patient Certification-Payment Classification Authorization to Release Information and Payment Request: I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carries any information needed for this or a related Medicare, Medicaid, or other third-party claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and co-insurance.

**Please Note**
Insurance contracts are made between you and the insurance company. We do not render service under the assumption that the charges will be paid by your insurance company. Payments of any and all charges are presumed to be your responsibility. All charges are due in full upon receipt of our state. A photocopy of this form shall be valid.

_____ _____

Date Signature of Patient or Responsible Party

ANA PAIN MANAGEMENT, P.C.

# Financial Policies

Thank you for choosing ANA Pain Management. 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.

If your insurance plan requires a copayment, it is payable at the time of service. If you present without a payment, we reserve the right to reschedule you or to bill you a $10.00 administration fee.

We are happy to bill your primary insurance company directly if a copy of both sides of your insurance card is provided at the 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 the time of service. If payment is not received from your insurance company in ninety days, you will be expected to assist resolution of the open claim. If the claim continues to be unpaid after 120 days, we reserve the right to bill you directly. It is in your best interest to ensure that the correct insurance information is provided at the 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. If you fail to do so, we reserve the right to reschedule your appointment.

Filing a secondary insurance is a courtesy to the patient and we will make one attempt to do so and then the balance will be your responsibility. If we receive payment from you and your secondary carrier, a refund of the overpayment will be made to you. We will not file tertiary insurance, but will provide a claim to you upon request. You are responsible for all tertiary balances.

All patients are expected to pay at the time of service. We accept cash, check, money order, Master Card, Visa American Express and Discover. Self-pay patients are required to pay in full at the time of service.

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 cash, certified check, money order or credit care for all future services.

We do accept Workers Compensation and Personal Injury cases. We will only file these claims with your regular insurance if a written denial from the workers compensation or personal injury carrier is received. We accept liens only for services provided in our office. All necessary legal contact information must be provided in advance of your service to allow us time to process the necessary lien paperwork.

We are participating providers for many plans. However, it is your responsibility to verify that the provider you are to see is in your network. If the provider is out of network and you see this physician, you are responsible for payment in full regardless of any insurance plan's arbitrary determination of usual and customary fees. There may be times when our physician is out of the office and you are required to see a physician who is not in your network. In these instances, we will work with your insurance plan to obtain in-network benefits and you will not be responsible for payment of the entire fee.

If you fail to meet your financial obligations in a timely manner, we reserve the right to discontinue care and refer your account to collections. You are responsible for any agency, attorney, interest, and other charges associated with collections.

# 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 care if your coverage changes. We reserve the right to change the required demographics in order to comply with legal or billing requirements.

ANA PAIN MANAGEMENT, P.C.

## Privacy

A copy of our complete privacy policy is provided to you at the 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 contest 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). If a family member has concerns about your care, we may not discuss these concerns without your written permission.

## Appointments

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 require 24 hours' notice if you intend to cancel your appointment. Should you cancel, reschedule, or no-show for an appointment without 24-hour notice, we reserve the right to charge a $75.00 no-show fee.

If you are scheduled for a procedure and cancel without 24-hour notice to our office, a cancellation fee of $ 200.00 will be billed to you directly.

**If you are more than 15 minutes late for your appointment, we reserve the right to reschedule your appointment or see you as the schedule permits. If you are a new patient and do not complete your forms in advance, you are required to be at the office at least 45 minutes in advance of your appointment to complete the necessary forms. Failure to do so will result in the rescheduling of your new patient visit.**

## Psychological Evaluation

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 spinal cord stimulator trials. **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 their immediate supervisor or practice administrator. **We will document your record and depending on the severity of the situation, you may be discharged from the practice.**

We are committed to providing the best treatment and ask your cooperation in following our policies.

ANA PAIN MANAGEMENT, P.C.

**I ACKNOWLEDGE RECEIPT OF A COPY OF THE PRACTICE'S FINANCIAL 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

ANA PAIN MANAGEMENT, P.C.

# HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT of 1996

## Notice of Privacy Practices

**Effective: November 12, 2012**

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

*If you have any questions about this Notice, please contact our Privacy Officer at the number listed at the end of this Notice.*

Each time you visit a healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This Notice applies to all of the records of your care generated by your health care provider.

***Our Responsibilities***

ANA Pain Management, P.C. is required by law to maintain the privacy of your health information and to provide you with description of our legal duties and privacy practices regarding your health information. The current Notice will be posted in the waiting room. The notice will include the effective date. In addition, we will make our best effort to provide you with a copy of this notice and we request that you acknowledge receipt with your signature.

We are required by law to abide by the terms of this Notice and notify you if we make any changes to this Notice, which may be at any time. Changes to the Notice will apply to your medical information that we already maintain as well as new information received after the change occurs. If we change our Notice, it will be made available to anyone who asks for it, and be posted in the waiting room. You may also request that a revised Notice be sent to you in the mail or you may ask for one at your next appointment or appropriate visit. This Notice will also serve to advise you as to your rights with regard to your medical information.

***How We May Use and Disclose Medical Information About You***

The following categories describe examples of the way we use and disclose medical information.

**For Treatment:** We may use and disclose medical information about you to provide, coordinate and manage your treatment or services. We may disclose medication information about you to other doctors, nurses, technicians (e.g. clinical laboratories or imaging companies) medical students, or other personnel who are involved in your care. We may communicate your information either orally or in writing by mail or facsimile.

We may also provide subsequent healthcare provider with copies of various reports that should assist him or her in treating you. For example, your medical information may be provided to a physician to whom you have been referred so as to ensure that the physician has appropriate information regarding your previous treatment and diagnosis.

**For Payment:** We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information before it approves or pays for the health care services we recommend for you.

**For Health Care Operations:** We may use or disclose, as needed, your health information in order to support our business activities. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, legal advice, accounting support, information systems support and conducting or arranging for other business activities. In addition, we may also call your by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment by telephone or reminder card.

# Notice of Privacy Practices Continued

**Business Associates:** There are some services provided in our organization through contracts with business associates. Examples include collections and software support. If these services are contracted, we may disclose your health information to our business associate so that they can perform the job that we have 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 through written contract. In addition, business associates are individually required to abide by the HIPPA rules.

### *Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object*

We may also use and disclose your health information as set forth below. You have the opportunity to agree or object to the use or disclosure of all or part of your health information in these instances. If you are not present or able to agree or object to the use or disclosure of the health information (such as an emergency situation), then your clinician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the information that is relevant to your health care will be disclosed.

**Individuals Involve in Your Care or Payment for Your Care:** Unless you object, we may release medical information about you to a friend or family member who is involved in your medical care or who helps to pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition status and location.

**Future Communications:** We may communicate to you via newsletters, mailings or other means regarding treatment options, information on health-related benefits or services; to remind you of your appointment for medical care; or other community based initiatives or activities in which our facility is participating. If you are not interested in receiving these materials please contact our Privacy Officer.

### *Other Permitted and Required Uses and Disclosures That May Be Made <u>Without</u> Your Consent, Authorization or Opportunity to Object*

We may use or disclose your health information in the following situations without your authorization or without providing you with an opportunity to object. These situations include:

**As required by law:** We may use and disclose health information to the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors, Coroners and Medical Directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others
- Authority that receives reports on abuse and neglect

**Law Enforcement/Legal Proceedings:** We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

**State-Specific Requirements:** Many States have requirements for reporting, including population-based activities related to improving health or reducing health care costs.

ANA PAIN MANAGEMENT, P.C.

# Notice of Privacy Practices Continued

***Your Health Information Rights***

Although your health record is the physical property of the facility that compiled it, you have the right to:

**Inspect and Copy:** You have the right to inspect and copy medical information that may be used to make decisions about your care. We ask that you submit these requests in writing. Usually, this includes medical and billing records, but does not include psychotherapy notes or information compiled in reasonable anticipation of or for use in a civil, criminal, or administrative action or proceeding. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. Requests for access to and copies of your medical information must be submitted to ANA Pain Management, P.C. in writing. The practice complies with state record release laws.

**Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information by submitting a request in writing. You have the right to request an amendment for as long as we keep the information. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

**An Accounting of Disclosures:** You have the right to request an accounting of our disclosures of medical information about you except for certain circumstance, including disclosures for treatment, payment, health care operations or where you specifically authorized a disclosure. ANA Pain Management, P.C. will provide the first accounting to you in any 12-month period without charge. The cost for subsequent requests for an accounting within the 12-month period will be in accordance with the state records release laws. We ask that you submit these requests in writing.

**Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a procedure that you had. We ask that you submit these requests in writing.

Except under specific circumstances, we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment or is required by law. We must agree to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPPA) if the information pertains solely to a health care item or service for which we have been paid by you out-of-pocket, and in full.

**Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. For example, you can ask that we use an alternative address for billing purposes. We ask that you submit these requests in writing.

**A paper Copy of This Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To exercise any of your rights, please obtain the required forms from the Privacy Officer and submit your request in writing.

***Complaints***

If you believe your privacy rights have been violated, you may file a complaint with use by calling (586) 286-7246 and asking for the Privacy Officer or by contacting the Secretary of the Federal Department of Health and Human Services. All complaints must be also submitted in writing. You will not be penalized for filing a complaint.

***Other Uses of Medical Information***

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. However, we are unable to take back any disclosures we have already made with your permission and we are required to retain our records of the care that we provided to you.

Privacy Officer: Dr. Anand C. Thakur
Telephone Number: (586) 286-7246

## Notice of Privacy Practices

**I acknowledge having received a copy of the practice's Notice of Privacy Policies.**

_____

*Patient Name (Print)*

_____ _____

*Patient Signature* *Date*

ANA PAIN MANAGEMENT, P.C.

Patient's Name: _____ Date:_____
Date of birth: _____ Sex: M F Right handed Left handed
Daytime Phone: _____ Night Phone: _____
Name of Primary Care Physician: _____ Name of referring Physician_____
Phone #: _____ Fax #: _____
List other physicians that your records should be sent to:
Doctor: _____ Doctor: _____
Phone #: _____ Phone #: _____
Fax #: _____ Fax #: _____

## CAUSES OF YOUR PAIN: PLEASE ANSWER ALL QUESTIONS

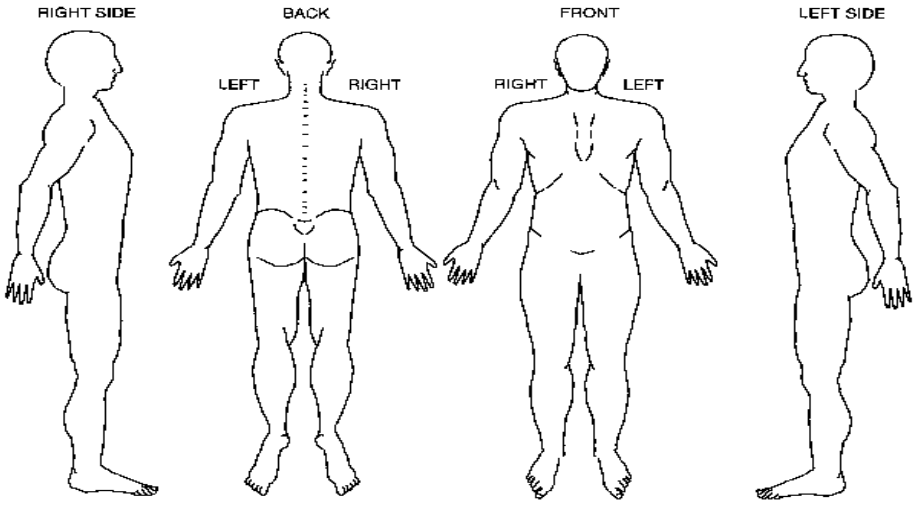
| Event(s) surrounding the onset of your pain | Date Pain Began | Pain intensity today |
|---|---|---|
| _____ | _____ | Better Same Worse |
| _____ | _____ | Better Same Worse |
| _____ | _____ | Better Same Worse |
| _____ | _____ | Better Same Worse |

I believe my pain is due to (write description on line provided):

- ☐ The effects of treatment (medication, surgery, radiation, ect.) : _____
- ☐ My primary disease (meaning the disease currently being treated): _____
- ☐ A medical condition unrelated to my primary disease: _____
- ☐ Pain is related to a Motor Vehicle or work accident: _____

## PAIN DESCRIPTION

On the Diagram, shade in the areas where you feel pain. Put on X on the area that hurts the most.



ANA PAIN MANAGEMENT, P.C.

## PAIN DESCRIPTION continued

Check all the things that make your pain **worse**:

□ Sitting □ Standing □ Rest □ Heat □ Cold □ Walking □ Exercise □ Lifting □ Bending □ Other

Check all the things that make your pain **better**:

□ Sitting □ Standing □ Rest □ Heat □ Cold □ Walking □ Exercise □ Lifting □ Bending □ Other

Please rate your pain by circling the one number that best describes your pain at its **worst in the last week**:

0 1 2 3 4 5 6 7 8 9 10

No pain as bad as you can imagine

Please rate your pain by circling the one number that best describes your pain at its **best in the last week:**

0 1 2 3 4 5 6 7 8 9 10

No pain as bad as you can imagine

Please rate your pain by circling the one number that best describes your pain **right now:**

0 1 2 3 4 5 6 7 8 9 10

No pain as bad as you can imagine

For the following, check Yes or No if that word applies to your pain:

( **Please add location of pain next to each symptom)**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Aching | □ YES | □ NO | _____ | Burning | □ YES | □ NO | _____ |
| Throbbing | □ YES | □ NO | _____ | Exhausting | □ YES | □ NO | _____ |
| Shooting | □ YES | □ NO | _____ | Tiring | □ YES | □ NO | _____ |
| Stabbing | □ YES | □ NO | _____ | Nagging | □ YES | □ NO | _____ |
| Gnawing | □ YES | □ NO | _____ | Numb | □ YES | □ NO | _____ |
| Sharp | □ YES | □ NO | _____ | Miserable | □ YES | □ NO | _____ |
| Tender | □ YES | □ NO | _____ | Unbearable | □ YES | □ NO | _____ |

Circle the one number that describes how, during the past week, pain 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

ANA PAIN MANAGEMENT, P.C.

## PAIN DESCRIPTION continued

**Concentration and thinking:**

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely Interferes

**Normal Work:** (includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely Interferes

**Relationships 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

**Appetite:**

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely Interferes

## PAIN TREATMENT(S)

How many physicians have been involved in the treatment of your pain?

□ 0 □ 1-3 □ 4-5 □ 6-10 □ 11-15 □ 16 or more

If you have treated with another physician, please let us know who and when.

_____

_____

ANA PAIN MANAGEMENT, P.C.

## PAIN TREATMENT(S) continued

How many emergency room visits have you had in the past year for pain?
□ 0 □ 1-3 □ 4-5 □ 6-10 □ 11-15 □ 16 or more
If so where?

_____

_____

Check all other methods you use to relieve your pain:
□ Warm Compresses □ Cold Compresses □ Relaxation techniques □ Distraction □ Medication □ Rest
□ Other _____

Check the nerve blocks, injections or procedures that have been performed. If you've had a procedure, but you don't remember what is was called, please choose "other".

| | How Many | Date(s) Preformed |
|---|---|---|
| □ Cervical (neck) epidural steroid injection | _____ | _____ |
| □ Lumbar epidural steroid injection | _____ | _____ |
| □ Caudal epidural steroid injection | _____ | _____ |
| □ Lumbar Facet joint block | _____ | _____ |
| □ Cervical Facet joint block | _____ | _____ |
| □ Stellate ganglion block | _____ | _____ |
| □ Lumbar sympathetic block | _____ | _____ |
| □ Trigger point injection | _____ | _____ |
| □ Discogram | _____ | _____ |
| □ Occipital nerve block | _____ | _____ |
| □ Spinal cord stimulator | _____ | _____ |
| □ Intrathecal pump | _____ | _____ |
| □ Other_____ | _____ | _____ |

Are you currently in Physical therapy? NO YES If yes are you getting relief? NO YES
If so where and how long?_____

## PAIN MEDICATION

Do you have some form of pain now that requires medication every day? NO YES
Did you take any pain medication in the last 7 days? NO YES
Do you feel you need to take more of the pain medication than your doctor has prescribed? NO YES

ANA PAIN MANAGEMENT, P.C.

## PAIN MEDICATION continued

Check the box that pertains to you:

How do you prefer to take pain medication:

□ On a regular basis □ Only when necessary □ Do not take pain medication

How do you take pain medication over a 24-hour period?

□ Not every day □ 1-2 times a day □ 3-4 times a day □ 5-6 times a day □ More than 6 times per day

How long have you been on opioid pain medications?

□ 0-1 year □ 1-2 years □ 3-4 years □ 5-6 years □ 6-7 years □ 8-9 years □ 10 + years

What % relief do your opioid pain medications provide?

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

No relief Complete relief

Are your medications kept in a safe place? NO YES Where? _____

Do you feel you need to receive further information about your pain medications? NO YES

**Past Pain Medications:** Have you ever taken the following pain-related medications in the **PAST**? Do not list current medications on this page.

| | NO | YES | Why did you stop? |
|---|---|---|---|
| Acetaminophen (Tylenol) | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |
| Amitriptyline (Elavil) | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |
| Baclofen | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |
| Belbuca | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |
| Butrans patch | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |
| Capsaicin Cream | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |
| Celebrex | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |
| Codeine (Tylenol #3) | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |
| Cymbalta | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |
| Dilaudid | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |
| Fentanyl (Duragesic) | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |
| Flexeril (Cyclobenzaprine) | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |
| Hydrocodone | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |
| Ibuprofen (Motrin) | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |

ANA PAIN MANAGEMENT, P.C.

## PAIN MEDICATIONS CONTINUED

**Past Pain Medications continued:** Have you ever taken the following pain-related medications in the **PAST**? Do not list current medications on this page.

| | YES | NO | Why did you stop? |
|---|---|---|---|
| Kadian | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |
| Lidoderm Patch or cream | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |
| Lyrica | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |
| Methadone | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |
| Mobic (Meloxicam) | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |
| MS Contin (Morphin) | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |
| Neurontin (Gabapentin) | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |
| Nucynta (Tapentadol) | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |
| Opana (Oxymorphone) | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |
| Percocet (Oxycodone) | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |
| Oxaydo | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |
| Oxycontin | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |
| Robaxin | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |
| Skelaxin | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |
| Soma | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |
| Suboxone | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |
| Toradol | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |
| Ultram (Tramadol) | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |
| Voltaren Gel | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |
| Zanaflex (Tizanidine) | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |
| Xtampza | □ | □ | □ Side Effect(s)_____ □ Didn't Work □ Stopped working |

**Have you ever had an allergy or serious reaction to any food or medications including shellfish, Latex, or IVP Dye?** □ Yes □ No **If yes, please describe:**

_____

_____

_____

ANA PAIN MANAGEMENT, P.C.

## HOSPITALIZATION AND SURGICAL HISTORY

**Please list with dates all surgeries or procedures you have had under anesthesia (including tooth extractions and tonsillectomy) as well as any problems with each:**

_____

_____

_____

**Have you ever been hospitalized?** □ Yes □ No If yes, explain:

_____

_____

## REVIEW OF SYSTEMS

| **SELF** | | | **Family Member** | | |
|---|---|---|---|---|---|
| | | When | | | Who |
| Heart attack | □ Yes □ No | | Heart attack | □ Yes □ No | |
| High Blood Pressure | □ Yes □ No | | High Blood Pressure | □ Yes □ No | |
| Stroke | □ Yes □ No | | Stroke | □ Yes □ No | |
| Asthma | □ Yes □ No | | Asthma | □ Yes □ No | |
| Diabetes | □ Yes □ No | | Diabetes | □ Yes □ No | |
| Epilepsy or seizures | □ Yes □ No | | Epilepsy or seizures | □ Yes □ No | |
| Cancer | □ Yes □ No | | Cancer | □ Yes □ No | |
| Chest pain on exertion | □ Yes □ No | | | | |
| Chest pain at rest | □ Yes □ No | | | | |
| Heart murmur | □ Yes □ No | | | | |
| Anemia | □ Yes □ No | | | | |
| Bleeding Time | □ Yes □ No | | | | |
| Difficulty breathing | □ Yes □ No | | | | |
| Shortness of breath | □ Yes □ No | | | | |
| Abnormal chest x-ray | □ Yes □ No | | | | |
| Jaundice or hepatitis | □ Yes □ No | | | | |
| Ulcers | □ Yes □ No | | | | |
| Glaucoma | □ Yes □ No | | | | |
| Urine Retention | □ Yes □ No | | | | |
| Fainting | □ Yes □ No | | | | |

**FEMALE PATIENTS ONLY:**

**Do you think you are pregnant?** □ Yes □ No

**Do you use contraceptives?** □ Yes □ No

**If yes, what type?**

_____

**Date of your last menstrual cycle:**

_____

ANA PAIN MANAGEMENT, P.C.

## PAST MEDICAL HISTORY

| | | | |
|---|---|---|---|
| **High blood pressure?** | **Yes** | **No** | |
| **Heart disease?** | **Yes** | **No** | |
| **Heart attack?** | **Yes** | **No** | |
| **CHF?** | **Yes** | **No** | |
| **Stroke?** | **Yes** | **No** | |
| **Chest Pain?** | **Yes** | **No** | |
| **High Cholesterol?** | **Yes** | **No** | |
| **Arrhythmia?** | **Yes** | **No** | |
| **Smoker?** | **Yes** | **No** | |
| **Asthma?** | **Yes** | **No** | |
| **COPD?** | **Yes** | **No** | |
| **Emphysema?** | **Yes** | **No** | |
| **Liver disease?** | **Yes** | **No** | |
| **Kidney disease?** | **Yes** | **No** | |
| **Ulcers?** | **Yes** | **No** | |
| **GERD?** | **Yes** | **No** | |
| **PUP?** | **Yes** | **No** | |
| **Diabetes?** | **Yes** | **No** | **If yes, what type? _____** |
| **Cancer?** | **Yes** | **No** | **If yes, what type? _____** |
| **Thyroid disease?** | **Yes** | **No** | |
| **Anxiety?** | **Yes** | **No** | |
| **Depression?** | **Yes** | **No** | |
| **Osteoarthritis?** | **Yes** | **No** | |
| **Rheumatoid arthritis?** | **Yes** | **No** | |
| **Bleeding disorders?** | **Yes** | **No** | |

**Any other past or current medical history not noted above?**

_____

_____

_____

_____

ANA PAIN MANAGEMENT, P.C.

## SOCIAL HISTORY

What is your involvement in social activities?

0 1 2 3 4 5 6 7 8 9 10

No involvement Actively involved

Is this a change since the onset of your pain? NO YES

Do you currently smoke? NO YES If Yes: Packs per day _____ For how many years: _____

Where you a smoker in the past? NO YES If Yes: for how many years? _____ Year you Quit:_____

Do you use Alcohol? NO YES

If yes, on average, how many drinks do you have **per week**? □ 3 or less □ 4-7 □ 8-12 □ 13 or more

Was there ever a time in your life when you may have had an alcohol problem? NO YES

Did you ever, or do you now, use street drugs including Marijuana? NO YES

If yes, list _____

Have you ever been addicted to prescription drugs? NO YES

Does anybody in your family have a history of drug misuse/addiction? NO YES

Have you ever been in a treatment program for alcohol or drug abuse? NO YES

If YES explain: _____

What is your present marital status: Single Married Separated Divorced Widowed

Do you have children? NO YES If yes, how many? _____ Boys ____ Girls_____

What are the ages of your children _____

Check the highest level of education completed.

□ Grade school □ High school □ GED □ Some college □ College graduate □ Trade school □ Bachelors □ Masters

## WORK

Are you currently employed? NO YES

**If yes:** What do you do: _____ How many hours per day? _____

**If no:** How long have you been out of work? _____ What was your occupation?_____

How do you spend your day? _____

Is unemployment due to your pain? NO YES

Have you ever been in the military? NO YES

Are you able to do household chores? NO YES

List your Hobbies _____

_____

_____

**Patient Signature:** _____

**Patient Name:** _____ **Date:** _____

ANA PAIN MANAGEMENT, P.C.

- Are you **currently taking** any blood thinning medications such as **Aspirin, Coumadin, Plavix, Vitamin E, etc.**?

  □ Yes □ No

  If you answered yes, please tell us which blood thinning medications you are currently taking:

  _____

  _____

- **Do you have a Pacemaker?**

  □ Yes
  □ No

- **Do you have a Defibrillator?**

  □ Yes
  □ No

- **Would you like to discontinue using opioids?**

  □ Yes
  □ No

**Patient Signature:** _____

ANA PAIN MANAGEMENT, P.C.

## Pharmacy Information

**Patient Name:** _____

**Patient's Email:** _____

**Pharmacy Name:** _____

**Pharmacy Address:** _____

**Pharmacy City:** _____

**Pharmacy State and Zip Code:** _____

**Pharmacy Phone Number:** _____

**Pharmacy Fax:** _____

## Prescription History Consent

I give my consent to have ANA Pain Management, P.C. to obtain my prescription history from external sources.

Date: _____

Patient or Authorized Person's Signature: _____

***FOR PHYSICIAN USE ONLY***

## ASSESMENTS

### Head/Face

□ Atypical Facial pain: G50.1

□ Cervicogenic Headache/suboccipital Headache: R51

□ Cluster headache: G44.009

□ Occipital neuralgia/headache: M54.81

□ Spinal headache: G97.1

□ Temporomandibular Joint dysfunction: RT/M26.601 LT/ .602 BL/ .603

□ Tension Headache: G44.209

□ Trigeminal neuralgia: G50.0

### Cervical Spine

□ Neck pain: M54.2

□ High DDD: M50.31

□ Mid DDD: C4-5/M50.321 C5-6/.322 C6-7/.323

□ C/T1 DDD: M50.33

□ High Disc herniation: M50.21

□ Mid Disc herniation: C4-5/M50.221 C5-6/.222 C6-7/.223

□ C7/T1 Disc herniation: M50.23

□ Dystonia/Torticollis: M43.6

□ Facet radiculopathy: M54.12

□ Post-Laminectomy syndrome: M96.1

□ Cervicothoracic Radiculopathy: M54.13

□ Spinal Stenosis: M48.02

□ Cervical Spondylosis: M47.812

□ Sprain/Whiplash: S13.4xxA/D

□ Cervical Strain: S16.1xxA/D

### Thoracic Spine

□ Thoracic pain: M54.6

□ Compression fracture: M80.88XA/D/S

□ Collapsed vertebrae: M48.54xA/D/S

□ DDD: M51.34

□ Disc herniation: M51.24

□ DISH: M48.10

□ Post-Laminectomy syndrome: M96.1

□ Intercostal Neuropathy: G58.0

□ Thoracic radiculopathy: M54.14

□ Rib Sprain: S23.41xA/D

□ Scoliosis: M41.9

□ Spinal Stenosis: M48.04

□ Thoracic spondylosis: M47.814

□ Sprain of Ligaments: S23.3xxA/D

□ Thoracic outlet syndrome: G54.0

**Lumbar Spine**

□ Ankylosing Spondylitis: M45.6

□ Arachnoiditis (unspecified Meningitis): G03.9

□ Bertolotti's syndrome: Q76.49

□ Osteoporosis with fracture: M80.08XA/D/S

□ Collapsed Vertebrae: M48.56xA/D

□ DDD Lumbar: M51.36

□ DDD L/S: M51.37

□ Disc Herniation Lumbar: M51.26

□ Disc Herniation L/S: M51.27

□ Post- Laminectomy: M96.1

□ Iliolumbar syndrome(sprain): S33.5xxA/D

□ Low back pain: M54.5

□ Lumbosacral plexopathy: G54.4

□ Lumbar Radiculopathy: M54.16

□L/S Radiculopathy: M51.17

□ Spinal Stenosis: M48.061 w/o claudation

M48.062 w/ claudation

□ 2/2 facet joint spurs and spondylolisthesis: M99.63

□ 2/2 disc bulge and soft tissue: M99.73

□ Spondylosis: M47.816

□ Spasm of back muscle: M62.830

□ Strain: S39.012A/D/S

**Sacrum/Buttock**

□ Cuneal Neuroma: M79.2

□ Coccyx pain: M53.3

□ Piriformis syndrome: LT G57.02 RT G57.01

BL G57.03

□ Sacroiliac joint disorder: M12.9

□ Sacroiliac joint sprain: S33.6xA/D

□ Sacroiliitis: M46.1

□ Sacral and Sacrococcygeal spondylosis: M47.818

**Pelvis/Hip/Thigh**

□ Arthritis of the hip: LT M25.752 RT: M25.751

□ Bursitis Ischial or ischiogluteal: LT M70.72 RT: M70.71

□ Bursitis Trochanteric: LT M70.62 RT M70.61

□ Femoral Neuropathy: LT G57.22 RT G57.21

BL G57.23

□ Gluteal tendinitis: LT M76.02 RT M76.01

□ Hamstring Strain: LT S76.312A/D/S

RT S76.311A/D/S

□ Iliotibial band syndrome: LT M76.32 RT M76.31

□ Meralgia paresthetica: LT G57.12 RT G57.11

BL G57.13

□ Pain in hip: LT M25.552 RT M25.551

□ Pain in leg: LT M79.605 RT M79.604

**Knee**

□ Arthritis: M17.0

□ Bursitis Prepatellar: LT M70.42 RT M70.41

□ Chondromalacia Patella: LT M22.42 RT M22.41

□ Knee pain: LT M25.562 RT M25.561

□ Patellar Tendinitis: LT M76.62 RT M76.61

□ Peroneal Neuropathy: LT S84.12xA/D RT S84.11xA/D

**Other Lower Extremity**

□ Complex pain syndrome Type 1: LT G90.522 RT G90.521 B/L G90.523

□ Complex pain syndrome Type 2: LT G57.72 RT G57.71 B/L G57.73

□ Phantom limb pain: G54.6

□ Restless leg syndrome: G25.81

**Ankle/Foot**

□ Achilles tendinitis/bursitis: LT M76.62 RT M76.61

□ Metatarsalgia: LT M77.42 RT M77.41

□ Morton's neuroma: LT G57.62 RT G57. 61

BL G57.63

□ Pain in ankle/foot: LT M25.572 RT M25.571

□ Plantar fasciitis: M72.2

□ Tarsal Tunnel syndrome: LT G57.52 RT G57.51

BL G57.53

**Shoulder**

□ Frozen Shoulder: LT M75.02 RT M75.01

□ Bicipital tendinitis: LT M75.22 RT M75.21

□ Bursitis Subacromail: LT M75.52 RT M75.51

□ Bursitis Scapulothoracic: LT M75.82 RT M75.81

□ Labral Tear: LT S43.432A/D/S RT S43.431A/D/S

□ Osteoarthritis of shoulder: LT M25.712 RT M25.711

□ Pain in arm: LT M79.602 RT M79.601

□ Pain in shoulder: LT M25.512 RT M25.511

□ Paresthesia of skin: R20.2

□ Sprain of Sternoclavicular joint: S23.420A/D

□ Rotator cuff Strain: LT S46.012A/D/S

RT S46.011A/D/S

**Elbow**

□ Tennis elbow: LT M77.12 RT M77.11

□ Golfer's elbow: LT M77.02 RT M77.01

□ Median Neuropathy (other than CTS): LT G56.12 RT G56.11 BL G56.13

□ Olecranon Bursitis: LT M70.22 RT M70.21 BL G56.31

□ Radial Neuropathy: LT G56.32 RT G56.31

**Other Upper Extremity**

□ Complex pain syndrome Type 1: LT G90.512 RT G90.511 B/L G90.513

□ Complex pain syndrome Type 2: LT G56.42 RT G56.41

**Wrist/Hand**

□ CTS: LT G56.02 RT G56.01 BL G56.03

□ Ulnar Neuropathy: LT G56.22 RT G56.21

BL G56.23

□ Radial styloid tenosynovitis: M65.4

□ Osteoarthritis of the wrist: LT M19.032 RT M19.031

□ Osteoarthritis of the hand: LT M19.042 RT M19.041

□ Trigger finger: M65.30

□ Wrist drop: LT M21.332 RT M21.331

**Miscellaneous**

□ Chronic pain Syndrome: G89.4

□ Opioid induced constipation: K59.09

□ Costochondritis: M94.0

□ Edema: R60.1

□ Fibromyalgia: M79.7

□ Gait abnormality: R26.81

□ Long term Opioid usage: Z79.891

□ MS: G35

□ Myalgia: Mastication muscle M79.11 Auxiliary muscle M79.12 Other Site M79.18

□ Muscle weakness: M62.81

□ Obesity (overweight): E66.3

□ Obesity (morbid obesity): E66.01

□ Post herpetic neuralgia: B02.29

**Diagnostic Testing**

□ MRI Cervical Spine with/without contrast □ with sedation

□ MRI Thoracic Spine with/ without contrast □ with sedation

□ MRI Lumbar Spine with /without contrast □ with sedation

□ CT of Cervical Spine with/without contrast □ with sedation

□ CT of Thoracic Spine with/without contrast □ with sedation

□ CT of Lumbar Spine with/without contrast □ with sedation

□ Bilateral Upper Nerve Conduction Study and EMG

□ Bilateral Lower Nerve Conduction Study and EMG

**Physical Therapy**

□ Physical Therapy

**Procedures**

□ Facet (Right side, Left side, Bilateral) (Cervical Thoracic Lumbar) Level_____

□ SI joint (Right side, Left side, Bilateral)

□ Epidural (Cervical, Thoracic, Lumbar) Level_____

□ Occipital (Right side, Left side, Bilateral)

□ Medial Branch Block: (Right side, Left side, Bilateral) (Cervical, Thoracic , Lumbar) Level _____

□ Radiofrequency Ablation (Right Side, Left side, Bilateral) (Cervical, Thoracic, Lumbar, SI) Level_____

□ NeuroStim Trial

**Medical Assistant Portion**

**Verified and Reconciled items**

| | |
|---|---|
| □ HPI | Complete |
| □ ROS | Complete |
| □ Assessment | Complete |
| □ Examination | Complete |
| □ Plan | Complete |
| □ Problem List | verified (Matches all diagnoses in Assessment) |
| □ Vital signs taken/documented | verified |
| □ Surgical History | verified |
| □ Allergies | verified |
| □ Social History | verified |
| □ Family History | verified |
| □ Smoking | verified |

**Preventative Medicine**

□ Correct Modalities are selected

**Next appointment**

□ Next appointment scheduled

Procedure Codes/E&M codes are accurately completed

□ all codes including G-codes are entered into EMR

**Notes /Procedure Completed**

□ Note is locked

**Faxed**

□ Note is faxed to referring physician

Initials of MA completing note _____