THE ORTHOPAEDIC INSTITUTE
SOUTHERN ILLINOIS WESTERN KENTUCKY

100 Clint Hill Blvd.
Paducah, Kentucky 42001
270-450-7229

MRN: _____

Patient Name: Date of Birth: Date Today:

Social Security Number: _____ Height:____ft_____in Weight:_____lbs

Phone Number: _____

Address: _____

PRIMARY CARE PHYSICIAN and their Location:_____

REFFERING PHYSICIAN and their Location:_____

Do you have any imaging (MRI/CT or X-rays) of your area/s of pain? oYes o NO

If yes, WHERE and WHEN were imaging studies done?_____

DESCRIBE YOUR PAIN

Main reason for visit:

How & when did the current pain start?

Have you ever had this pain before? o Yes o No If yes, how long ago?

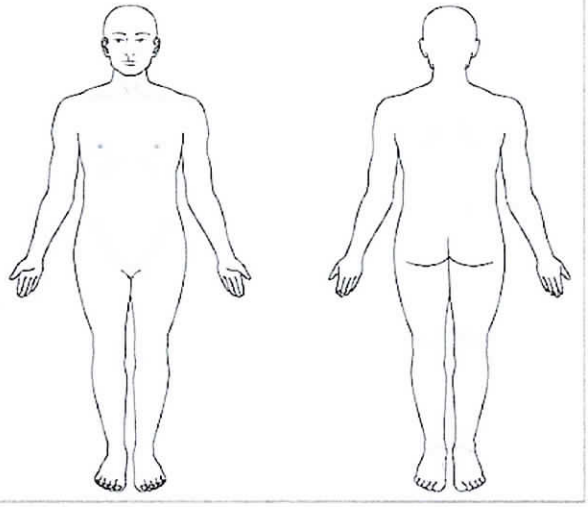
Instructions:

1. **On the body diagram to the right, indicate where your pain to be addressed today is located. DO NOT indicate areas of pain that are not related to your present injury or condition. Only 1 body area at a time will be treated.**

2. **On the line below, place an "X" to describe your present pain level.**

No Pain — Worst Pain

1 2 3 4 5 6 7 8 9 10



PAIN		
Describe your pain (mark all that apply):	**Pain is aggravated by (mark all that apply):**	**Pain is improved by (mark all that apply):**
o Aching o Constant o Cramping o Dull o Electric o Hot/Burning o Intermittent o Numbness o Pressure o Tingling o Sharp o Shooting o Spasms o Stabbing o Throbbing o Weakness o Other:_____	o Activity o Bending o Changing Position o Exercise o Lifting o Lying Down o Movement o Repetitive Motion o Sitting o Standing o Stress o Walking o Work o Other:_____	o Activity o Bending o Heat o Ice o Injections o Lying Down o Medications o Nothing o Sitting o Stretching o Rest o TENS Unit o Other:_____

MRN:_____

PAIN MEDICATIONS & THERAPIES

Pain level before taking pain medication: 0 1 2 3 4 5 6 7 8 9 10

Pain level after taking pain medication: 0 1 2 3 4 5 6 7 8 9 10

Activities you can do as a result of taking pain medications: (Please be specific. Examples: cooking, laundry, etc...)

_____ _____ _____ _____

_____ _____ _____ _____

Pain Medications You Are **Currently** Taking: Please include the dose and frequency of each medication you take.

	dose/frequency		dose/frequency
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

Pain Medications **Previously** Tried (no longer taking): Mark all that apply.

- o Acetaminophen (Tylenol)
- o Gabapentin
- o Lyrica
- o Muscle Relaxers: cyclobenzaprine, methocarbamol, tizanidine, metaxalone
- o NSAIDs: ibuprofen, naproxen, diclofenac, meloxicam
- o Opioids: hydrocodone, oxycodone, fentanyl, morphine, hydromorphone, tramadol, methadone, buprenorphine
- o SNRI's: duloxetine, venlafaxine, milnacipran
- o Steroids: prednisone, methylprednisolone
- o Topicals: Lidocaine, diclofenac, menthol, capsaicin, compound
- o Tricyclics (TCAs): amitriptyline, nortriptyline
- o Other_____

CURRENT/ PREVIOUS TREATMENTS FOR THIS PAIN:

Pain Management

Facility/ Physician: _____

Why are you no longer being treated there?_____

Date of last injection: _____ Type of Injection/s: _____

Physical Therapy

Was physical therapy tried? o Yes o No

Did physical therapy help? o Yes o No

Location of PT_____

Date PT was last completed_____ Total durration of PT ____ weeks.

Chiropractic Therapy

Was chiropractic therapy tried? o Yes o No

Did chiropractic therapy help? o Yes o No

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MRN: _____

ALLERGIES: _____

o No Known Drug Allergies

SOCIAL HISTORY		
Alcohol Use	**O None**	**O Yes Number of drinks: _____ per day** **Frequency; _____**
Tobacco Use	**O None**	**O Yes Smoke, or Other: _____** **# of packs per day_____** **O Quit Date: _____**
Other Drug Use (Recreational/Illicit)	**O None**	**O Yes What Drugs: _____** **Frequency: daily weekly monthly rarely** **When last used_____**

SURGICAL HISTORY Include year of each surgery		
1. _____	4. _____	7. _____
2. _____	5. _____	8. _____
3. _____	6. _____	9. _____

MEDICAL HISTORY (mark all that apply)		
oAlcohol Abuse	o Drug Abuse	o Osteoporosis
o Alzheimer's Disease	o High Cholesterol	o Parkinson's Disease
o Anemia	o Fibromyalgia	o Peptic (Gastric) Ulcer
o Angina (chest pain)	o Gout	o Psoriasis
o Anxiety	o Headache	o Schizophrenia
o Asthma	o Heart Disease	o Scoliosis
o Arthritis: Rheumatoid or Osteo	o Hepatitis, Type_____	o Seizure Disorder
o Bipolar Disorder	o Kidney (Renal) Disease	o Sleep Apnea
o Cancer, Type_____	o Liver Disease	o Stroke
o Congestive Heart Failure	o Hypertension	o Systemic Lupus Erythematosus
o Crohn's Disease	o Myocardial Infarction	o Thyroid Disease
o Deep Vein Thrombosis	o Obesity	o Other:_____
o Depression		
o Diabetes		

FAMILY HISTORY (mark all that apply)		
o Alcoholism	o COPD	o Osteoporosis
o Alzheimer's Disease	o Depression	o Parkinson's Disease
o Cancer, Type:_____	o Diabetes	o Peripheral Vascular Disease
o Heart Disease	o Drug Abuse	o Renal Disease
	o High Cholesterol	o Seizure Disorder
	o Hypertension	o Stroke
	o Liver Disease	o Thyroid Disorder
		o Other:_____

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REVIEW OF SYSTEMS

Circle any symptoms/conditions which apply or that you are currently experiencing:
General o Chills o Fever o Night Sweats o Weight Gain o Weight Loss o Fatigue o Weakness o Malaise (discomfort)
HEENT o Blurred Vision o Fascial Pain o Nasal Congestion o Double Vision o Headache o Ringing Ears o Dysphagia (difficulty swallowing) o Hearing Loss o Vertigo o Ear Drainage o Hoarseness o Vision Loss
Respiratory O Chest Pain o Dyspnea (shortness of breath) o Known TB Exposure o Cough o Wheezing O Recent Infections
Cardiovascular o Chest Pain o Heart Murmur o Syncope o Cyanosis (Bluish) o Leg Swelling o Irregular Heartbeat/Palpitations
Gastrointestinal o Abdominal Pain o Diarrhea o Loss of Appetite o Constipation o Heartburn o Nausea o Black Tarry Stools o Jaundice o Vomiting
Genitourinary o Dysuria (Painful Urination) o Urge Incontinence o Frequent Urination 0 Urinary Incontinence o Hematuria (Blood in Urine)
Metabolic/Endocrine o Cold Intolerant o Hair Loss o Heat Intolerant
Neurological o Difficulty Walking o Memory Loss o Seizures o Dizziness o Muscle Weakness o Tremors o Poor Coordination o Paresthesia (Pins & Needles Feeling)
Psychiatric o Anxiety o Depression o Insomnia
Integumentary o Contact Allergy o Rash o Skin Lesion o Itchy Skin o Skin Infections
Hematologic o Bleeding o Bruising
Immunological o Asthma o Contact Dermatitis o Food Allergies o Bee Sting Allergies o Environmental Allergies o Seasonal Allergies

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UPDATED MEDICATION LIST

List all current medications including pain meds and non-pain meds.

	Medication	Dosage		Medication	Dosage
1.			11.		
2.			12.		
3.			13.		
4.			14.		
5.			15.		
6.			16.		
7.			17.		
8.			18.		
9.			19.		
10.			20.		

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Date _____

Patient Name _____

OPIOID RISK TOOL©

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 – 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder Obsessive Compulsive Disorder Bipolar Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
TOTAL		[ ]		

Total Score Risk Category Low Risk 0 – 3 Moderate Risk 4 – 7 High Risk ≥8

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BILLING INFORMATION, FINANCIAL POLICY, INFORMATION RELEASE

Billing Information

This office is required by Federal compliance law to report the services provided based on the documentation in the medical record, as a matter of policy, we cannot improperly alter a claim for the purpose of obtaining payment. If you discover a bona fide billing error, duplicate charge, or other posting error, we would greatly appreciate you bringing the matter to the attention of our business office staff for further investigation, upon which further corrective action may be taken. If you receive a questionnaire from your insurance asking how your injury occurred, please complete the form, and return it promptly. Your insurance company will not pay until the form is returned to them. Insurance coverage and payment amounts vary greatly by payer. If you have any questions about your coverage, it is best to inquire with your insurance company's representative. Our business staff is happy to assist in the claims filling process for prompt adjudication and payment of your insurance claim.

Financial Policy

Contracted insurances: Medicare, Railroad Medicare, Kentucky Medicaid, Health Alliance HMO, Health Alliance PPO, Healthlink HMO (Tier I & Tier II), Aetna, Wexford, Corvel Group Health Plan, Anthem BC BS, Federal BC BS plan, UMWA H&R Fund, Harmony Health, and United Healthcare. Any co-payments assigned by your specific insurance plan are due at the time of service.

Private Insurance: We will submit your claim to your insurance company for payment. You are responsible for pay8ing all balances not paid by your insurance company. Your insurance policy is a contract between you and your insurance company- we are not a party to that contract. If your insurance company does not remit payment within 90 days, you are ultimately responsible for your balance due.

No Insurance: Full payment is due at the time of service unless you have made prior arrangements with a member of our billing department by calling 270-450-7224. We gladly accept payment via cash, check, CISA, Mastercard, or Discover. Worker's Compensation: Charges will be submitted for you IF all information has been fully furnished and agreed to by your employer. If all information is not provided, we assume and expect payment from you. "I authorize any treating physician or management consultant, field nurse case manager, and/or attorneys as to the treatment provided associated with my assumed work-related injury and do hereby waive my physician-patient privilege."

Authorization: "I authorize OIWK Pain Center to release records pertaining to my health to insurance companies, referring physicians, attorneys, employer, employer's insurance company, case manager, field nurse case manager, claims administrator and/or my other responsible party. I authorize release of my x-rays to above said persons. I request payment under the medical insurance program to be made directly to appropriate above said physicians. Should my account become delinquent and referred to collection, I shall pay all reasonable collection expenses, court costs, and attorney fees associated.

"I have read and understand the billing information, financial policy, and information release, and agree to the contents."

Patient Signature: _____ Date: _____

Signature of other Responsible Party: _____ Date: _____

NOTICE OF PRIVACY UPDATES

I, _____, have read the notice of privacy practices, and authorize the purpose described herein. I understand that by signing this document, I release the Orthopaedic Institute of Western Kentucky harmless for any release made pursuant to this authorization.

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PAYMENT AUTORIZATION FORM

We are committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner for all our patients, we ask that you adhere to our practice's financial policy. **By signing below, you are agreeing to its terms.**

1. I am ultimately responsible for payment of charges for services I receive from this practice including those covered by my insurance. As a convenience, this practice will submit claims for reimbursement with my insurance provider; however, all payment responsibility is ultimately mine.
2. Some immediate payment may be expected at the time of service. This may include a co-pay and additional payment if this practice determines that the cost of my visit today will not be reimbursed by my insurance provider. This often happens if my deductible is not yet satisfied.
3. This practice may deny service for failure to pay a co-pay at the time of service.
4. It is my responsibility to provide my current address, telephone number, email address, and insurance information at each visit.
5. I agree to provide that above practice and/or its designated payment agent with my debit/credit card and/or banking information.
6. **I understand that my signature and payment information will be maintained on file for future use by the practice. The applicable payment card or bank account number will be truncated and "tokenized" by the payment agent in order to help maintain the security of my payment information.**
7. If warranted, this practice may offer the option of paying my share of costs via an automated payment plan.
8. **I authorize the above practice and/or its designated payment agent to apply charges to my payment card and/or bank account for all amounts owed to the practice for medical visits, procedures or supplies.,** including (i) amounts agreed as part of a payment plan, (ii) copayments, (iii) coinsurance (after application of insurance proceeds), (iv) amounts not covered by insurance and/or (v) fees (if applicable) charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation. **For office and Ancillary Tests, a maximum of $50 per month will be charged until patient financial responsibility, less payment at time of service, has been fully paid.** For MRI's and Surgery services, amount charged will be the amount designated on the approved payment plan.
9. In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I may receive a monthly statement for any outstanding balance. I am responsible for paying this balance by its due date.
10. If a payment balance arranged and I have provided a valid email address, the Orthopaedic Institute will make reasonable attempts to provide advance notice of payments authorized hereunder for transactions up to an amount specified by me. I will be provided with a courtesy notification prior to processing any payment in excess of such amount.
11. I authorize the above practice and/or its designated provider to send electronic account statements and invoices to my email address on file. I understand that I will not receive a copy of any such invoice via U.S. Mail. I understand that it is always my responsibility to maintain a current email address on file with the practice.

This authorization will remain in effect until I provide written notice of cancellation to the practice. I understand that I can cancel the authorization only for future services. Authorization for services already rendered cannot be cancelled or refunded.

I agree to notify the practice in writing of any changes in my payment or other information.

Account Holder: _____ Email Address: _____

Billing Address: _____

Phone Number: _____

Account Holder Signature: _____ Date: _____

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NICOTINE POLICY

We at the Orthopedic Institute Pain Management Center of Western Kentucky have a no-nicotine policy. If you are currently a smoker or using any nicotine products (chewing tobacco, nicotine gum, and nicotine patches, etc..) and we are treating you with opioid medication, you will be given 6 months to be completely nicotine free or we will no longer prescribe your opioid medication. This policy is based on our stance that the use of nicotine products greatly affects your overall pain status. In addition, nicotine disrupts your pain cycle and limits the effectiveness of medication.

Patient/Authorized Signature: _____ **Date:** _____

or

By signing below, you are certifying that you do not smoke and do not use nicotine products of any kind.

Patient/Authorized Signature: _____ **Date:** _____