COMMERCE Pain Management
*Relieving Pain, Restoring Possibilities*

# Patient Demographic Form

| PATIENT INFORMATION | | | | | |
|---|---|---|---|---|---|
| ❑ Mr.<br>❑ Mrs.<br>❑ Miss<br>❑ Ms. | Last Name: | First Name: | Middle Name: | Marital status (circle one)<br>Single / Mar / Div / Sep / Widow | |
| | Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | | | |
| Home phone no.:<br>( ) - | Cell phone no.:<br>( ) - | Birth date:<br>/ / | Age: | Sex:<br>❑ M ❑ F | Social Security #:<br>- - |
| Street Address: | | | P.O. Box: | | |
| City: | State: | ZIP Code: | City: | State: | ZIP Code: |
| Employer: | | | Work phone no.:<br>( ) - | Work fax no.:<br>( ) - | |
| Employer Address: | | | May we contact you at work? ❑ Yes ❑ No | | |

| INSURANCE INFORMATION | |
|---|---|
| Company name | ID Number |
| Group Name | Phone Number |

| MEDICAL INFORMATION | |
|---|---|
| Primary Physician | Phone |
| Address | Fax |
| Date of last physical | Are you allergic to any medications? If yes list here: |
| List All Currant Medications here: | |
| Pharmacy Name | Phone |

| IN CASE OF EMERGENCY | | | |
|---|---|---|---|
| Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: | Work phone no.: |
| | | ( ) | ( ) |
| | | ( ) | ( ) |
| | | ( ) | ( ) |

By signing below, I affirm that all the above information is true and correct to the best of my knowledge.

| Patient signature | Date |
|---|---|
| | |



413 Pottery Factory Drive, Commerce, GA 30529
Phone: 706-423-9449 Fax: 706-423-9443
Website: www.commercepain.com Email: newpatient@commercepain.com

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| | | | |
|---|---|---|---|
| **Patient Name:** | | | |
| Referring Physician: | | | |
| Is your problem: | ❑ Work related<br>❑ Auto or Other Accident related<br>❑ Neither | Do you have legal representation:<br>❑ Yes ❑ No | Are you being covered under Work Comp<br>❑ Yes ❑ No |
| Please briefly describe your **MAIN** problem/ complaint: | | | |
| How long have you had this problem: | | | |
| Did your problem start suddenly or gradually with time? | | | |
| Are there any events, such as injuries, falls, illnesses, etc. that coincide with the date the problem started? If yes explain: | | | |

| **MEDICATIONS:** Please indicate all current **medications** with **dosages** and **frequency**: | | |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| Please indicate all **previous medications** prescribed in the past with **maximum dosages** and **frequency** tried: | | |
| | | |
| | | |
| | | |

**ALLERGIES:** List all medication you have taken that caused side effects/allergic reaction – **ALSO LIST WHAT HAPPENS WHEN TAKE THE MED**:

| **Allergy** | **Reaction** | **Allergy** | **Reaction** |
|---|---|---|---|
| **Allergy** | **Reaction** | **Allergy** | **Reaction** |
| X-ray Contrast ❑ Yes ❑ No | | Shellfish ❑ Yes ❑ No | |
| Iodine/Betadine ❑ Yes ❑ No | | Other ❑ Yes ❑ No | |

**Past Medical and Surgical History: (List all problems/surgeries, not just the problem(s) you are here for)**

| | | | |
|---|---|---|---|
| ❑ High Blood Pressure | ❑ High Cholesterol | ❑ Diabetes | ❑ Stroke |

**Other:**

**Social History**

| | | | |
|---|---|---|---|
| Occupation: | ❑ Light Duty<br>❑ Full Duty | ❑ Unemployed<br>❑ Retired | ❑ Disability ** ❑ Permanent ❑ Temporary<br>Reason: |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Tobacco use** | ❑ Current<br>❑ Never<br>❑ Quit | Packs per day: | Age started:<br>Age stopped: | **Drug Use** | ❑ Current<br>❑ Never<br>❑ Quit | What type:<br>❑ Marijuana<br>❑ Cocaine<br>❑ Heroin<br>❑ Methamphetamine<br>❑ Other: | Age started:<br>Age stopped: |
| **Alcohol use** | ❑ Current<br>❑ Never<br>❑ Quit | How Much per day:<br>What type: | Age started:<br>Age stopped: | **Have you ever been treated for substance:** | | | |
| | | | | Dependency | ❑ Yes | ❑ No | When: |
| | | | | Abuse | ❑ Yes | ❑ No | |
| | | | | Addiction | ❑ Yes | ❑ No | |

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**Patient Name:**

**Review of Systems: Do you have any of the following problems?**

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| **General Symptoms:** | | | **Cardiac:** | | | **Respiratory:** | | |
| Fatigue | | | Heart Failure | | | Shortness of Breath | | |
| Weight Loss | | | Cardiovascular Disease | | | Frequent Cough | | |
| Fever, Chills | | | Chest Pain | | | Wheezing | | |
| Night Sweats | | | Palpitations | | | Lung Disease | | |
| Loss of Appetite | | | Pace Maker | | | Tuberculosis | | |
| Other | | | Heart Attack | | | Coughing Blood | | |
| | | | High Blood Pressure | | | Pneumonia | | |
| **Neurological/HEENT:** | | | (Hypertension) | | | Emphysema | | |
| Bowel/Bladder Dysfunction | | | Pace Maker | | | Asthma | | |
| Headaches | | | Other | | | Other | | |
| Blurry or Double Vision | | | | | | | | |
| Dizziness | | | **Musculoskeletal:** | | | **Gastrointestinal:** | | |
| Passing Out (Syncope) | | | Swelling Feet/Legs | | | Incontinence | | |
| Hearing Loss | | | Pain/Swelling Joints | | | Nausea or Vomiting | | |
| Weakness | | | Back Pain | | | Mouth Sores | | |
| Difficulty Speaking | | | Rheumatoid Arthritis | | | Abdominal Pain | | |
| or Walking | | | Osteoarthritis | | | Constipation | | |
| Problems Swallowing | | | Other | | | Diarrhea | | |
| Strokes | | | | | | Ulcers | | |
| Seizures | | | **Genitourinary** | | | Bloody Bowel Movements | | |
| Other | | | Incontinence | | | Liver Disease/Problems | | |
| | | | Prostate Disorder | | | Gall Bladder Disease | | |
| **Hematologic/Lymphatic:** | | | Blood in Urine | | | Other | | |
| Bruising | | | Difficulty or Pain | | | | | |
| Bleeding Problems | | | on Urination | | | **Endocrine:** | | |
| Low Blood Cant | | | Kidney Disease | | | Thyroid Disease/problems | | |
| Swollen Glands | | | Other | | | Diabetes | | |
| Lymph Nodes | | | | | | Other | | |
| (Lumps or Bumps) | | | **GYN:** | | | | | |
| Blood Clots | | | **Are you pregnant or** | | | **Skin/Integumentary:** | | |
| Other | | | **is there any chance that** | | | Rash | | |
| | | | **you could be pregnant?** | | | Ulcers | | |
| **Psychiatric:** | | | Vaginal Bleeding | | | Skin Disorders | | |
| Depression | | | Other | | | Other | | |
| Insomnia | | | | | | | | |
| Anxiety | | | | | | | | |
| Psychiatric Illness | | | | | | | | |

| **The preceding patient information has been reviewed and discussed with my patient.** | |
|---|---|
| Signature of patient or person completing the form | Physician's signature |


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# Consent for Use of Protected Health Information (PHI)

It is the policy of Commerce Pain Management Clinic. to take reasonable actions to protect the privacy of our patients. In order to protect privacy, the staff will not discuss protected health information nor acknowledge your patient status except as required by law with anyone other than the patient except as detailed in our Patient Agreement and Consent for Release unless otherwise noted below.

☐ _____ Initials

NO, I am requesting Commerce Pain Management **not** to acknowledge that I am a patient or to release any protected health information to anyone other than my referring and/or primary care physician and myself.

OR

☐ _____ Initials

YES, I am authorizing Commerce Pain Management to acknowledge my patient status and/or discuss my protected health information with the following family members and/or friends.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name: _____ DOB: _____

Patient/Guardian Signature: _____ Date: _____

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## Revocation of Personal Information Release

At this time I no longer wish for my PHI to be discussed with anyone other than myself. By this statement I wish to revoke the above authorization with any of the above named individuals.

Patient Signature:_____Date:_____


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# Doctor / Patient / Commerce Pain Management Agreement

This agreement is between_____ (Patient), Commerce Pain Management Clinic (the Center), and _____(Doctor) . We at Commerce Pain Management understand that your pain is a significant hindrance to the quality of life you desire. In order to help you achieve your goals, we may recommend different medicines, selective diagnostic and therapeutic procedures, physical and occupational therapy, therapeutic massage, and psychological counseling, as needed. **Narcotic Medication for pain may not be prescribed on first visit. This type of medication is solely given based on the medical findings and treatment plan of our doctor and not doctors you may have visited previously.** Although narcotics have a long history of safety, there are possible side effects. Therefore, we must weigh the risks versus benefits before prescribing these medications. If we decide to use these medicines, the following conditions must be met:

- I understand that a reduction in the intensity of my pain and an improvement in my quality of life are the goals of this program.
- If deemed necessary, we may require a consult from a pain psychologist.
- Additional Therapy may be recommended for which you are required to participate.
- I realize that all narcotic medications have potential side effects. In addition to analgesia, narcotics may produce dependency, addiction, respirator depression, drowsiness, and changes in mood, anxiety, and mental clouding. I will report any such side effects to the physician immediately. Narcotics may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. I agree that I will not attempt to perform any such activity until my ability to perform the activity has been evaluated.
- You must maintain the dosing schedule prescribed by the doctors from this clinic. You may not increase the dose on your own. You must come in and discuss any changes before they are made. If you take your medication in any way other than prescribed, it may not be refilled.
- If you receive narcotics from any other clinic, doctor, or hospital, you are required to notify this clinic by telephone within one working day prior to filling the prescriptions.
- You must have your narcotic prescriptions filled at only one pharmacy and must have the pharmacy name and number on file at this office. Narcotics cannot be called in for any reason. Narcotic prescriptions can only be given to the patient. You may not sell, share or trade your prescriptions.
- Narcotic Prescriptions may not be replaced if lost, stolen, flushed, burned, or any other reason-even with a police report.
- You may be required to undergo random urine drug screen testing and random pill counts. If so, you will be contacted by telephone. **It is your responsibility to provide a telephone number where you can be contacted during regular business hours 8-5 M-F. If you cannot answer your telephone personally, you are responsible for an answering machine or other method of receiving the telephoned message that day. If you fail to come in for a drug screen or pill count on the day you are called, you may not receive narcotic prescriptions from this clinic in the future.**
- You must submit a urine Drug Screen at every office visit. These will be sent off to an independent lab for confirmation.
- In the event of a need to discontinue taking these medications, I will consult with the Doctor and strictly follow her instructions for the safe tapering off my medication. Failure to do so may result in severe withdrawal effects and possible even death. I understand that even with the tapering process there may be some discomfort or withdrawal effects.
- You must not take any illegal drugs or medications prescribed to someone other than you. You must avoid drinking alcohol, if you are taking a narcotic medication for pain control. I understand I must contact my physician before taking sedatives, antihistamines, or benzodiazepines. Some examples include but are not limited to: Soma, Xanax, Ativan, and Benadryl.
- By signing this agreement you give this office permission to request information and share information about your narcotic prescription history with other pharmacies, medical offices or law enforcement agencies.
- I understand that all female patients should notify the physician if they are pregnant or possibly at risk to become pregnant. I understand that children born while the mother is on Opiate therapy would likely be physically dependent at birth.
- Should this office feel that I might be doing harm to another or myself, I agree to waive any applicable privilege or right to privacy or confidentiality with respect to the prescribing of my pain medication and/or mental state.
- If I am or ever have been on probation, or arrested for a narcotic-related offense, I understand I **must disclose** this information **immediately** .

This agreement is entered into on the _____ day of _____, _____
(Day) (Month) (Year)

My signature below acknowledges my understanding and agreement with the above stated terms.

| | |
|---|---|
| Patient Name | Patient Signature |
| Doctor Signature | Witness Signature |

# Policies and Disclosures

## Patient Privacy Practices

By signing this form I am stating I have received a copy of the "Patient Privacy Practices" from Commerce Pain Management, which describes how medical information about you may be used or disclosed and how you can obtain access to information.

## Patient Policy

1. **Payment Methods-** Payment is due at time of service. If you do not have your payment we will have to reschedule your appointment. We accept Cash, MasterCard, Visa. We will file a claim with your insurance company after your co-payment has been paid for all office visits and procedures. Although it is our policy to verify your benefits, please understand that you are responsible for any services not covered by your insurance. Some payment plans are available.
2. **Medical Records Request**: Medical records request may be submitted in writing and are subject to a fee. We must have a Medical Records consent signed by the patient from the Medical office the patient wants the records sent to.
3. **Missed Appointments or "No-show" Appointments**- We ask that you call if you cannot make your scheduled appointment. If you do not call at least 24 hours in advance the following fees will be assessed to your account, are not billable to insurance and are due before your next visit: $25.00 for missed appointment and $100.00 for a missed procedure. If you fail to no show for 2 appointments we reserve the right to refuse scheduling or rescheduling of any appointments for you to be seen again. A no show is defined as not showing for an appointment or canceling an appointment less than 24 hours before the scheduled time.
4. **Consent for treatment:** I hereby give consent to Commerce Pain Management and their respective staff and providers to perform medical procedures and testing, which are appropriate for my condition, symptoms, illness (es) or injury (ies).

Patient Name: _____Date of Birth:_____

Signature: _____Date:_____


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# Notice of Patient Privacy Practices

## THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO INFORMATION.

## PLEASE REVIEW IT CAREFULLY.

Commerce Pain Management is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

### USES AND DISCLOSURES OF HEALTH INFORMATION

Commerce Pain Management uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide. For example, Commerce Pain Management may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you. Commerce Pain Management may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, and for emergencies. We may provide de-identified information for research studies. We also provide information when required by law. In any other situation, Commerce Pain Management's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time. Commerce Pain Management may change its policy at any time. When changes are made, a new Notice of Patient Information Practices will be posted in a common area of our clinic. You may also request an updated copy at any time.

### PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reason other than treatment, payment, or other related administrative purposes. You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. Commerce Pain Management will consider all such requests on a case-by-case basis, but the company is not legally required to accept them.

### CONCERNS AND COMPLAINTS

If you are concerned that Commerce Pain Management may have violated your privacy rights, or if you disagree with any decisions that we have made regarding access or disclosure of your personal health information, please contact our HIPAA Compliance Office at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Commerce Pain Management health information practices, or if you have a complaint, please contact us below:

HIPAA Compliance Office
Commerce Pain Management
413 Pottery Factory Drive
Commerce, GA 30529
706-423-9449

## EVERY PATIENT MUST RECEIVE A COPY OF THIS FORM