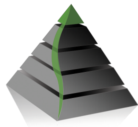

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NEW PATIENT FORM PACKET

! ATTENTION PATIENTS !
PLEASE FILL THIS FORM OUT COMPLETELY.
THIS FORM MUST BE COMPLETED FOR AUTHORIZATIONS ON ANY IMAGING OR OTHER TREATMENTS.

PATIENT INTAKE FORM

PATIENT NAME:______________________________ DOB:_______________Date: _______________

Height: ____________________ Weight:_______________

Have you had severe to moderate pain for at least 3 months? YES ___ NO ___

When was the onset of your pain? DATE: MONTH/YEAR__________________

How does the pain affect your activities and daily living? (i.e. walking, sleeping, getting dressed, bathing etc.)

____

What makes your pain better or worse?

____
____
____

Have you attended physical therapy? YES ___ NO ___

How many visits did you attend? _____________

When and where did you attend physical therapy?:____

Was there any improvement? Change to pain: ____

Have you ever tried and failed NSAIDS (aspirin, ibuprofen, etc.) or muscle relaxers?
If so list the Rx & when you failed them.

____
____

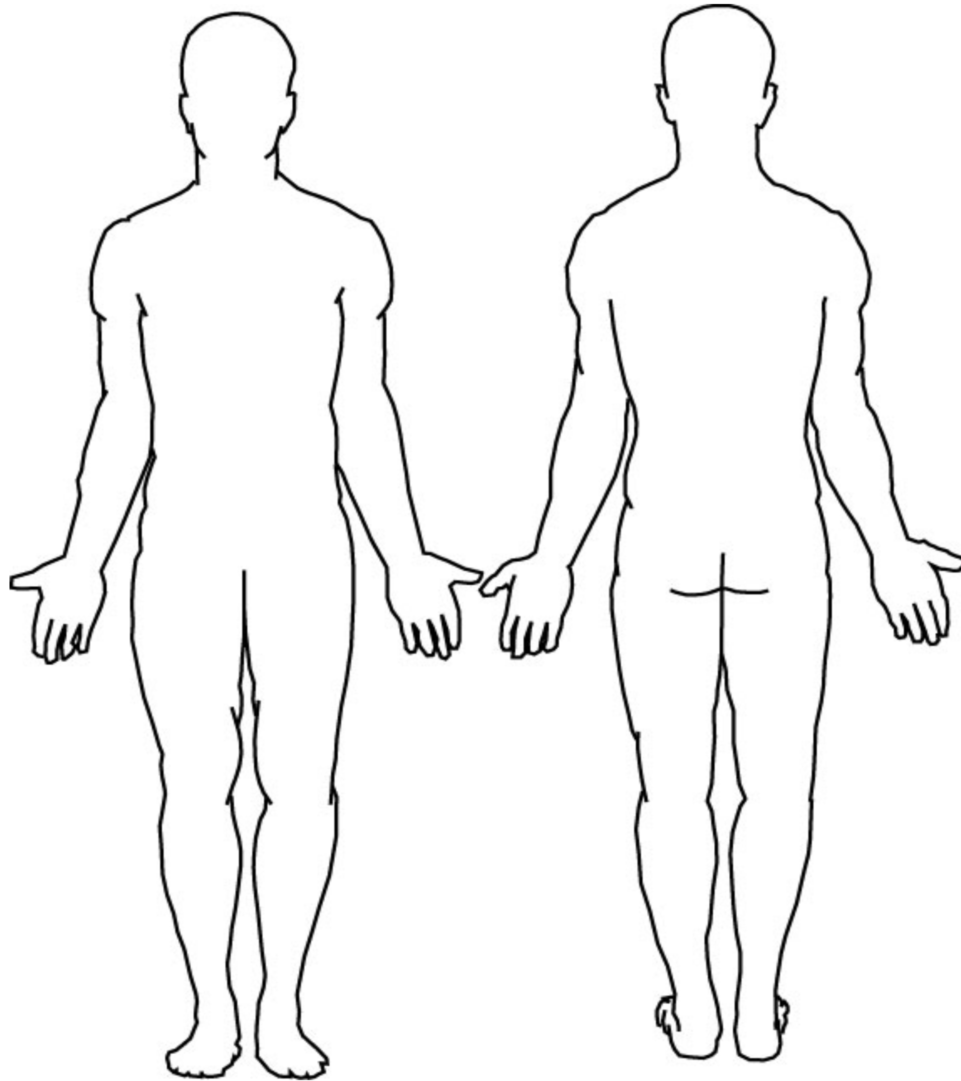
Have you seen a chiropractor? YES _________ NO ____________
How many times did you see the chiropractor? __________________________

What was the name of the chiropractor and/or the practice name?

____

Mark the areas of your body where you <u>typically</u> feel your pain. If you are having multiple types of pain please use the provided key:

Aching - ---------- Tingling – 00000000 Burning – XXXXXX Sharp/Stabbing - //////////



MEDICAL HISTORY

Current Physician Name/Number:_________________________________(_____)_____-_______

Current Pharmacy Name/Number:_________________________________(_____)_____-_______

Current/Past Medications

Name	Dose	Frequency	Start	End	Dr	Purpose

Surgical Procedures

Date	Procedure	Surgeon	Notes

Current Medical Problems

Illness	Start Date	Treating Physician	Treatment Notes

List all your allergies and your reactions:

____

____

____

Family History

M = Mother F = Father S = Sister B = Brother

Illness	M	F	S	B	Illness	M	F	S	B
Alzheimers					Migraine Headaches				
High Blood Pressure					Cancer				
Stroke					Epilepsy				
High Cholesterol					Diabetes				
Blood Clots					Heart Disease				
Muscular Weakness					Arthritis				
Other Dementia					Allergic Diseases				
Depression					Drug Addiction				
Alcoholism									

Social History

Are You?: (circle one) Single Married Widowed Divorced Separated Significant Other

Do You?:

1. Smoke: NO ____ YES ____ How many per day?______________________
2. Drink: NO ___ YES ___ How many per day?_____ (Circle one) Socially Rarely Moderately
3. Use Marijuana: NO ___ YES ___ How often?
   ____
4. Use Kratom: NO ___ YES ___ How much/how often? ____________________________
5. Use Illegal Substances: NO ___ YES ___ Which ones?_______________________________
   In the Past?: _____________________
   Presently?:____

Have you ever been treated for, or do you feel you have problems w/ alcoholism, or any type of substance abuse? NO ___ YES ___

Explain:

____

____

____

Have you ever been hospitalized for psychiatric condition? NO ___ YES. ___

When? ___________________

Where?:____

Do you have a history of prescription or street drug abuse? NO ___ YES ___

explain:____

Does anyone in your family have a substance abuse history? NO ___ YES ____

Is there any substance abuse in your household? NO ___ YES ___ Type?___________________

Work: (Circle One) Full Time Part Time Retired Disabled Unemployed

What kind of work do you do?

____

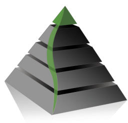
____

What kind of hobbies and/or recreational activities do you do and/or partake?

REVIEW OF SYSTEMS
Please check all boxed that apply

General:	❑ Weakness ❑ Fatigue ❑ Headaches	❑ Body Aches ❑ Weight Gain/Loss	❑ Fever/ Chills ❑ Excessive Appetite	❑ Poor Appetite
Skin:	❑ Hives ❑ Eczema	❑ Dryness ❑ Itching	❑ Rash ❑ Color Changes	❑ Change in Nails
Head/ Neurologic:	❑ Headaches ❑ Migraines ❑ Numbness	❑ Dizziness ❑ Passing Out ❑ Tremor	❑ Fainting ❑ Head Injury ❑ Seizures	❑ Tingling Other:
Ears:	❑ Ringing ❑ Hearing Loss	❑ Drainage ❑ Vertigo	❑ Ear Ache	
Eyes:	❑ Pain	❑ Blurred Vision	❑ Changes in Vision	❑ Double Vision
Nose:	❑ Congestion ❑ Hay Fever	❑ Itching ❑ Sinus Pain	❑ Nosebleeds ❑ Runny Nose	❑ Snoring
Throat/Mouth:	❑ Difficult Swallowing	❑ Dry Mouth	❑ Sores in Mouth	❑ Hoarseness
Respiratory:	❑ Asthma ❑ Shortness of Breath	❑ Wheezing ❑ Sleep Apnea	❑ Cough ❑ Pneumonia	❑ Painful Breathing
Gastrointestinal:	❑ Abdominal Pain ❑ Heartburn ❑ Ulcers	❑ IBS ❑ Diarrhea ❑ Blood In Stool ❑ Colitis	❑ Jaundice ❑ Hernia ❑ Bloating ❑ Change in Appetite	❑ Nausea / Vomiting ❑ Constipation ❑ Excessive Gas
Cardiovascular:	❑ Pacemaker ❑ High Blood Pressure	❑ Blood Clots ❑ Heart Attack ❑ Chest Pain	❑ High Cholesterol ❑ Leg Edema	❑ Rheumatic Fever ❑ Murmur
Psychiatric/ Mood:	❑ Depression ❑ Anxiousness ❑ Poor Energy	❑ Short Temper ❑ Trouble Sleeping	❑ Compulsive Behavior ❑ Mood Changes	❑ Poor Concentration ❑ Stress

Muscles/Bones/ Joints:	❑ Arthritis ❑ Muscle/Joint Pain ❑ Cramps	❑ Joint Swelling ❑ Fractures ❑ Gout	❑ Osteo-porosis ❑ Fi-bromyalgia ❑ Polio	Other:
Back and Neck	❑ Back Pain ❑ Back Stiff-ness ❑ Sciatica	❑ Neck Pain ❑ Neck Stiff-ness	❑ Restricted Movement ❑ Disc Prob-lems	Fractures Other:
Other conditions not listed:				



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PATIENT REGISTRATION FORM

Patient Name: ______________________________ DOB: ________________

Address: ______________________________ City: __________ Zip Code: ________

Preferred Contact Phone #: ________________ Alt #: ________________

SSN: ______________________

Telephone Authorization:
May we leave a detailed message on the preferred contact phone listed above? YES NO

Email (please print legibly): ______________________________________

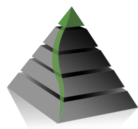
Name of Primary Care Physician: ______________________________________
(REQUIRED)

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino
Race: ☐American Indian ☐Asian ☐Native Hawaiian ☐African American ☐White ☐Hispanic ☐Other: ____________

☐ Check box if declining to answer

EMERGENCY CONTACT: If you would like to authorize an individual to speak to our staff (Dr, NP, MA, or Reception) regarding your **appointments/health care and/or treatment**. Please list their information below:

1. Name: ____________________ Relationship: __________ Phone: __________
2. Name: ____________________ Relationship: __________ Phone: __________
3. Name: ____________________ Relationship: __________ Phone: __________



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INSURANCE INFORMATION

Primary Insurance: ____

Policy Holder: ______________________________ DOB:_________________

Member/Subscriber #: ___________________________ Group #: ____________

Secondary Insurance: ____

Policy Holder: _______________________________ DOB: ________________

Member/Subscriber #: __________________________ Group #:_____________

All information stated above is to the best of my knowledge, true and accurate.

____________________________________ ___________________

Signature Date

LONG TERM CONTROLLED SUBSTANCE/NARCOTIC AGREEMENT

_____ **Initial -** If this line is initialed, I do not want controlled prescriptions. However, if I ever get controlled substances, I will need to sign this agreement in full.

I understand the following:

_____ Initial – Early refills will not be given.

_____ Initial – I can not call after regular hours or weekends for prescription refills.

_____ Initial – All controlled substances must be obtained from the same pharmacy where possible. Should the need arise to change pharmacies, our office must be notified.

My preferred pharmacy is: ____

Name Cross Streets Phone

_____ Initial – I am expected to inform our office of any new medications, medical conditions, and any adverse effects I experience from any medications. I consent to have my electronic RX history from all physicians reviewed.

_____ Initial – These drugs should not be stopped abruptly, as withdrawal symptoms will likely develop.

_____ Initial – **Prescriptions and/or medications WILL NOT be replaced if they are lost, stolen, get wet, are destroyed, ect. UNDER NO CIRCUMSTANCE WILL THEY BE REPLACED. Prescriptions and medications are patient's responsibility to manage and secure.**

_____ Initial – **It is not advisable and it is illegal in the State of Idaho to drive while taking narcotics.**

_____ Initial – I WILL NOT request or accept pain medication from any other physician or individual while receiving medication from Exodus Pain Clinic. I understand by doing so I could be endangering my health and it is illegal. Exceptions will be made ONLY IF I have discussed with, and approved by Dr. Marsh, MD or while in I am admitted to the hospital.

_____ Initial – Use of prohibited substances can interfere with my opioid therapy and cause adverse effects. Therefore, I agree to notify my provider of the use of all substances: to include,

marijuana, alcohol, and illicit drugs. I understand that I should not be using these substances while on opioid therapy.

_____ Initial – Medication changes will NOT be made over the phone. A doctor visit is required to reevaluate medications.

_____ Initial - I WILL NOT DESTROY ANY OF MY UNUSED MEDICATION. I WILL BRING IN ALL MEDICATIONS IN THEIR ORIGINAL CONTAINERS TO GET A NEW PRESCRIPTION IF MY CURRENT ONE IS NOT EFFECTIVE FOR MY TREATMENT.

_____ Initial – I will take the medication at the dose and frequency prescribed by my provider. I UNDERSTAND THAT I AM NOT TO INCREASE THE DOSE OF MY MEDICATION. By doing so I may no longer receive controlled substances from Exodus Pain Clinic physicians.

_____ Initial – **Prescriptions may take up to 48 hours to refill. I will be responsible and plan accordingly in order to get my refills on time and will also plan for weekends/holidays so I will not run out of my medication. <u>Same day requests or walk in requests WILL NOT be honored or filled.</u>**

_____ Initial – Opioids have common potential side effects that include: constipation, sweating, itching/rash, and allergic reactions. Drowsiness may occur when starting or increasing dosage. I will refrain from driving motor vehicles or operating machinery until drowsiness subsides.

_____ Initial – I will be randomly drug tested by my physician to monitor my compliance with proper medication use. I waive certain privacy rights so that my physician may talk to other healthcare providers, family members, and even law enforcement officials. I also agree to come into the office when asked and submit to a drug screen or produce unused portions of medications to verify they are being taken correctly.

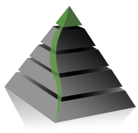
_____ Initial – I can become dependent on opioid medications which in a small number can lead to addiction. If addiction occurs the physician will offer appropriate treatment, may discontinue the medication and/or refer the patient to a drug treatment program.

_____ Initial – I fully understand that if I violate any of the above conditions that my controlled substance prescriptions and/or treatment with Exodus Pain Clinic may be immediately terminated and I risk being discharged from the clinic. I also understand that this may result in withdrawal symptoms.

Patient Name (print): ______________________________ Date: __________

Patient Signature__________________________ Witness Initials: ______________________

Wait to sign in front of Exodus Pain Clinic Staff



EXODUS
PAIN CLINIC
INTERVENTIONAL SPINE & PAIN MEDICINE

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PATIENT FINANCIAL AGREEMENT

This Form is a legally binding Financial Agreement between Exodus Pain Clinic, PLLC ("Clinic") and the Patient.

I ____________________________ understand that as a recipient of medical care I am responsible for all charges regardless of my circumstances for reimbursement.

I understand that a fee is charged for all visits, examinations, and/or treatments. I agree that the determination of the professional services to be rendered by my physician/provider and the fees to compensate him/her for these services are matters which concern my physician/provider and me. I understand that I have the primary duty and obligation to pay for the services rendered, notwithstanding any contract I may have with any third party payer (for example, insurance company, employer, etc.).

I authorize the release of any and all information or documents to all parties related to obtaining my insurance benefits for claims submitted on behalf of myself and/or my dependents.

I further expressly agree and acknowledge that my signature on this document authorizes my physician/provider and all necessary parties to submit claims to obtain benefits, for services rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents, and that I will be bound by this signature as if the undersigned had personally signed the particular claim.

I hereby authorize my insurance company to pay and hereby assign directly to Exodus Pain Clinic, PLLC, all benefits. Insurance companies provide an explanation of benefits outlining payments and patient's financial responsibility under their contract with the patient. I understand I am financially responsible to the Clinic for all charges incurred and not paid by the third party insurance. I further acknowledge that any insurance benefits received by the Clinic, will be credited to my account, in accordance with my insurance company's assignment. Any unpaid charges are my personal responsibility. **PLEASE INITIAL EACH LINE.**

______ I acknowledge that I have received a copy of the financial policy

______ I understand and agree that all copayments are due and to be paid at the time of service.

______ I understand and agree that there is a $30.00 service charge for a returned check.

______ I understand and agree that full payment is due within 90 days from the date of service and are not contingent upon receiving a statement.

______ I understand and agree that unpaid charges over 90 days will receive a letter for final demand of payment.

______ I understand and agree that accounts with no activity for 120 days may be forwarded for further collection action, except as otherwise arranged with the Clinic, or mandated by law.

______ I understand and agree that the Clinic will charge $50 for missed follow up appointments and $75 for missed procedure appointments that are not canceled within 24-hours prior to the patient's appointment.

______ I understand and agree that should I default and my account is referred to a collection agency or attorney, I will be responsible for all costs of collecting monies owed, including interest, court costs, collection, collection agency and attorney fees. Any and all advance collection fees incurred by the Clinic will be included in my final bill.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW WHAT THE TERMS OF MY INSURANCE ARE, AND IN COMPLIANCE WITH THOSE TERMS, AGREE TO THE FOLLOWING:

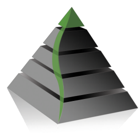
1. Providing Exodus Pain Clinic, PLLC, with complete and accurate billing information, including, but not limited to a current insurance card, authorization numbers, and/or referral forms for each visit and/or procedure. I am responsible for all visits and procedures not properly authorized.

2. I give my consent to Exodus Pain Clinic, PLLC to provide medical care and treatment to the below named patient deemed necessary and proper in diagnosing or treating his/her/my physical condition.

I HAVE READ AND AGREE TO THE TERMS OUTLINED ABOVE:

SIGNED: (patient or guarantor)______________________________DATE: ______________

FOR: (print patient name) ____



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EXODUS PAIN CLINIC FINANCIAL POLICY

Welcome to Exodus Pain Clinic ("Clinic"). This form sets forth the Clinic's financial payment policy. We ask all patients to review and sign this Financial Agreement.

As a recipient of medical care, the Patient is responsible for all charges regardless of the circumstances for reimbursement.

1. Insurance: The Clinic accepts assignment and participates in most insurance plans. If the Patient's insurance is not a plan we participate in, payment in full is expected at each visit. It is the Patient's responsibility to know his/hers insurance benefits. it is the Patient's responsibility to communicate with his/hers insurer with any questions regarding the available coverage to receive the maximum benefit.

2. Patient payment: All copayments and deductibles are to be paid at the time of service. This arrangement is part of the Patient's contract with his/hers insurance company.

3. Registration: All Patients must complete the Patient information form, which will be entered into the Clinic's computer system to maintain accurate information for proper billing. The Patient must provide a copy of the driver's license and current valid insurance card to provide proof of insurance. If the Patient fails to provide the correct insurance information and/or insurance changes in a timely manner, the Patient may be responsible for the entire balance of the claim.

Most insurance companies have time filing restrictions; if a claim is not received within 90 days of the date of service, it can be rendered ineligible for payment and you will be responsible for the balance that remains.

4. Claims: The Clinic will submit the Patient's claims to the insurance company of record and will reasonably assist the Patient to get your claims paid. However, should the insurance company of record does not accept information provided, it is the patient's responsibility to cooperate and comply with the insurance company's requests for additional and/or different information. The Patient's insurance benefit is a contract between the Patient and the insurance company, i.e. the Clinic not party to that contract.

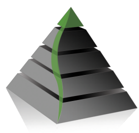
The balance of the claim is the Patient's responsibility irrespective of his/hers insurance company's reimbursement.

5. Credit and collection: If your account is more than 90 days past due, (without payment activity) you will receive a letter stating that you have 10 days to pay your account in full. Accounts with no activity for 120 days may be sent to a collection agency. If an account is sent to collection, it is the policy of this office to discharge the patient and possibly immediate family members from the practice.

6. Missed appointments: The Clinic will charge $50 for missed appointments and $75 for missed procedures not canceled within 24-hours prior to the patient's appointment. These charges will be Patient's responsibility and billed directly to the Patient. Repeat offenders will be subject to dismissal from the practice.

7. Returned Checks: The Clinic will charge $35 for the returned checks and the Patient will be denied any future payments by check.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.



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INFORMATION & RECORDS RELEASE

PATIENT NAME: ____ DOB :__________________

ADDRESS: ____PHONE:________________

(Please circle one)

TO or FROM: EXODUS PAIN CLINIC

TO or FROM: ____

____

____

____

Information to be released:

____ chart notes ____ imaging ____ lab reports ____ all records

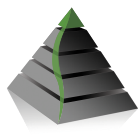
____ surgical reports ____ other: ____

This information is to be used for the following purpose: ________________________________

I hereby consent to release the above state information. I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDs virus), other sexually transmitted diseases, drug or alcohol abuse, mental illness or psychiatric treatment. I give specific authorization for these records to be released. This information may be used by the person I authorize to receive it for medical treatment, consultation, billing or claims. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature: _____________________________________ Date: ___________________________

Relationship to the patient: ____________________________



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PRIVACY PRACTICES

This document describes how your health information may be used or given to others. It also explains how to access this information. Please review it carefully; you may request a copy of this document at any time.

Typical Uses and Disclosure of Health Information:

We will keep your health information confidential, using it only for the following purposes:

1. **Treatment:** We may use your health information to provide you with our professional services. We have established privacy practices to assure non-essential persons do not view your information.
2. **Disclosures:** We may disclose your healthcare information with other healthcare professionals who provide treatment and/or services to you. These professionals will have a privacy and confidentiality policy also. Information may also be shared with your family/friends/caregiver you choose to have involved in your care, only if you agree that we may do so. If you wish to restrict information, please let us know in writing; 1) the information you wish restricted 2) whom you want the limits applied to.
3. **Payment:** We may use and disclose your health information to seek payment for services we provide you. This may include our business office staff and insurance companies, or other business involved in the process of mailing statements and/or collecting unpaid balances.
4. **Emergencies:** We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of emergency involving your care, your location, your general condition or death. You may designate an emergency contact and we will use our professional judgement to determine which information will be disclosed. We will also use our professional judgement to make reasonable inference of your best interest by allowing your designee to pick up prescriptions, x-rays, or other similar forms unless you have advised us otherwise.
5. **Healthcare Operations:** We will use and disclose your health information to keep our practice operable.

6. **Required by Law:** We will disclose your healthcare information where required by law, court, or administrative orders, subpoena, discovery request, or other lawful process. Also, for the use as requested lawfully by national security, intelligence and other State and/or Federal officials, if you are an inmate.

7. **Abuse or Neglect:** We may disclose your healthcare information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes, or if you are homicidal or suicidal. This information will be disclosed only to the extent necessary to prevent serious threat to your health or safety or that of others.

8. **Public Health Responsibilities:** We will disclose your health information to report problems with products, reactions to medications, product recalls, disease or infection exposure and to prevent and control disease, injury or disability.

9. **Marketing/Research:** We will not use your health information for marketing or research without your written consent.

10. **Appointment Reminders:** We may use/disclose your health information to provide you with appointment reminders, including but not limited to, voicemail messages, postcards, and/or letters.

11. **Access:** You may inspect and receive copies of your health information, or that of an individual for whom you are a legal guardian. There may be a small fee for copies and postage and we may request you make an appointment to review your chart. If you wish any of your health information to be amended, you must submit your request in writing with an explanation of why you feel it should be changed. Under certain circumstances, your request may be denied.

12. **Complaints:** You have the right to fill a complaint with us if you feel we have not complied with our Privacy Practices. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us.

______________________________ ______________________

Signature **Date**