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: _____Ethnicity: _____

Employer: _____

Home Phone: _____ Cell Phone: _____

May we leave a detailed message? YES NO Telehealth/Virtual Appointment capability? YES NO UNSURE

E-mail Address: _____

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: _____

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

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

****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.**

PHYSICIANS CONSENT FORM

_____ (initial) I authorize Regenerative Medicine and Pain Management Physicians to provide reasonable and necessary medical examinations, testing and treatment. I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I understand I have the right to discuss the care plan with my physician about the purpose, potential risks, and benefits of any treatment ordered for me.

_____ (initial) I consent to treatment at this office or any other satellite office under common ownership. This consent will remain fully effective until it is revoked in writing. I understand I have the right to discontinue services at any time. I understand that if interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the procedure(s).

_____ (initial) I hereby assign all medical and/or surgical benefits to which I am entitled to Regenerative Medicine & Pain Management Physicians, PLLC. This assignment remains in effect until revoked by me in writing. A facsimile or photocopy of this assignment is to be considered valid as an original. I hereby authorize said assignee to release all information necessary to secure payment. I consent to the release of information by Regenerative Medicine & Pain Management Physicians, PLLC, and its employees/representatives to facilitate peer review and of my treatment including utilization and quality management. I understand that Regenerative Medicine & Pain Management Physicians, PLLC will maintain the confidentiality of this information at all times. I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand that my medical insurance is a contract between myself and the insurance company and/or my employer. Regenerative Medicine & Pain Management Physicians, PLLC is not a party to said contract. I understand that I am responsible for any legal and/or collection fees necessary to settle my account, should it become delinquent.

_____ (initial) 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.

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

_____ (initial) 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

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. OPIOID RISK TOOL:

FAMILY HISTORY OF:

Alcohol abuse?	YES	NO
Illegal drug abuse?	YES	NO
Prescription 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

13. PAST MEDICAL HISTORY: Please circle any of the following that apply to you or check if none apply. ☐

CNS	GENITOURINARY	PSYCHIATRIC
Cerebral Aneurysm	Kidney Disease	Depression
Stroke	Pregnant	Anxiety
Brain Tumor		
Seizure Disorder	**CARDIOVASCULAR**	**METABOLIC**
Neuropathy	Hypertension	Liver Disease
	Valve Disease	Hyperthyroidism
GASTROINTESTINAL	Heart Attack	Hypothyroidism
Hiatal Hernia	Irregular Heartbeat	Cancer
Ulcer	Pacemaker	Diabetes Type I
GERD		Diabetes Type II
BONE/MUSCLE	**RESPIRATORY**	**INFECTIOUS**
Arthritis	Asthma	Hepatitis
Fibromyalgia	Emphysema	HIV/AIDS
	Bronchitis	

14. SURGICAL HISTORY: ☐ Neck ☐ Back ☐ Heart ☐ Abdominal ☐ Other related to pain _____ ☐ N/A

15. FAMILY HISTORY:

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

16. SOCIAL HISTORY:

Employment Status: Full time Part Time Retired Disabled

Marital Status: Married Divorced Separated Widowed Single

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? _____

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

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

Patient signature: _____ 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: _____ Address or Intersection: _____

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. If 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 if 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.**

Preferred lab for submitting urine samples:
_____ Quest Facilities or _____ Ascension Sacred Heart Facilities

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: _____

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 Effective 6/1/2021: Self-pay patients will be required to pay at the time of check in. New patient visits: $250; Follow-up visits: $110; Trigger point injection: $75. Procedure costs vary.

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 so we can 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 "NONE."

NAME	RELATIONSHIP	PHONE NUMBER
1.		
2.		
3.		

_____ _____

Patient Signature **Date**

_____ _____

Witness **Date**