PATIENT INFORMATION SHEET

PATIENT NAME: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____

HOME PHONE: _____ CELL (IF DIFFERENT): _____

DOB: _____ SS#_____ MARITAL STATUS_____

EMPLOYER: _____ PHONE: _____

REFERRED BY: _____ PHONE: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

IS THIS WORKMAN'S COMP? _____ YES _____ NO

MOTOR VEHICLE ACCIDENT? _____ YES _____ NO

ACCIDENT RELATED/LITIGATION PENDING? _____ YES _____ NO

ATTORNEY: _____ PHONE: _____

ADJUSTOR: _____ PHONE: _____

ADDRESS: _____ STATE: _____ ZIP: _____

CLAIM NUMBER: _____ DATE OF ACCIDENT: _____

PRIMARY INSURANCE

NAME OF INSURANCE: _____ PHONE: _____

POLICY NUMBER: _____ GROUP: _____

SUBSCRIBER NAME: _____ DOB: _____ SSN: _____

SECONDARY INSURANCE

NAME OF INSURANCE: _____ PHONE: _____

POLICY NUMBER: _____ GROUP: _____

SUBSCRIBER NAME: _____ DOB: _____ SSN: _____

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME: _____ PHONE:_____

DID YOU RECEIVE A COPY OF OUR HIPPA POLICY? _____ YES _____ NO DATE:_____

THE ABOVE INFORMATION HAS BEEN REVIEWED AND IS CORRECT:

_____ _____

SIGNATURE OF INSURED/GUARDIAN DATE

RECEIPT OF NOTICES OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT

DR. THOMAS HART
INTERVENTIONAL SPINE SPECIALIST

I have received a copy of the Privacy Practices Policy.

_____ _____
Patient/Guardian Signature Date

REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION AND CONTACT INFORMATION

Please list the following phone numbers (+area code), so that we may have a way to contact you:

Home Phone: _____
Work Phone: _____
Cell Phone: _____

_____ NO RESTRICTIONS ON THE WAY I AM CONTACTED
_____ YES, THERE ARE RESTRICTIONS ON THE WAY I AM CONTACTED AND TO WHOM YOU COMMUNICATE INFORMATION WITH:

_____
_____
_____
_____

Please note: This clinic is not required to agree to your request, though we do try to accommodate all reasonable restrictions.

Pain Consultants of Arkansas, P.A.

GENERAL RELEASE OF INFORMATION FORM
Authorization for Release of Information

Release of Information Agreement:

This document shall permit the clinic representative, physicians, and other licensed providers participating in my care, at their discretion to disclose all or part of my medical record to any person or corporation which is, or may be liable for all or part of the clinic's charge, including: insurance companies, worker's compensation carriers, welfare funds, Social Security Administration (or its intermediaries or carries), as well as to any corporation engaged by the clinic to make collection of any unpaid clinic charges. They may also disclose medical information to third parties to assist in collection of any unpaid balance due on this account. My employer may obtain information only when actually liable for the clinic charges incurred during this visit. I also understand and agree that, unless I request to the contrary in writing, the clinic may release certain information about me without my specific consent including: my name, age, verification of clinical treatment, visit date, address at time of visit, and name of attending physician. Should I wish to void this agreement after treatment, I understand that my request must be submitted in writing to be honored by the clinic as of the date of receipt. This agreement shall be valid from one year from date of treatment.

Referring Physician/Patient Care:

I authorize any employee, physician, or representative of this clinic, at their discretion to release any of my medical information to any referring physicians or any other physician that is participating in my care at the time. I also authorize any employee, physician, or representative of this clinic, at their discretion, to obtain any of my medical information from any referring physician or any other physician that has participated in my care at any time.

Patient or other Authorized Party: _____

Date: _____

Print Name: _____

Relationship to Patient: _____

Witness: _____

CONSENT FOR TREATMENT AND CARE

DR. THOMAS M. HART
INTERVENTIONAL SPINE SPECIALIST

CONSENT

I, the undersigned, do hereby agree and give my consent for Pain Consultants of Arkansas, P.A. to furnish medical care and treatment considered necessary and proper in diagnosing or treating my physical and medical condition.

_____ _____
Patient/Guardian Signature Date

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare and private insurance, and any other health plans. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

_____ _____
Patient/Guardian Signature Date

FINANCIAL POLICY STATEMENT

It is our policy to bill your insurance as a courtesy to you, although you are responsible for the entire bill when the services are rendered. We require that payment of your estimated share be made today. If additional services are rendered in the future, your payment plan will be adjusted to include payment for those services. If your insurance carrier does not remit payment within sixty (60) days, the balance will be due in full from you. If any payment is subsequently made by your insurance carrier in excess of the balance of your account we will promptly refund the credit. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit it to Pain Consultants of Arkansas, P.A. The above does not apply for those patients that are considered Worker's Compensation. **However, be advised as a "Compensation Patient," that you may be held responsible for your charges in the event your claim is controverted.**

I understand and agree that if I fail to make any payments for which I am responsible for in a timely manner (after such default and upon referral to a collection agency or attorney by Pain Consultants of Arkansas, P.A.), I will be responsible for all costs of collecting monies owed, including court costs and collection agency fees. Furthermore, Pain Consultants of Arkansas, P.A. may refuse further treatment and dismiss me as a patient.

Cancellations and rescheduled appointments after 12 (Noon) the day before your appointment will be subject to a $25.00 fee payable before you next scheduled visit. "No Show" cancellations are subject to a $25.00 fee payable before your next scheduled visit.

The above information has been read and explained to me.

I UNDERSTAND MY RESPONSIBILITY FOR THE FULL PAYMENT OF MY ACCOUNT

_____ _____
Patient/Guardian Signature Date

_____ _____
Clinic Representative Signature Date

PATIENT QUESTIONAIRE

1. Briefly describe your current pain complaint, and main reason for today's visit:

_____

_____

2. When and how did your pain begin? Was it work or non-work related, illness, vehicle accident?

_____

_____

3. Are you presently involved in, or considering, litigation (or a lawsuit) resulting from this accident?

_____ YES _____ NO Attorney Name: _____

4. Has your pain changed from when it began? If so, how: increased, decreased, stayed the same?

_____

5. Describe your pain (i.e. burning, sharp, shooting, throbbing, aching):

_____

6. What makes your pain better? _____

7. What makes your pain worse/at what time is it worse? _____

8. What do you do when you hurt badly? _____

9. How does your pain affect your activities of daily living, sleep, and/or exercise?

_____

10. What are you expecting from your treatment here?

_____

11. Do you work? _____ YES _____ NO Occupation: _____

How long since you've last worked? _____

12. Are you rated as disabled? _____ YES _____ NO

Applying for Disability? _____ YES _____ NO

Throughout your treatment here, we will ask you to evaluate your pain on a scale of 0 -10, whereas zero (0) = no pain, and ten (10) = pain so severe that you think about suicide.

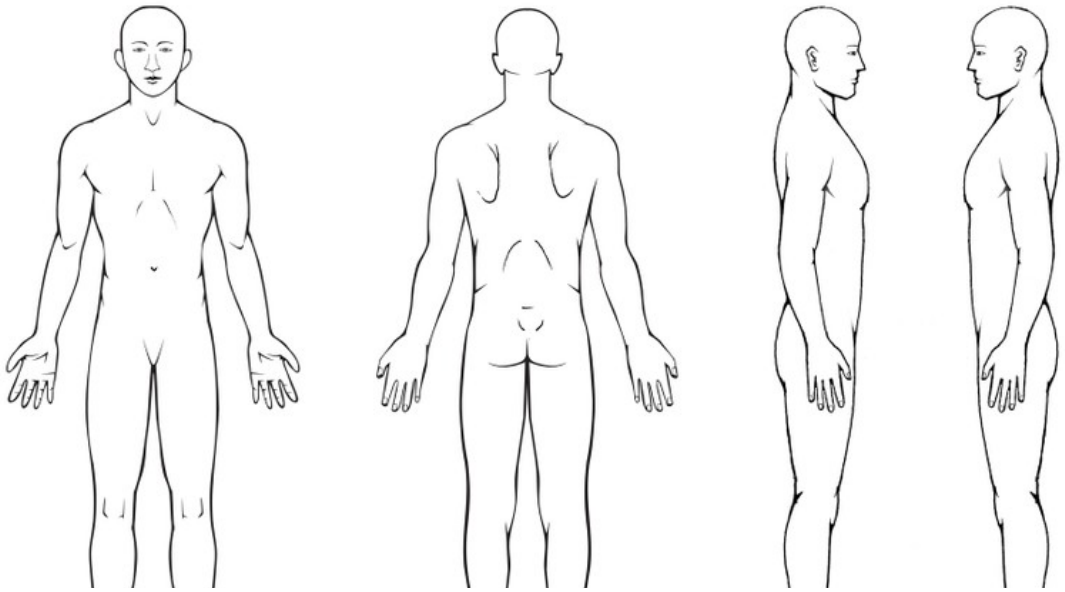
CIRCLE A NUMBER FROM 0 TO 10 THAT <u>CURRENTLY</u> DESCRIBES YOUR PAIN:

No Pain — Distressing Pain — Unbearable Pain

0 1 2 3 4 5 6 7 8 9 10

Continued…

Please indicate on the diagram where your pain occurs by shading the painful area(s)



13. Have you had any of the following? If yes, please list where and the date.

_____ MRI Scan _____ _____ X -Rays _____
_____ CAT Scan _____ _____ Myleogram _____
_____ Bone Scan _____ _____ Other _____

14. Please check any of the following treatments and procedures that you have had:

Treatment	Date	Pain Relief?
_____ Epidural Steroid Injection	_____	_____ YES _____ NO
_____ Nerve Blocks	_____	_____ YES _____ NO
_____ Discogram	_____	_____ YES _____ NO
_____ TENS Unit	_____	_____ YES _____ NO
_____ Chiropractor	_____	_____ YES _____ NO
_____ Physical Therapy	_____	_____ YES _____ NO
_____ Acupuncture	_____	_____ YES _____ NO
_____ Psychiatrist/Psychologist	_____	_____ YES _____ NO
_____ Biofeedback	_____	_____ YES _____ NO
_____ Hypnosis	_____	_____ YES _____ NO
_____ Pain Clinics	_____	_____ YES _____ NO
_____ Other Treatments	_____	_____ YES _____ NO

15. Do you feel you are dependent on medication to control your pain? _____ YES _____ NO
16. Do you ever take your medication other than as prescribed? _____ YES _____ NO
17. Please list any previous surgeries and dates:

Surgery	Date
_____	_____
_____	_____
_____	_____

18. List any medication allergies:

Medications	Effect
_____	_____
_____	_____
_____	_____
_____	_____

19. Have you had problems with anesthesia? _____ YES _____ NO

20. List all medication that you are currently taking. Include prescription, over the counter, or any recreation drugs (i.e. marijuana).

Medication	Dose	How often?	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

21. Please describe briefly your use of the following (indicate frequency/years/amount):

Liquor _____ Coffee _____

Chewing Tobacco _____ Cigarettes _____

22. Are you: _____ Married _____ Single _____ Divorced _____ Widowed

23. Circle any of the following that **increases** your pain:

Alcohol	Heat	Cold	Damp	Weather	Massage	Sleep
Rest	Lying Down	Sitting	Standing	Walking	Sneezing	Coughing
Stress	Driving	Sexual Intercourse				

24. Circle any of the following that **decreases** your pain:

Alcohol	Heat	Cold	Massage	Standing	Sitting	Walking
Rest	Lying Down					

Continued…

SYSTEMS REVIEW

Please check if any of the following pertain to you.

General
- Recent chills and/or fever
- Recent night sweats
- Weight gain
- Weight Loss
- Weakness

Skin
- Sores
- Rash
- Skin Cancer
- Warts or moles removed
- Any change in glands

Respiratory
- Shortness of breath
- Smothering at night
- Chronic cough
- Pleurisy (pain on breathing)
- Coughing up blood
- Asthma
- Chronic bronchitis
- Tuberculosis

Cardiovascular (Heart)
- Heart attack
- Angina
- Chest Pain
- Rapid heartbeats
- Slow heartbeats
- Pacemaker
- Mitral valve prolapse
- Pain in legs when walking
- Painfully cold hands
- Blood clots
- High blood pressure
- High cholesterol

Blood diseases/disorders
- Bleeding Problems
- Anemia
- Hepatitis

Endocrine
- Thyroid problems
- Hyperthyroid
- Hypothyroid
- Diabetes
- Insulin dependent
- Non-insulin dependent

Genitourinary
- Get up at night to urinate
- Bladder infection
- Kidney infection
- Difficult urination
- Blood in urine
- Kidney stones
- Inability to retain urine

Muscular Skeletal
- Bursitis, tendonitis
- Arthritis, rheumatism
- Gout
- Sciatica
- Neck pain
- Back pain
- Leg pain on exertion
- Leg pain at night
- Total join replacement

HEENT
- Headaches
- Dizziness
- Wear glasses/contacts
- Glaucoma
- Cataracts
- Hearing problems
- Wear hearing aid
- Ear infections
- Nose bleeds
- Sinusitis
- Hoarseness
- Mouth ulcers
- Pain when chewing
- Wear dentures

Gastrointestinal
- Poor appetite
- Painful swallowing
- Difficult swallowing
- Food intolerances
- Indigestion/heartburn
- Change of bowel habits
- Inability to retain stool
- Gas/bloating
- Abdominal pain
- Bleeding hemorrhoids
- Blood in stool
- Black stool
- Nausea or vomiting
- Constipation
- Diarrhea
- Hiatus hernia
- Liver problems
- Jaundice

Neurological
- Sensory or motor deficits
- Mental illness
- Memory problems
- Fainting or blackouts
- Depression
- Anxiety
- Parkinson's Disease
- Stroke
- TIA's (mini strokes)
- Paralysis
- Seizures
- Tremors
- Difficulty walking
- Frequent falls

Comments:

_____

_____

_____

_____

_____

_____