IMPERIAL PAIN SPECIALIST

Johnson City **Patient Demographics** **Kingsport**

Date: _____ Sex: M F DOB: _____ Social: _____

Name: _____Address: _____City: _____ Zip: _____

You **MUST** provide two phone numbers where you can be reached or where we can leave a message.

1._____ Home Cell Other: _____ Can we leave information Y N

2._____ Home Cell Other: _____ Can we leave information Y N

Marital Status: Married Single Divorced Separated Widowed Domestic Partnership Civil Union

Emergency Contact: _____ Phone _____

May this person receive information concerning your private health Information? Y N

Please List anyone who may receive information concerning your private health information.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

INSURANCE: PRIMARY _____ SECONDARY _____

Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I have certain right s to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:
Conduct, plan, and direct my treatment and follow up among the multiple healthcare providers who may be involved in the treatment directly and indirectly. Obtain payment from third party payers. Conduct normal healthcare operations such as quality assessments and physician's certifications.
I received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name or Legal Guardian: _____

Signature: _____ Date: _____

Release of Information

Authorization to release information: I acknowledge that any information acquired during my treatment may be released. In accordance to the HIPPA Consent Form signed

_____ _____

Patients Signature or Legal Guardian Date

PATIENT PAYMENT RESPONSIBILITY FORM

I _____, agree to the payment terms set forth by Imperial Pain Specialist for the provision of medical services by its providers. I further agree that I am responsible for any fees and charges related to the medical care provided to me that are deemed necessary by the physician. I additionally agree that I will be responsible for payment in full at the time services are rendered. I further agree that, should I be sent to collection for failure to pay for services rendered, I will be responsible for all reasonable fees and costs associated with collections, including reasonable attorney fees and court costs, and agree to pay interest on any charges sent to collection at the rate permissible by law.

Signature_____ Date:_____

Patient Name: _____ **DOB:** _____

INITIAL EVALUATION HISTORY

When was your LAST visit to your Primary Care Physician: _____

Name of your Primary Care Physician:_____

Name of any specialists you see (i.e. Cardiologist, GI etc..)_____

_____

Where is the location of your pain: _____

What is the date your pain began: _____ What Caused your pain: _____

How would you describe your pain? Constant Intermittent Gnawing Tingling Numb Sharp Miserable Dull
Stabbing Shooting Burning Aching Throbbing Horrible Uncomfortable
Unbearable Excruciating

Pain is made worse by: Laying Down Sitting Standing Exercise Other: _____
Pain is made better by: Laying Down Sitting Standing Exercise Other: _____
My Sleep is: Good Fair Poor
Are you currently in Physical Therapy? Yes No If yes where? _____
Do you use a TENS UNIT or Stimulator? Yes No

Functional Assessment:
Today are you able to:

Standing Upright	No Difficulty	Some Difficulty	Much Difficulty	No Difficulty
Walk Normally	No Difficulty	Some Difficulty	Much Difficulty	No Difficulty
Sit Comfortably	No Difficulty	Some Difficulty	Much Difficulty	No Difficulty
Bending Over	No Difficulty	Some Difficulty	Much Difficulty	No Difficulty
Concentrating	No Difficulty	Some Difficulty	Much Difficulty	No Difficulty
Bathing Grooming Yourself	No Difficulty	Some Difficulty	Much Difficulty	No Difficulty
Shopping	No Difficulty	Some Difficulty	Much Difficulty	No Difficulty
Housekeeping/Chores	No Difficulty	Some Difficulty	Much Difficulty	No Difficulty
Driving/ Getting out of a car	No Difficulty	Some Difficulty	Much Difficulty	No Difficulty
Lifting a cup/glass to mouth	No Difficulty	Some Difficulty	Much Difficulty	No Difficulty
Opening a jar	No Difficulty	Some Difficulty	Much Difficulty	No Difficulty

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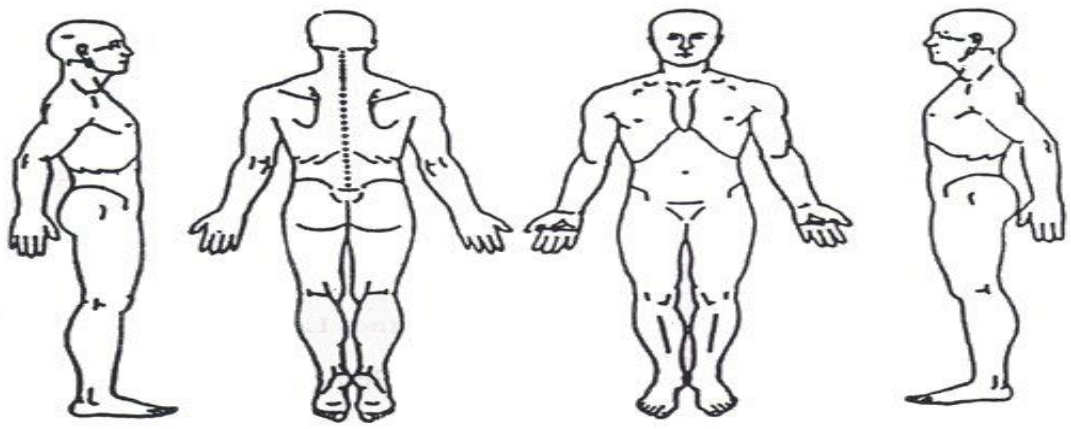
How Intense is your pain: 1 2 3 4 5 6 7 8 9 10
No Pain Horrible Pain



Using the diagram above, mark all the areas of pain completely. Indicate more intense pain with XXXX and radiating pain with ///// .

Patient Name: _____ DOB: _____

Which if any of the following has affected your pain and How?

Sleep?	Yes	No	_____	Weight?	Yes	No	_____
Mood?	Yes	No	_____	Daily Activities?	Yes	No	_____
Relationships?	Yes	No	_____	Work?	Yes	No	_____

What Diagnostic Testing have you had for your pain?

X-rays_____ CT Scan _____ Ultra sound _____ Bone Scan _____

Arteriogrm_____ MRI Scan _____ EMG/NCS _____ Myelogram _____

Please list all surgeries that you have had and the year of the surgery

_____ _____

_____ _____

_____ _____

Which, if any of the following pain treatments have you had? Did it Help? Yes or No
Please Circle any of the following pain treatments you have tried in the past

Bed Rest	Yes	No	Tens Unit	Yes	No	Exercise Program	Yes	No
Traction	Yes	No	Biofeedback	Yes	No	Physical Therapy	Yes	No
Heat Therapy	Yes	No	Acupuncture	Yes	No	Work Hardening	Yes	No
Ultrasound	Yes	No	Chiropractor	Yes	No	Psychotherapy	Yes	No

Medical History

Please circle any history of the following illness

Asthma Sleep Apnea CPAP BIAP COPD Oxygen Diabetes Diabetic Neuropathy

HIV/AIDS Hepatitis High Blood Pressure High Cholesterol Osteoporosis Shingles Hyperthyroidism

Overactive thyroid Kidney Disease Dialysis Stroke Heart Disease Pulmonary Embolism-Blood Clot in Lungs

Deep Venous Thrombosis- Blood Clot in arms/legs Seizure/Epilepsy

Cancer Location: _____Other: _____

Patient Name: _____ DOB: _____

Psychiatric/Mental Health History (circle all that apply)

Depression Bipolar Disorder Post-Traumatic Stress Disorder Schizophrenia Anxiety ADD Attention Deficit Disorder

Suicide Attempt(s) _____ Psychiatric Hospitalizations: _____

Have you EVER been treated by a Psychiatrist/ Mental Health Provider: Yes No

Name: _____ Location: _____ Phone: _____

Which, if any of the following pain procedures have you had? When? Did it help?

Procedure	Year	Did it Help
Joint Injections	_____	Yes No
Trigger Point Injections	_____	Yes No
Nerve Block Injections	_____	Yes No
Spinal Cord Injections	_____	Yes No
Internal Narcotic Pump	_____	Yes No
Surgery	_____	Yes No

Patient Name _____ DOB _____

Family Medical History

Please circle any history of the following illness

Stroke Reflux Seizures Ulcer Migraine Diverticulitis Emphysema Diabetes Liver Disease
Heart Disease Gout High Blood Pressure Osteoporosis Kidney Disease Cancer Arthritis Asthma
Congestive Heart Failure

Social History

Do you Smoke? Yes No

Current Every Day Smoker Former Smoker Never Smoked Heavy Tobacco Smoker Light Tobacco Smoker

When was your last use of tobacco? _____Current Smoker How many packs per day? _____

Do you drink Alcohol? Yes No If yes, how many drinks per day? _____ How long have you been drinking Alcohol? _____

Have you ever been hospitalized for alcohol abuse, or do you currently have or ever had a problem with Alcohol Abuse?_____

Have you ever been or are you currently in a treatment program for alcohol abuse? _____

Have you used in any of the following drugs within the past 12 Months? Circle all that apply

Heroin Cocaine Ecstasy Methamphetamines Another person's medication

I have NEVER used illicit drugs or taken prescription drugs illegally Other: _____

Have you EVER had a drug overdose, whether intentional or unintentional? Yes No
If Yes, please provide details: _____

Have you EVER been in or are you CURRENTLY in a drug treatment program? Yes No
If Yes, please provide details: _____

Have you taken Suboxone (buprenorphine) for drug addiction in the PAST 12 MONTHS? Yes No
If Yes, please provide details: _____

Patient Name: _____ DOB: _____

OCCUPATION

What type of work do you do? _____Hours per week_____

Employment Type: Employed Disabled Employed Full Time Employed Part Time Self Employed

Retired Homemaker Short Term Disability Long Term Disability Workers Comp

Are there any illegal issues concerning your pain problem? Yes No

Have you retained an attorney? Yes No Attorneys Name: _____

Patient Name_____ **DOB**_____

Review of Symptoms:

Do you now have or experience any of the following, or have you been diagnosed with any of the illness listed? Please Circle.

General Fatigue Fever Weight Loss Weight Gain
Gastrointestinal Blood in Stool Heart Burn Nausea Changes in Bowel Movements Loss of Appetite Vomiting
Endocrine Excessive Urination Heat Tolerance Excessive Thirst Cold Intolerance Gland or Hormone Problems
Skin Itching Skin Color or Changes Rash
Hematologic Anemia Bruising Tendencies Slow Healing Past Blood Transfusions Bleeding Tendencies
Heenet Headache Double Vision Earache /Drainage Mouth Sores Swollen neck or glands Bleeding Gums Blurred Vision Pain in Eyes Hearing Loss Sinus Problems
Psychiatric Depression Nervousness Suicidal Thoughts Poor Sleep
Cardiovascular Chest Pain Swelling of Feet Irregular Heart Beat Swelling of the Hand
Respiratory Chronic Cough Shortness of Breath Coughing up Blood
Musculosketal Muscle Pain Neck Pain Joint Pain Difficulty Walking Morning Stiffness Muscle Cramps Back Pain Joint Stiffness Joint Swelling
Neurological Frequent Headaches Numbness Tremors Trouble with Memory Tingling

Ibuprofen Y N	Baclofen Y N	Methadone Y N	Zomig Y N
Naproxen Y N	Skeizain Y N	Paxil Y N	Lyrica Y N
Relafen Y N	Flexeril Y N	Celexa Y N	Trazodone Y N
Arthnotec Y N	Soma Y N	Zoloft Y N	Elavil Y N
Vioxx Y N	Zanaflex Y N	Prozac Y N	Reneron Y N
Valium Y N	Klonopin Y N	Effexor Y N	Ambien Y N
Ultram Y N	Percocet Y N	Restoril Y N	Wellbutrin Y N
Tylenol 3 Y N	Oxycontin Y N	Midrin Y N	Neurotin Y N
Darvacet Y N	Ms Contin Y N	Fiorinal Y N	Depakote Y N
Hydrocodone Y N	Kadian Y N	Amerge Y N	Dilantin Y N
Duragesic Y N	Imitrex Y N	Lomictil Y N	Demerol Y N
Dilaudid Y N	Maxalt Y N	Topamax Y N	Mepregan Y N
Tegretol Y N	Stadol Y N		

Which if any of the following Medications have you taken? Did it help?

List all current Medications including Herbs, Vitamins and Supplements you are currently taking:

Patient Name: _____ DOB_____

List all Allergies including Medications and reactions:

Allergies	Reaction

Are you allergic to Latex? Yes No Reaction: _____

Are you allergic to Metals? Yes No Reaction: _____

Wellness History

Please circle Yes or No or marked as indicated to answer each of the following questions:

Insurance Provider: _____

1. **Do you depend on controlled (opioid type) medications to manage a pain condition? Yes No**
2. **Have you ever experienced pain for which you sought help but could not find the cause? Yes No**
3. **Are you currently taking any of the following medications? (if any are circled who is the prescribing Physician)**

Prozac Zoloft Ambien Lithium Xanax Citalopram Paxil Cialis Viagra

Prescribing Physician _____

4. **Please circle any of the following conditions that you have been prescribed medications for in the last 12 months.**

Depression Anxiety Panic Disorder Obsessive Compulsive Disorder Post-Traumatic Stress Disorder

Bipolar Sleep Disorder Eating Disorder Erectile Dysfunction

5. **Please Indicate an pain medications that you have been taking daily for more than 3 months.**

Fentanyl Hydrocodone Norco Oxycodone Morphine Avinza

Vicodin Dilaudid Hydromorphone Oxycontin Duragesic

Other

6. **Have you been treated for tension or stress related headaches? Yes No**
7. **Have you taken any prescription drugs not prescribed to you? Yes No**
8. **Are you experiencing physical abuse? Yes No**
9. **Are you experiencing emotional abuse? Yes No**
10. **Have you used any of the following in the past year?**

Marijuana Hallucinogens Mushrooms Cocaine Meth/Crack

I have answer these questions honestly.

_____

Patient Signature Date

1. 0. I do not feel sad.
   1. I feel sad.
   2. I am sad all the time and I cannot snap out of it.
   3. I am so sad and unhappy that I cannot stand myself

2. 0. I am not particularly discouraged about the future.
   1. I feel discouraged about the future.
   2. I feel I have nothing to look forward to.
   3. I feel the future is hopeless and things can not improve.

3. 0. I do not feel like a failure
   1. I feel like I have failed more than the average person.
   2. As I look back on my life, I can see is a lot of failures.
   3. I feel I am a complete failure as a person.

4. 0. I get as much satisfaction out of things as I used to.
   1. I don't enjoy things the way I used to.
   2. I don't get real satisfaction out of anything anymore.
   3. I am dissatisfied or bored with everyone.

5. 0 I don't feel particularly guilty.
   1. I feel guilty a good part of the time.
   2. I feel quite guilty most of the time.
   3. I feel guilty all of the time.

6. 0. I don't feel I am being punished.
   1. I feel I may be punished.
   2. I expect to be punished.
   3. I feel I am being punished.

7. 0. I don't feel disappointed in myself.
   1. I am disappointed in myself.
   2. I am disgusted with myself.
   3. I hate myself.

8. 0. I don't feel I am any worse than anybody else.
   1. I am critical of myself for my weakness or my mistakes.
   2. I blame myself all the time for my faults.
   3. I blame myself for everything bad that happens.

9. 0. I don't have any thoughts of killing myself.
   1. I have thoughts of killing myself, but I would not do it.
   2. I would like to kill myself.
   3. I would kill myself if I had the chance.

10. 0. I don't cry any more than usual.
    1. I cry more than I used to.
    2 I cry all the time now.
    3. I used to be able to cry, now I can't even though I want to.

11. 0. I am no more irritated by things than I ever was.
    1. I am slightly more irritated now than usual.
    2. I am quite annoyed or irritated a good deal of the time.
    3. I feel irritated all the time

12. 0. I have not lost interest in other people.
    1. I am less interested in in other people that I used to be.
    2. I have lost most of my interest in other people.
    3. I have lost all of my interest in other people.

13. 0 I make decisions about as well as I ever could.
    1. I put off making decisions more than I used to.
    2. I have greater difficulty in making decisions more than I used to.
    3 I can't make decisions at all anymore.

14. 0. I don't feel that I look any worse that I used to.
    1. I am worried that I am looking old or unattractive.
    2. I feel there are changes in my appearance that make me look unattractive
    3. I believe that I am ugly.

15. 0. I can work about as well as before.
    1. It takes an extra effort to get started at doing something.
    2. I have to push myself very hard to do anything.
    3. I can't do any work at all.

16. 0. I can sleep as well as usual.
    1. I don't sleep as well as I used to.
    2. I wake up 1-2 hours earlier than usual, it hard to get back to sleep.
    3. I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0. I don't get more tired than usual.
    1. I get tired more easily than I used to.
    2. I am get tired from doing almost anything.
    3. I am too tired to do anything.

Print Patient Name: _____ DOB_____

Patient Signature: _____ Date: _____

DO NOT COMPLETE, FOR OFFICE USE ONLY

TOTAL SCORE: _____ Provider Signature: _____ Date: _____

SOAPP

Name: _____Dob:_____ Date: _____

_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 have mood swings?**	**0 1 2 3 4**
2.	**How often do you smoke a cigarette within an hour after you wake up?**	**0 1 2 3 4**
3.	**How often have any of your family members, including your parents and grandparents, had a problem with alcohol or drugs?**	**0 1 2 3 4**
4.	**How often have any of your close friends had a problem with alcohol or drugs?**	**0 1 2 3 4**
5.	**How often have others suggested that you have a drug or alcohol problem?**	**0 1 2 3 4**
6.	**How often have you attened an AA or NA meeting?**	**0 1 2 3 4**
7.	**How often have you taken medication other than the way that it was prescribed?**	**0 1 2 3 4**
8.	**How often have you been treated for an alcohol or drug problem?**	**0 1 2 3 4**
9.	**How often have your medications been lost or stolen?**	**0 1 2 3 4**
10.	**How often have others expressed concern over your use of medications?**	**0 1 2 3 4**
11.	**How often have you felt a craving for medication?**	**0 1 2 3 4**
12.	**How oftgen have you been asked to give a urine screen for substance abuse?**	**0 1 2 3 4**
13.	**How often have you used illegal drugs (for example, marijuana, cocaine, etc.)**	**0 1 2 3 4**
14.	**How often, in your lifetime, have you had legal problems or been arrested?**	**0 1 2 3 4**

Sign Name: _____ Date: _____

DO NOT COMPLETE OFFICE USE ONLY

TOTAL SCORE: _____

Providers Signature: _____ Date:_____

Patients Name: _____ Date: _____DOB _____AGE:_____

Mark each box that applies

(if **you** are a MALE check the Male column, If you are a Female, check the Female column)

		Female	Male
1. Family history of substance abuse	Alcohol Illegal Drugs Prescription Drugs	[ ] [ ] [ ]	[ ] [ ] [ ]
2. Personal history of substance abuse	Alcohol Illegal Drugs Prescription Drugs	[ ] [ ] [ ]	[ ] [ ] [ ]
3. Age (mark box if 16-45 years)		[ ]	[ ]
4. History of preadolescent sexual abuse		[ ]	[ ]
5. Psychological Disease	Attention-deficit/ hyperactivity disorder obsessive-compulsive disorder, bipolar disorder, schizophrenia, Depression	[ ] [ ]	[ ] [ ]

Patient Name_____ Dob_____

Please answer each question as honestly as possible. Keep in mind that we are only asking about the past 30 days.
There are no right or wrong answers. If you are unsure how to answer the question, please give the best answer that you can.

Please answer the questions using the following scale.	Never	Seldom	Sometimes	Often	Very Often
	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, or 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 medication?					
12. In the past 30 days, how often have you had to make an emergency phone call or shown 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 medications than prescribed?					
15. In the past 30 days, how often have you borrowed pain medications from someone else?					
16. In the past 30 days, how often have you used your pain medications for symptoms other than for pain (e.g., to help you sleep, improve your mood, or relieve					

HIPPA Consent Form- Health Insurance Portability and Accountability Act

Patient Name: _____ DOB: _____

In connection with the medical services that I receive from the above-named physician. I hereby authorize Imperial Pain Specialist to disclose any/or all information concerning my medical condition and treatment, including copies of applicable hospital and medical records, to:

Any third-party payer covering the medical services received

Other health care professions and institutions involved in the delivery of health care to me, the patient

The proponent of any legal sufficient subpoena or court order

Employees/Contractors of the provider, to facilitate the necessary provision of health care services and payment or such services

Pharmacies

Other parties required by law

In each case the practices shall take legal steps to ensure that only the necessary information is disclosed in accordance with the above. I further understand that I have been given access to the physician's privacy notice and that I have had the opportunity to place any restrictions upon the consent hereby given.

Please list the names /relationships of anyone you wish you Imperial Pain Specialist to speak with regarding your medical care and condition.

Name:	Relationship:
_____	_____
_____	_____
_____	_____

Imperial Pain Specialist may leave a message on or with:

Voicemail Employer Cellphone

This consent is valid from the date executed until revoked in writing by the patient or verbal consent and witnessed.
Patient Signature: _____ Date: _____
Witness: _____ Date:_____

Consent to Medical Treatment

Name:_____DOB_____DATE_____

I hereby authorize Imperial Pain Specialists to perform upon me the following treatment: pain management treatment.

My provider has fully explained and informed me of expected benefits and complications (from known and unknown causes), attendant discomforts and risks that may arise, as well as possible alternatives to proposed treatment, including no treatment. I have been given the opportunity to ask questions, and all my questions have been answered fully and satisfactorily. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from treatment.

I understand that during the course of treatment, unforeseen conditions may arise which necessitates my care differ from those contemplated. I, therefore, consent to the performance of additional treatments if the above need physician or associates may consider necessary.

I understand that I am responsible for ALL fees, as we are a fee for service facility I understand that as treatment progresses the above fees may be adjusted, but that I will be informed of these adjustments and how they will affect my payments.

I confirm that I have read and fully understand the above and that all blank spaces have been completed prior to signing. I hereby consent to the proposed medical treatment.

_____ _____

Signature Date

Printed Name

Patient Name:_____ DOB_____

Pain Management Agreement: Controlled Substance Treatment

I,_____ understand that I have entered into a treatment relationship with the physicians and staff of Imperial Pain Specialists, P.L.L.C.. I further understand that part of the treatment may include the use of OPIATES and OTHER CONTROLLED SUBSTANCES. In order to use these medications safely, I understand that I will follow the following guidelines:

- I will take the medications at the dose and frequency prescribed
- I agree to bring ALL over the counter and prescribed medications with to ALL of my appointments
- I understand that if opiates and controlled substances are prescribed I will be required to come to the clinic MONTHLY for follow-up appointments
- I will not increase or change how I take my medications without the approval of this healthcare provider
- I will arrange refills at the prescribed intervals ONLY during regular office hours. I will not ask for refills earlier than agreed, after hours, on holidays or on the weekends
- I will obtain refills only at the following pharmacy with the full consent for my provider and pharmacist to exchange information in writing or verbally. If this pharmacy does not have my medication, I will use another pharmacy WITH THE APPROVAL AND PRIOR NOTIFICATION OF MY PROVIDER

  Name of Pharmacy: _____

I will not request any pain medications or controlled substances from other providers and will inform this provider of all other medications I am taking

- I will inform my other healthcare provider that I am taking these medications and of the existence of this agreement. In case of emergency, I will provide this same information to emergency room providers
- I will protect my prescriptions and medications. I understand that lost or misplaced prescriptions WILL NOT BE REPLACED. Police reports for stolen prescriptions or medications WILL NOT BE ACCEPTED.
- I will keep medications only for my own use and will not share them with others. I will keep all medications away from children.
- I agree to participate in any medical, psychological or psychiatric assessments recommended by my provider
- I will actively participate in any program designed to improve function, including physical therapy and occupational therapy, psychological and social training, and daily or work activities.
- I will not use illegal or street drugs or another person's prescription. If I have an addiction problem with drugs and/or alcohol and my provider asks me to enter a program to address the issue,

  12-step program and securing a sponsor **Individual counseling** **Inpatient or outpatient treatment**

- I will consent to random and directed drug screening to assure that I am the only taking prescribed medications. I understand that a drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking
- I will keep all my scheduled appointments. If I need to cancel an appointment, I will do so a minimum of 24 hours before it is scheduled.
- I will keep this clinic informed of all primary and emergency contact addresses and telephone numbers
- I acknowledge that I have read and understand the Controlled Substance Informed Consent material provided by the clinic
- I understand that this provider may stop prescribing the medications listed if

  I do not show any improvement in pain control or my activity is not improved

  I develop rapid tolerance or loss of improvement from the treatment or develop significant side effects to the treatment

  My behavior is inconsistent with the responsibilities outlined above, which may also result in being discharged from this clinic

Patient Sig: _____ DOB: _____ Date:_____

IMPERIAL PAIN SPECIALISTS

411 PRINCETON ROAD, STE 101
JOHNSON CITY TN 37601
423-461-0021

1201 N, WILCOX DRIVE
KINGSPORT, TN 37660
423-900-2221

Dear Imperial Pain Specialists Patients,

Imperial Pain Specialists operates as a fee for service clinic. This means that Imperial Pain Specialists do not accept private insurance plans, nor do we accept Medicare, Medicaid (in any form) .

Payment for all services are due at the time of service. There are no exceptions.

Imperial Pain Specialists is able to provide all patients with a receipt with all codes and details needed for patients to contact their insurance to submit for possible reimbursement. This varies by insurance company and we **can not guarantee any reimbursement in any form**. You will need to contact the insurance company for proper forms and instructions for submitting. **Medicare and Medicaid usually DO NOT reimburse patients who choose to see a Physician who does not accept Medicare or Medicaid**. This also includes the cost of medications prescribed. We can not guarantee that your insurance will cover medications or test ordered by our physicians.

Your signature on this page documents that you understand this information.

Patient Name:_____ DOB:_____

Patient Signature:_____ Date:_____

Imperial Pain Specialists Representative:_____ Date:_____

Imperial
Pain Specialists

CHRONIC PAIN GUIDELINES (INFORMED CONSENT)

Please read the information below carefully and ask your provider if you have any questions relating to the medication prescribed to you.

Using Controlled Medications to Treat Pain

a. These medications are used to treat moderate-to-severe pain of any type, and to treat anxiety and stress associated with moderate-to-severe pain.
b. These medications are best understood as potentially effective tools that can help reduce pain, improve function, and improve quality of life.
c. Using these medications requires that both the physician and patient work together in a responsible way to ensure the best outcome, lowest side effects, and least complications.

How Do Opioids Work?

a. Opioid medications work at the injury site, the spinal cord, and the brain.
b. They dampen pain, but do not treat the underlying injury.
c. They may help to prevent acute pain from becoming persistent chronic pain.
d. These medications may work differently on different people because of a number of factors.
e. Side effects and complications will also individually vary.

How Do Benzodiazepines Work?

a. The benzodiazepines are a class of drugs with varying properties, which act by slowing down the central nervous system.
b. Benzodiazepines are useful in treating anxiety, insomnia, agitation, seizures, and muscle spasms. While Benzodiazepines do not treat acute or chronic pain, they are taken by patients with pain for other issues (such as anxiety or muscle spasms).
c. These medications may work differently on different people because of a number of factors.
d. Side effects and complications may also individually vary.

What to Expect When You Take Controlled Medications for Pain and Related Conditions

a. Pain relief
b. Reduction of anxiety and stress caused by pain
c. Side effects

What Should Not Be Expected From Treatment with Controlled Medications

a. Cure of the underlying injury
b. Total elimination of pain, anxiety, and stress

c. Loss of ability to feel other physical pain

Negative Effects of Controlled Medications Vary in Different People

1. *Opioid Side Effects*
   a. Common effects include: Constipation, dry mouth, sweating, nausea, drowsiness, euphoria, forgetfulness, difficulty urinating, and itching.
   b. Uncommon effects include: Confusion, hallucinations, shortness of breath, depression, lack of motivation.
2. *Benzodiazepines Side Effects*
   a. The most common side effects include: Clumsiness or unsteadiness, dizziness or lightheadedness and drowsiness, slurred speech.
   b. Less common side effects include: Anxiety, confusion (may be more common in the elderly), fast – pounding – or irregular heartbeat, mental depression, abdominal or stomach cramps or pain, blurred vision or other changes in vision, changes in sexual desire or ability, constipation, diarrhea, dryness of mouth or increased thirst, false sense of well-being, headache, increased bronchial secretions or watering of mouth, muscle spasms, nausea or vomiting, problems with urination, trembling or shaking, unusual tiredness or weakness.
3. *Physical Dependency*
   a. Opioid medications will cause a physical dependency marked by abstinence syndrome when they are stopped abruptly. If these medications are stopped or rabidly decreased, the patient will experience chills, goose bumps, profuse sweating, increased pain, irritability, anxiety, agitation, and diarrhea. The medications will not cause these symptoms if taken as prescribed and any decision to stop these medications should be done under the supervision of your physician in a slow downward taper.
   b. Benzodiazepines may be habit-forming (causing mental or physical dependence), especially when taken for a long time or in high doses. Some signs of dependence on benzodiazepines are: a strong desire or need to continue taking the medicine; a need to increase the dose to receive the effects of the medicine. Withdrawal effects occurring: (for example) irritability, nervousness, trouble sleeping, abdominal cramps, trembling or shaking.
4. *Misuse of Medications: Addiction*
   This is a psychological condition of use of a substance despite self-harm. Between six and ten percent of the population of the United States have problems with substance abuse and addiction. Controlled medications are likely to activate addictive behavior in this group of people.
5. *Diversion*
   It is illegal to share your controlled medications with other people. It is illegal to provide false information to a prescriber in an attempt to obtain controlled medication. It is illegal to doctor shop, or visit multiple doctors in an attempt to obtain controlled medications.

Federal and State laws exist to address diversion problems. It is critical that you safeguard your controlled medications and use them only as prescribed by your doctor.

6. *Driving*

   Studies of patients with chronic pain demonstrate improved driving skills when taking certain controlled medications, but individuals may have problems driving and need to realistically assess their own skills, as well as listen to others who drive with them to determine if they should be driving while taking these medications. You should consult the State Department of Transportation if you have questions about driving and taking controlled medications. This is especially important if your work involves driving, making important decisions that affect others, etc.

<u>Common Sense Rules for Using Controlled Medications</u>

a. Follow your doctor's recommendations
b. Do not take more or less pills than prescribed without discussing this first with your physician and receiving permission to do so
c. Do not share medications with family or friends
d. Do not take medications from family or friends
e. Do not stop these medications abruptly. Dose reductions need to be discussed and cleared by your physician. This is important no matter which controlled medication you take.
f. Do not sell medications
g. Do not take medications in any manner other than prescribed. For example: Do not chew or inject your medications
h. Keep all medications out of reach of children
i. Do not leave your prescriptions or controlled medications lying around unprotected for others to steal and abuse them
j. Do not operate a motor vehicle if you feel mentally impaired using controlled medications. You are responsible for exhibiting good judgment in your daily affairs, including your use of controlled medications.
k. Alcohol use should be curtailed when using controlled medications.

Continued Use of Controlled Medication is based on your physician's judgment and a determination of whether the benefits to you of using controlled medications outweigh the risks of using them.

Your physician may discontinue treating you at his or her discretion. Your physician may require a consultation with an addiction specialist. Your physician may require more frequent visits.

CHRONIC PAIN GUIDELINES (INFORMED CONSENT)

We believe in treating your pain and we recognize the value of controlled medications in this process. When used properly, controlled medications can help restore comfort, function, and quality of life. However, as stated above, controlled medications may also have serious side effects and are highly controlled because of their potential for misuse and abuse. It is important to work with your physician and communicate openly and honestly with him or her about your pain control needs. By doing so, medications can be used safely and successfully.

By your signature below, you are acknowledging that you have read and reviewed these matters with your physician and that you have sufficient information to make a decision to use the controlled medications prescribed.

You should NOT sign this form if you do not believe you have enough information to make an informed decision about your use of controlled medications and how they fit into your pain management treatment plan.

Patient Name: _____DOB_____

Patient Signature: _____

Physician Signature: _____

Date:_____