Restorative Pain Institute
REGISTRATION FORM

Today's Date:	Name of Family Physician:

PATIENT INFORMATION

Patient's last name: _____ First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐		
(Former name):	Social Security no.:		Birth date:	Age:	Sex: ☐ M ☐ F	
Email address:	Cell Phone:		Home Phone:			
Street address:	OK to leave message with detailed information on Cell & Home Phone? CELL Phone: ☐ Yes ☐ No Home Phone: ☐ Yes ☐ No					
City:	State:		ZIP Code:			
Occupation:	Employer:		Employer phone no.:			
Referred to clinic by (Please check one box):	☐ Dr.		☐ Other:			
Preferred Pharmacy:						

INSURANCE INFORMATION

(Please give your insurance card & picture ID to the receptionist.)

Primary insurance					
Subscriber's name:	Subscriber's SS #:	Birth date:	Policy #:	Group #:	Co-payment:
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Policy #:	Group #:	
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #:	Work phone #:

AUTHORIZATION TO TREAT * INSURANCE ASSIGNMENT * FINANCIAL POLICY

I, the undersigned patient, hereby authorize Restorative Pain Institute and its staff to administer such treatment as is necessary, and to perform services and/or procedures as are considered necessary on the basis of findings during the course of delivery of health care services and treatment.

I hereby authorize the assignment of benefits (payments) directly to Restorative Pain Institute for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-pays, deductibles and non-covered services are due at the time of service. I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

I understand and agree that I am personally responsible for all balances owed to Restorative Pain Institute , either uninsured or deemed not medically necessary and/or not paid by my insurance. All balances are due at the time of service making any unpaid balances delinquent. I agree to pay all costs of collections, including, but not limited to, Third-Party Collection Agency Fees, reasonable attorney fees, court costs and allowable interest.

_____ _____

Patient/Guardian signature *Date*

RECEIPT OF NOTICE OF PRIVACY PRACTICES POLICY

I acknowledge that I have received the HIPAA Notice of Privacy Practices and Patient Bill of Rights. (Attached)

_____ _____

Patient/Guardian signature *Date*

In accordance with the HIPAA guidelines, Restorative Pain Institute is authorized to discuss my medical information with the following individuals.

HIPAA Authorized Persons _____

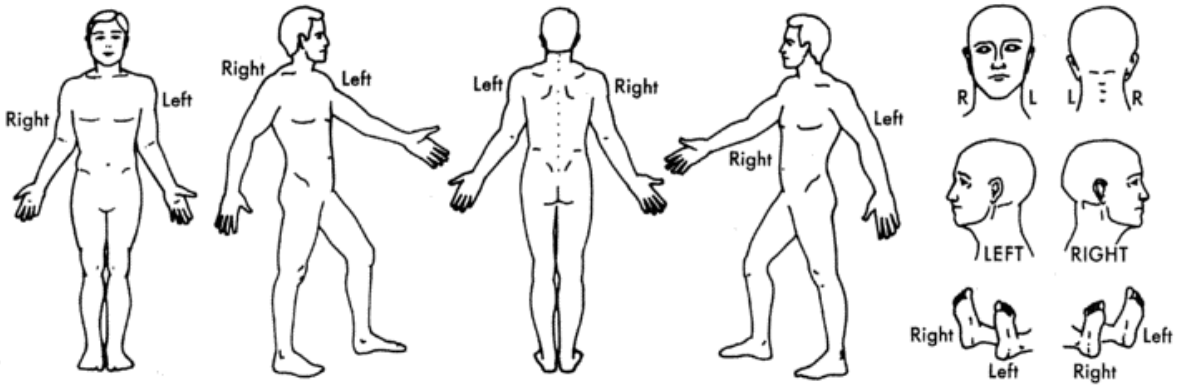
Relationship to patient _____

Phone # (_____)_____

New Patient History

Patient Name:_____ **DOB:**_____**Today's Date:**_____

Location of pain: Please mark the location of your pain.



PLEASE COMPLETE THIS SECTION FIRST-----

What is your pain level today? _____ (0=no pain, 10=worst pain)

What is your pain level most of the time? _____ (0=no pain, 10=worst pain)

Most recent procedure/injection: _____

Percentage of pain relief achieved from **MEDICATIONS** _____ %, lasting for _____ hrs/days/months

List any side-effects you believe are caused by your pain medication: _____

Most recent procedure/injection: _____

Percentage of pain relief achieved from **INJECTION** _____ %, lasting for _____ hrs/days/months

Month & Year your pain first began: _____ Did pain start after an accident? □ Yes □ No

If so, please explain the accident: _____

Frequency of your pain? □ **Constant** or □ **Fluctuating** but □ always □ usually □ rarely present

Description of pain: □ Aching □ Burning □ Cramping □ Sharp □ Stabbing □ Numb □ Tingling
Other: _____ Location of worst pain: _____

What makes your pain worse?: □ Bending/Stooping □ Changing from sitting to standing □ Nothing
□ Lifting or carrying items □ Lying on back □ Lying on side Other: _____

What makes your pain better?: □ Sitting □ Standing □ Exercise □ Stretching □ Walking □ Nothing
□ Walking □ Lying on back □ Lying on side Other: _____

What does your pain interfere with? □ Daily Chores □ Sleep □ Exercise □ Mood □ Grooming
□ Nothing □ Walking □ Employment □ Relationships Other: _____

---------- **OFFICE USE ONLY** ----------

Follow up: 1 mo 2 mos 3 mos **NO UDS** **Other:** _____

CESI _____ **LESI** _____ **CAUDAL**
T/F ESI at _____ **RT LT**

CMBB TMBB LMBB GNB
RT LT B/L _____ **x2**

RFA - Cerv Lumb Gen
RT LT B/L

GTB / HIP -- RT LT B/L

SIJ – RT LT B/L

MTPI – Cerv Lumb

KNEE GEL / IA -- RT LT B/L

Physical Therapy **Pain Cream** **Back Brace** **PSYCH EVAL / Educ -- SCS Pain Pump ORA/CBT**

IMAGING -- **MRI Cerv MRI Lumb** **XRAY Cerv XRAY Lumb** Neurosurgery Ortho Surgery

Patient Name:_____ **DOB:**_____**Today's Date:**_____

Past Imaging/Tests Have you had any of the following to assist in the evaluation of your pain? □ Yes □ No

TEST / BODY AREA (back, neck, etc)	DATE	WHERE
MRI _____	_____	_____
CT _____	_____	_____
XRay _____	_____	_____
EMG/NCS_____	_____	_____
Other _____		

Past Injections Have you had any injections to treat your pain? □ Yes □ No List type, date and where.

_____ _____

_____ _____

Past therapies & treatments PT, OT, Chiropractic, Aqua, Back brace, TENS unit? List type, date and where.

_____ _____

_____ _____

Surgical history List surgeries / dates / surgeon □ Yes □ No If yes, please list type, date and surgeon

_____ _____

_____ _____

Hospitalizations List any hospital visits other than the previously listed surgeries. List only the last two years

_____ _____

_____ _____

Medical History Check all diseases/disorders you have had:

□ Migraine headaches	□ High blood pressure	□ Emphysema	□ Cirrhosis	□ Kidney disorder	□ Cancer
□ Head injury	□ High cholesterol	□ Asthma	□ Hepatitis	□ Prostate disorder	□ Depression
□ Stroke	□ Coronary artery disease	□ Sleep apnea	□ Gallbladder	□ Osteoporosis	□ Anxiety
□ Seizures	□ Heart attack (MI)	□ Hiatal hernia	□ Pancreatitis	□ Spine disorder	□ ADD/ADHD
□ Multiple Sclerosis	□ Heart arrhythmia	□ Reflux	□ Diabetes	□ Arthritis OA/RA	
□ Peripheral nerve disease		□ Ulcers	□ Bowel disease	□ Muscle disorder	

List any medical condition not listed above: _____

Allergies Are you allergic to latex? □ Yes □ No Are you allergic to any medications? □ Yes □ No

If yes, what medications? _____

Any other allergies? _____

Family History Please list disease or cause of death, if any.

Father: _____

Mother: _____

Grandparents: _____

Siblings: _____

Child: _____

Family history of substance abuse?

Alcohol □ Yes □ No

Illegal Drugs □ Yes □ No

Prescription Drugs □ Yes □ No

Social History Check all that apply

Tobacco Use

□ Never

□ Quit on:

□ Current smoker

_____ packs/day

_____ # years

Alcohol Use

□ Never

□ Rarely

□ # drinks/week

□ Alcoholic

Drug Use

□ Never

□ Past use

□ Regular use

□ Any street drug use? □ Yes □ No

What is your occupation? _____

Who resides in your same home and assists you with care if needed? _____

Please check Yes or No for each of the following:

Any prior/pending charges/convictions? □ Yes □ No

Any thoughts of suicide in the past or present? □ Yes □ No

Ever overdosed? □ Yes □ No

Any drug treatment, rehab or detox? □ Yes □ No

Any drug conviction, indictment or investigation? □ Yes □ No

Any recreational drug use? □ Yes □ No

Have you ever used/abused illegal substances? □ Yes □ No

Have you ever been diagnosed with schizophrenia, psychosis, hallucinations, major depression, or bipolar / borderline personality disorder? □ Yes □ No

If you answered yes to any question, please explain. _____

PLEASE ATTACH A LIST OF ALL CURRENT MEDICATIONS WITH STRENGTH & FREQUENCY TAKEN

AGREEMENT FOR CONTROLLED PRESCRIPTIONS

This agreement must be reviewed and signed in order to proceed with narcotic and/or non-narcotic treatment with Restorative Pain Institute . Controlled substance medications are very useful but have significant potential for misuse and are, therefore, closely controlled. This agreement is required to comply with the law regarding controlled pharmaceuticals and to prevent any misunderstandings about any treatments you receive. Because a Restorative Pain Institute physician may be prescribing such medication as part of your plan of care, you must agree to the following:

- I understand that the main goal of treatment is to improve my ability to function or work. In consideration of this goal, and the fact that I am being given potent medication to help me reach that goal, I agree to help myself by following preventive and better health habits such as: exercising regularly, losing weight as directed by a physician, and abstaining from the use of tobacco, alcohol and illicit drugs. I will also participate in physical therapy as prescribed.
- I agree to submit to a blood, urine or saliva test, if requested by my provider, to determine compliance with my program of pain medication and I waive privacy rights.
- I understand that my first office visit may be a consultation only and no pain medication given at that time if further investigation and/or testing are deemed necessary.
- I understand I may be called to bring all prescribed medication for a mandatory pill count within a specified time period (usually 24 hours).
- I agree that I will use my medications **ONLY** as prescribed by my doctor. I understand that any change to my prescriptions will require an office visit. I understand that self-medicating is not tolerated. No refills will be made during evenings or weekends
- I will not use any illegal substances, including heroin, cocaine, methamphetamines etc.
- I understand that lost or stolen medication or unfilled prescriptions **WILL NOT** be replaced, and I will safeguard my medication from theft.
- I understand that I will follow the guidelines on properly disposing of controlled substances that will be explained to me by clinical staff. I will not discard, flush, give away or in any way lose control of my medications.
- I will not share, sell or trade my medications with anyone.
- I will not alter the form of the medication nor will I take the medication in a route other than as prescribed by my provider.
- I will not attempt to obtain controlled medication from any other provider, nor will I borrow or buy medication from any other person.
- In the event of an emergency, if I do obtain controlled substances from another provider, I understand I am required to disclose this information to Restorative Pain Institute within 48 hours of discharge or emergency service. I understand it is my responsibility to make sure Restorative Pain Institute is notified of any such treatments and that I am to check with staff before combining any pain medication with the prescriptions Restorative Pain Institute provides me.
- I will notify Restorative Pain Institute of any change in name, address or phone number. I understand that I must at all times have an updated phone number with my provider. I cannot be on dangerous medications, such as opioids, if my provider cannot reach me in a reasonable period of time (usually considered within 24 hours of the initial attempt). I agree to return any phone call from Restorative Pain Institute within 24 business hours.
- I authorize my provider to investigate fully any possible misuse of my pain medication using any city, state or federal law enforcement agency, including this state's Board of Pharmacy.
- I understand that any follow-up appointment may be scheduled with a Licensed Nurse Practitioner or Physician Assistant. Additionally, I understand that refusing to see one of Restorative Pain Institute providers will likely result in my no longer being able to be treated by the practice.
- Once a prescription has been filled, all questions regarding that prescription should be directed to that pharmacy.
- I understand that with any controlled substance that is prescribed to me there are inherent risks, namely;
    - loss of efficacy over time, symptoms of withdrawal if abruptly stopped, and addiction;
    - medication taken in excess (this is different for everyone – ranging from the prescribed dose to taking more than prescribed or combining with other controlled substances or even alcohol) may result in respiratory suppression or failure or death;
    - sedation, loss of function, impairment may also occur – I agree not to drive while under the influence of any prescribed controlled substance;
    - constipation, allergic reaction, itching, nausea and dry mouth are also common side effects;
    - my immune system may be suppressed and my hormone levels may decrease over time while being on chronic opioids.
- I understand that the combination of controlled substances and alcohol are contra-indicated; the combination may result in serious harm or even death.
- I understand that non-compliance with my pain management treatment plan may result in providers' inability to properly treat my symptoms and could cause symptoms to worsen or become life threatening.
- I agree that the goals of pain management have been explained to me as to what is considered appropriate and reasonable and that alternative treatment plans, outside of use of controlled pain medications, have been made available to me. I have agreed to proceed with pain management after a full explanation of the risks and benefits. I understand if I break this agreement, it will result in a change in my treatment plan, including safe discontinuation of my opioid medications when applicable or complete termination of the provider/patient relationship.
- I understand that, if I violate any of the above conditions, my controlled substance prescriptions may be immediately terminated. If the violation involves obtaining controlled substances from another individual, or providing controlled substances to another individual, I may also be reported to my other healthcare providers, medical facilities and law enforcement officials.

I have read this contract and have also been informed regarding psychological physical dependence to controlled substances.

Print Name: _____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO RESTORATIVE PAIN INSTITUTE

Patient Name: _____ DOB: _____ SSN: _____

Entity Providing Information: _____

Address: _____

Phone: _____ Fax: _____

Description of information to be disclosed – I authorize the above practice to disclose the following protected health information about me to the entity, person or persons identified below.

- ☐ Entire patient record, including but not limited to: office notes, lab results, x-rays, hospital, nursing home, home health, hospice and other physician records.
- ☐ Record of mental health or substance abuse treatment
- ☐ Office notes, labs and x-rays only
- ☐ Only send the following: _____

Release the above medical records to Restorative Pain Institute – 502-883-0016

☐ **Louisville, KY** – 4201 Springhurst Blvd Suite 102 Louisville, KY 40241

Reason for Request:

- ☐ Continuity of Care
- ☐ Other: _____

I understand that I have a right to revoke this authorization by providing written consent to Restorative Pain Institute. However, this authorization may not be revoked if Restorative Pain Institute its employees or agents have acted on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization will expire 365 days after date signed unless otherwise specified as follows _____

Patient Signature: _____ Date: _____

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the person identified above and will provide written proof (e.g, Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the patient's behalf with respect to this authorization form.

Name of Legal Rep: _____ Relationship to patient: _____

Signature of Legal Rep: _____ Date: _____

Signature of Witness: _____ Date: _____

Opioid Risk Tool

PATIENT NAME: DATE:

	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal Drugs	2	3
Prescription Drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal Drugs	4	4
Prescription Drugs	5	5
Age between 16 – 45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring Totals		

Score of 3 or lower indicates low risk for future opioid abuse
Score of 4 to 7 indicates moderate risk for opioid abuse
Score of 8 or higher indicates a high risk for opioid abuse