**PATIENT REGISTRATION FORM**

|  |
| --- |
| **PATIENTS INFORMATION** |
| **Patient Name Last First Middle** | * Mr. □ Mrs. □ Sra.
* Miss. □ Ms □ Sra./Srta.
 | Marital Status (Circle)Single/ Married/ DivorcedSeparated/ Widow |
| Is this your legal name?* YES □ NO
 | If not, what is your legal name? | Birth/ / | Age Sex* M □ F □ T
 |
| Street or Mailing Address (circle one) City State Zip code | Home Phone Number( ) |
| Cell Phone Number( ) | E-Mail Address (To be used for appointment reminders) | Social Security- - |
| Occupation | Employer | Employer Phone Number |
| **Employment Status: □**1 –Full Time □2 –Part Time □3 – Not Employed □4 – Self Employed □5 – Retired □6 – Active Military**Student Status:** □F – Full-Time Student □P –Part-Time Student □N – Not a Student |
| **Race:** □American Indian/Alaska Native □Asian □Native Hawaiian/Pacific Islander □Black/African American□White □Hispanic □Other □Declined**Ethnicity:** □Hispanic or Latino □Not Hispanic or Latino □Declined**Language:** □English □Spanish □Indian □Japanese □Chinese □Korean □French □German □Russian□Other \_\_\_\_\_\_\_\_ |
| **Pharmacy:** | Do you have a living will? □ YES □ NO |
| Referred By (Please check one box)* Dr.\_\_\_\_\_\_\_\_\_\_\_ □ Insurance □ Hospital □ Family □ Friend □ Yellow Pages □ Other \_\_\_\_\_\_\_\_­
 |
| Other Family Members Seen Here |
| PCP Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  **RESPONSIBILE PARTY INFORMATION (information used for patient balance) statements)** |
| Responsible Party: □Another Patient □Guarantor □Self □Check here if information is same as patient |
| Name | Address | Home Phone Number( ) |
| Birth Date / / | E-Mail Address |
| Occupation | Employer | Employer Address | Employer Phone Number( ) |
| **INSURANCE INFORMATION (provide your insurance card to the front desk) check in)** |
| Is this visit for one of the following? □ WORKERS COMPENSATION (WC)* OCCUPATIONAL MEDICINE (OM) □MOTOR VEHICLE ACCIDENT(MVA) □ ACCIDENT DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| Does the patient have healthcare coverage? □YES □ NO | **Primary Insurance Name** |
| Name of Insured | Social Security Number- - | Birth Date./ / | Effective Date/ / | Group ID | Subsciber ID (Policy Number) |
| Patient Relationship to Insured □ Self □ Spouse □ Child □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Name of Secondary Insurance** | Name of Insured  | Birth Date/ / | Group ID | Subsciber ID (Policy Number) |
| Patient Relationship to Insured □ Self □ Spouse □ Child □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **EMERGENCY CONTACT** |
| Name (Last,First) | Relationship to Patient | Home Phone Number( ) | Other Phone Number( )  |
|  |  |  |  |

**Today’s Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I consent to receive text message and/or email messages from the practice to any cell number and/or email provided which may include appointment reminders, bills, payment receipts, or marketing materials. I understand that a patient’s care is directed by his/her physicians(s) and I consent to any services that are appropriate for my care and as ordered by my physicians.

**Eastern Utah Spine and Pain**

**FINANCIAL POLICY**

Thank you for choosing us as your health care provider. The following is our Financial Policy. Our main concern is you receive the proper and optimal treatment needed to restore and maintain your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our staff.

1. Your insurance will be filed as a courtesy to you; however, you are responsible for the entire bill. **All co-payments, unmet deductibles and other patient responsible services must be paid at the time of the visit.** If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. **If you do not have insurance, payment in full will be expected at the time of the visit.**
2. In the event your insurance company does not pay the claim within a reasonable amount of time (45 – 60 days) then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we will place your account with an outside collection agency.
3. If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.
4. Returned checks will be subject to a returned check fee. A fee may be charged for missed appointments.
5. **PATIENT’S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUESTS:** I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I request that payment of assignment benefits be made on my behalf.
6. **FINANCIAL AGREEMENT:** The undersigned in consideration of the services to be rendered to the patient is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney’s fees, court costs and collection agency fees and/or commissions, which might be as much as 50% of the principal balance due. The undersigned hereby assigns to the medical practice all insurance benefits for services provided. The undersigned agrees to be responsible for charges not covered by insurance. It is understood the obligation to pay the practice may not be deferred for any reason, including pending legal actions against other parties to recover medical costs.
7. **CONSENT FOR ROUTINE TREATMENT** I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s) at Eastern Utah Spine and Pain. I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body.  This may include having blood drawn or tissues removed during tests, treatment, or surgery.   Further, I understand that should any hospital or emergency medical personnel, physician, or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis Band C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination at Eastern Utah Spine and Pain.  I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me.
8. **ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION AT DISCHARGE:** I authorize Hospital to provide a copy of the medical record of my treatment, the discharge summary, and a summary of care record to my primary care physician(s), specialty care physician(s), and/or any health care provider(s) or facility(ies) identified on my discharge paperwork to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this admission, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.
9. **ADVANCE DIRECTIVE:** □ I have executed an Advance Directive  □ I have not executed an Advance Directive

I have read and fully understand the Financial Policy and have been given the opportunity to ask questions.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient, legal representative for health care services Date

If other than patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship of Representative Reason individual is unable to sign, i.e. minor or legally incompetent

**Eastern Utah Spine and Pain**

**No-Show/Returned Check Policy**

The following is our No-Show/Returned Check Policy. Our main concern is you receive the proper and optimal treatment needed to restore and maintain your health. We are implementing this policy as a result of a demand for appointments in our busy schedule. Your no-show appointment could have been given to another patient who is waiting. Therefore, if you have any questions or concerns about our policies, please do not hesitate to ask our staff.

1. As the patient, **YOU will be responsible to pay for all no-show fees** before scheduling your next appointment. Your insurance will not be billed for this fee.
2. We require at least **24 hours’ notice** for rescheduled appointments. Notice after 24 hours’ will result in a fee.
3. If you arrive to your appointment **10 or more minutes past your appointment time**, it will be marked as a no-show and will result in a fee.
4. There will be a **$75 fee for all no-show office visits.**
5. There will be a **$100 fee for all no-show procedures.**
6. There will be a **$25 returned check fee.**

I have read and fully understand the No-Show/Returned Check Policy and have been given the opportunity to ask questions.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient, legal representative for health care services Date

If other than patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship of Representative Reason individual is unable to sign, i.e. minor or legally incompetent



New Patient Form

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for visit today\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you want to have happen as a result of this visit?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How and when did your problem begin?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is today’s visit due to a job related injury? Yes/No If yes, please provide the following: Date of Injury:\_\_\_\_\_\_\_\_\_\_\_\_\_

Workers Compensation company name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Case worker \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact number for case worker :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Case number\_\_\_\_\_\_\_\_\_\_

Do you have pending litigation: Yes/No

Pain score today 0-10 (0=no pain 10=worst pain imaginable)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Average daily pain 0-10\_\_\_\_\_\_\_\_\_\_\_

**Please describe your symptoms:** (Please circle all that apply) Sharp Burning Aching Stabbing Dull

Pins & Needles Throbbing Numbness Tingling Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Treatments? (Please circle all that apply to REASON for visit)**

Tylenol Ibuprofen Naproxen Ice Heat Pain Medicine Muscle relaxants

Physical Therapy Chiropractic treatment Massage Yoga Surgery

Epidural injections or nerve blocks Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Workup?**

Xray CT MRI EMG Recent labs Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, to any of the above workup; which facility was it done at?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications: (Please include all medications)

|  |  |  |  |
| --- | --- | --- | --- |
| Medicine | Strength | Frequency | Last time takenDate and time |
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**Medical History: (Please circle all that apply)** Diabetes Bleeding disorder Pacemaker

Sleep apnea Depression Anxiety Fibromyalgia Bipolar Disorder ADD/ADHD Rheumatoid arthritis

Others\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any known drug allergies?** Yes / No If yes, to what medication and what kind of a reaction did you have?\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WOMEN**: Last menstrual cycle?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgical History: Hospitalizations:**

|  |  |  |  |
| --- | --- | --- | --- |
| Date Mo/Year | Surgery | Date Mo/Year | Reason |
|  |  |  |  |
|  |  |  |  |
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Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History: (Please mark all that apply)**

 Alive/ Deceased Diabetes High Blood Pressure Heart disease Osteoporosis Other

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Father |  |  |  |  |  |  |
| Mother |  |  |  |  |  |  |
| Brother #1 |  |  |  |  |  |  |
| Brother #2 |  |  |  |  |  |  |
| Brother #3 |  |  |  |  |  |  |
| Sister #1 |  |  |  |  |  |  |
| Sister #2 |  |  |  |  |  |  |
| Sister #3 |  |  |  |  |  |  |
| Maternal Grandmother |  |  |  |  |  |  |
| Maternal Grandfather |  |  |  |  |  |  |
| Paternal Grandmother |  |  |  |  |  |  |
| Paternal Grandfather |  |  |  |  |  |  |
| Adopted |  |  |  |  |  |  |

**Social History:** Single Married Divorced Widowed

Number of children: Son(s)?\_\_\_\_\_\_\_ Daughter(s)?\_\_\_\_\_\_

**Tobacco Use:** Non user

Current Tobacco user: Chewing Tobacco Cigarette

How soon after you wake up do you use tobacco? \_\_\_\_\_\_\_\_\_ How many times daily do you use tobacco?\_\_\_\_\_\_\_\_\_\_

Are you interested in quitting? Yes / No

Former User: When did you quit?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Alcohol Use:** Non User

Current User: 1 monthly or less 2-4 times a month 2-3 times a week 4 or more a week

Type(s)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many drinks per sitting?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Former User: How long has it been since your last drink? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Illegal drugs?** Yes / No If yes, what and how long has it been?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous personal or family history of sexual, emotional, physical or substance abuse? Yes / No

If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please mark on the diagram where you have your symptoms

**Have you recently experienced any of the following? (Please circle all that apply)**

Gen: Chills Fever Unexpected weight loss/gain more than 10 lbs. Night sweats

Eyes: Blurry Vision Dryness

ENT: Dry Mouth Hearing Loss Throat Soreness

Resp: Cough Pain with breathing Shortness of breath

CV: Chest pain Heart beat irregular

GI: Constipation Diarrhea Nausea/vomiting Stool Incontinence

GU: Incontinence Kidney problems Painful urination

MSK: Arthritis Joint Pain Muscle ache

Skin: Lesion(s) Rash Skin changes

Neuro: Headache Numbness/Tingling Sleeping difficulties

Psych: Anxiety /worry Depression Mood swings

Endo: Fatigue Thyroid problems

Heme: Anemia Bruising easily Slow to heal

Allergic/Immunologic: Frequent infections Seasonal allergies

SOAPP® Version 1.0

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.***

Please answer the questions below using the following scale:

**0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often**

1. How often do you feel that your pain is “out of control”? 0 1 2 3 4

2. How often do you have mood swings? 0 1 2 3 4

3. How often do you do things that you later regret? 0 1 2 3 4

4. How often has your family been supportive and encouraging? 0 1 2 3 4

5. How often have others told you that you have a bad temper? 0 1 2 3 4

6. Compared with other people, how often have you been in a car accident? 0 1 2 3 4

7. How often do you smoke a cigarette within an hour after you wake up? 0 1 2 3 4

8. How often have you felt a need for higher doses of medication to treat your pain? 0 1 2 3 4

9. How often do you take more medication than you are supposed to? 0 1 2 3 4

10. How often have any of your family members, including parents

 and grandparents, had a problem with alcohol or drugs? 0 1 2 3 4

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**0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often**

11. How often have any of your close friends had a problem with alcohol or drugs? 0 1 2 3 4

12. How often have others suggested that you have a drug or alcohol problem? 0 1 2 3 4

13. How often have you attended an AA or NA meeting? 0 1 2 3 4

14. How often have you had a problem getting along with the doctors who

 prescribed your medicines? 0 1 2 3 4

15. How often have you taken medication other than the way that it was prescribed? 0 1 2 3 4

16. How often have you been seen by a psychiatrist or a mental health counselor? 0 1 2 3 4

17. How often have you been treated for an alcohol or drug problem? 0 1 2 3 4

18. How often have your medications been lost or stolen? 0 1 2 3 4

19. How often have others expressed concern over your use of medication? 0 1 2 3 4

20. How often have you felt a craving for medication? 0 1 2 3 4

21. How often has more than one doctor prescribed pain medication for you 0 1 2 3 4

 at the same time?

22. How often have you been asked to give a urine screen for substance abuse? 0 1 2 3 4

23. How often have you used illegal drugs (for example, marijuana, cocaine, etc.)

 in the past five years? 0 1 2 3 4

24. How often, in your lifetime, have you had legal problems or been arrested? 0 1 2 3 4

*Please include any additional information you wish about the above answers. Thank you.*

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**Eastern Utah Spine and Pain**

**RELEASE OF INFORMATION**

**AUTHORIZATION / REQUISITION FORM**

|  |
| --- |
| Section A**:** *This section is to be completed by the patient.* |
| Patient Name: |  | Date of Birth: |
| Address:  |  | Phone#: |
| City: | State: | Zip: |  |
| Name of Disclosing Hospital/Provider | Facility Name:Address:City/State/Zip:Phone #:Fax: |  |
|  |
|  |
|  |
|  |
| **Name of Recipient** | Requestor Name:Address:City/State/Zip:Phone:Fax: | Russell Beecher, D.O. |
| 230 North Hospital Dr. # 2 |
| Price, Utah 84501 |
| 435-613-7246 |
| 435-613-7247 |
| Date(s) of Service: |  |
| List specific description of information to be released: | * Anesthesia
* Billing Records
* UB92
* Itemized Bills
* Consultation
 | * Discharge Summary
* EKG’s
* Emergency Records
* Face Sheet
* History & Physical
 | * Imaging Reports
* Laboratory
* Medication Records
* Nursing Records
* Sgy/Proc Report
 | * Physician Orders
* Outpatient Records

Pathology Report* Progress Notes
* Acctg of Disclosure
 | * All Records
* Other \_\_\_\_\_\_\_\_\_
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| Do you want the office to release your psychotherapy notes (if any) to the person or facility you have listed above? (Circle One) YES NO |
| Describe the purpose/reason for this request: |
| **Section B:** *Must be completed by the patient for all authorizations*  |
| **The patient or the patient’s representative must read/acknowledge the following statements:** |
| 1. I understand that the persons hereby authorized to use/disclose information will not condition treatment or payment on my providing this authorization.
 |
| 1. I understand that this authorization is for a one-time use.
 |
| 1. I understand that information used or disclosed to any entity other than a health plan or health care provider may be subject to redisclosure by the recipient and no longer protected by the Standards for Privacy of Individually Identifiable Health Information, as set forth in 45 C.F.R. 160 and 164.
 |
| 1. I understand that I may revoke this authorization at any time by notifying the office in writing, except to the extent the office has already taken action in reliance on the previous authorization.
 |
| 1. I understand that I may see the information described on this form if I ask to see it and I understand that I will receive a copy of this form after I sign it.
 |
| 1. I understand that if my records contain sensitive information that I may need to have my physician authorize the use or disclosure of it.
 |
| 1. I understand that I may refuse to sign this authorization and in doing so, understand refusal to sign this authorization will not affect my treatment
 |
| *I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information may not be a health plan or health care provider covered by federal privacy regulation; therefore, the released information may no longer be protected by federal privacy regulations* |
| (Signature of Patient or Patient’s representative)  | (Date) (Time) |
| (If patient representative, please print name below and provide proof/documentation the representative has which provides the authority to act for the patient. |

|  |
| --- |
| FOR OFFICE USE ONLY: |
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