Kevin T. Smith, M.D.
Christopher J. Huser, M.D.
Giancarlo Checa, M.D.
Mindy Evangelisti, PA-C

Patient Information Form

Pain Management Physician: (circle one) K. Smith MD / C. Huser MD / G. Checa MD

Referring Physician: ____________________ **Telephone Number:** ____________

Primary Care Physician: ____________________ **Telephone Number:** ____________

Patient Name: ________________________________

Date of Birth: ____________ **Sex: M / F** **Marital Status:** ____________

Social Security Number: ____________ **E-mail Address:** ____________________

Home Address: ________________________________

City: ____________ **State:** ________ **Zip:** ____________

Home Number: ____________ **Work Number:** ________ **Cell Number:** ____________

Emergency Contact: ____________________ **Relationship to Emergency Contact:** ____________

Home Number: ____________ **Work Number:** ________ **Cell Number:** ____________

Primary Insurance: ____________________ **Telephone Number:** ____________

Claim Submission: ____________ **City:** ________ **State:** ______ **Zip:** ____________

ID Number: ____________________ **Group Number:** ____________

Effective Date: ____________ **Subscriber's Name:** ____________________

Subscriber's Date of Birth: ____________ **Relationship to Subscriber:** ____________

Secondary Insurance: ____________________ **Telephone Number:** ____________

Claim Submission: ____________ **City:** ________ **State:** ______ **Zip:** ____________

ID Number: ____________________ **Group Number:** ____________

Effective Date: ____________ **Subscriber's Name:** ____________________

Subscriber's Date of Birth: ____________ **Relationship to Subscriber:** ____________

Auto Accident / Work Comp ❐YES ❐NO **Date of Injury:** ____________

Name of Insurance / Work Comp Provider: ____________________

Claim ID: ____________________ **Adjuster's Name:** ____________________

Telephone Number: ____________ **Fax Number:** ____________

Claim Submission: ____________ **City:** ________ **State:** ______ **Zip:** ____________

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QUESTIONNAIRE TO BE FILLED IN BY ALL NEW PATIENTS

NAME: ______________________ **DATE:** ______________________

Age:__________ **Sex:** ❐ **Male** ❐ **Female**
Marital Status: ❐ **Single** ❐ **Married** ❐ **Divorced** ❐ **Widowed**
Employment Status: ❐ **Full Time** ❐ **Part Time** ❐ **Unable to Work** ❐ **Retired**
Disabled/Reason for Disability:______________________
Occupation: ______________________

Nature of your Problem: ______________________
____

How do you describe your pain (i.e. stabbing, pins and needles, etc.)? ______________________
____
____

To the best of your understanding, what is the cause of your pain? ______________________
Is your pain related to an injury ❐ Yes ❐ No (If yes, please describe.)______________________
____

How long have you had this problem? ______________________

What physician(s), Surgeon(s) have you seen for treatment of your pain? ______________________
____

What other treatment options have you tried? (Physical therapy, alternative therapy, blocks, etc.) ______________________
____
______________________. Which were effective? ______________________

What medication(s) do you currently take for pain? Are they effective?______________________
____
____

What medication(s) have you tried that were not effective or may have caused side effects? ______________________
____

What things do you do (or can do) to bring on the pain? ______________________
____

What things do you do (or can do) to lessen the pain? ______________________
____
____

Do you engage in physical activity daily/weekly? If so, explain: ______________________
____
____

Do you have numbness of your skin? ❐ Yes ❐ No If yes, where? ____________________

Do you have weakness of your muscles? ❐ Yes ❐ No If yes, where? ____________________

How many times have you been to an ER or urgent care clinic in the past 6 months for the treatment of pain?
____

What are your expectations of how we can help you? ____________________

Circle the corresponding number (1-10) to show how far from normal toward the worst possible situation your pain has caused you to be. The left side of each line is the "best" or "normal" situation and the right side of the line is the "worst" it could be.

Severity of your pain (average):
None 1 2 3 4 5 6 7 8 9 10 severe/worst

To what extent do you need to use pain medications?
Never 1 2 3 4 5 6 7 8 9 10 More than recommended/Prescribed

What is the effect of the pain on your work (please take into account absence from work or interfering with work abilities, etc.)?
None 1 2 3 4 5 6 7 8 9 10 Unable to work

How does the pain affect your need for help with daily activities (household chores and personal care?)
None 1 2 3 4 5 6 7 8 9 10 Need total assistance

Effect of your pain on your mood (depression/anxiety):
None 1 2 3 4 5 6 7 8 9 10 Severe

How much does the pain interfere with your sleep?
None 1 2 3 4 5 6 7 8 9 10 Cannot sleep at all

Effect of pain on your lifestyle (i.e. social, sports, hobbies, etc.):
None 1 2 3 4 5 6 7 8 9 10 Severe

How much do you feel your pain has changed your relationships with others?
No change 1 2 3 4 5 6 7 8 9 10 Drastic Change

Do you have allergies to medications? ❐ Yes ❐ No If yes, please list____________________

Please list all medications you currently take: ____________________

Prior surgeries (& year): ____________________

Anesthesia Complications/Problems: ____________________

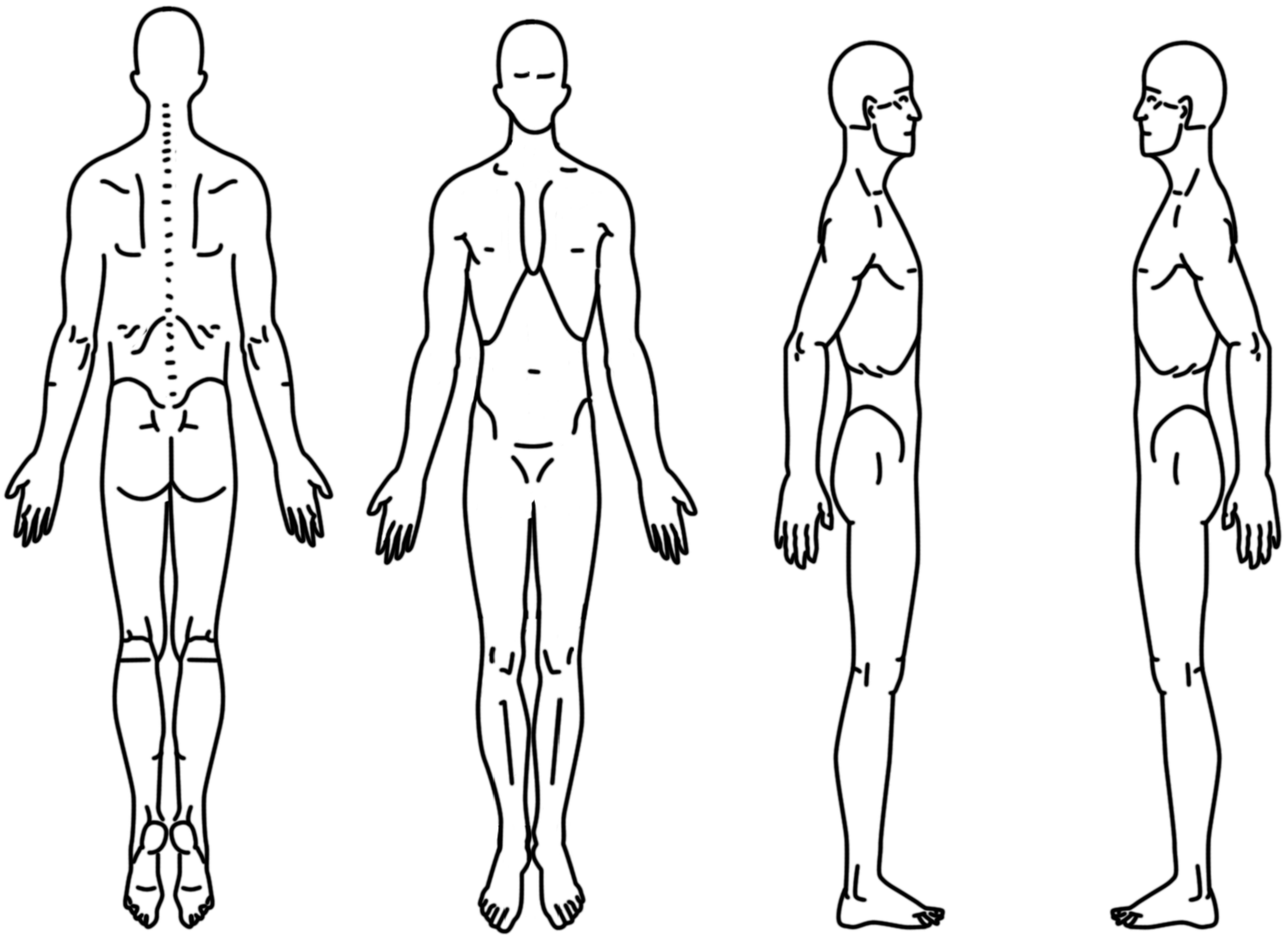
Family Medical and Drug Abuse History: ____________________

REVIEW OF SYSTEMS & MEDICAL ILLNESSES

Please check either Yes or No to the following:

Constitutional Symptoms:	**Hematological**
❒ Yes ❒ No Weight Changes	❒ Yes ❒ No Anemia
❒ Yes ❒ No Fever or Chills	❒ Yes ❒ No Easy bleeding
❒ Yes ❒ No Cancer or tumors	
	Psychiatric
Genitourinary	❒ Yes ❒ No Fatigue
❒ Yes ❒ No Frequent urine infections	❒ Yes ❒ No Loss of appetite
❒ Yes ❒ No Kidney disease	❒ Yes ❒ No Hallucinations
❒ Yes ❒ No Loss of urine control	❒ Yes ❒ No Anxiety / Nervousness
How often do you get up at night to void?	❒ Yes ❒ No Depression
	❒ Yes ❒ No Panic attacks
Eyes, ears, nose, mouth, and throat	❒ Yes ❒ No Memory changes
❒ Yes ❒ No Visual changes	❒ Yes ❒ No Difficulty with work
❒ Yes ❒ No Hearing loss	❒ Yes ❒ No Attention Deficit Disorder
❒ Yes ❒ No Hypertension	❒ Yes ❒ No Obsessive Compulsive Disorder
❒ Yes ❒ No Rheumatic fever	❒ Yes ❒ No Schitzophrenia
❒ Yes ❒ No Chest pain (Angina)	
❒ Yes ❒ No Heart attack	**Endocrine**
❒ Yes ❒ No Irregular heart beat	❒ Yes ❒ No Thyroid disease
❒ Yes ❒ No Heart murmur	❒ Yes ❒ No Diabetes
❒ Yes ❒ No Leg swelling	
❒ Yes ❒ No Blood clots in legs	**Female**
	❒ Yes ❒ No Pregnant
Respiratory	When was your last menstrual period: ______________
❒ Yes ❒ No Pneumonia	
❒ Yes ❒ No Emphysema	**Musculoskeletal**
❒ Yes ❒ No Tuberculosis	❒ Yes ❒ No Joint pain
❒ Yes ❒ No Chronic obstructive disease	❒ Yes ❒ No Joint swelling
❒ Yes ❒ No Asthma	❒ Yes ❒ No Muscle wasting
❒ Yes ❒ No Shortness of breath	❒ Yes ❒ No Osteoporosis
	❒ Yes ❒ No Arthritis
Gastrointestinal	❒ Yes ❒ No Skin lesions/rash
❒ Yes ❒ No Frequent heart burn/reflux	❒ Yes ❒ No Hair and/or nail changes
❒ Yes ❒ No Nausea and vomiting	
❒ Yes ❒ No Hepatitis or cirrhosis	**Neurological**
❒ Yes ❒ No Constipation	❒ Yes ❒ No Seizures
❒ Yes ❒ No Ulcers	❒ Yes ❒ No Loss of consciousness
❒ Yes ❒ No Change in bowel movements	❒ Yes ❒ No Paralysis
❒ Yes ❒ No Bloody bowel movements	❒ Yes ❒ No Tremors
	❒ Yes ❒ No Gait disturbances
	❒ Yes ❒ No Headache
	❒ Yes ❒ No Stroke

Other Illnesses	
❒ Yes ❒ No Do you Smoke cigarettes? If yes, how many packs per day? ____________________	❒ Yes ❒ No Do you consume alcoholic beverages? If yes, how many per day___________________
❒ Yes ❒ No Do you use illicit drugs? If yes, what type? ________________________	❒ Yes ❒ No Have you abused narcotic drugs? If yes, what type? _______________________



Using the figures above, mark the locations of your pain.

Indicate an **X** for Stabbing or Burning Pain; Use a **Z** to indicate Tingling; and Use an **N** for Numbness

Also indicate if the pain radiates to any other part of your body, by placing arrows from where the pain originates to where it goes.

Patient Signature ______________________

Date ______________________

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6950 East Belleview Ave
Suite 300
Greenwood Village, CO 80231
Phone: 303-750-8100
Fax: 303-369-1891

CONTRACT FOR CONTROLLED SUBSTANCE (NARCOTIC) PRESCRIPTIONS. OFFICE RULES AND REGULATIONS.

Controlled substance medications (narcotics: opioids, tranquilizers, barbiturates) can be very useful to treat painful conditions, but have a high potential for misuse and abuse and are therefore closely controlled by the government.
Possible benefits can include improved overall functioning, quality of life, improved sleep and increased ability to work and return to enjoyable hobbies and activity. It is unlikely you will be completely pain free. We expect you to have realistic pain goals.

To insure that these medications are used properly to treat my pain, I agree to follow the instructions listed below:

Initial: ___________I will not request nor accept narcotic medication from any other provider (i.e. Physicians including surgeons or dentists, NP's, or PA-C's) other individuals (neighbors, friends, relatives) or the emergency room while I am receiving such medication from my provider at MD Pain. In addition to being illegal to obtain narcotic medications from multiple physicians (NRS 453.391), it may endanger my health. I understand I cannot share my narcotics with others, and must safely secure them from others.

Initial: ____________I am responsible for my narcotic medications. They are like money in the sense that if the prescription or the medication itself is lost, misplaced, stolen or over used (less than 30 days) it is gone and will NOT be replaced.

Initial: ___________I have been informed by my physician about narcotic side effects, including normal physiologic effects of tolerance (need for more medicine to achieve the same pain relief), withdrawal (an uncomfortable reaction which may occur if I stop taking the medicine abruptly), and the abnormal effect of addiction (psychological dependence leading to abnormal behavior). Narcotics can adversely affect physical coordination, alertness, and sexual function. Opiate therapy can cause severe constipation, nausea, drowsiness, breathing problems or difficulty with urination. My judgment in making business decisions and in operating equipment such as automobiles may be impaired and is discouraged by our practice.

Initial: ___________I authorize my physician to attain information from my pharmacy and to provide a copy of this contract to my pharmacy. I agree to waive any applicable privilege or right of privacy and confidentiality with respect to communication of controlled substance usage.

Initial: ___________I will not use any illegal controlled substance including cocaine, heroin, stimulants, or other hallucinogens. If I am found to be positive for an illicit substance on urinalysis I understand that I will be automatically discharged from the practice.

Initial: ___________I have been informed that the combination of alcohol and narcotics increases the sedative effect of both, combination could lead to respiratory depression increasing the risk of death from overdose. If only on a short acting medication I realize that I must not take my medication 6 hours prior to or after drinking an alcoholic beverage. If on a long acting medication I realize that I may not consume alcoholic beverages at any time. I understand this policy and realize if I come up positive for alcohol while on a long acting opioid I will be discharged from the practice.

Initial: ___________I authorize my physician to order a urine test for controlled drug screening at any time, at my own expense, to determine if my medications are being taken properly. Altering or failing to submit urine for screening upon request will lead to immediate termination.

Initial: ____________Attaining narcotics for the purpose of selling, giving or sharing with others as well as altering prescriptions in any way are all illegal activities and may lead to immediate dismissal from the practice as well as reporting to the police or DEA.

Initial: ___________I understand that if I violate any of the above instructions or conditions or if benefits are not achieved MD Pain can stop prescribing me narcotics. I also understand that if I incur an outstanding balance that is not being paid to MD Pain or I am non-compliance with this contract, my prescriptions or my recommended treatment may be stopped immediately.

CLINIC RULES:

1. Refills of most controlled substances will be made only in person during regularly scheduling office visits (30 day intervals unless otherwise specified). We request that all non-narcotic medications be refilled by requesting a refill from your pharmacy. In turn the pharmacy will fax us with a request which will be returned within 48 hrs.

2. No refills will be done after 5 pm MST, on holidays, nor on weekends. Please get your refills in prior to Fridays as we are short staffed on this day. You must bring your pain medication bottles with you when you come in for your office visit. Changes in medication (Strength, quantity, directions) are by follow up appointment only.

3. If you are experiencing any side effects, increased pain, feel the need for an increase in your narcotics or have recently incurred a new trauma please speak with our staff nurse Meg. (You must not take it upon yourself to increase the amount of medications you are taking!) She will speak with your provider and instruct you on what to do until you can be seen.

4. If you must be seen in the emergency room or hospital, please inform our office during normal business hours so that we can help to control your pain issues upon discharge. Please inform the ER and or other physicians that you are under a pain contract with our office and that you may not accept narcotics from anyone other than our staff.

5. We do understand that deaths in the family, vacations and other unforeseen circumstances do occur which may cause you to need an earlier than usual refill. This may be done at our discretion rarely. Early refills for vacations will require a copy of your flight itinerary for verification purposes. The following month the next script will be given accordingly late.

6. **Medication refill appointments** will occur if you are stable on your current medications and do not need any changes or have new issues to discuss. These appointments are a quick check of your status and occur with the Physician Assistant ONLY. Patients will see the Physician Assistant for medication refill appointments and no changes in medications or doses will be made at these visits.

7. **Follow up appointments** are required for more in-depth matters such as medication side effects, possible need for change in medications, radiography results, procedural scheduling or further management of care. These appointments occur with your doctor or our physician assistant based on the depth of the issue. This will be made at our discretion. You may expect to see the physician at least every 6 months; more frequent physician visits will be determined by the provider, not the patient.

8. All future appointment should be made prior to leaving the office. If you must call in to make an appointment we must have at least 8-9 days notice for medication refills and 2-3 weeks' notice for physician visits as our practice is busy and appointment times fill up quickly. If you violate this rule there is no guaranty that your medications can be filled in a timely manner.

9. If you are more than 15 minutes late for your appointment time you will have to be rescheduled.

10. Your Co-pay or full payment (self pay patients only) is required at the time of your appointment and must be paid before you will be seen. We accept personal checks, visa, master card and American express. We also accept cash but you must have the correct amount as we cannot provide you will change.

You must attain narcotics from one pharmacy only and you must notify MD Pain if you need to change pharmacies.

My Pharmacy Name: ___________________________ Phone: _________________________________

__________________________________ __________________________________

Patient Name Signature/Date

__________________________________ __________________________________

Provider Name Signature/Date

I certify that this signed agreement has been placed in the patients chart as well as a copy given to the patient for their personal records.

MD PAIN

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

MD Pain understands and agrees that patient confidentiality can be an integral part of patient care. Under the Health Insurance Portability and Accountability Act (commonly, HIPAA), all health care providers must maintain as confidential your protected health information, or PHI. Your PHI can include your name, address, social security number, email address, telephone number, date of birth, driver's license number, and medical record number. Health care providers must also provide patients with notice of the legal duties incumbent upon health care providers and their privacy practices so that the health care providers avoid any accidental or inappropriate disclosure of your PHI.

In February 2009, The American Recovery Reinvestment Act (ARRA or more commonly, the "Stimulus Bill") made some significant modifications to the HIPAA Privacy and Security Rules dealing primarily with the protection of your PHI in all media (meaning paper files <u>and</u> electronic storage). In addition, the Stimulus Bill introduced some new terminology – "Personally Identifiable Information" or "PII" along with penalties and mitigation associated with any violations and/or breaches of PHI or PII.

Personally Identifiable Information (again, the PII) is defined as any patient's first name or first initial and the last name in combination with any one or more of the following data elements belonging to that patient: social security number; driver's license number of ID card number, account number or credit/debit card number in combination with any required security code or access code or password that would permit access to the patient's financial account.

MD Pain uses health information about your for treatment purposes, to obtain payment for treatment it has provided to you, for internal administrative purposes, and to evaluate the quality of care you receive. In addition, as part of your ongoing treatment, health information may be shared with other health care providers (for example, certain medical specialists) to whom you are referred or from whom you were referred to Metro Denver Pain Management. Such information maybe shared by paper mail, electronic mail, facsimile or other methods.

Further, MD Pain may disclose your PII (in whole or in part) without your authorization under certain circumstances. For example, subject to specific requirements, we may disclose your PII without your authorization for public health purposes such as reporting communicable diseases, birth, death, injury, child abuse or neglect; for auditing purposes; for research studies; for worker's compensation claims; and for emergencies. We will also provide information when required to do so by law enforcement authorities or by court authorities. Contact with you may also take place in the form of appointment reminder, prescription refills test results, etc.

When other situations arise we will ask you for your written authorization before using or disclosing any of your PII. If you o choose to sign an authorization to disclose some or all of your PII, you may later request to revoke either all or part of the authorization.

As the patient, you have the right to see and receive a copy of all information that is contained in your medical record (chart) at this office, with the following exceptions: psychotherapy notes; information compiled in reasonable anticipation of civil, criminal or administrative litigation or enforcement proceedings; and protected health information if it is subject to protection under other applicable law. If MD Pain denies your right of access, you are entitled to have that determination reviewed if the reason for the denial was one of the following: a health care professional has determined that access to the information is reasonable likely to endanger the life or safety of you or another person; or the protected health information refers to another person and access to the information is reasonable likely to cause harm to that person. If MD Pain denies your right of access, you will not be entitled to have that determination reviewed if the reason for the denial was one of the following: the protected health information is excepted from the right of access under applicable law; or the protected health information was obtained from someone other than the health care provider under a promise of confidentiality.

MD PAIN
NOTICE OF PRIVACY PRACTICES

MD Pain shall have thirty (30) days to act on a written request for access to your medical records. Any written request from you will be responded to in writing from MD Pain and we will provide you with the anticipated date by which we will complete action on your request. If access is denied, we will inform you in writing of the basis or bases for the denial.

If you believe that information contained in your medical record is incorrect or if important information is missing, you have the right to request that a correction be made to the information in your record. This request must be submitted in writing and must include a reason to support the request. MD Pain must act on such a request within 60 days of our receipt of your request. The acceptance or denial of a request to amend or correct your medical record will follow the same process as described above concerning access to your medical record.

You have the right to request and receive a written list of certain disclosures of your health information, made after April 14, 2003. You may ask for disclosures we made up to six (6) years before your request. This listing will include the date of the disclosure, the name (and address, if available) of the person or organization receiving the information, a brief description of the information disclosed and the purpose of the disclosure. MD Pain is not required to include on the list of disclosures those disclosures which were made: for purposes of treatment; for purposes of billing and collection of payment for your treatment; for our health care operations; in response to a prior request from you that was authorized by you or which was made to individuals involved in your care or treatment; or as otherwise allowed pursuant to applicable law. A first request of disclosures will be provided to you free of charge; a subsequent request made within 12 months of a first may result in a reasonable charge to you for such service.

You have the right to request that we limit our use and disclosure of your health information for treatment, payment and health care operations. You also have a right to request a limit on the health care information we disclose about you to someone who is involved in your care or the payment of your care, for example, a family member or friend. We are not required to agree to such request however if MD Pain agrees to such a request, we must follow the agreed upon restriction. You may cancel the restriction at any time and we, too, may cancel the restriction at any time as long as we notify you of the cancellation.

You have the right to complain about any perceived privacy violations or if you disagree with a decision we made about access to your medical records. All complaints, concerns or questions should be submitted in writing to our Privacy Officer. You may contact MD Pain's Privacy Officer as follows:

Matthew Bigalk
Metro Denver Anesthesia, P.C.
1900 Grant Street, Suite 700
Denver, Colorado 80203
Tel. 303.407.0521
Fax 303.407.0506

We are required to obtain your written acknowledgment that you have read this notice, been given the opportunity to ask questions about this notice, and been given a copy of this notice.

PLEASE SIGN AND RETURN THE ACKNOWLEDGMENT ACCOMPANYIUNG THESE PRIVACY PRACTICES WHICH INDICATES THAT YOU HAVE READ THIS NOTICE OF PRIVACY PRACTICES, THAT YOU HAVE BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS ABOUT IT, AND THAT YOU HAVE BEEN GIVEN A COPY OF THE NOTICE OF PRIVACY PRACTICES IF YOU WANT ONE.

MD PAIN

NOTICE OF PRIVACY PRACTICES

Acknowledgement of receipt of Notice of Privacy Practices

I have received MD Pain's Notice of Privacy Practices, and I have been given the opportunity to review them and ask questions about them.

Signature: ____

Print Name: ____

Date: ____

MD Pain
Comprehensive Pain Management SM

Kevin T. Smith, M.D.
Christopher J. Huser, M.D.
Giancarlo Checa, M.D.
Mindy Evangelisti PA-C

AUTHORIZATION FOR THE RELEASE MEDICAL RECORDS

Patient: ____ SS#: ________-_______-____________

Date of Birth: ______ /______ /__________ Telephone #: ____

Current Address: ____

City, State, Zip: ____

❒ I authorize the MD Pain **to release information to**:	❒ I authorize the MD Pain **to obtain information from**:
Name of Provider or Facility	Name of Provider or Facility
Address	Address
City, State, Zip Code	City, State, Zip Code
Phone #/Fax # (include area code)	Phone #/Fax # (include area code)

INFORMATION REQUESTING:

❒ ALL RECORDS ❒ HOSPITAL STAY ❒ HOSPITAL DISCHARGE SUMMARY
❒ LABORATORY ❒ PROCEDURE REPORT ❒ PROCEDURE FILMS
❒ BILLING RECORDS ❒ OTHER (SPECIFY): ____

I hereby authorize the release the health information indicated above that is contained in my patient records to the Recipient named above. **I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and or HIV/AIDS test results or diagnoses.**

X____ ______________________________
PATIENT NAME / SIGNATURE DATE

6950 East Belleview Avenue, Suite 300 Greenwood Village, CO 80111
Phone: 303-750-8100 / Fax: 303-369-1891