Patient Information Form

INTEGRATED PAIN & NEUROSCIENCE, LLC

Appt Date/Time: **Appt Provider** **Chart #**

Appt Comments:

Patient Information

First Name **Middle Initial** **Last Name**

Address **Address Line 2** **City** **State** **Zip Code**

Email **Preferred Language** **SSN** **Date of Birth**

Driver's License **State** **Primary Phone** **Phone Type** **Secondary Phone** **Phone Type**

CELL CELL

Gender ☐ Male ☐ Female **Marital Status** SINGLE **Ethnicity** ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Declined

Race ☐ White ☐ Black or African American ☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Hispanic ☐ Declined

Employer Name **Employer Phone**

Emergency Contact Name **Emergency Contact Phone** **Relationship to Patient**

Referring Physician **Primary Care Physician**

Insurance Information

Primary Insurance **Member #** **Group #**

Primary Insured Name **SSN** **Relationship** **Date of Birth** **Gender** ___ Male ___ Female

Secondary Insurance **Member #** **Group #**

Primary Insured Name **SSN** **Relationship** **Date of Birth** **Gender** ___ Male ___ Female

Financial Responsibility Information

Responsible Party Name **SSN** **Relationship to Patient** **Primary Phone**

Address **Address Line 2** **City** **State** **Zip Code**

Preferred Pharmacy

Pharmacy Name **Pharmacy Phone** **Pharmacy Address**

Patient/Guardian Signature **Date:**

INTEGRATED
PAIN AND NEUROSCIENCE

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT, ACKNOWLEDGEMENT OF PRIVACY PRACTICES, DISCLOSURE OF FINANCIAL INTEREST

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Integrated Pain and Neuroscience, LLC for services furnished by Integrated Pain and Neuroscience, LLC. I authorize any holder of medical information about me to release to Medicare and its agents any information needed to determine these benefits or the release of medical information necessary to pay the claim. If I have other insurance coverage, my signature authorizes releasing the information to the insurer or agency shown. Integrated Pain and Neuroscience, LLC accepts the Medicare allowable determination of the carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services.
2. **PARTICIPATING INSURANCE AND RELEASE OF INFORMATION:** I understand that Integrated Pain and Neuroscience, LLC may use and disclose medical information about me for services and procedures so they may be billed and collected from an insurance agency or other third party. Integrated Pain and Neuroscience, LLC may also tell my health plan and/or referring physician about a treatment I am going to receive to obtain prior approval or to determine whether my plan will cover the treatment, to facilitate payment, or the like.
3. **NON-PARTICIPATING WITH PATIENT'S INSURANCE:** The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to be by Integrated Pain and Neuroscience, LLC if I belong to a plan that Integrated Pain and Neuroscience, LLC does not participate with.
4. **NON-COVERED SERVICES:** The undersigned accepts full financial responsibility for all items and services which are determined by my insurance plan not to be covered. The undersigned agrees to cooperate with Integrated Pain and Neuroscience, LLC to obtain necessary healthcare service plan authorizations.
5. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Integrated Pain and Neuroscience, LLC. I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Integrated Pain and Neuroscience, LLC for payment.
6. **FINANCE CHARGES:** I agree to pay a finance charge of 1% per month, compounded, for any balance I am responsible for which is over 60 days old. I also agree to pay for any returned check fees incurred by Integrated Pain and Neuroscience, LLC. It is the policy of Integrated Pain and Neuroscience, LLC to charge a non-refundable fee no less than $25.00 for checks that are returned. I understand that Integrated Pain and Neuroscience, LLC has the right to charge a non-refundable fee of no less than $25.00 for any missed appointment (visit, orientation, consultation, procedure, etc.) not cancelled 24 hours in advance. I also agree that if I am the parent/guardian bringing a child in for treatment that I am responsible for all fees incurred by the child. If an account is sent to a collection agency or attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to Integrated Pain and Neuroscience, LLC. If copayments and/or deductibles are designed by my insurance company or health plan, I agree to pay them to Integrated Pain and Neuroscience, LLC. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.
7. **ACKNOWLEDGEMENT OF PRIVACY PRACTICES:** I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Integrated Pain and Neuroscience, LLC. There is also a copy posted in the office. I understand that if I have questions or complaints regarding my privacy rights that I may contact the Privacy Officer.
8. **CONSENT:** I hereby authorize the doctors and staff of Integrated Pain and Neuroscience, LLC to administer or perform medical treatment including procedures or services as the may deem necessary or reasonable, including laboratory services and diagnostic procedures. Additionally, I authorize Integrated Pain and Neuroscience, LLC to obtain my medication history.
9. **DISCLOSURE OF FINANCIAL INTEREST:** Louisiana law requires physicians to disclose to a patient, when the physician refers the patient to another health care provider or facility, that the physician has a financial interest in that entity. The purpose of this disclosure is to notify you that Eric Royster, MD has an ownership interest in Old Gretna Pharmacy, LLC and The Wellness Corner, LLC. Dr. Royster also has an ownership interest in Alliance Surgery Center, LLC. If you are referred to one of these entities and have any questions, please discuss this with your physician directly. You have the right to choose a different entity or choose not to receive the services by letting the doctor know prior to the referral.

PATIENT SIGNATURE _____

SIGNATURE OF PATIENT'S REPRESENTATIVE_____

RELATIONSHIP TO PATIENT_____

PATIENT NAME (PRINT)_____ **DATE**_____

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Name: _____

OPIOID CONTRACT FOR CHRONIC PAIN

This contract is to assure that you and your physician comply with state and federal regulations concerning the use of medications for pain. Success depends on communication and understanding of the risks of using pain medicines. **Overuse or misuse of opioids can cause sedation and death.**

1. Please use one physician and one pharmacy to prescribe and dispense all prescription pain medications.
2. Please inform your physician of all medications you take, including supplements and over-the-counter medications.
3. **Appropriate refill dates are determined by the Board of Pharmacy Prescription Website**, which is based on information from your pharmacy. Please allow up to 72 hours to process refill
4. **If you wish to change your prescription before your next refill date for any reason, you will be asked to present the appropriate remaining medicine at your visit prior to obtaining a new prescription.** You will need to be evaluated by a provider at this time and we will make every effort to schedule you an appointment promptly.
5. You are responsible for keeping your pain medication in a secure place, such as a locked cabinet or safe. If your medications are lost or stolen, your physician may choose not to replace the medications or discontinue the medications.
6. You may not share or sell your medications to any other person under any circumstances. **It is against the law.**
7. Any evidence of drug misuse or obtaining pain medication from other physicians may result in discontinuation of the treatment. The presence of a non-prescribed drugs or illicit drug in the urine can be grounds for discharge as well as the absence of prescribed medications.
8. **You should not use alcohol, or any illicit substances, such as cocaine, marijuana, etc., while taking these medications.** If you have a history of alcoholism or addiction, you must notify the physician as **treatment with pain medications may increase the possibility of relapse.**
9. You agree to scheduled and random urine drug testing. Urine testing is in accordance with legal and regulatory guidelines.
10. There can be serious side effects of pain medications. These include over-sedation, impaired cognitive mental status, and impaired motor ability. You are advised not to drive or operate heavy machinery until on a stable dose for 4 weeks and then only if you are without side effects. It is your responsibility to report any possible side effects to your treatment team. **Overuse of opioids can cause sedation and death.**
11. You agree to random pill counts by staff.
12. You agree to maintain an active phone number and voicemail, and update the office with changes.

_____ _____

Patient Signature Date

2801 Napoleon Avenue
New Orleans, LA 70115
Phone: (504) 300-9020 Fax: (504) 300-9021

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name:_____ **Date of Birth:**_____

Previous Name:_____ **Social Security#:**_____

I request and authorize _____**to release healthcare information of the patient named above to:**

NAME: Integrated Pain & Neuroscience LLC

ADDRESS: 2801 Napoleon Avenue_____

CITY: New Orleans_____ **STATE:** _LA_____ **ZIP CODE:** 70115_____

This request and authorization applies to:

☐ **Healthcare Information relating to the following treatment(s), condition(s) or date(s):**

_____

☐ **All Healthcare information**

☐ **Other :**_____

This Authorization is Effective Until:_____

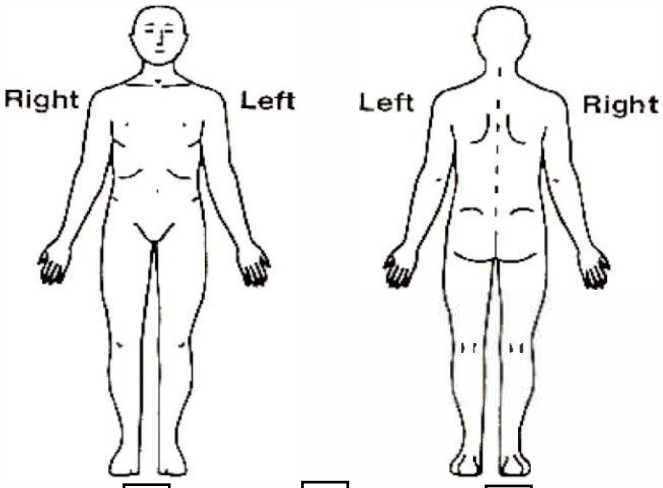
Patient Signature: _____ **Date Signed:** _____

INTEGRATED
PAIN AND NEUROSCIENCE

Date: _____ Name _____ Date of Birth: _____

Where is your worst pain? _____

Please shade painful areas:



Pain History:
Any changes since last visit? ☐ Improving ☐ Same ☐ Worsening

Rate your pain: (Circle words and numbers that describe your experience)

Usually: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Mild Moderate Severe

Location: ☐ no change in location ☐ change in location _____

☐ neck ☐ upper back ☐ lower back ☐ abdominal ☐ buttock

☐ flank ☐ generalized ☐ right leg ☐ left leg ☐ right arm ☐ left arm

Radiation of Pain: no change to (Left / Right / Both) arm(s) to (Left / Right / Both) leg(s)

From: _____ To: _____

Quality: ☐ no change in quality change in quality _____

☐ aching ☐ burning ☐ cramping ☐ dull ☐ numbness ☐ pounding

☐ sharp ☐ stabbing ☐ tightness

Duration: ☐ present <1 month ☐ present for 1-6 months ☐ present for 6-12 ☐ present for >12 months ☐ actual date: ☐ years ☐ recurrent episode

Timing: ☐ constant ☐ intermittent ☐ constant with flares ☐ symptoms worse in the evening ☐ symptoms worse during the day ☐ symptoms do not vary with time of day

What Makes It Better?

☐ rest ☐ heat ☐ stretching ☐ medication ☐ lying down ☐ nothing helps ☐ sitting ☐ standing ☐ ice ☐ NSAIDS ☐ cortisone injection ☐ massage ☐ walking

What Makes It Worse?

☐ activity ☐ sitting ☐ standing/walking ☐ head turning ☐ lying down ☐ stress ☐ nothing makes it worse ☐ going from sit to stand ☐ lifting ☐ prolonged sitting or lying ☐ bending/twisting ☐ cold weather ☐ touching ice

Are Any of These Symptoms Present?

☐ fever ☐ weak limbs ☐ tingling ☐ numbness of the legs/feet ☐ incontinence ☐ unable to urinate

Please List Any New Allergies to medications:

Recent Interventions:

None ☐	Epidural Steroid Injection ☐	Facet Injection ☐	Radio Frequency ☐
Trigger Point Injection ☐	Stimulator Trial ☐	Acupuncture ☐	Joint Injection ☐

Relief with Intervention:

None ☐	20% ☐	40% ☐	60% ☐	80% ☐	100% ☐

Duration of Relief:

1 day ☐	3 days ☐	5 days ☐	1 week ☐	2 weeks ☐	3 weeks ☐
4 weeks ☐	6 weeks ☐	2 months ☐	3 months ☐	Longer ☐	continues ☐

Pain Relief with Current Medications:

20% ☐	40% ☐	50% ☐	60% ☐	80% ☐	90% ☐	100% ☐	
1 hour ☐	2 hours ☐	3 hours ☐	4 hours ☐	6 hours ☐	8 hours ☐	12 hours ☐	24 hours ☐

No side effects from medication? ☐ **yes** ☐ **no**

If yes, side effects:

Constipation ☐	Drowsiness ☐	Itching ☐
Nausea ☐	Other: ☐	Other: ☐

Activities of Daily Living:

Walking ☐	Household chores ☐	Overall activity ☐
Improve with medication ☐	Do not improve with medication ☐	

Are you currently experiencing any of these symptoms? (Please circle any that apply)

Constitutional: Fever; Significant Weight Gain:_____lbs; Significant Weight Loss:_____lbs; Exercise Intolerance

Eyes: Dry Eyes; Irritation; Vision Change

Ears: Difficulty Hearing; Ear Pain

Nose: Frequent Nosebleeds; Sinus Problems

Mouth/Throat: Sore Throat; Bleeding Gums; Dry Mouth; Teeth Problems

Cardiovascular: Chest Pain; Arm pain on exertion; Shortness of breath when walking; Shortness of breath when lying down; Palpitations; Known heart murmur

Respiratory: Cough; Wheezing; Shortness of breath; Coughing up blood

GI: Abdominal Pain; Vomiting; Change in appetite; Frequent Diarrhea; Vomiting blood; Constipation; Nausea; Blood in stool; Ulcer Disease

Genitourinary: Incontinence; Difficulty urinating; Blood in urine; Increased frequency

Musculoskeletal: Muscle aches; Muscle weakness; Joint pain; Back pain; Extremity swelling

Skin: Jaundice; Rash; Itching; Growths/Sores

Neurologic: Weakness; Numbness; Seizures; Dizziness; Frequent Headaches; Drowsiness

Psychiatric: Depression; Sleep disturbances; Anxiety; Suicidal thoughts

Endocrine: Fatigue; Increased thirst; Hair loss

Hematologic Swollen glands; Easy bruising

Allergy/Immune Runny nose; Sinus pressure; Hives; Frequent Sneezing

Past Medical History

Anxiety Disorder ☐
Arthritis ☐
Asthma ☐
Back Problems ☐
Bleeding Disorder ☐
Blood Clots (or DVT) ☐
Cancer ☐
Claustrophobic ☐
Coronary Artery Disease ☐
Depression ☐
Diabetes – Insulin ☐
Diabetes – Non-Insulin ☐
Dialysis ☐
Diverticulitis ☐
Fibromyalgia ☐
Gout ☐
HIV or AIDS ☐
Pacemaker ☐
Heart Attack ☐
Heart Murmur ☐
Hiatal Hernia ☐
High Blood Pressure ☐
High Cholesterol ☐
Kidney Disease ☐
Kidney Stones ☐

Liver Disease ☐
Osteoporosis ☐
Other

_____

_____

_____

Overactive Thyroid ☐
Polio ☐
Pulmonary Embolism ☐
Reflux or Ulcers ☐
Stroke ☐
Tuberculosis ☐

Please list any surgeries and their dates:

_____

_____

_____

_____

_____

_____

Please list all known allergies:

_____

_____

_____

_____

_____

Social History

Education:

Occupation:

Caffeine intake:

Marital Status:

Exercise level:

Smoking status:

Smoking (PPW = packs per week, PPD = packs per day):

Has smoked since age:

Tobacco years of use:

Chewing tobacco:

Alcohol intake:

Illicit drugs:

Auto related injury? Yes No

Work related injury? Yes No

Please list any family history (cancer, heart disease, hypertension, Alzheimer's, etc.)

Condition	Relation