Patient Name: _____ D.O.B._____ Date: _____

INTAKE ASSESSMENT FORM

This questionnaire must be completed prior to your appointment with The HEAG Pain Management Center. Your careful answers will help us to understand your pain problem, and design the best treatment program for you. It is understandable that you might be concerned about what happens to the information you provide, as much of it is personal. Our records are strictly confidential and no outsider is permitted to see your case record without your written permission.

NAME: _____

DOB: _____

SEX: ☐ Female ☐ Male ☐ Other

Current Address: _____

City: _____ State: _____ Zip:_____

Telephone: Home: _____

Work: _____

Mobile: _____

_____

Patient Signature

Patient Name: _____ D.O.B._____ Date: _____

Chief Complaint

What is bothering you?

_____

_____

_____

_____

_____

_____

_____

Are there any symptoms associated with your pain (check all that apply)?

- ☐ Numbness
- ☐ Weakness
- ☐ Urinary Incontinence
- ☐ Incontinence of bowel
- ☐ Tenderness of affected area
- ☐ Pain with only a light touch
- ☐ Cool, pale skin
- ☐ Swelling
- ☐ Redness
- ☐ Tingling
- ☐ Sleeplessness

Other (describe): _____

_____

_____

_____

_____

Patient Signature

Patient Name: _____ D.O.B._____ Date: _____

History of Present Illness – Locations(s) of Your Pain

Describe the location(s) of your pain:

_____

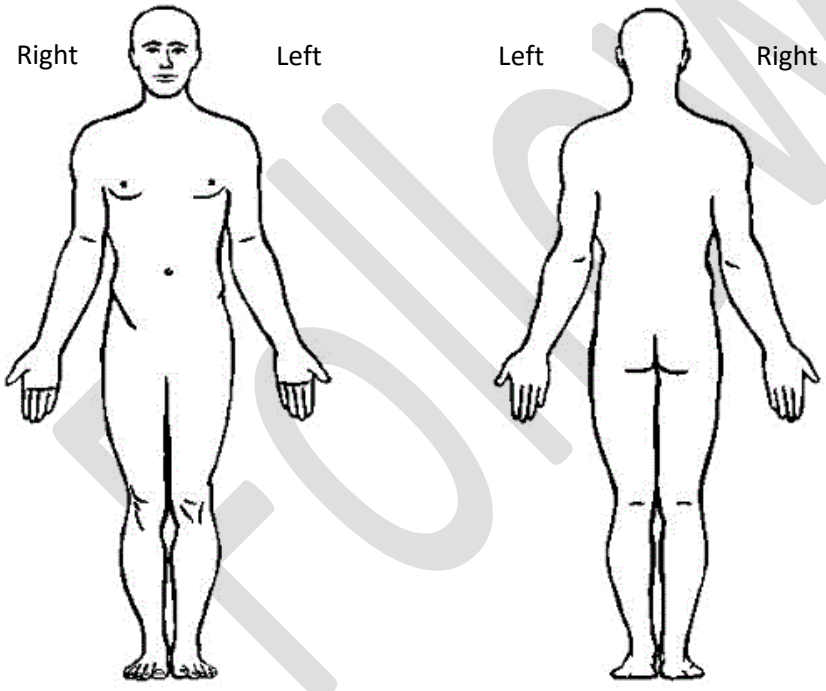
_____

_____

_____

_____

On the diagram, SHADE in the areas where you feel pain.



Please list areas in order of greatest to least pain.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

_____

Patient Signature

Patient Name: _____ D.O.B._____ Date: _____

History of Present Illness – Quality of Pain

Describe the characteristics of your pain (check the box in each column that best describes your average pain the past month).

Intensity	Reaction	Sensation
☐ Excruciating	☐ Agonizing	☐ Piercing
☐ Intolerable	☐ Intolerable	☐ Stabbing
☐ Very intense	☐ Unbearable	☐ Shooting
☐ Extremely strong	☐ Awful	☐ Burning
☐ Severe	☐ Miserable	☐ Grinding
☐ Very strong	☐ Distressing	☐ Throbbing
☐ Intense	☐ Unpleasant	☐ Cramping
☐ Strong	☐ Uncomfortable	☐ Aching
☐ Uncomfortable	☐ Tolerable	☐ Stinging
☐ Moderate	☐ Bearable	☐ Squeezing
☐ Mild	☐ None	☐ Numbing
☐ Weak		☐ Itching
☐ Very weak		☐ Tingling
☐ Just noticeable		☐ None
☐ Extremely weak		
☐ None		

_____

Patient Signature

Patient Name: _____ D.O.B._____ Date: _____

History of Present Illness – Severity of Pain

1) Rate your pain by circling the number to best describe your pain at its WORST in the past month.

No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it could be.

2) Rate your pain by circling the number to best describe your pain at its LEAST in the past month.

No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it could be.

3) Rate your pain by circling the number to best describe your pain on the AVERAGE.

No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it could be.

4) Rate your pain by circling the number to best describe pain you have RIGHT NOW.

No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it could be.

_____

Patient Signature

Patient Name: _____ D.O.B._____ Date: _____

History of Present Illness – Analgesia

1. What percentage of your pain has been relieved during the past week?

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

2. Is the amount of pain relief you are now obtaining from your current pain reliever(s) enough to make a real difference in your life? Yes ☐ No ☐
3. Do you think you benefit from the prescribed medications? Yes ☐ No ☐

Activities of Daily Living

Please indicate whether you are functioning Better, the Same, or Worse with your current pain reliever(s) since the last assessment.

		Better	Same	Worse
1.	Physical Functioning	☐	☐	☐
2.	Family Relationships	☐	☐	☐
3.	Social relationship	☐	☐	☐
4.	Mood	☐	☐	☐
5.	Sleep patterns	☐	☐	☐
6.	Overall functioning	☐	☐	☐

Adverse Effect

Are you experiencing any side effects from your current medications?

		None	Mild	Moderate	Severe
a.	Nausea	☐	☐	☐	☐
b.	Vomiting	☐	☐	☐	☐
c.	Constipation	☐	☐	☐	☐
d.	Itching	☐	☐	☐	☐
e.	Confusion	☐	☐	☐	☐
f.	Sweating	☐	☐	☐	☐
g.	Fatigue	☐	☐	☐	☐
h.	Drowsiness	☐	☐	☐	☐
i.	Other_____	☐	☐	☐	☐
j.	Other_____	☐	☐	☐	☐

_____

Patient Signature

Patient Name: _____ D.O.B._____ Date: _____

History of Present Illness – Previous Therapy/Adjuvant Therapy

For each treatment listed below that you have tried, choose ONE number indicating the result:

1) No relief or pain worsened
2) Some relief – Temporary
3) Some relief – Permanent
4) Complete relief – Temporary

_____ Acupuncture	_____ Heat/Cold Treatment	_____ Psychotherapy
_____ Biofeedback	_____ Hospital Bed Rest	_____ Surgery
_____ Chiropractor	_____ Hypnosis	_____ TENS (Elec Stim)
_____ Epidural Steroid Inj.	_____ Nerve Block	_____ Traction
_____ Exercise	_____ Physical Therapy	_____ Ultrasound
_____ Brace	_____ Collars	_____ Corset

_____ Other (specify): _____

_____

Patient Signature

Patient Name: _____ D.O.B._____ Date: _____

Past Medical History

Allergies

Do you have any allergies? (please list) _____

_____

_____

_____

_____

Current Medications

What medications are you currently taking? (please list)

Medication	Strength or Dosage	How Often do Take this Medication	Why do you take this Medication	Who Prescribed This Medication

_____

Patient Signature

Patient Name: _____ D.O.B._____ Date: _____

Past Medical History (cont'd)

Past Surgical History

Please List

Date	Type of Operation	Complications (describe)

_____

Patient Signature

THE HEAG
PAIN MANAGEMENT CENTER, P.A.

Patient Name: _____ D.O.B._____ Date: _____

Review of Systems

Check all that apply:

Neurologic			
☐ Headache	☐ Facial pain	☐ Vision loss	☐ Tingling
☐ Numbness			
Psychiatric			
☐ Depression	☐ Anxiety	☐ Insomnia	☐ Nervousness
Cardiovascular			
☐ Chest pain	☐ Wheezing	☐ Skipped beats	☐ Swelling
Renal/Liver			
☐ Frequent urination	☐ Burning urination	☐ Foul odor of urine	☐ Blood in urine
☐ Yellow jaundice			
Endocrine			
☐ Hair/skin changes	☐ Cold or heat intolerance	☐ Frequent urinating	☐ Excessive thirst
ENT			
☐ Hearing	☐ Smelling	☐ Swallowing	☐ Hoarseness
Respiratory			
☐ Wheezing	☐ Coughing	☐ Sputum	
Hematology/Oncology			
☐ Easy bleeding	☐ Bruising	☐ Do you ever feel or look pale?	
☐ Lumps or bumps that are new?		☐ Any sores that will not heal?	
GI			
☐ Belly pain	☐ Constipation	☐ Reflux/burning	☐ Blood in stool
☐ Grey or black stools	☐ Vomiting	☐ Nausea	
Orthopedics/Rheumatology			
☐ Pain in joints	☐ Swelling or red joints	☐ Cool hands and/or feet	☐ Cracking or popping joints
Constitutional			
☐ Fatigue	☐ Weight loss/gain	☐ Night sweats	☐ Fevers
OB/GYN			
☐ Pregnant	☐ Breast-feeding		

_____

Patient Signature

THE HEAG PAIN MANAGEMENT CENTER, P.A.

Patient Name: _____ D.O.B._____ Date: _____

Pre-Urine Drug Testing

Please answer all the questions in all columns by circling Yes (Y) or No (N)

1. Y N Dizziness
2. Y N Insomnia/ Sleeplessness
3. Y N Tremors
4. Y N Shaking hands or feet or head
5. Y N Numbness
6. Y N Taken someone else's medication
7. Y N Loss of memory
8. Y N Difficulty walking - impaired motor function
9. Y N Reduced sense of pain
10. Y N Restlessness
11. Y N Nervousness
12. Y N Increased Irritability
13. Y N Loss of appetite
14. Y N Unusual Sweating
15. Y N Hallucinations/ Hearing or Seeing things
16. Y N Dry mouth
17. Y N Anxiety/ Anxious
18. Y N Sudden weight loss or gain
19. Y N Mood changes/ swings
20. Y N Late for work
21. Y N Decreased sexual drive
22. Y N Forgetfulness/ short term memory loss
23. Y N Increased energy
24. Y N Slow reflexes
25. Y N Disorientation
26. Y N No energy/lethargy/ apathy
27. Y N Blurred Vision
28. Y N Not in school
29. Y N Unemployed
30. Y N Change in personal grooming
31. Y N Withdrawal from family
32. Y N Loss in interest and hobbies
33. Y N Itching Scratching
34. Y N Skin Discoloration
35. Y N Fearfulness
36. Y N Skin Flushing
37. Y N Miss work on Mondays
38. Y N Stress
39. Y N Grinding teeth
40. Y N Muscle spasm/tension
41. Y N Chronic low back pain
42. Y N Used prescription drug to "get going"
43. Y N Used prescription to "calm down"
44. Y N Family history of drug related crimes
45. Y N Family History of alcohol/ drug problems
46. Y N Family history of mental illness
47. Y N Family history of physical abuse
48. Y N Received drug treatment, detoxification or rehabilitation services
49. Y N Received treatment at a suboxone /methadone clinic
50. Y N Panic Attacks
51. Y N Depression
52. Y N Sniffles/runny nose
53. Y N Nausea
54. Y N Rapid heart Rate
55. Y N Flashbacks
56. Y N Unusual Shaking
57. Y N Mental confusion
58. Y N Excessive Sweating
59. Y N Loss/poor physical coordination
60. Y N Suicide thoughts
61. Y N Frequent infections
62. Y N Use eye drops
63. Y N Frequent vomiting
64. Y N Headaches
65. Y N Easily excited
66. Y N Have/had hepatitis, cirrhosis, HIV (AIDS), liver disease
67. Y N Skipping Work or school
68. Y N Fever/increased body temperature
69. Y N Paranoia
70. Y N Nose Bleeds
71. Y N Coughing
72. Y N Bronchitis
73. Y N Sinusitis
74. Y N Dental problems
75. Y N Excess Sleep
76. Y N Unusual calmness
77. Y N Increased agitation/anger
78. Y N Divorce
79. Y N DUI
80. Y N Legal problems, involved in police investigation, criminal charges, convictions
81. Y N Fainting/passing out
82. Y N Smelling/hearing loss
83. Y N Excessive laughter
84. Y N Laziness
85. Y N Forgetfulness
86. Y N Poor judgment
87. Y N Relaxed muscles
88. Y N Increasing dose of pain medication
89. Y N Increasing dose of other medication
90. Y N Chronic pain after motor vehicle accident
91. Y N Pain in three (3) regions of the body
92. Y N Felt need to reduce use of prescription drugs
93. Y N Felt annoyed due to remarks due to use of medications
94. Y N Felt remorseful or guilty about using prescription drugs
95. Y N Abnormal urine/alcohol test
96. Y N Tried marijuana (THC), cocaine, speed or other drugs
97. Y N Become intoxicated or high from alcohol/drugs
98. Y N Attended a 12 step program, AA or other drug counseling meetings
99. Y N Accidental or intentional overdose
100. Y N Treated for schizophrenia, bipolar, antisocial borderline.
101. Y N Personality disorder, post-traumatic stress
102. Y N Associate with/around others with drug, alcohol problems

OTHER: _____

Based on signs/symptoms, chronic pain, controlled substance use and/or previous noncompliant UDT/BAT patient's EHR, Narcotic Profile, consideration of patients risk factors, current high risk medications (V58.69), reasonable suspicion of drug misuse/abuse, symptoms of anxiety, depression, somatization, monitoring/ observation of other suspected behavioral health condition (V71.09). I believe the ordered UDT/BAT is reasonable and medically necessary and needed for this chronic pain patient in order to discern discoordination between patient reports and objective facts. The patient has read or had this evaluation explained to him/her.

_____

Patient Signature

THE HEAG
PAIN MANAGEMENT CENTER, P.A.

Patient Name: _____ D.O.B._____ Date: _____

COMM

Please answer each question as honestly as possible. Keep in mind that we are only asking about the **past 30 days**. There are not right or wrong answers. If you are unsure about how to answer the questions, please give the best answer you can.

Please answer the questions using the following scale:					
	Never 0	**Seldom 1**	**Sometimes 2**	**Often 3**	**Very Often 4**
1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?	○	○	○	○	○
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (doing things that need be done, such as going to class, work or appointments)	○	○	○	○	○
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (another doctor, Emergency Room, friends, street sources)	○	○	○	○	○
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?	○	○	○	○	○
5. In the past 30 days, how often have you seriously thought about hurting yourself?	○	○	○	○	○
6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?	○	○	○	○	○
7. In the past 30 days, how often have you been in an argument?	○	○	○	○	○
8. In the past 30 days, how often have you had trouble controlling your anger? (road rage, screaming, etc.)	○	○	○	○	○
9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?	○	○	○	○	○

THE HEAG
PAIN MANAGEMENT CENTER, P.A.

Patient Name: _____ D.O.B._____ Date: _____

	Never 0	Seldom 1	Sometimes 2	Often 3	Very Often 4
10. In the past 30 days, how often have you been worried about how you're handling your medications?	○	○	○	○	○
11. In the past 30 days, how often have others been worried about how you're handling your medications?	○	○	○	○	○
12. In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?	○	○	○	○	○
13. In the past 30 days, how often have you gotten angry with people?	○	○	○	○	○
14. In the past 30 days, how often have you had to take more of your medication than prescribed?	○	○	○	○	○
15. In the past 30 days, how often have you borrowed pain medications from someone else?	○	○	○	○	○
16. In the past 30 days, how often have you used your pain medication for symptoms other than for pain (to help you sleep, improve your mood, or relieve stress)?	○	○	○	○	○
17. In the past 30 days, how often have you had to visit the Emergency Room?	○	○	○	○	○

Patient Signature: _____ Date: _____

Patient Name: _____ D.O.B._____ Date: _____

History of Present Illness – Activity

Circle the number that best describes how pain has interfered with your:

a. Normal Daily Activities:

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

b. Mood:

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

c. Walking Ability:

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

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

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

e. Sleep:

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

f. Family Relationship;

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

g. Relationship with your spouse/partner:

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

h. Social activities with other people:

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

i. Enjoyment of life:

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

_____

Patient Signature

Patient Name: _____ D.O.B._____ Date: _____

History of Present Illness – Pain Disability Index

Pain disability index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.
For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. **A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.**

Family/Home Responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g., yard work) and errands or favors for other family members (e.g., driving the children to school).

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Recreation: This category includes hobbies, sports, and other similar leisure time activities.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Social Activity: This category refers to activities that involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Occupation: This category refers to activities that are a part of or directly related to one's job. This includes nonpaying jobs as well, such as that of a housewife or volunteer worker.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Sexual Behavior: This category refers to the frequency and quality of one's sex life.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Self-Care: this category includes activities that involve personal maintenance and independent daily living (e.g., taking a shower, driving, getting dressed, etc.)

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Life-Support Activity: This category refers to basic life-supporting behaviors such as eating, sleeping, and breathing.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

_____

Patient Signature

Patient Name: _____ D.O.B._____ Date: _____

OTHER COMMENTS

I agree that I will be seen and examined by The HEAG Pain Management Center, PA (HPMC), their staff, LPNs, RNs and physicians today and will answer all questions truthfully.

HPMC has agreed to participate with numerous managed care programs. It is extremely difficult for us to keep track of all the individual requirements of the numerous plans. Each one has different policies regarding how often services may be rendered and even more importantly, where those services may be performed. I agree that if I do not supply copies of all insurance cards and applicable referrals on each visit that may be secondary to motor vehicle, personal injury or Worker's Comp coverage, I will be responsible for all charges in full that are not covered by the liability carrier. Providing quality medical care to our patient's is our primary concern. We are more than willing to provide that care within your insurance contract guidelines if you let us know at **EACH** time of service exactly what those guidelines are. You may need to contact your carrier (customer service number is usually on the back of the card) and ask for this information. We are unable to do this for you. If you do not inform us of any kind of special requirement in your contract and we subsequently order services, i.e. lab work or hospitalization, that are not covered, we or the selected medical facility will have no choice but to bill you directly for those charges. You will be responsible for those charges. With your cooperation and help, you should be able to receive all of the benefits offered to you and we will be able to concentrate on caring for your medical needs.

The initial visit ranges in price from $195. to $600. Follow-up visits range from $90. to $235. Forms are $50. per page and narrative reports are $550. and both must be prepaid. Orthotics and supplies range in price from $30. to $3,695. On most orthotics, there is a handling/adjust/fit charge ranging from $25. to $150. All orthotics over $500. will be pre-certified with the patient's insurance. *No orthotics returns will be accepted.* I understand that I have a choice regarding orthotic suppliers, diagnostic imaging centers, lab testing centers, physical therapy centers, pharmacies, psychologist, psychiatrist, MRI centers, urine drug testing, hospitals, physicians, etc., regarding my care. I agree that only formulary medications will be prescribed to provide cost-effective quality care.

I understand my insurance will be billed as a courtesy to me. If my insurance does not pay within 45 days, I will be responsible for the bill in full. I also understand that I am responsible for any co-payment or amount that is not paid by insurance within 45 days. I understand interest in the amount of 1.5% monthly and 18% annually will be added to my account on any balance over 45 days and I will also be responsible for any interest charges on my account. I will also be responsible for collection fees, attorney fees and all court costs incurred to collect my balance in full. If I am involved in litigation regarding a motor vehicle accident, personal injury, Worker's Compensation injury, I authorize HPMC to intervene in the litigation to collect any monies owed for medical services related to my injury. I authorize release of my PIP log to HPMC.

I hereby authorize HPMC to furnish any information concerning my illness to my insurance carrier(s) and my attorney. I authorize payment for medical services to go directly to the physician. I understand that I am responsible for paying any amount not covered by my insurance. I understand that if my treatment is for a non-work-related injury or if I seek treatment outside of network, I will be responsible for the bill in full. I understand and agree that HPMC does not issue refunds to patients who receive back-dated or spend-down Medicaid cards. HPMC accepts Medicaid insurance cards and submits claims on my behalf for dates of service on and after presentation of the medical card. I authorize release of my past, present and future medical records (including drug, alcohol, behavioral health) from all and any healthcare providers to and from HPMC or any surgical assistant or their employer. I will authorize HPMC to obtain a narcotic profile and authorize release of past, present and future profiles. I understand that if my condition worsens or fails to improve, I am to return to the office or go to the emergency room immediately. I authorize my free copy(s) of medical records to go to the medical provider that sent me here as well as with my bill to the insurance company. I understand that receiving controlled substances from more than one doctor is a felony. I understand that no diagnosis or treatment can be done by phone.

I have read and understand the above statement regarding office policy and procedures and consent for HPMC. I understand that I personally will be responsible for any amount not covered by my insurance (i.e. P3s, physical therapy, MRI, pain procedure, surgery, etc.) I further certify that if I am unable to read or write that the witness below has explained this form to my satisfaction. I also give full consent to be treated by physicians and staff of HPMC and understand that no guarantees have been made regarding outcome. Noncompliance such as missing appointments, rude behavior, not following physician's orders, may result in my being released from this practice. I understand that doctors seek to deliver good care and if I have any questions or problems whatsoever, a separate office visit may be scheduled with the office manager and the doctors. I understand that if I allow other people to accompany me to the office visit, I give consent for them to hear my personal health information. If I have a complaint, I will leave my complaint in writing today with the office manager.

I understand that many times there will be long delays before seeing one of the physicians. I understand I may wait even up to four to eight hours and then have the appointment canceled. I understand that office appointments are for non-emergent problems and agree to hold HPMC and staff harmless for any delays. I understand I may seek treatment elsewhere at any time with other medical practices. I certify that I have not provided false information on the intake form, to referring physicians or seeking care under false pretense. I agree to obtain a second opinion before initiating treatment. I understand that it may be necessary to be referred for outside services as a result of the information obtained from my P3. Should this occur, I will be notified by certified mail of the location and date of my appointment. If I am unable to keep this appointment, it will be my responsibility to reschedule. Failure to reschedule could result in my release as a patient from HPMC.

Subsequent care will be provided at times by a Physician Assistant (PA) or a Nurse Practitioner.

Patient Signature Date Pharmacy Name

The HEAG Pain Management Center Staff Witness Date

Patient Name: _____ D.O.B._____ Date: _____

TREATMENT AGREEMENT – CONDITION TERMS FOR TREATMENT

To receive treatment with or without narcotic pain medication, the patient must meet the following condition/terms:

1. The patient has never been diagnosed with, treated, or arrested for substance abuse or trafficking.
2. The patient has never been involved in the sale, illegal possession, dispersion, or transport of controlled substances (narcotics, sleeping pills, nerve pills, pain pills); or, under investigation or arrested for such activities.
3. **(FEMALE ONLY) - The patient certifies that she is not pregnant.** The patient agrees and understands that it is her responsibility to notify The HEAG Pain Management Center immediately if she is planning a pregnancy, or believes that she may be pregnant; and, agrees not to take any medication without approval of OB-GYN doctor, if pregnant.
4. The patient agrees to supply The HEAG Pain Management Center the name, address, and telephone number of the pharmacy that is filling the prescription of pain medication, and will use only one pharmacy.
5. The patient agrees to have his/her prescriptions prescribed by The HEAG Pain Management Center physicians, filled by only one pharmacy. In the event a pharmacy does not cover prescribed medication, the patient will attend another office visit to complete appropriate paperwork for pharmacy change per our controlled substance agreement. In the event of an emergency requiring another physician's attention, the patient will immediately inform his/her physician at The HEAG Pain Management Center of such prescribing physician and dispensing pharmacy.
6. The patient agrees to allow his physician at The HEAG Pain Management Center to send a copy of the agreement to the patient's pharmacy, referring physician(s), and all other physicians involved in the patient's care. The patient agrees to allow the physician at The HEAG Pain Management Center to discuss his/her care freely with other physicians.
7. The patient agrees to **take the medication only and exactly** as prescribed by the physician at The HEAG Pain Management Center. The patient agrees **not to share the medication with other individuals**. The patient agrees that medications will only be prescribed that are on plan formulary. The patient **will not drink alcohol** with controlled medications.
8. The patient agrees not to take any over the counter medication (i.e. Tussionex Robitussin, Vicks inhaler, etc.), Marinol, hemp oil, and/or Chinese herbs.
9. The patient agrees to random urine testing.
10. The patient understands that each prescription is for a specific number of pills, designed to last a certain amount of time. **NO EARLY REFILL. NO EXCEPTIONS**.
11. The patient understands that NO refills will be given if the prescription does not last until the next scheduled visit.
12. The patient understands that NO allowance will be made for lost or stolen prescription pills, or those destroyed by fire, flood, etc. **If medications prescribed cause adverse reactions, patient is to stop medicine immediately and inform physician and is required to bring unused medication to next office visit. The patient will safeguard medications.**
13. The patient understands that prescriptions will be dispensed only after a scheduled office visit, not over the phone.
14. The patient understands that **NO** prescriptions for pain medication will be given over the telephone. **NO EXCEPTIONS.**
15. The patient agrees that they will not seek pain medication at night, on weekends, holidays, or prior to the next visit.
16. The patient agrees not to obtain pain medication from any other physician, emergency room, or other person.
17. The patient agrees to keep all scheduled appointments at The HEAG Pain Management Center. If the patient is unable to keep an appointment, he/she must give at least 24-hours advance notice. However, **NO PRESCRIPTIONS WILL BE CALLED IN.**
18. The patient agrees to see the physician at The HEAG Pain Management Center if the physician feels it is necessary to change the patient's dosage. If the physician suspects the patient is not following his/her orders when asked to cease use of a controlled substance, the patient permits The HEAG Pain Management Center to pursue remedies which will disable the patient's driving privileges. The patient understands not to drive or operate machinery while taking controlled medications.
19. The patient allows The HEAG Pain Management Center to call other pharmacies for poly-drug prescriptions and/or usage. All patients are required to undergo a mandatory drug screen at facility of choice (i.e. primary care physician, hospital, or walk-in clinic), and agrees not to use Vicks inhalers, poppy seeds, or cough/cold remedies.
20. The patient certifies they are a legitimate patient needing legitimate care.
21. The patient understands that the physicians at The HEAG Pain Management Center may stop treatment, and cancel any prescriptions if any of the following occur: **a) The patient gives, sells, or misuses the pain medication, or fails to keep appointments b) The patient fails to reach goals such as decreased pain levels. c) The patient attempts to obtain pain medication at night, on weekends, on holidays, sooner than next office visit, from any other physician, from an emergency room, or from any other source d) the patient is released for any reason or fails to show improved function.**
22. The patient understands that an accurate diagnosis requires an accurate history, physical exam, and imaging. Therefore, treatment recommendations are not made over the phone, only in person after being seen by a physician.
23. The patient certifies that they have not provided misleading or false information or false medical history to the referring physician or physicians at The HEAG Pain Management Center, and they are not seeking treatment under false pretense. The patient understands that physicians base treatment, at least 50%, on history and if it is found that the patient has provided false statements they may be released. The patient agrees they (or anyone with them) do not carry concealed weapons, tape recorders, cameras, or other devices. The patient certifies they are not appearing to seek care as part of an ongoing investigation or threat of prosecution. The patient agrees to set a goal such as decreased pain, improved function, return to work, or return to school.
24. The patient will adhere to the advice of the physicians regarding operation of motor vehicles or any other machinery. If The HEAG Pain Management Center witnesses, or is able to validate information of the patient's driving under the influence (i.e. drugs or alcohol), the patient authorizes The HEAG Pain Management Center to notify the authorities and not to be held liable for any damages which may occur.
25. The patient agrees their record may be given to Narcotic Detectives, DEA, or other authorities and will hold The HEAG Pain Management Center harmless, and the patient agrees to random drug testing.
26. I authorize The HEAG Pain Management Center to obtain narcotic profile from DEA and release all past, present, and future profiles to anyone with written authorization to receive medical records, and understand that obtaining controlled medications from more than one physician is a felony.
27. I understand that controlled medications such as codeine, Tylenol #3, Methadone, Morphine, MS Contin, Kadian, Avinza, Percocet, Tylox, OxyContin, Roxicet, Darvon, Darvocet, Dilaudid, Lortab, Lorcet, Vicodin, Valium, Xanax, Soma, Ambien, Ativan, Fiorinal, Restoril, Hydrocodone, etc. have risks

Patient Name: _____ D.O.B._____ Date: _____

associated with their use, such as drug interactions, respiratory, depression, death addiction, drowsiness, allergic reactions, and agree to discuss all risks/side effects with my pharmacist, family members, family physician, other treating physicians before and during treatment.,

28. I understand obtaining controlled medications from more than one physician/dentist/ clinic is a felony.
29. I understand that I should take the least amount of controlled medications to relieve the symptoms and should never exceed the prescribed amount, and should slowly taper off all controlled substances over several weeks whenever possible. I understand that these medications are only to be taken as needed. I understand the risks of taking controlled medications up to and including death. I will take the minimal amount of medication to improve function.
30. I understand that all medications and any refills will be canceled immediately if, in the opinion of the physician/staff, an unsatisfactory psychological/psychiatric test result is received back after the patient takes the test, any allegations, suspicious information or investigation is initiated by anyone regarding potential violations of this contract is brought to The HEAG Pain Management Center.
31. We reserve the right to require the patient to submit to psychological/psychiatric evaluation and/or pain patient profile and release this information as part of any medical records request.
32. The patient understands that physical dependence is a normal response to many types of medications including steroids, antidepressants, and controlled medications, but tolerance to pain relieving effects are rare.
33. The patient understands that impaired control, craving, compulsive use, continued use despite negative consequences, inability to take medications as prescribed, isolation from friends and family, doctor shopping, using illegal drugs, intoxication, apathy, depression, noncompliance, and inability to function represent abnormal behavior patterns and agrees to discontinue medications, and immediately seek psychiatric care, and notify The HEAG Pain Management Center and primary care provider.
34. The patient realizes pain medication may interfere with endocrine function, i.e. interference with libido, sexual function, etc and the patient agrees to see their family physician or endocrinologist if they have any of these problems.
35. If I develop any feelings of hopelessness, suicidal thoughts, or desire to hurt myself or others, I agree to immediately seek immediate psychiatric care, and notify The HEAG Pain Management Center and primary care provider. I will return all medication to the office if this feeling happens.
36. The patient agrees that The HEAG Pain Management Center physicians/staff may cancel medications at any time without cause and without warning for any medical or non medical reason, suspicious incarceration, or even without a specific reason, and understand to see primary care provider, mental health provider immediately when medications are canceled or treatment discontinued.
37. I understand that not taking medications as prescribe or over dosing on medications usually causes death.
38. I have told (or will tell)my family members and caregivers of my use of controlled medications for treatment of pain and discontinue treatment if family is not in agreement, or my family physician is not in agreement, or if I fail to reach goals.
39. I will discuss my diagnosis and treatment with family, family physician, mental health provider, second opinion physician, and if they are not in agreement, will discontinue treatment and notify The HEAG Pain Management Center.
40. I hereby authorize any pharmacy of record to release any and all Information to the physician and/or nursing staff of The HEAG Pain Management Center upon their request.
41. I agree that I have been seen and examined by a HEAG Pain Management Center physician today and have no complaints, regarding any diagnosis, treatment plan, physicians, or staff at The HEAG Pain Management Center, and if I do have problems will hand deliver it in writing to office manager today. I agree to discontinue treatment if I don't reach set goals such as decreased pain, improved function, return to work and return to school.
42. I have read the conditions and terms stated above and have had all of my questions regarding these conditions and terms explained to my satisfaction. I have met the conditions, and I agree to honor all of the terms unconditionally. I also understand that if I violate any term of this agreement, it is cause for the physicians at The HEAG Pain Management Center to refuse prescriptions and/or treatment. I agree that if I am unable to read or write that this have been verbally explained to my satisfaction.
43. The patient will notify The HEAG Pain Management Center if they have been or are currently receiving treatment at a Methadone Clinic
44. The patient will notify The HEAG Pain Management Center if they have been or are currently receiving treatment at a Pain clinic
45. The patient will notify The HEAG Pain Management Center if they have been or are currently receiving treatment from a Psychiatrist.
46. If you are having a serious reaction to medication or a severe pain problem, call 911 or go to the Emergency Room.
47. You agree to a family conference or a conference with a close friend or significant other if the physician feels it is necessary.
48. Medication in its original container should be brought in to **each** office visit.
49. Medications will not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen/lost, you will need to bring a police report regarding the theft/loss.
50. I am aware that certain other medications such as nalbuphine (Nubain™), pentazocine (Talwin™), buprenorphine (Buprenex™) and butorphanol (Stadol™) may reverse the action of the narcotic medicine I am using for pain control. Taking any of these other medications while I am taking my pain medications can cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of these medications and to tell any other doctors that I am taking an opioid as my pain medicine and cannot take any of these medications listed above.
51. **(Males only)** I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.
52. Subsequent care will be provided at times by a Physician Assistant (PA) or Nurse Practitioner.
53. I agree to release my doctor and his/her staff from any and all liability caused by or due to my misuse of narcotic drug(s).

The above agreement has been explained to me by _____ and I agree to its terms so that Dr. _____ can provide quality pain management using opioid therapy to decrease my pain and increase my function.

_____

Patient Signature Date Pharmacy Name

_____

The HEAG Pain Management Center Staff Witness Date

Patient Name: _____ D.O.B._____ Date: _____

PILL COUNT

1) Please complete this form **each and every time** you make an office visit. You should also bring your pill bottles and all remaining pills with you.

2) Entries should be made for all medications prescribed by The HEAG Pain Management Center. Incomplete or partial entries will be counted as non-compliance and may result in release from the clinic. If you leave your pills in a pill organizer at home, and your count is deficient it would be counted as non-compliant.

3) **Absolutely no refill** will be allowed if this form is **not** completed and signed by the patient.

4) You are **responsible** for the **safety** of **all** your scheduled medications at **all** times. This includes when you are in the office of The HEAG Pain Management Center.

5) It is important to know that the vast majority of prescription drug crimes in the USA are felonies, making abusers subject to possible penitentiary sentences. In addition to selling prescription drugs, the act of doctor shopping, forging, or altering prescription drugs and various other pharmaceutical scams are serious felonies in North Carolina and other states. One dangerous activity is for people to give or exchange their prescription drugs with friends or family members. This activity is not only physically dangerous, but legally is the same felony offense as selling your drugs to another.

6) I have read and I clearly understand the content of this form. I certify that I have truthfully completed this form in full. I have been made aware that I will be released immediately and no scheduled drugs will be prescribed if I engage in any of the prescription drug crime discussed above. I have been told that I could be released even if it is only suspected that I have engaged in any prescription drug crime anywhere in the USA. I will also be released immediately if my pill count shows discrepancies. By signing my signature I accept the conditions for release.

_____

Patient Signature

THE HEAG PAIN MANAGEMENT CENTER, P.A.

Patient Name: _____ D.O.B._____ Date: _____

PILL COUNT (cont'd)

Medications	Dosage	How often was med *Prescribed* to be taken	How often did you *Actually* take medication?	Date and time you took the *last dose*?	How many pills left in bottle?	Total # of pills Dispensed	Fill Date

If your count is deficient, please copy this statement in box below in your own handwriting or your representative's handwriting.

"My oxycodone is short by 10 pills because……."(example)

_____

_____

_____

_____

_____

_____

_____

Patient Signature Date Representative Signature Date

Additional complaints you would want the physician/staff to address at this visit:

_____

_____

_____

_____

_____

_____

Patient Signature Date Representative Signature Date

_____

Heag Staff Date Witness Date