Revival

PAIN MANAGEMENT

1925 N. Bridge St. Suite 101 Elkin NC 28621-2105
1909 W Park Dr North Wilkesboro NC 28659-3564
905 Rockford St LWR LVL Mount Airy NC 27030-5323
336.835.5330(p) 336.835.5337(f)

Welcome New Patient:

Welcome to Revival Pain Management. Thank you for taking the time to get to know us. We have been serving Northwest NC and Southwest Virginia for seventeen years as a comprehensive pain program in the tri-state area. We have offices in Elkin, NC, North Wilkesboro, NC and Mount Airy, NC. Our Board Certified providers have over 55 years combined experience with medical and interventional management of pain disorders to help meet a variety of pain care needs.

At Revival Pain Management, we recognize that any form of chronic pain can make life challenging, even in the day to day tasks. This pain can originate from injuries, surgeries, disease and other life events. Our physicians and staff will work personally with you to offer a personalized treatment plan to help you with your pain concerns from diagnosis and evaluation to completion of your treatment process.

At Revival Pain Management we perform fluoroscopic guided interventional pain management procedures. Our office operates with a full service CLIA certified High Complexity laboratory on site that performs Urine Drug Screening, Hematology and Chemistry Studies. We have a physician Board Certified in Addiction Medicine by the American Society of Addiction Medicine. The Pain Management clinic is certified to use Buprenorphine in office detox. We believe in offering top quality facilities, procedures and techniques to create a care plan that will help you live to each day to the fullest.

Please complete forms front and back

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ADMISSION ASSESSMENT/HISTORY & PHYSICAL

(Please use black or blue ink; do not use pencil)

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

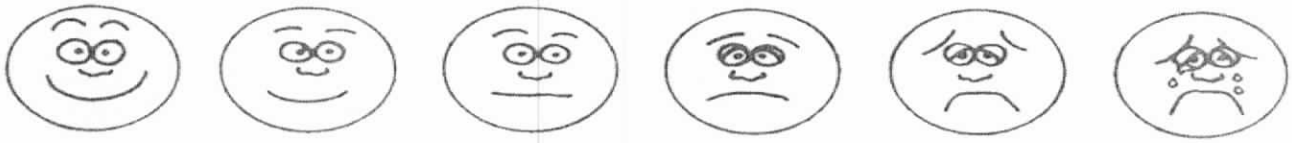
What is your preferred language for discussing your healthcare? English ☐ Spanish ☐ Other ☐ _____

Do you have an Advanced Directive? (A plan for someone to make medical decisions for you if you are not able) ___Yes ___No
If "No", would you like information on Advanced Directives? __Yes __No
Referring Physician _____ Phone ( ) _____

Primary Care Physician _____ Phone ( ) _____

Where is the primary site of your pain? _____

1. How long have you had this pain? Years _____ Months _____
2. Is your pain due to an injury? Yes _____ No _____ If yes, please explain _____
3. Does your pain radiate into any other parts of your body? Yes _____ No _____
   If yes, where does your pain radiate? _____
4. Is your pain? Infrequent _____, Intermittent _____, Constant _____, Increased with activity _____
5. What is your pain level at this time? No pain(0) Mild pain(1-3) Moderate Pain(4-7) Severe Pain(8-10)



0 No Hurt | 2 Hurts Little Bit | 4 Hurts Little More | 6 Hurts Even More | 8 Hurts Whole Lot | 10 Hurts Worst

6. Check Yes or No to the following:
   a. Change in bowel control? Yes_____ No _____
   b. Change in bladder control? Yes_____ No _____
   c. Any color change or temperature change at your pain site? Yes _____ No _____
   d. Do you experience weakness? Yes_____ No_____
   e. Do you experience tingling? Yes _____ No_____ or burning pain Yes_____ No_____
   f. Do you experience swelling? Yes _____ No_____
   g. Does the pain interrupt sleep? Yes _____ No_____
   h. What makes your pain worse? (Any activity, prolonged standing, prolonged walking, bending, etc.)
      other: _____
   i. What makes your pain better? (lying down, sitting, rest, heat, medication, etc.)
      other: _____
   j. What pain medication have you had in the past?
      _____
   k. Have you ever had Nerve Blocks for this pain? Yes _____ No _____
      If yes, for what body part? _____

l. Have you ever had Tens/Nerve Stimulator for this pain? Yes _____ No _____

If yes, for what body part? _____

m. Have you ever had Physical Therapy for this pain? Yes _____ No _____

If yes, for what body part? _____

n. Have you ever had chiropractic treatment? Yes _____ No _____
If yes, who was the chiropractor? _____
If yes, for what body part? _____

o. Do you use a cane, wheelchair, crutches, or a brace? No_____ If Yes, describe _____

p. Have you been evaluated by a surgeon? Yes _____ No _____

If yes, who was the surgeon? _____

If yes, is surgery an option? _____ What body part? _____

6. Do you have a history of falls? No_____ Yes_____ If yes, did it cause injury:_____

Past Medical History: Have you had any of the following?

Check	No	Yes	Check	No	Yes	Check	No	Yes	Check	No	Yes
Heart Disease			Rheumatic Fever			Depression			Kidney Stone		
Enlarged Heart			Rheumatoid Arthritis			Lupus			Stroke		
Heart Murmur			Arthritis			Anesthesia sensitivity			Epilepsy		
Hypertension			Emphysema			Lung Disease			Convulsion		
Phlebitis			Pneumonia			Gall Bladder					
Blood Clot			Tuberculosis			Stomach Ulcer					
Cancer			Pleurisy			Hepatitis					
Back Disorder			Thyroid			Liver Disease					
Diabetes			Anxiety			Kidney Infection					

List Past Surgery:

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

List Medication Allergies and Reactions

1. _____ Reaction:_____
2. _____ Reaction: _____
3. _____ Reaction: _____
4. _____ Reaction: _____

Have you had the following:
Mammogram within last 2 years? Yes: ____ No: ___
Colonoscopy within the last 9 years? Yes: ___ No:___
Dexa Scan? Yes: ___ No: ___

Do you have a family history (Mother, Father, Brother, Sister, Aunt, or Uncle) of the following:

Heart Disease ____ High Blood Pressure _____ Diabetes _____ Stroke _____ Cancer _____ Thyroid _____

Anesthesia Problems/Sensivity _____

Please check each question that applies to you: Do you exercise regularly _____ Smoke: (if yes how much?)_____

Use Alcohol: (if yes how much?) _____ Use Illegal drugs _____

Have you ever had to visit the Emergency Room for overdose or pain ( ) Yes ( ) No Have you ever been admitted to the hospital for overdose or pain? ( ) Yes ( ) No Did that admission require a stay in the ICU? ( ) Yes ( ) No

Do you have a history of participation in an alcohol or substance abuse treatment program? ( ) Yes ( ) No If yes, please list the facility name, alcohol or substance used, length of treatment)

Do you have a history of abuse or neglect? No ( ) Yes ( ) If 'yes' then please explain:

Review of Systems: Do you have now or have had in the past month?

Condition	No	Yes	Present Now?	In the past year?
Fever				
Weight Loss				
Vision Problems				
Hearing Problems				
Chest Pain				
Arm Pain				
Jaw Pain				
Irregular Heart Beat				
Stomach Pain				
Heartburn				
Diarrhea				
Constipation				
Rectal Bleeding				
Black Tarry Stools				
Urinary Frequency				
Urinary Burning				
Blood in urine				
Swollen/painful joints				
Yellow skin				
Skin Lesions/Ulcers				
Neck Swelling				
Shortness of Breath				
Coughing up blood				
Blackouts				
Anxiety				
Depression				
Bleeding Problems				

List your current medications:

Name	Strength	Dose	Name	Strength	Dose

COMM QUESTIONAIRE					
Patient Name:	**Date:**				
DOB: _____	Never	Seldom	Sometimes	Often	Very Often
Please answer the questions using the following scale:	**0**	**1**	**2**	**3**	**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? (i.e., doing things that need to 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? (i.e., another doctor, the 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 (e.g., road rage, screaming, etc.)?					
9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?					
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 medication from someone else?					
16. In the past 30 days, how often have you used your pain medicine for symptoms other than for pain (e.g., 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?					
SUM:					

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ DATE: _____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL: _____

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

SOAPP-R QUESTIONAIRE

NAME:_____ DOB:_____ DATE:_____

Please answer the following 24 questions listed below and evaluate them (0 up to 4) on the scale listed:

0= I never have this feeling **1**= I seldom have this feeling **2**=Sometimes I have this feeling
3=Often I have this feeling **4**= Very often I have this feeling

1. How often do you have mood swings? _____
2. How often have you felt a need for higher doses of medication to treat your pain? _____
3. How often have you felt impatient with your doctors? _____
4. How often have you felt that things are just too overwhelming that you cant handle them? _____
5. How often is there tension in the home? _____
6. How often have you counted pain pills to see how many are remaining? _____
7. How often have you been concerned that people will judge you for taking pain medication? _____
8. How often do you feel bored? _____
9. How often have you taken more pain medication than you were supposed to? _____
10. How often have you felt worried about being left alone? _____
11. How often have you felt a craving for medication? _____
12. How often have others expressed concern over your use of medication? _____
13. How often have any of your close friends had a problem with alcohol or drugs? _____
14. How often have others told you that you had a bad temper? _____
15. How often have you felt consumed by the need to get pain medication? _____
16. How often have you run out of pain medication early? _____
17. How often have others kept you from getting what you deserve? _____
18. How often, in your lifetime, have you had legal problems or been arrested? _____
19. How often have you attended an AA or NA meeting? _____
20. How often have you been in an argument that was so out of control that someone got hurt? _____
21. How often have you been sexually abused? _____
22. How often have others suggested that you have a drug or alcohol problem? _____
23. How often have you had to borrow pain medications from your family or friends? _____
24. How often have you been treated for an alcohol or drug problem? _____

PLEASE ADD UP YOUR SCORE: _____

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PATIENT DEMOGRAPHIC INFORMATION

PATIENT NAME: _____ _____ _____ _____
LAST FIRST MIDDLE MAIDEN

SEX: __M __ F BIRTHDATE __/__/__ SOCIAL SECURITY#____-____-_____ MARITAL STATUS: __S__M__D__W

ADDRESS:_____CITY_____STATE_____ZIP_____

TELEPHONE: HOME_____WORK_____CELL_____

EMAIL ADDRESS: _____EMPLOYER NAME: _____

EMERGENCY CONTACT NAME: _____ PHONE: _____

PHARMACY NAME: _____ LOCATION: _____

REFERRING PHYSICIAN: _____ PRIMARY CARE PHYSICIAN: _____

PRIMARY INSURANCE CO: _____ ID# _____

POLICY HOLDER NAME: _____ POLICY HOLDER SOCIAL: ____-____-_____

SECONDARY INSURANCE CO: _____ ID# _____

POLICY HOLDER NAME: _____ POLICY HOLDER SOCIAL: ____-____-_____

I recognize and agree that I am responsible for all payment obligations arising out of my treatment or care and guarantee payment for these services. I am responsible for deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by my insurance carrier. I agree that I am responsible to know my insurance policy and will be held responsible for any charges if any of the following apply: (i) insurance requires referral by PCP or authorization that I did not obtain; (ii) insurance limits the quantity of certain services and I exceed that quantity; (iii) insurance carrier is not in network with Revival Pain Management; (iv) insurance coverage lapsed or expired prior to services; (v) failure to provide Revival Pain Management the correct insurance information. If you are not familiar with your insurance plan coverage, we recommend you contact your insurance directly.

I authorize Revival Pain Management to verify my insurance benefits and submit my claims to my insurance carrier for any services rendered and request direct payment of authorized benefits be made to Revival Pain Management. I authorize Revival Pain Management to release patient information and medical records related to treatment as deemed necessary to process my claims.

I understand that failure to pay my co-pay, co-insurance or outstanding balance could result in my appointment being re-scheduled. It is my responsibility to be prepared to pay my copay, co-insurance and/or outstanding balance as required for services to be rendered. By signing this form, I agree to all the terms and conditions contained herein.

_____ _____ _____
Patient/Responsible Party Signature Date Witness

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of June 10, 2002, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information, by asking to speak to our Privacy Officer or for written inquiries, note "Attention Privacy Officer".

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

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Patients Legal Name _____

Date of Birth_____ Sex ( ) F ( ) M Race:_____ SS#_____

Marital Status ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated

I hereby acknowledge receipt of the NOTICE OF PRIVACY PRACTICES and PATIENTS/PARENTS/GUARDIANS RESPONSIBILTY given to me by Revival Pain Management.

I give permission to Revival Pain Management to file any claims on my behalf to my insurance company for billing purposes. I also give permission to Revival Pain Management to send any medical records requested by my insurance company to process these claims.

I understand that I am responsible for any charges in full at time of visit if I do not have insurance. I am responsible to pay the copay or deductibles at the time of my visit. I further understand that I am responsible for any charges that are NOT a covered service with my insurance plan. I understand that an insurance card presented to Revival Pain Management is not a guarantee of payment.

I give Revival Pain Management permission to send information to my referring physician and referred physician if deemed necessary by my physician.

I give the names listed below permission to discuss my treatment, pick up prescriptions and pick up forms.
_____

_____

I understand that I may revoke this authorization at any time by presenting a request for revocation in writing to Health Information Department of Revival Pain Management; however, a revocation will not reverse any action already taken in reliance upon this Authorization.
I also understand that the information disclosed pursuant to the authorization may include information concerning patient's mental health, use or treatment concerning drugs and/or alcohol, HIV/AIDS and/or other communicable diseases and/or genetic testing results.

I give Revival Pain Management permission to retrieve my medication history through Sure Scripts E-Prescription Network.

I understand that I have the right to request restrictions concerning the use of any information. Below are those restrictions:
_____

Patient or Guardian Signature_____Date_____

CULTURAL AND SPIRITUAL BELIEFS
The right to exercise any cultural and spiritual beliefs that are not violations of the law. The care of a patient shall include the psychosocial, spiritual and cultural values that influence the perceptions of illness.

FORMULATE ADVANCED DIRECTIVES
The right under State law to formulate advanced directives. Information regarding advanced directives will be given at the time of admission or registration.

FREE FROM VERBAL OR PHYSICAL ABUSE OR HARASSMENT
The right to be free from abuse. While the patient is under the hospital's care and on its property, the hospital is responsible for ensuring the patient's health and safety and his or her physical, emotional, and psychological well being.

FREE FROM SECLUSION AND RESTRAINT
The right to be free from seclusion, physical restraints, and drugs that are used as a restraint that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff.

NOTIFICATION OF ADMISSION
The right to have a family member or representative of his/her choice and his/her personal physician notified promptly of admission to the hospital.

PAIN MANAGEMENT
The right to have pain relieved or controlled.

VISITATION
The right to be informed of their visitation rights, including any clinical restrictions or limitations on visitation. The patient or support person, where appropriate, may consent or deny to receive visitors whom he or she designates, including, but not limited to, a spouse, domestic partner (including same-sex domestic partner), another family member, or a friend, and may withdraw or deny consent at any time. Visitation will not be restricted, limited, or denied based on race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.

Patient Responsibilities

1. To provide, to the best of their knowledge, accurate and complete information about present conditions, past illnesses, hospitalizations, medications and other matters relating to their health.
2. To report to the practitioner responsible for their care, any unexpected changes in their condition.
3. To report whether they clearly comprehend a contemplated course of action and what is expected of them.
4. To inform their physicians of any existing advance directives and for providing a copy of any and all current such documents as near to the time of admission as possible.
5. To follow the treatment plan recommended by the practitioner primarily responsible for their care.
6. To keep appointments and, if they are unable to do so for any reason, notify the responsible practitioner (or the hospital).
7. To assure that the financial obligations of their health care are fulfilled as promptly as possible.
8. To follow hospital rules and regulations in place to support quality patient care and a safe environment.
9. To support mutual consideration and respect by maintaining civil language and conduct in interactions with staff and licensed independent practitioners.
10. To be respectful of the property of other persons and of the hospital.
11. Patients are responsible to:
    - ask their doctor or nurse what to expect regarding pain and pain management,
    - discuss pain relief options with their doctors and nurses,
    - work with their doctor and nurse to develop a pain management plan,
    - ask for pain relief when pain first begins,
    - help their doctor and nurse assess their pain,
    - tell their doctor or nurse if their pain is not relieved, and
    - tell their doctor or nurse about any worries they have about taking pain medication.

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PATIENT RIGHTS ACKNOWLEDGEMENT OF RECEIPT

I, _____, acknowledge that I have received a copy of Revival Pain Management Patient Rights.

Patient Signature: _____Date:_____