REGENERATIVE MEDICINE AND PAIN MANAGEMENT PHYSICIANS

Ruben B. Timmons, MD
Wayne Barrineau, APRN

NEW PATIENT INTAKE FORM

Today's date: _____

Patient Name: _____ DOB: _____

Social Security Number: _____ Gender: M F Marital Status: _____ Race: _____

Address: _____

Employer: _____

Home Phone: _____ May we leave a detailed message? YES NO

Cell Phone: _____ May we leave a detailed message? YES NO

E-mail Address: _____ Please log in on our patient portal when you receive emailed invitation.

Emergency Contact Name: _____

Emergency Contact Phone Number: _____ Relationship: _____

Primary Insurance Information:

Carrier Name: _____

Insured Name (if other than the patient): _____ DOB _____

Relationship to Patient: _____

Insured ID Number: _____ Group Number: _____

Secondary Insurance Information:

Carrier Name: _____

Insured Name (if other than patient): _____ DOB _____

Relationship to Patient: _____

Insured ID Number: _____ Group Number: _____

RADIOLOGICAL STUDIES:

	Body Location(s)	Facility Where Performed	Year of Study			
X-rays	_____	_____	_____	Do we have a copy?	YES	NO**
MRI	_____	_____	_____	Do we have a copy?	YES	NO**
CT scan	_____	_____	_____	Do we have a copy?	YES	NO**

****If you have had any radiological studies performed in the past 5 years, please check with your referring physician to ensure we have a copy of the written diagnostic summary prior to your appointment.**

1. Name of primary care physician: _____

2. What is the reason for your visit today? Where is your pain? _____

3. How long have you had this problem? _____

4. What caused your problem? INJURY MOTOR VEHICLE ACCIDENT WORK ACCIDENT UNKNOWN

5. Give a brief description of what caused your pain to start. If accident/injury, include the date: _____

_____

6. Have you previously been treated for the same symptoms? YES NO If so, when and by whom?_____

_____

7. Circle the intensity of your pain today: No pain = 0 1 2 3 4 5 6 7 8 9 10 = the worst pain possible

8. Circle all that apply to your symptoms:

a. Frequency/duration:	Constant Intermittent
b. Pain Quality:	Sharp Aching Burning Shooting Stabbing Dull
c. Increases Pain:	Sitting Lying down Standing Walking Bending Weather Cold Heat
d. Decreases Pain:	Sitting Lying down Standing Walking Bending Weather Ice Heat
e. Associated Symptoms:	Weakness Numbness Tingling Fever Chills Sleep disturbance
	Sexual dysfunction Bowel/bladder Problems Weight loss

9. **PREVIOUS TREATMENT:**

Physical Therapy?	YES	NO	If so, was it helpful?	YES	NO
Chiropractic Care?	YES	NO	If so, was it helpful?	YES	NO
Nerve Blocks?	YES	NO	If so, was it helpful?	YES	NO
Surgeries?	YES	NO	If so, was it helpful?	YES	NO

10. **CURRENT MEDICATION LIST**

List all medications that you are **CURRENTLY** taking, including over-the-counter medications. (If you have a list please let the front desk know and we can make a copy) ***INCLUDE ALL BLOOD THINNERS***

_____ _____
_____ _____
_____ _____
_____ _____

11. **ALLERGIES:**

List all medication allergies **including IV dyes, shellfish, or latex**: (if you have a list please let the front desk know and we can make a copy)_____ _____

_____ _____

12. PAST MEDICAL HISTORY: Please circle any of the following that apply to you.

CNS

Cerebral Aneurysm

Stroke

Brain Tumor

Seizure Disorder

Neuropathy

GASTROINTESTINAL

Hiatal Hernia

Ulcer

GENITOURINARY

Kidney Disease

Pregnant

CARDIOVASCULAR

Hypertension

Valve Disease

Heart Attack

Irregular Heartbeat

Pacemaker

PSYCHIATRIC

Depression

Anxiety

METABOLIC

Liver Disease

Diabetes

Hyperthyroidism

Hypothyroidism

Cancer

BONE/MUSCLE

Arthritis

Fibromyalgia

RESPIRATORY

Asthma

Emphysema

Bronchitis

INFECTIOUS

Hepatitis

HIV/AIDS

13. SURGICAL HISTORY: Neck Back Heart Abdominal Other surgery related to pain _____

14. FAMILY HISTORY:

Diabetes	Mother	Father	Sibling
Heart disease	Mother	Father	Sibling
Cancer	Mother	Father	Sibling
High Blood Pressure	Mother	Father	Sibling

15. SOCIAL HISTORY:

Employment Status: Full time Part Time Retired Disabled

Marital Status: Married Divorced Separated Widowed Single

Do you have children? YES NO

Do you smoke? YES NO If yes, how many per day? _____

Do you drink alcohol? Never Social Light Moderate Heavy

Do you use recreational drugs? Never Occasionally Frequently If so, what kind? _____

16. OPOID RISK TOOL:

FAMILY HISTORY OF:

Alcohol abuse?	YES	NO
Illegal drug abuse?	YES	NO

PERSONAL HISTORY OF:

Alcohol abuse?	YES	NO
Illegal drug abuse?	YES	NO
Prescription drug abuse?	YES	NO
Preadolescent sexual abuse?	YES	NO
Psychological Disease?	YES	NO

17. PHQ-2 DEPRESSION SCREENING:

Little interest or pleasure in doing things? ___not at all ___several days ___more than ½ the days ___nearly every day

Feeling down, depressed, or hopeless? ___not at all ___several days ___more than ½ the days ___nearly every day

18. DO YOU HAVE A LIVING WILL (ADVANCED DIRECTIVE): YES NO

I DO HEREBY CONFIRM THAT ALL OF THE INFORMATION PROVIDED IS TRUE AND CORRECT.

Patient signature: _____ Date: _____

PHYSICIANS CONSENT FORM

_____ I authorize Regenerative Medicine and Pain Management Physicians to perform the treatments or procedures approved by my referring physician. I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. The nature and purpose of the procedure, possible alternative methods of treatment and risks involved, and the possibilities of complications have been fully explained to me.

_____ I authorize payment of medical benefits to Regenerative Medicine and Pain Management Physicians for any services furnished. I understand that I am financially responsible for any amount not covered by my insurance carrier. I authorize you to release to my insurance company or its agent, information concerning healthcare, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

_____ I authorize the release of the results of my care at Regenerative Medicine and Pain Management Physicians to my primary care physician and my referring physician.

_____ I acknowledge that I have received a copy of Regenerative Medicine and Pain Management Physicians' Notice of Privacy Practices.

_____ I consent to release my prescription history from any external sources.

_____ _____ _____

Patient, Parent or Guardian Signature Date Relationship to Patient (if not signed by patient)

FOR OFFICE USE ONLY:_____ _____

Witness Date

REGENERATIVE MEDICINE & PAIN MANAGEMENT PHYSICIANS, PLLC
Ruben B. Timmons, MD

CONTROLLED MEDICATION AGREEMENT

The purpose of this agreement is to give you the information about the medications you will be taking for pain management and to assure that you and your physician comply with all state and federal regulations concerning the prescribing of controlled substances. A trial of narcotic therapy can be considered for moderate to severe pain with the intent of reducing pain and increasing function. The physician's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the physician/patient relationship and full agreement and understanding of the risks and benefits of using narcotics to treat the pain.

1. You should use one physician to prescribe and monitor all narcotic/controlled medications and adjunctive analgesics.

2. You should use one pharmacy to obtain all narcotic/controlled prescriptions and adjunctive analgesics prescribed by your physician.

   Pharmacy: _____ Phone: _____

3. You should inform your physician of all medications you are taking, including herbal remedies, since narcotic mediations can interact with over-the-counter medications and other prescribed medications, especially cough syrups that contain alcohol, codeine or hydrocodone.

4. You will be seen on a regular basis and given prescriptions for enough medications to last from appointment to appointment. In the event that you do have to call for a refill ***you must allow 72 hours for the request to be processed.***

5. Prescriptions for pain medicine or any other prescriptions will be done only during regular office hours. **NO** refills of any medications will be done during the evening, weekends or holidays that the office will be closed.

6. You must bring all controlled medications prescribed by the physician in the original bottles to each office visit.

7. You are responsible for keeping your controlled medication in a safe and secure place, such as a locked cabinet or safe. You are expected to protect your medications from loss or theft. We are not responsible for lost or stolen medications and/or written prescriptions and will not replace medications in the event that this happens.

8. You may not give or sell your medications to any other person under any circumstances. If you do, you may endanger that person's health. It is also against the law.

9. Any evidence of drug hoarding, acquisition of any narcotic medication or adjunctive analgesia from other physicians (which includes emergency rooms), uncontrolled dose escalation or reduction, loss of prescriptions, or **failure to follow the agreement may result in termination of the doctor/patient relationship.**

10. You will communicate fully to your physician, to the best of your ability, at the initial and all follow-up visits your pain level and functional activity along with any side effects of the medications. This information allows your physician to adjust your treatment plan accordingly.

11. You should not use illicit substances, such as cocaine, marijuana, etc. while taking these medications. This may result in a change to your treatment plan, including safe discontinuation of your narcotic medications when applicable or complete termination of the doctor/patient relationship.

12. The use of alcohol and narcotic medications is contraindicated.

13. You agree and understand that your physician reserves the right to perform random or unannounced urine drug testing (as it is required by state law). If requested to provide a urine sample, you agree to cooperate. If you decide not to provide a urine sample, you understand that your doctor may change your treatment plan, including safe discontinuation of your narcotic medications when applicable or complete termination of the doctor/patient relationship. **The presence of a non-prescribed drug(s) or illicit drug(s) in the urine can be grounds for termination of the doctor/patient relationship.**

14. There are side effects with narcotic therapy, which may include, but not limited to; skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, or the possibility of impaired cognitive (mental status) and/or motor ability. Overuse of narcotics can cause decreased respiration (breathing).

15. Physical dependence and/or tolerance can occur with the use of narcotic medications. **Physical dependence** means that if the narcotic medication is abruptly stopped or not taken as directed, a withdrawal symptom can occur. This is a normal physiological response. The withdrawal syndrome could include, but not limited to; sweating, nervousness, abdominal cramps, diarrhea, goose bumps, and alterations in one's mood. It should be notes that physical dependence does not equal addiction. **Addiction** is a primary, chronic neurobiological disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases one's quality of life. **Tolerance** means a state of adaptation in which exposure to the drug induces changes that result in diminution of one or more of the drug's effects over time. The dose of the narcotic may have to be titrated up or down to a dose that produces maximum function and a realistic decrease of the patient's pain.

16. If you have a history of alcohol or drug misuse/addiction, you must notify the physician of such history since the treatment with narcotics for pain may increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one for narcotic treatment of pain, but starting or continuing a program for recovery is a must.

Print Name: _____

Patient Signature: _____ Date: _____

Office Use Only:

Witness Signature: _____ Date: _____

REGENERATIVE MEDICINE AND PAIN MANAGEMENT PHYSICIANS

Ruben B. Timmons, M.D.

WE FILE YOUR INSURANCE AS A COURTESY.

WE ASK THAT YOU ASSIST US IN FILING YOUR CLAIMS CORRECTLY BY MAKING SURE WE ALWAYS HAVE THE CORRECT INSURANCE IN OUR RECORDS. Our office does verify your benefits; however, it is your responsibility to know what your plan covers.

SELF-PAY PATIENT POLICY

If you have insurance, this policy still needs to be signed

Policy: **IF** you are a self-pay patient of Regenerative Medicine and Pain Management Physicians, your signature below states that you are aware that we will not be billing your insurance for your visit. You will be financially responsible for any charges incurred at the office today.

Pricing: Self-pay patients will be required to pay $80 at the time of check in for follow-up visits. If you have a trigger point injection today, you will be required to pay an additional $60 at the time service.

NO SHOW POLICY

If you are unable to keep your scheduled appointment, we ask that you please call the office 24 hours in advance to cancel or reschedule to accommodate another patient. If you cancel or no show without 24 hours' notice you will be charged a $25 no show fee for office visits and $50 for procedures. This fee will **NOT** be billed to your insurance and must be paid **BEFORE** you will be rescheduled.

Please be aware that multiple no shows may also result in you being discharged from the practice.

By signing below, you acknowledge that you have read the policies above and fully understand their terms.

PATIENT NAME: _____ **DATE:** _____

PATIENT SIGNATURE: _____

.....

OFFICE USE ONLY: **WITNESS:** _____ **DATE:** _____

REGENERATIVE MEDICINE AND PAIN MANAGEMENT PHYSICIANS

Ruben B. Timmons, M.D.

PATIENT PRIVATE HEALTH INFORMATION RELEASE FORM

PATIENT NAME: _____

DATE OF BIRTH: _____

Before we can discuss your medical information with anyone, we must have an authorization on file. The physician and his staff have my permission to discuss and/or release my protected information to the following individuals. If you do not want to list anyone, please write "no one".

NAME	RELATIONSHIP	PHONE NUMBER
1.		
2.		
3.		

_____ _____

Patient Signature **Date**

_____ _____

Witness **Date**