Name:
Chart:
Date:

Thank you for choosing* Wenatchee Pain Relief *for your pain management needs!

We want your first appointment to go as smoothly as possible. For that reason, please remember to bring the following information with you to your appointment.

- ***The enclosed packet, completed with your health and insurance information. This packet may seem lengthy, but in order to provide you with the best possible care and customer service, it is important that we collect all of the enclosed information.***
- ***Your Photo ID (must be state or federally issued- Driver's License, State of Washington Photo ID, Passport)***
- ***Insurance Cards- please remember to bring your primary insurance information, secondary insurance information (if applicable) and your prescription insurance card (if separate from your medical card).***
- ***Any radiology films or reports.***
- ***Medical records from any previous treating physician or pain practice.***
- ***Referral, if applicable***
- ***Copay, if applicable***

If you are able to complete this packet, please arrive at your scheduled appointment time so that we may process the paperwork and get you checked in.

If you are unable to complete this packet for any reason, please arrive 30 minutes prior to your appointment so that we may assist you in gathering the necessary information for your appointment.

Our of respect for other patients, if you are more than 15 minutes late or not properly prepared for your appointment by bringing these items, we reserve the right to reschedule your appointment. If you're unable to come to your appointment, please give us 48 hours notice. <u>There is a $100 fee for a no show visit</u>.

Directions can be found at www.WenatcheePainRelief.com

Patient Demographic Form

Please PRINT

Wenatchee Pain Relief

Dr. Jared Wagner

MRN **Date**

PATIENT INFORMATION

Last Name **First Name** **Middle Initial** **Nickname/AKA**

Date of Birth **Social Security Number** **Gender** ❑ Male ❑ Female

Marital Status ❑ Married ❑ Single ❑ Divorced ❑ Life Partner ❑ Separated ❑ Widowed ❑ Other **Language** other than English

Race (Optional) ❑ Black – Non Hispanic ❑ American Indian/ Alaskan Native ❑ Hispanic ❑ Asian/Pacific Islander ❑ White – Non Hispanic ❑ Other

Home Address **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Other Phone** ❑ Cell ❑ Pager ❑ Fax

Email Address **Employment Status** ❑ Active Duty Military ❑ Child ❑ Disabled ❑ Employed Full-Time ❑ Employed Part-Time ❑ Homemaker ❑ Not Employed ❑ Retired ❑ Self Employed ❑ Student Full-Time ❑ Student Part-Time ❑ Other

Employer **Employer Phone**

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician **Referring Physician**

How did you hear about us? ❑ Billboard ❑ Employer ❑ Family Member ❑ Friend ❑ Health Fair Event ❑ Insurance ❑ Magazine ❑ Mail ❑ News ❑ Physician ❑ Radio ❑ Television ❑ Website ❑ Yellow Pages ❑ Other

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient ❑ Self (If self, skip to Emergency / Next of Kin) ❑ Spouse ❑ Parent ❑ Other

Last Name **First Name** **Middle Initial**

Date of Birth **Social Security Number**

Home Address **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Other Phone** ❑ Cell ❑ Pager ❑ Fax

Employer **Employment Status** ❑ Active Duty Military ❑ Child ❑ Disabled ❑ Employed Full-Time ❑ Employed Part-Time ❑ Homemaker ❑ Not Employed ❑ Retired ❑ Self Employed ❑ Student Full-Time ❑ Student Part-Time ❑ Other

Employer Phone

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name **First Name** **Relationship to Patient**

Address **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Other Phone** ❑ Cell ❑ Pager ❑ Fax

OTHER CONTACT INFORMATION – NOT LIVING WITH PATIENT

Last Name **First Name** **Relationship to Patient**

Address **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Other Phone** ❑ Cell ❑ Pager ❑ Fax

Rev. December 2018

INSURANCE (PRIMARY)

Primary Insurance Company (Name and Address) | **ID#** | **Group or Plan #** (please list all characters)

Primary Insured's Name (Policyholder) | **Patient's Relationship to Insured** (circle one) | **Insured's Birth Date**

Self Spouse Child Other _____

Name as listed on Insurance card if difference from above:

Name and Address of Employer | **Telephone #** | **Insured's Social Security #**

INSURANCE (SECONDARY)

Secondary Insurance Company (Name and Address) | **ID#** | **Group or Plan #** (please list all characters)

Secondary Insured's Name (Policyholder) | **Patient's Relationship to Insured** (circle one) | **Insured's Birth Date**

Self Spouse Child Other

Name as listed on Insurance card if difference from above:

Name and Address of Employer | **Telephone #** | **Insured's Social Security #**

MEDICATION PRESCRIPTION INSURANCE

Insurance Company Name: _____

Rx BIN No.: _____

Rx PCN No.: _____

Rx Grp No.: _____

ID No.: _____

Name:
Chart:
Date:

New Patient Information Sheet

Name: _____ **Visit Date:** _____

Date of Birth: _____ **Age:** _____

Please fill in the questions below as concisely and accurately as possible.

The form may seem lengthy but it is very important to help us understand your pain complaints. This will help us provide you with the highest level of care.

Primary Care Doctor: **Doctor's Name** **Doctor's Address/Phone**

Referring Doctor: **Doctor's Name** **Doctor's Address/Phone**

Pain Medicine Doctor you have seen before:

Specialist Name:_____

Specialist Name:_____

Are there any claims pending or is this Workers Compensation related? ☐ Yes ☐ No

Explain: _____

List areas of pain:

1. _____
2. _____
3. _____
4. _____

When did your pain begin: _____ weeks/months/years

How did your pain start: _____

Describe where your pain is:

Does your pain radiate anywhere? (Examples: into your arm, leg, chest, abdomen)

Circle the words which best describe your pain:

Aching	Sharp	Gnawing
Throbbing	Shooting	Cramping
Tightness	Stabbing	Tearing
Deep	Searing	Other_____

Is the pain intermittent? ☐ **or constant?** ☐

Name:
Chart:
Date:

Name: _____ **Date of Birth:** _____

Circle the number between 0 - 10 that represents the intensity of your pain:

KEY **0 = No Pain**
5 = Interferes with activities
10 = Worst pain imaginable

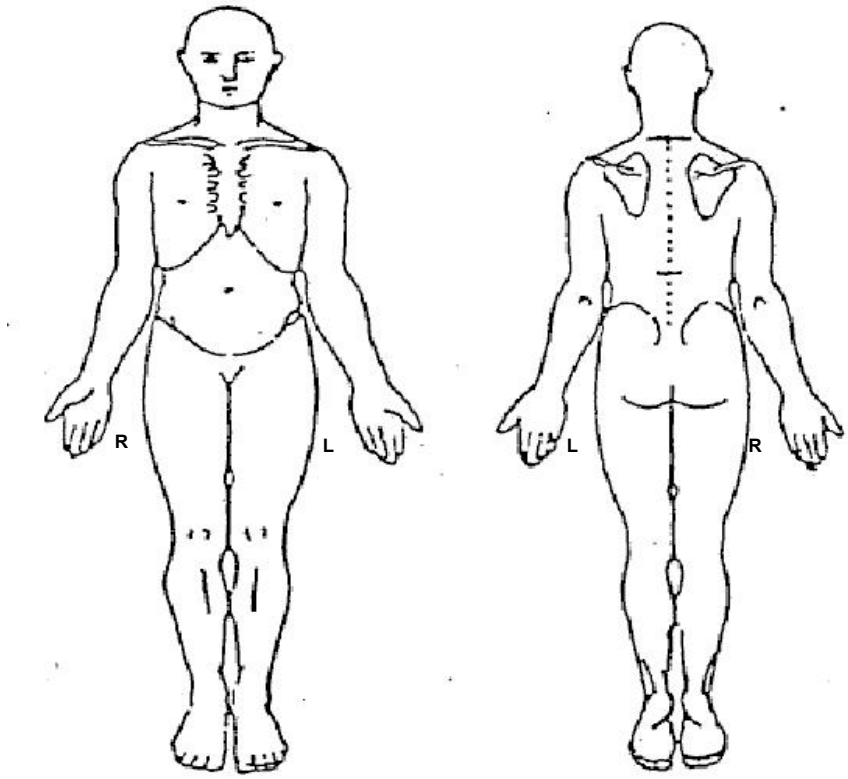
Average Pain = 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10
Worst Pain = 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10
What makes pain worse?

What makes pain better?

Pain Diagram:

Stabbing: / / / / / **Burning: XXXXX** **Pins and Needles: 0 0 0 0**

Aching/Throbbing: ^ ^ ^ ^ ^ **Numbness: = = = = =** **Other: …… ..**



Name:
Chart:
Date:

Name: _____ **Date of Birth:** _____

What pain medications have you tried:

Medication	Still Using	Stopped Because
Tylenol	☐	☐ _____
Asprin	☐	☐ _____
Ibuprofen (Motrin/Advil)	☐	☐ _____
Naprosyn (Aleve)	☐	☐ _____
Toradol (Ketorolac)	☐	☐ _____
Diclofenac (Arthrotec)	☐	☐ _____
Flector Patches	☐	☐ _____
Mobic	☐	☐ _____
Celebrex	☐	☐ _____
Flexeril	☐	☐ _____
Zanaflex	☐	☐ _____
Soma	☐	☐ _____
Skelaxin	☐	☐ _____
Neurontin	☐	☐ _____
Lyrica	☐	☐ _____
Cymbalta	☐	☐ _____
Savella	☐	☐ _____
Amitriptyline (Elavil)	☐	☐ _____
Nortriptyline (Pamelor)	☐	☐ _____
Lidoderm Patches	☐	☐ _____
Tramadol	☐	☐ _____
Codeine	☐	☐ _____
Tylenol #2, 3, or 4	☐	☐ _____
Lortab/Norco	☐	☐ _____
Vicodin	☐	☐ _____
Percocet	☐	☐ _____
Methadone	☐	☐ _____
Morphine	☐	☐ _____
Zohydro ER	☐	☐ _____
Hysingla	☐	☐ _____
Nucynta ER	☐	☐ _____
Fentanyl Patches	☐	☐ _____
Oxycodone	☐	☐ _____
Oxycotin	☐	☐ _____
Hydromorphone (Dilaudid)	☐	☐ _____
Exalgo	☐	☐ _____

Name:
Chart:
Date:

What treatments have you tried

Procedure	How Long Ago	Effective? (Y/N)
Trigger Point Injections		
Epidural Steriods		
Nerve Blocks		
Facet Blocks		
Sacro-iliac Joint Injections		
Spinal Cord Stimulator		
Intrathecal Pumps		
Physical Therapy		
Chiropractor		
Aquatherapy		
Accupuncture		
TENS		
Other		

Activities of Daily Living:

1. Does your pain stop you from the things you enjoy? ☐ Yes ☐ No
2. Does your pain interfere with your ability to cook or prepare food? ☐ Yes ☐ No
3. Does your pain limit your ability to bath or get in and out of a bathtub? ☐ Yes ☐ No
4. Does your pain affect your ability to get dressed in the morning? ☐ Yes ☐ No
5. Does your pain affect your ability to get on and off or use the toilet? ☐ Yes ☐ No
6. Does your pain limit your ability to get out of bed in the morning? ☐ Yes ☐ No

List ALL Medical Problems: (Include any diagnosis of anxiety or depression)

	Medical Problem	Treating Doctor	Address	Telephone Number
1.				
2.				
3.				
4.				
5.				

List ALL Surgeries:

	Surgery	Date	Doctor	Hospital
1.				
2.				
3.				
4.				
5.				

Name:

Chart:

Date:

Family History:

Is your mother — Alive ☐ — List major illnesses _____
Dead ☐ — Age and cause of death _____

Is your father — Alive ☐ — List major illnesses _____
Dead ☐ — Age and cause of death _____

Do you have any children? Please list. Yes ☐ No ☐

	Son/ Daughter	Age	Medical Problems
1.			
2.			
3.			
4.			

Social History:

Marital Status:
Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partner ☐ Other ☐

Living Situation:
I Live alone ☐ Live with parents ☐ Live with roommates ☐ Live with family ☐ Homeless ☐ Other ☐

Education: Dropped out ☐ High school diploma ☐ GED ☐ Some college ☐ Graduated college ☐

Work Status: Employed ☐ Disabled ☐ Retired ☐ Other ☐

Substance abuse of:

I currently use or consume	Alcohol ☐	Illicit drugs ☐	Cigarettes ☐
I have a current or prior addiction to	Alcohol ☐	Illicit drugs ☐	Cigarettes ☐

List ALL Medication Allergies:

	Drug	Reaction
1.		
2.		
3.		
4.		
5.		

List ALL Medications you're taking:

	Drug	Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

Name:
Chart:
Date:

Do you have any of the following symptoms:

General/ Constitutional:

Fever	No ☐	Yes ☐	If yes, explain. _____
Fatigue	No ☐	Yes ☐	If yes, explain. _____

Head:

Dizziness	No ☐	Yes ☐	If yes, explain. _____
Fainting	No ☐	Yes ☐	If yes, explain. _____

Cardiovascular:

Chest Pain	No ☐	Yes ☐	If yes, explain. _____

Respiratory:

Short of breath	No ☐	Yes ☐	If yes, explain. _____

Gastrointestinal:

Constipation	No ☐	Yes ☐	If yes, explain. _____
Diarrhea	No ☐	Yes ☐	If yes, explain. _____

Genitourinary:

Incontinences	No ☐	Yes ☐	If yes, explain. _____
Currently pregnant	No ☐	Yes ☐	If yes, explain. _____

Musculoskeletal:

Joint Stiffness	No ☐	Yes ☐	If yes, explain. _____
Joint/ bone pain	No ☐	Yes ☐	If yes, explain. _____
Joint swelling	No ☐	Yes ☐	If yes, explain. _____
Muscle cramps	No ☐	Yes ☐	If yes, explain. _____

Integumentary (Skin and/or Breast):

Rash	No ☐	Yes ☐	If yes, explain. _____

Neurological:

Fainting	No ☐	Yes ☐	If yes, explain. _____
Weakness/paralysis	No ☐	Yes ☐	If yes, explain. _____
Headaches	No ☐	Yes ☐	If yes, explain. _____
Migraines	No ☐	Yes ☐	If yes, explain. _____

Psychiatric:

Depression	No ☐	Yes ☐	If yes, explain. _____
Suicidal thoughts	No ☐	Yes ☐	If yes, explain. _____
Anxiety	No ☐	Yes ☐	If yes, explain. _____
Sleep disturbance	No ☐	Yes ☐	If yes, explain. _____

Endocrine:

Heat/Cold intolerance	No ☐	Yes ☐	If yes, explain. _____
Weight loss/gain	No ☐	Yes ☐	If yes, explain. _____

Hematological:

Easy Bruising	No ☐	Yes ☐	If yes, explain. _____
Easy bleeding	No ☐	Yes ☐	If yes, explain. _____
Abnormal clotting	No ☐	Yes ☐	If yes, explain. _____

Name:

Chart:

Date:

HIPAA Privacy Notice

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.

A. The General Authorization for Release of Medical Records that you sign authorizes your medical care provider, Wenatchee Pain Relief ("Provider"), to disclose the information in your medical records to the extent needed for the following purposes:

1. **For the purpose of providing treatment to you. This would include, for example, sharing information with employees and contractors of Provider, or with other health care providers who are treating you or consulting in your care.**
2. **For the purpose of arranging payment for your care. This would include, for example, your insurer, or other third-party payor who is responsible for paying all or part of the cost of your care.**
3. **For the purpose of Provider's "health care operations." This would include such things as internal quality assessment activities, contacting other health care providers regarding treatment alternatives, evaluating provider performance, training providers of care, legal and medical review of care provided, business planning and management, customer service, resolutions of internal grievances and the provision of legal and auditing services.**
4. **For the purpose of other health care providers; "health care operations", to the extent that they have a treatment relationship with you.**

B. A Specific Authorization for Release of Medical Records that you may sign authorizes Provider to make a specific disclosure that is not covered under section A, above. A Specific Authorization will name the party to whom you are authorizing discourse, and will contain any limitations on the authority to disclose your records.

C. You may revoke an authorization by giving Provider a written notice of revocation. Provider may refuse to treat you if you revoke the General Authorization.

D. Provider may be required by law, in some cases, to make disclosures of your record that you have not authorized. Examples are *subpoenas* in criminal or civil litigation, or requests/surveys by licensure agencies or the U.S. Department of Health and Human Services.

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

F. You have the following *rights* with respect to your medical records/information:

1. You have the right to request restrictions on the use and disclosure of your medical records/information, however Provider is not required to agree to restrictions not guaranteed by law. You will be informed if Provider will not agree to a requested restriction.

2. You have the right to receive confidential communications of your health information and to direct the place and manner of communication.

3. You have the right to inspect and copy your medical records. (Provider is entitled to charge you a reasonable fee related to the cost of copying your records).

4. You have the right to seek to amend your medical records, and if Provider does not agree with your request, to note your objection in the medical record.

5. You have a right to receive an accounting (list) of disclosure of your medical records/information made by Provider. (Except for close disclosures that are made to you or with your specific authorization, that fall with the scope of Provider's "health care operations", or disclosures made for payment or treatment purposes.)

6. You have the right to receive a paper copy of this notice.

G. Provider is required by law to maintain the privacy of protected health information, and to provide patients with this notice of its duties and practices, as well as changes to those practices. *Patients will be provided with revised notices*, as appropriate.

H. If a patient believes that his or her privacy rights have been violated, then patient may complain to Provider, or the Secretary of the U.S. Department of Health and Human Services. To complain to Provider, please write or call us with the details. Provider will not retaliate in any way against a patient for making a complaint.

I. If you as a patient or guardian believe that your privacy rights have been violated, and wish to notify our practice, please call our office and ask to speak with our designated Privacy Complaints Contact Person: Practice Administrator.

J. Provider reserves the right to change its privacy practices, and to make its new policies effective for all protected health information that Provider maintains. If such changes are made, Provider will issue and updated "Notice of Patients" to all of Provider's patients.

Please acknowledge receipt and review of this notice by signing below. For further information, please call the Practice Administrator at 509-888-3496.

Name of Patient (printed) Date

Signature of Patient or Lawfully Authorized Representative

Name:

Chart:

Date:

PAYMENT & CONSENT FORM

Please read carefully before signing

INSURANCE ASSIGNMENT: If I have an insurance with which the Practice participates, a claim for reimbursement for services rendered will be submitted based on the information I provide to Wenatchee Pain Relief ("Practice"). If due to incomplete or incorrect information, payment has not been received by the Practice within 45 days from the date of services, all charges become my responsibility and are immediately payable by me.

PATIENT RESPONSIBILITY FOR NON-CONTRACTED PLANS: My signature below acknowledges that the office of Wenatchee Pain Relief has informed me if they are not contracted with my insurance plan that as a courtesy, they will provide me with a form listing the services (procedures) and the reasons for the services (diagnoses) for me to submit for possible reimbursement by my insurance company.

REFERRALS/AUTHORIZATIONS: If required, I understand that without a referral/authorization from my insurance carrier, I am financially responsible for all charges I incur.

SELF-PAY: If on the day services are rendered I: 1) do not have health insurance or am uncertain as to which insurance I have 2) do not want my insurance to be billed, 3) do not comply with the terms of the insurance policy (including, but not limited to, failing to supply adequate insurance information or bring authorization/referral forms), I agree to be financially responsible for all charges incurred, will pay in full for services rendered at the time of the visit and will pursue reimbursement from third parties myself. I understand that I have the right to request that no information be released to my insurance company for services I choose to self-pay for.

WORKERS' COMPENSATION: I understand that if my workers compensation insurance carrier or the Workers' Compensation Commission denies my claim and I failed to supply adequate health insurance information. I will be financially responsible for any unpaid balances. PLEASE NOTE: If your health insurance requires a referral/authorization to be seen, your health insurance company still requires you to obtain it, even though your workers' compensation insurance carrier is being billed as the primary insurance. I understand that failure to obtain the referral/authorization can result in my health insurance denying payment once Workers' Compensation denies the claim. In such a situation, I agree that I am financially responsible for the unpaid balance.

MVA/PERSONAL INJURY: We will file claims with your PIP carrier with the necessary documentation from your physician. In the event your PIP becomes exhausted, your health insurance will be billed and you will become responsible for any co-insurance, co-payment or deductible. PLEASE NOTE: if your health insurance requires a referral/authorization to be seen, your health insurance company still requires you to obtain it, even though the PIP carrier is being billed as the primary insurance. I understand that failure to obtain the referral/authorization can result in my health insurance denying payment once PIP has been exhausted. In such a situation, I agree that I am financially responsible for the unpaid balance.

MISSED APPOINTMENTS: If you fail to provide at least 48 hours notice to cancel or fail to show up for an appointment, we will charge $100.00. All missed appointment fees must be paid in full before future care is rendered.

RETURNED CHECKS: There will be a returned check fee of $35.00 assessed for any check returned for insufficient funds.

MEDICAL RECORDS: Any information from the medical record must have the patient's signed consent to release. Please allow 2 weeks for the copying of medical records.

This agreement is valid for all episodes of care rendered by physicians associated with Wenatchee Pain Relief. I permit a copy of this authorization and agreement to be used in place of the original. By signing below, the patient, parent, legal guardian or responsible party agrees to make all required payments as provided above.

Signature: _____

Date: _____

Printed Name: _____