Dear Patient:

Welcome to Tulsa Integrated Pain Services. We look forward to seeing you and working with you to evaluate and treat your pain. Enclosed you will find a Patient Registration form, a Patient History packet, and a Release for Medical Information. **Please leave the top section of the Release form blank** so that we can duplicate it. We use this form to obtain a copy of your medical records prior to your appointment time.

We realize that this is a lot of material to go through, but a complete history of your problem is essential in evaluating your future treatment. If you cannot mail this information back to our office before your appointment, please bring these forms with you. Please arrive **at least 30 minutes early** so that we have sufficient time to process your paperwork and prepare your chart. You do not want to spend your appointment time doing this. We want to give your doctor enough time to perform your evaluation. In order to allow appropriate time and avoid inconveniencing our other patients, we have the following standard policies:

1) If you are more than 10 minutes late for your appointment, you will need to be rescheduled for another day so that the schedule can continue uninterrupted.
2) If you are late for your appointment on three occasions, you may be dismissed from our practice.
3) If you fail to show for an appointment without calling or cancel within 48 hours prior to appointment, you will be charged a **$50.00 fee** to reschedule another appointment.
4) If you fail to show for an appointment on two occasions without having called us to cancel at least 48 hours in advance, you may be dismissed from our practice.

Procedures are not usually performed on the first visit. However, if you are scheduled for a procedure on your first visit, please arrive at least one hour early and note these special instructions:

- **Eat no solid food for at least 6 hours prior to your appointment**
- **You may have clear liquids up to 4 hours prior to your appointment**
- **Take your usual medication with a sip of water (no blood thinners)**
- **If you take insulin or have special needs, please call the office for instructions.**
- **Bring a driver with you. (This person must remain on the premises during your procedure)**
- **If you are taking any of the following medication, please contact one of our nurses at (918)477-5950: Insulin, Glucophage, or any blood thinners (i.e. Coumadin and/or aspirin).**

Please understand that if you are scheduled for a service at a location other than our office, you will incur separate charges from both the physician and the facility.

Your appointment is scheduled at:

_____ Office, 2448 E. 81st Street (81st and Lewis) Use Valet Instructions
_____ Satellite Office, 6565 S. Yale Avenue, Kelly Bldg. Suite 803
_____ Oklahoma Surgical Hospital, 2408 East 81st Street (81st and Lewis)**use free valet parking**
_____ Tulsa Spine Hospital, 6901 S. Olympia Avenue (71st and Hwy 75)
_____ St. Francis South, 10501 E 91st St. (91st and Hwy 169)
_____ St. Francis Natalie, 6475 S. Yale, (65th and Yale)

TULSA INTEGRATED PAIN SERVICES 2448 E. 81st Street, Suite 363 Tulsa, OK 74137 (918) 477-5950

PATIENT INFORMATION

Last	First	Middle	-- --
Full Legal Name			Soc. Sec. #

( )	( )	/ /	M / F
Home Phone	Cell	Date of Birth	Gender

Address	City	State	Zip

Marital Status	Spouse Name	Referring Physician	Physician City/State

	( )	
Employer Name and Address	Work Phone #	Ext.

	( )	
Emergency Contact Name	Telephone #	Relationship

	( )		( )
Work Comp Carrier	Phone #	Atty's Name	Phone #

RESPONSIBLE PARTY (If different from patient)

	/ /	-- --
Responsible Party Name	Date of Birth	Social Security Number

Relationship to Patient	Address	City	State	Zip

	( )	( )
Responsible Party Employer	Business Phone #	Other Phone #

INSURANCE INFORMATION

Insurance Name				
Primary Insurance Carrier	Claims Address	City	State	Zip

		-- --
Policy ID #	Group #	Policy Holder Social Security #

Name of Policyholder	Employer	DOB

Insurance Name				
Secondary Insurance Carrier	Claims Address	City	State	Zip

		-- --
Policy ID #	Group #	Policy Holder Social Security #

		/ /
Name of Policyholder	Employer	DOB

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have the above stated insurance coverage and assign directly to Tulsa Integrated Pain Services all insurance benefits payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Tulsa Integrated Pain Services to release any information necessary to secure payment of benefits on all insurance submissions. Further, I authorize the release of my medical records from the office to either myself or any and all medical personnel necessary for my continued medical care. In providing this consent, I am fully aware that the physicians of Tulsa Integrated Pain Services, the staff, and employees cannot be responsible for the confidentiality of the information disclosed after the medical records have been released. Therefore, the physicians of Tulsa Integrated Pain Services, the staff, and employees are released from any liability arising from such disclosure.

X	/ /
Patient Signature	**Date**

PATIENT INFORMATION FORM

Welcome to Tulsa Integrated Pain Services. Please take a few moments to fill out this questionnaire. We realize that this form is long and detailed, but this information is essential to us when we try to manage your pain. Thank you!

Name:_____ Date of birth: _____

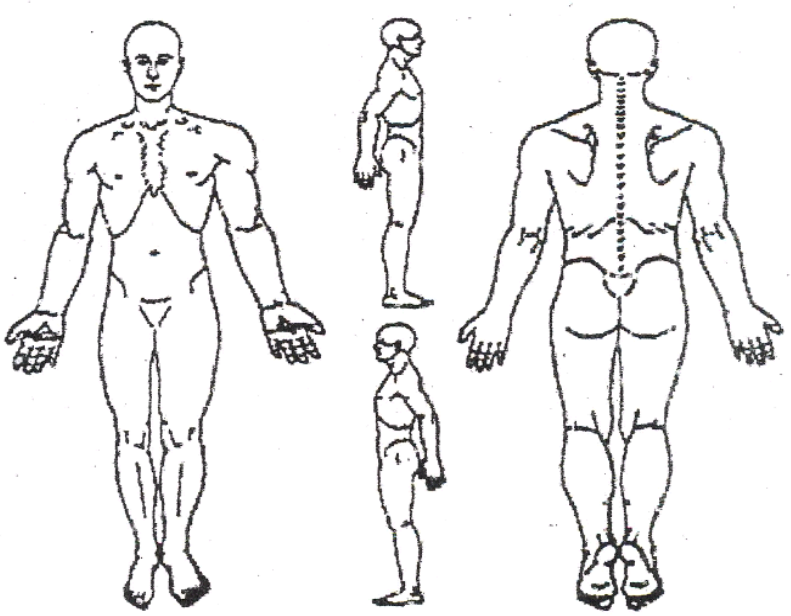
Age: _____ Sex: _____ Weight: _____ Height: _____ R/L Handed: _____

Referring Physician:_____ Primary Care Physician:_____

Please briefly describe your main problem: _____

_____

xxx - pain ooo = numbness



How did your pain start?

_____

Is your pain __ constant? or __ comes and goes?

Which words best describe your pain? (Circle as many as apply)

Throbbing	Shooting	Cramping	Burning	Coldness
Dull	Stabbing	Tingling	Crushing	Electricity
Aching	Hotness	Sharp	Other_____	

Present level of pain intensity (circle one)

---

0 1 2 3 4 5 6 7 8 9 10

No pain Mild Moderate Severe Excruciating

Patient Name: _____

What brings on the pain or makes it worse? (Circle as many as apply)

Sitting Standing Walking Twisting Lifting

Sneezing Coughing Bending forward Bending backwards

Using arms Other _____

What eases or eliminates the pain? (Circle as many as apply)

Lying down Standing Exercise Arthritis Medicine

Pain pills Muscle relaxants Nothing Other _____

Do you have any loss of control of your bowels or bladder? ____Yes ____No

Do you have pain that shoots down your arms or legs? ____Yes ____No

Do you have any increasing weakness in your arms or legs? ____Yes ____No

---

Please circle all the following <u>medical problems</u> that you have had: (Circle as many as apply)

Heart problems	Heart attack	High blood pressure	Stroke	Blood Clots
Diabetes	Asthma	Kidney problems	Liver problems	Thyroid problems
Lung problems	COPD	Depression	Headaches	Glaucoma
Seizures	Ulcers	Hepatitis	Cancer_____	

Other_____

Please list all <u>past surgeries</u> that you have had:

Year:_____/_____ Year:_____/_____

Year:_____/_____ Year:_____/_____

Year:_____/_____ Year:_____/_____

Year:_____/_____ Year:_____/_____

Please list all <u>current pain medications</u> and other medications:

Pain medication / Dose and frequency	Other medication / Dose and frequency
_____/_____	_____/_____
_____/_____	_____/_____
_____/_____	_____/_____
_____/_____	_____/_____

Do you take any of the following medications: Coumadin Aspirin Plavix Lovenox Heparin

Please list any allergies to medications: _____

Please list any pain medications that you have tried in the past: _____

_____

Patient Name:_____

Please indicate which <u>tests</u> you have had to evaluate your present pain (with date):

MRI _____ CT Scan _____ Myelogram _____

Bone Scan _____ Discogram _____ EMG _____ Other _____

Please list any injections that you have received for your pain (with date):_____

_____

Please list any other treatments that you have received for pain (TENS, chiropractic, Physical therapy, biofeedback, etc.): _____

_____

Work History:

What is/was your occupation?

Full time ____ Part time ____ Unemployed ____ Homemaker ____

Retired ___ On disability ___ Other _____

When did you last work? _____

If your pain is work related, what was the date of your injury? _____

Do you currently have an attorney in regards to your pain condition? ___

If yes, please provide name and phone number: _____

Social History:

What is your marital status?

Single _____ Married _____ Separated _____ Divorced ____

Do you have any children?_____ How many? _____

Who lives in your home with you? _____

Do you smoke? _____How many packs per day? _____

Do you drink alcohol?_____ If yes, how much per week? _____

Do you have a history of alcohol, drug, or prescription medication abuse? Yes___ No___

Sleep and Mood:

How many hours of sleep do you get at night? _____

Have you ever been diagnosed with depression, psychosis, schizophrenia, or bipolar disorder? Which one? _____

Are you seeing a psychiatrist or a psychologist? _____ If yes, for what? _____

Do you have any thoughts of hurting yourself or others? Yes ____ No ____

Do you have <u>family history</u> of any of these problems? (Circle as many as apply)

Alcoholism Depression Substance abuse Mental illness

Cancer Heart problems Stroke Other _____

Please provide any further information that you feel will help us in managing your pain.

_____

_____

Patient Name:_____

Are you pregnant? Yes ___ No _____

Please circle if any of the following applies to you:

General: Fever, fatigue, weight loss/gain, poor appetite, sexual problems, insomnia

Neurological: Headaches, seizures, paralysis, confusion, irritability, disorientation

Eye, Ear, Nose, Throat: Blurry vision, trouble swallowing, loss of hearing, voice changes

Respiratory: Emphysema, bronchitis, asthma, tuberculosis, shortness of breath

Cardiovascular: Chest pain, abnormal heart beats, heart failure, heart murmurs

Gastrointestinal: Nausea, vomiting, hepatitis, pancreatitis, blood in stool, constipation

GU: Blood in urine, recurrent urinary infections, kidney stones, trouble urinating

Musculoskeletal: rheumatoid arthritis, lupus erythematosus

Skin: Rash, open sores, recurrent infections, tumors, skin cancer

Endocrine: Diabetes, thyroid problems, adrenal dysfunction, pituitary problems

Hematological: Easy bruising, leukemia, lymphoma, anemia, easy bleeding

Other: _____

Thank you for taking the time to complete this questionnaire. The information that you have provided us will be beneficial in managing your pain, and as always, all the information given wil' be held in the strictest of confidence.

Notes:

AUTHORIZATION AND CONSENT FOR RELEASE OF MEDICAL RECORDS

PLEASE FAX RECORDS TO (918) 477-5951

If you are unable to do this due to the size of a chart, please call our office or send a note by fax to inform us of the status of the request.

RECORD HOLDER:_____

FAX #:_____

APPOINTMENT SET FOR:_____

Being competent, eighteen (18) years of age or older and duly authorized; do willfully and voluntarily authorize the release of all medical records and medical information to:

Tulsa Integrated Pain Services
2448 E. 81st Street, Suite 363
Tulsa, OK 74137
(918) 477-5950

Who at this time requests the following information:

_____All dictated reports

_____All anesthesia reports

_____All radiology reports

_____All therapy records

_____Other_____

I further understand and acknowledge that the information authorized for release may include information which may be considered a communicable or venereal disease which may or may not include, but are not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea, and Human Immunodeficiency Virus (HIV), also known as Acquired Immune Deficiency Syndrome (AIDS).

_____
Full Name of Patient (please print)

_____ _____
Social Security Number Date of Birth

_____ _____
Authorized Signature Today's Date

No Show Policy

Patient Name (print): _____

Date of Birth: _____

Dear Patient,

Tulsa Integrated Pain Services is an extremely busy office due to the high demand of our schedule. We ask that you please give at least 48 hours notice if you will not be able to make your appointment. If 48 hours notice is not given, it will be considered a **NO SHOW** appointment.

Due to the number of patients we see every day and the amount of people on our waiting list, we will not tolerate **NO SHOW** appointments. When you **NO SHOW** an appointment, your next appointment will not be scheduled until a **$50** fee has been paid and then will be scheduled at the first available time slot and will **NOT** be worked in. If you are getting prescriptions, you will be required to pay this fee before the prescription will be filled. This document is to inform you that if you **NO SHOW** appointments, you are taking a risk of not being able to schedule future appointments with this office. By signing below, you are agreeing to these terms.

X _____ _____

Sign here Date

Thank you,

Tulsa Integrated Pain Services

Patient Release of Information/HIPAA Authorization Form

I, _____give permission to Tulsa Integrated Pain Services to disclose the following protected health information;

__ any information related to my medical care from this office

or specify below:

_____

_____

_____

_____

To: (list who may receive your protected medical information)

_____

_____

_____

_____

This protected health information is being used or disclosed for the following purposes:

_____

_____

This authorization expires one year from the date of this form or unless specified below:

_____

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, please know that the information given out is no longer protected by government regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment it will only affect who we can share your information with.

Finally, you may revoke this authorization in writing at any time by sending written notification to Tulsa Integrated Pain Services at 2448 E. 81st street #363 Tulsa, OK 74137. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

_____

Signature of Patient

_____

Date