MD PAIN

New Patient Paperwork

SPORT, SPINE, AND PAIN MANAGEMENT

Phone: 303-750-8100/Fax: 303-369-1891

Referral Information

Referring Physician: _____ Phone: _____ Fax: _____

Primary Care Physician: _____ Phone: _____ Fax: _____

Other provider(s) you would like MD Pain to notify of today's office visit:

Provider: _____ Phone: _____ Fax: _____

Provider: _____ Phone: _____ Fax: _____

Patient Information

Patient Name: _____ Appointment Date: _____

Driver's License Number/State: _____ Social Security Number (last 4 #s): _____

Date of Birth: _____ Age: _____ Gender: ❑ Male ❑ Female

Home Address: _____ City/State/Zip: _____

Mailing Address different than Home Address: ❑ Yes ❑ No If yes, provide mailing address:

Mailing Address: _____ City/State/Zip: _____

Preferred Phone Number: _____ ❑ Home ❑ Mobile ❑ Work

Secondary Phone Number: _____ ❑ Home ❑ Mobile ❑ Work

Email: _____

Emergency Contact Name: _____ Relationship: _____

Emergency contact phone number: _____

Race: ❑ Native American ❑ Alaska Native ❑ Asian/Pacific Islander ❑ African American/Black
❑ Caucasian/White ❑ Other

Ethnicity: ❑ Hispanic/Latino ❑ Non-Hispanic ❑ Other/Undetermined

Preferred Language: ❑ English ❑ Spanish ❑ Other: _____

Primary Insurance Plan

Insurance Company: _____ Telephone: _____

Policy/ID Number: _____ Group Number: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Relationship to Subscriber: _____

Secondary Insurance Plan

Insurance Company: _____ Telephone: _____

Policy/ID Number: _____ Group Number: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Relationship to Subscriber: _____

Workers' Compensation/Personal Injury Claim Information (fill out only if applicable)

Is this visit related to a **Workers' Compensation Claim**? ❑ Yes ❑ No

Insurance Company/Work Comp Carrier: _____ Date of Injury: _____

Claim ID: _____ Adjuster's Name: _____

Adjuster's Telephone: _____ Adjuster's Fax: _____

Claim Submission Address: _____

Is this visit related to an **auto or other accident and filed under a personal injury claim**? ❑ Yes ❑ No

Personal Injury Attorney's Name: _____ Phone: _____

Personal Injury Attorney's Practice Name: _____

Preferred Pharmacy

Pharmacy Name: _____ Phone Number: _____

Street Address: _____ City/State/Zip: _____

CLINICAL INFORMATION

Today's Date: _____

Your Name: _____ **Age:** _____ **Gender:** ❑ M ❑ F

Hand Dominance

❑ Right hand-dominant ❑ Left hand-dominant ❑ Ambidextrous (able to use both hands equally)

Please indicate your WORST PAIN or CHIEF COMPLAINT (Please mark only one)

❑ Headache	❑ Groin	❑ Anal/Rectal	❑ Left Shoulder
❑ Facial	❑ Neck	❑ Vaginal/Scrotal (circle)	❑ Right Shoulder
❑ Chest Wall	❑ Mid Back	❑ Left Upper Extremity	❑ Left Hip
❑ Breast	❑ Low Back	❑ Right Upper Extremity	❑ Right Hip
❑ Abdominal	❑ Buttock	❑ Left Lower Extremity	❑ Left Knee
❑ Pelvic	❑ Tailbone	❑ Right Lower Extremity	❑ Right Knee

Other pain location? _____

Please indicate ALL ADDITIONAL areas of pain (Please mark all that apply)

❑ Headache	❑ Groin	❑ Anal/Rectal	❑ Left Shoulder
❑ Facial	❑ Neck	❑ Vaginal/Scrotal (circle)	❑ Right Shoulder
❑ Chest Wall	❑ Mid Back	❑ Left Upper Extremity	❑ Left Hip
❑ Breast	❑ Low Back	❑ Right Upper Extremity	❑ Right Hip
❑ Abdominal	❑ Buttock	❑ Left Lower Extremity	❑ Left Knee
❑ Pelvic	❑ Tailbone	❑ Right Lower Extremity	❑ Right Knee

Other pain location? _____

History of COMMON PAINFUL CONDITIONS OR ILLNESSES (Please mark all that apply)

Please indicate if you have had any of the following common PAIN problems: (Mark ALL that apply)

❑ Headache	❑ Neuropathy	❑ Chronic back pain	❑ Chronic abdominal/pelvic pain
❑ Fibromyalgia	❑ Scoliosis	❑ Chronic neck pain	❑ Vertebral compression fracture
❑ Osteoarthritis	❑ Stroke	❑ RSD/CRPS	❑ Cancer-related pain
❑ Rheumatoid Arthritis	❑ Hepatitis	❑ Sickle cell anemia	❑ Autoimmune disease
❑ Chronic Sciatica	❑ Crohn's disease	❑ Interstitial cystitis	❑ Post-herpetic neuralgia
❑ Kidney disease	❑ Ulcerative colitis	❑ Multiple sclerosis	❑ Other: _____

ONSET and FREQUENCY of pain

How did the current pain episode begin? ❑ Gradually ❑ Abruptly

When did your pain first begin? Exact Date _____ or approximately _____ ❑ Months ❑ Years ago

What caused your pain? ❑ Surgery ❑ A Fall ❑ Accident at work ❑ Car Accident ❑ Sports Injury
❑ Normal Aging ❑ Unknown ❑ Other: _____

Since the pain started, how has it changed? ❑ Decreased ❑ Increased ❑ Unchanged

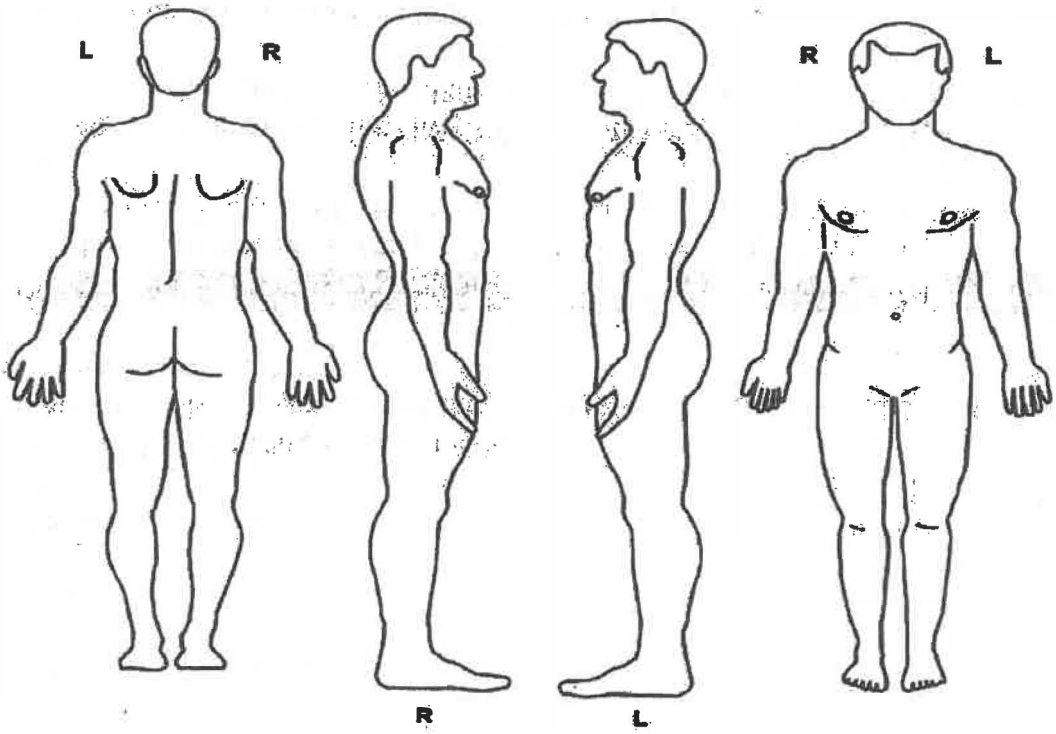
The frequency of my pain currently is: ❑ constant and never changing ❑ fluctuating but always present
❑ fluctuating but usually present ❑ fluctuating but rarely present

Pain SEVERITY, LOCATION, DESCRIPTION & OTHER FACTORS that affect your pain

Please rate your pain severity: (0 = No pain, 10 = Unbearable pain)

Now:	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10
Worst:	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10
Least:	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10
Average:	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10

Please describe your pain. Use the pictures below to mark the areas on your body where you feel the described sensations.



Use the following letters to describe your pain.

Ache = A
Burning = B
Cramping = C
Dull = D
Numbness = N
Pins/Needles = P
Stabbing = S
Throbbing = T
Muscle Spasm = M

Draw arrows where the pain radiates

Please indicate if the following **INCREASE** or **DECREASE** your pain:		
	Increase	Decrease
Heat		
Cold		
Weather Changes		
Sitting		
Standing		
Walking		
Exercise		
Bending forward		
Leaning back		
Twisting at waist		
Looking up		
Leaning back		
Turning head		
Lying down		
Lying on side (R/L)		
Massage		
Physical therapy		
Bowel movement		
Sneezing/Coughing		
Stress		
Medications		
Other:		

When is your pain worse?

- ❑ Morning
- ❑ During the day
- ❑ Evening
- ❑ In the middle of the night
- ❑ Other _____

Do you have any other symptoms associated with your pain?

- ❑ Sweating
- ❑ Skin color changes
- ❑ Swelling
- ❑ Hair/nail growth changes
- ❑ Skin temperature changes
- ❑ Bowel or bladder changes
- ❑ Dizziness
- ❑ Headaches
- ❑ Blurred vision
- ❑ Other _____

In the past 3 months have you developed any new symptoms?

- ❑ Balance problems
- ❑ Difficulty walking
- ❑ Bladder incontinence
- ❑ Bowel Incontinence
- ❑ Weakness; Where? _____
- ❑ Numbness; Where? _____
- ❑ Fine motor control problems (buttoning shirt, using a pencil, etc.)
- ❑ Falls/Near Falls; Date _____
- ❑ Use of assistive devices: ❑ Cane ❑ Walker ❑ Other_____
- ❑ Other symptoms (please explain) _____

How does your pain affect your functional abilities? (0 = Does not affect, 10 = Significant affect)

- Activities of daily living, such as hygiene & household chores: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
- Ability to function and interact well with family and friends: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
- Work in my usual occupation: (❑ if not working) ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
- Ability to sleep well: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Previous Pain Management Providers

Have you previously been under the care of a PAIN MANAGEMENT SPECIALIST? ❑ Yes ❑ No

If 'Yes', please list up to the two most recent physicians you have seen:

Name	Address/City/State/Zip Code
1.	
Why are you no longer under the care of this physician?	
2.	
Why are you no longer under the care of this physician?	

Current PAIN medications

Please list ALL CURRENT PAIN MEDICATIONS. Include all prescription and over-the-counter medications.

Medication Name	Dose (mg)	Frequency	Prescribing Provider	No Relief	Mild Relief	Moderate Relief	Excellent Relief

❑ I am currently not taking any pain medications.

If you are currently taking pain medications, will the prescribing provider continue to prescribe these medications? ❑ Yes ❑ No

Current PAIN medication EFFECTIVENESS and SIDE EFFECTS

Overall, do your pain medications provide PAIN RELIEF? ❑ Yes ❑ No ❑ N/A

If 'Yes', how much? ❑10% ❑20% ❑30% ❑40% ❑50% ❑60% ❑70% ❑80% ❑90% ❑100%

Overall, do your pain medications IMPROVE YOUR FUNCTION? ❑ Yes ❑ No ❑ N/A

If 'Yes', how much? ❑10% ❑20% ❑30% ❑40% ❑50% ❑60% ❑70% ❑80% ❑90% ❑100%

Overall, do your pain medications IMPROVE YOUR QUALITY OF LIFE? ❑ Yes ❑ No ❑ N/A

If 'Yes', how much? ❑10% ❑20% ❑30% ❑40% ❑50% ❑60% ❑70% ❑80% ❑90% ❑100%

Please indicate any SIDE EFFECTS caused by your current pain medication (Mark ALL that apply)

❑ Nausea	❑ Rash	❑ Confusion	❑ Acid Reflux	❑ Memory loss
❑ Vomiting	❑ Itching	❑ Dizziness	❑ Constipation	❑ Other: _____
❑ Diarrhea	❑ Sedation	❑ Upset Stomach	❑ Urinary retention	❑ **No Side Effects**

PAIN and RELATED medication history

Please mark all medications you have TRIED IN THE PAST FOR PAIN or PAIN-RELATED ISSUES (sleep problems, etc.) and their EFFECTTIVENESS. (Mark only those that apply)

OPIOIDS ❑ I have never taken opioid medications

If you have ever been prescribed opioids, what was your age when you first starting taking them? _____

Medication	Helpful	Not Helpful	Side Effects	Medication	Helpful	Not Helpful	Side Effects	Medication	Helpful	Not Helpful	Side Effects
Fentanyl (Duragesic patch, Actiq, Fentora, Subsys)				Propoxyphene (Darvocet, Darvon)				Tramadol (Ultram, Ultram ER, Tramadol ER, Ryzolt)			
Morphine (Avinza, Embeda, MS Contin, Kadian, Morphabond, MSER)				Oxymorphone (Opana, Opana ER)				Codeine (Tylenol #3, #4)			
Methadone (Dolophine)				Hydromorphone (Dilaudid, Exalgo)				Meperidine (Demerol)			
Oxycodone (Roxicodone, Percocet, Endocet, OxyContin)				Hydrocodone (Vicodin, Norco, Lortab, Hysingla, Zohydro)				Other:			
Buprenorphine (Butrans, Belbuca, Buprenex, Suboxone, Subutex)				Tapentadol (Nucynta, Nucynta ER)							

ANTI-INFLAMMATORIES ❑ I have never taken anti-inflammatories

Medication	Helpful	Not Helpful	Side Effects	Medication	Helpful	Not Helpful	Side Effects	Medication	Helpful	Not Helpful	Side Effects
Etodolac (Lodine)				Oxaprozin (Daypro)				Piroxicam (Feldene)			
Ibuprofen (Advil, Motrin)				Meloxicam (Mobic)				Indomethacin (Indocin)			
Naproxen (Aleve, Naprosyn)				Diclofenac (Arthrotec, Voltaren, Zipsor, Flector patch)				Ketorolac (Toradol)			
Celecoxib (Celebrex)				Nabumetone (Relafen)				Other:			

ASPIRIN and ACETAMINOPHEN ❑ I have never taken Aspirin or acetaminophen

Medication	Helpful	Not Helpful	Side Effects	Medication	Helpful	Not Helpful	Side Effects				
Aspirin				Acetaminophen (Tylenol)							

MUSCLE RELAXANTS ❑ I have never taken muscle relaxants

Medication	Helpful	Not Helpful	Side Effects	Medication	Helpful	Not Helpful	Side Effects	Medication	Helpful	Not Helpful	Side Effects
Baclofen (Lioresal)				Chloroxazone (Parafon-Forte, Lorzone)				Tizanidine (Zanaflex)			
Cyclobenzaprine (Flexeril, Amrix)				Orphenadrine (Norflex)				Diazepam (Valium)			
Methacarbamol (Robaxin)				Metaxalone (Skelaxin)				Other:			
Carisoprodol (Soma)											

ANTIDEPRESSANTS (SSRIs, SNRIs) ❑ I have never taken antidepressants

Medication	Helpful	Not Helpful	Side Effects	Medication	Helpful	Not Helpful	Side Effects	Medication	Helpful	Not Helpful	Side Effects
Duloxetine (Cymbalta)				Bupropion (Wellbutrin)				Desvenlafaxine (Pristiq)			
Venlafaxine (Effexor, Effexor XR)				Citalopram (Celexe)				Fluoxetine (Prozac)			
Amitriptyline (Elavil, Endep)				Escitalopram (Lexapro)				Nefazodone (Serzone)			
Nortriptyline (Pamelor, Aventyl)				Sertraline (Zoloft)				Milnacipran (Savella)			
Mirtazapine (Remeron)				Protriptyline (Vivactil)				Trazodone (Desyrel)			
Desipramine (Pertofran, Norpramine)				Doxepin (Sinequan, Silenor)				Other:			
Imipramine (Tofranil)				Paroxetine (Paxil)							

ANTICONVULSANTS ❑ I have never taken anticonvulsants

Medication	Helpful	Not Helpful	Side Effects	Medication	Helpful	Not Helpful	Side Effects	Medication	Helpful	Not Helpful	Side Effects
Gabapentin (Neurontin, Gralise)				Carbamazipine (Tegretol)				Oxcarbazepine (Trileptal)			
Pregabalin (Lyrica)				Levetiracetam (Keppra)				Lamotragine (Lamictal)			
Topiramate (Topamax, Trokendi XR, Qudexy XR)				Zonisamide (Zonegran)				Other:			
Tiagabine (Gabatril)				Valproic Acic (Depakote, Depakene)							

OTHER MEDICATIONS FOR PAIN or HEADACHES ❑ I have never taken these medications

Medication	Helpful	Not Helpful	Side Effects	Medication	Helpful	Not Helpful	Side Effects	Medication	Helpful	Not Helpful	Side Effects
Sumatriptan (Imitrex)				Nifedipine (Procardia)				Olmesartan (Benicar)			
Rizatriptan (Maxalt)				Nimodipine (Nimotop, Nymalize)				Valsartan (Diovan)			
Zolmitriptan(Zomig)				Metoprolol (Lopressor, Toprol)				Butalbital/acetaminophen/caffeine (Fioricet)			
Fovatriptan (Frova)				Propranolol (Inderal)				Butalbital/aspirin/caffeine (Fiorinal)			
Eletriptan (Relpax)				Nadolol (Corgard)				Acetaminophen/dichloralphenazone/Isometheptene (Midrin)			
Almotriptan (Axert)				Atenolol (Tenormin)				Lidoderm patches (Lidocaine patch)			
Naratriptan (Amerge)				Lisinopril (Zestril, Prinivil)				Hydroxyzine (Vistaril)			
Sumatriptan/Naproxen (Treximet)				Rimipril (Altace)				Mexilitine (Mexitil)			
Ergotamine (Ergostat, Cafergot, DHE, Migranal, Migergot)				Enalapril (Vasotec)				Steroids (cortisone, Medrol dose pack, prednisone)			
Methylsergide (Sansert)				Candesartan (Atacand)				OnabotulinumtoxinA (BOTOX) injections			
Diltiazem (Cardiazem)				Irbesartan (Avapro)				Lithium			
Verapamil (Calan, Isoptin, Verelan)				Losartan (Cozaar)				Other:			

SLEEP AIDS ❑ I have never taken sleep aids											
Medication	Helpful	Not Helpful	Side Effects	Medication	Helpful	Not Helpful	Side Effects	Medication	Helpful	Not Helpful	Side Effects
Zolpidem (Ambien)				Ramelteon (Rozerem)				Trazodone (Desyrel)			
Eszopiclone (Lunesta)				Sodium Oxybate (Xyrem)				Melatonin			
Temazepam (Restoril)				Doxepin (Silenor)				Other:			
Zaleplon (Sonata)				Suvorexant (Belsomra)							
SEDATIVES AND ANTI-ANXIETY MEDICATIONS ❑ I have never taken sleep aids											
Medication	Helpful	Not Helpful	Side Effects	Medication	Helpful	Not Helpful	Side Effects	Medication	Helpful	Not Helpful	Side Effects
Alprazolam (Xanax)				Clonazepam (Klonopin)				Lorazepam (Ativan)			
Diazepam (Vallum)				Clorazepate (Tranxene)				Other:			

Have you ever tried **Prescription** creams such as EMLA cream, Volatren gel, etc. for your pain? ❑ Yes ❑ No
Have you ever tried **Compounded** pain creams from a specialty pharmacy? ❑ Yes ❑ No

Previous Treatments

Mark any TREATMENTS FOR YOUR PAIN that you have had PRIOR to this visit: (Mark ALL that apply)

Treatment	Body Part/Area/Level	Date(s)	Improvement/Effect				
			Worse	None	Mild	Moderate	Excellent
Chiropractic							
Acupuncture							
Massage Therapy							
Physical Therapy							
Aqua/Pool Therapy							
Weight Loss Program							
Neck/Back Brace							
TENS Unit							
Trigger Point Injection							
Epidural Steroid Injection							
Facet Injection							
Medial Branch Blocks							
Radiofrequency Ablation							
Sacroiliac Joint Injection							
Other Joint Injection							
Peripheral Nerve Block							
Sympathetic Nerve Block							
Spinal Cord Stimulator							
Intrathecal (Pain) Pump							
Ketamine Infusion							
Vertebroplasty							
Kyphoplasty							
Other Treatment:							

❑ I have not had any treatments for my current pain complaint(s).

Diagnostic Tests and Imaging

List any TESTS or STUDIES you have had to evaluate your current pain complaint(s): (Mark ALL that apply)

Test	Body Part/Area	Date(s)	Facility
X-ray			
CT Scan			
MRI			
EMG/NCV Study			
Discogram			
Other:			

❑ I have not had any diagnostic test performed for my current pain complaints.

Past Medical History

Please check the following medical conditions you have or have had in the past: (❑ I have *never* had any medical problems.)

Head/Eyes/Ears/Nose/Throat
- ❑ Headaches
- ❑ Migraines
- ❑ Head Injury
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Blindness
- ❑ Deafness
- ❑ Hyperthyroidism
- ❑ Hypothyroidism

Respiratory
- ❑ Asthma
- ❑ Chronic Bronchitis
- ❑ COPD
- ❑ Emphysema
- ❑ Lung Cancer
- ❑ Pneumonia
- ❑ Tuberculosis

Cardiovascular
- ❑ Heart Attack
- ❑ High Blood Pressure
- ❑ Murmur
- ❑ Mitral Valve Prolapse
- ❑ Coronary Artery Disease
- ❑ Pacemaker
- ❑ Defibrillator
- ❑ Peripheral Vascular Disease
- ❑ Deep Vein Thrombosis

Hematologic
- ❑ Anemia
- ❑ HIV/AIDS
- ❑ Bleeding Disorder
- ❑ High Cholesterol
- ❑ Protein C/S Deficiency
- ❑ Systemic Lupus Erythematosus
- ❑ Protein C/S Deficiency
- ❑ Lymphoma
- ❑ Leukemia

Gastrointestinal
- ❑ Gastritis
- ❑ Gastric Ulcers
- ❑ GERD (Acid Reflux)
- ❑ Bowel Incontinence
- ❑ Diarrhea
- ❑ Constipation
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ Liver Cancer
- ❑ Liver Failure
- ❑ Pancreatitis
- ❑ Diabetes Type I
- ❑ Diabetes Type II

Musculoskeletal
- ❑ Amputation
- ❑ Phantom Limb Pain
- ❑ Bursitis
- ❑ Carpal Tunnel Syndrome
- ❑ Chronic Low Back Pain
- ❑ Chronic Neck Pain
- ❑ Chronic Knee Pain
- ❑ Chronic Hip Pain
- ❑ Chronic Shoulder Pain
- ❑ Rheumatoid Arthritis
- ❑ Osteoarthritis
- ❑ Osteopenia
- ❑ Osteoporosis
- ❑ Vertebral Body Fracture

Genitourinary/Kidney
- ❑ Kidney Disease
- ❑ Kidney Cancer
- ❑ Acute Renal Failure
- ❑ Chronic Renal Failure
- ❑ Kidney Stones
- ❑ Urinary Incontinence

Neurologic
- ❑ Multiple Sclerosis
- ❑ Alzheimer's Disease
- ❑ Parkinson's Disease
- ❑ Restless Leg Syndrome
- ❑ Epilepsy/Seizures
- ❑ Trigeminal Neuralgia
- ❑ Other Neuralgia's
- ❑ Peripheral Neuropathy

Psychologic
- ❑ Anxiety
- ❑ Depression
- ❑ Schizophrenia
- ❑ Bipolar Disorder
- ❑ Prescription Drug Abuse
- ❑ Illegal Drug Use
- ❑ Alcohol Abuse

Please list any other medical conditions you have had that are not listed above:

Past Surgical History

Please indicate any surgical procedures you have had in the past, including the dates, type and pertinent details. (❑ I have *never* had any surgical procedures.)

Abdominal Surgery:
- ❑ Gallbladder removal _____
- ❑ Appendix removal _____
- ❑ Hernia repair _____
- ❑ Laparotomy _____
- ❑ Gastric bypass _____
- ❑ Other _____

Cardiovascular Surgery:
- ❑ Coronary artery bypass _____
- ❑ Valve replacement _____
- ❑ Stent placement _____
- ❑ Aneurysm repair _____
- ❑ Peripheral vascular surgery _____
- ❑ Other _____

Orthopedic/Joint Surgery:
- ❑ Foot/Ankle surgery _____
- ❑ Knee scope/repair _____
- ❑ Knee replacement _____
- ❑ Hip scope/repair _____
- ❑ Hip replacement _____
- ❑ Shoulder surgery _____
- ❑ Other _____

Gynecological Surgery:
- ❑ Hysterectomy _____
- ❑ Tubal Ligation _____
- ❑ C-section _____
- ❑ Laparoscopy _____
- ❑ Other _____

Spine & Back Surgery:
- ❑ Cervical (neck) fusion _____
- ❑ Lumbar (lower back) fusion _____
- ❑ Laminectomy _____
- ❑ Discectomy _____
- ❑ Other _____

Common Surgery:
- ❑ Prostatectomy _____
- ❑ Thyroidectomy _____
- ❑ Tonsillectomy _____

Please list any other surgical procedures you have had not listed above:

_____

_____

Current NON-Pain Medications (such as those to treat high blood pressure, high cholesterol, etc.)

Please list ALL NON-PAIN medications. Include prescription, over-the-counter medications and herbal supplements. (Use separate page if necessary)

Medication Name	Dose	Frequency

Medication Name	Dose	Frequency

Blood-thinning Medication

Please indicate which, if any, of the following BLOOD THINNING medications you are taking: (Mark ALL that apply) ❑ I am not CURRENTLY taking any blood thinners.

- ❑ Aspirin (❑81 mg ❑ 325 mg)
- ❑ Pletal (cilostazol)
- ❑ Persantine (dipyridamole)
- ❑ Aggrenox (dipyridamole/aspirin)
- ❑ Arixtra (fondaparinux)
- ❑ Xarelto (rivaroxaban)
- ❑ Eliquis (apixaban)
- ❑ Savaysa (edoxaban)
- ❑ ReoPro (abciximab)
- ❑ Pradaxa (dabigatran)
- ❑ Plavix (clopidogrel)
- ❑ Effient (prasugrel)
- ❑ Anti-inflammatories
- ❑ Heparin
- ❑ Lovenox (enoxaparin)
- ❑ Coumadin (warfarin)
- ❑ Garlic
- ❑ Ginseng
- ❑ Gingko
- ❑ Fish oil

Please list any other blood-thinning medications not listed above: _____

Name and phone number of prescribing physician: _____

Allergies

Do you have any drug allergies? Yes ❑ No ❑ If 'Yes', please list all drugs and the allergic reactions:

Drug/Medication	Allergic Reaction

Pregnancy Status

If you are FEMALE, please tell us your child-bearing/pregnancy status:

❑ Hysterectomy
❑ Post-Menopausal
❑ Not able to get pregnant
❑ Child-bearing Age - No contraception
❑ Child-bearing Age - Birth Control Medication
❑ Child-bearing Age - Other contraception

Anesthesia and Pain Procedure History

Have you ever had any problems or adverse reaction to anesthesia? ❑ Yes ❑ No ❑ Never had anesthesia.
If 'Yes', which type of anesthesia? _____; What was the reaction? _____
Have you ever had an adverse reaction to the iodine contrast used during a pain procedure? ❑ Yes ❑ No
If 'Yes', what was the reaction? _____

Family History

Please mark each box that is pertinent to your family history (biological relatives only)

	Autoimmune Disorder	Cancer	Diabetes	Headache	Heart Disease	Mental Health Problems	Alcohol Abuse	Kidney Disease	Liver Disease	Rheumatoid Arthritis	Illicit Drug Abuse	Stroke
Mother												
Father												
Sibling												

Other family history not listed above: _____
❑ I have no significant family medical history ❑ I am adopted (No medical history available)

Social History

Alcohol Use ❑ Never ❑ Occasional ❑ Daily ❑ History of Alcoholism
Tobacco Use ❑ Never ❑ Occasional ❑ Daily, How many packs per week? _____
Illegal Drug Use ❑ Never ❑ Occasional ❑ Daily ❑ History of Drug use, What Drug? _____

Any problems with prescription medication misuse, abuse, addiction? ❑ Yes, currently ❑ Yes, in past ❑ No
If 'Yes', which prescription medications? _____

Marital Status ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Separated

Who do you live with? ❑ Alone ❑ Friend/Roommate ❑ Spouse ❑ Spouse & Children ❑ Children
❑ Parents ❑ Assisted living facility ❑ Skilled nursing facility

What is your current work status? ❑ Employed ❑ Unemployed ❑ Retired ❑ Disabled (% disabled _____)
Occupation (if employed): _____

Social History (continued)

If you are unemployed, employed part-time, or have work restrictions, is this due to your current pain condition? ❑ Yes ❑ No

What are your current work restrictions, if any? ('N/A' if not applicable) _____

Are you currently involved in litigation related to this pain? ❑ Yes ❑ No

If 'Yes', attorney's name/phone number _____

Psychiatric History

Do you currently see a psychiatrist, psychologist, or therapist? ❑ Yes ❑ No

If 'Yes', please list his/her name? _____

Have you had any recent thoughts of hurting yourself or others? ❑ Yes ❑ No

Do you suffer from any of the following psychiatric conditions?

- ❑ Depression
- ❑ Anxiety
- ❑ Bipolar Disorder
- ❑ Substance abuse/Addiction
- ❑ Attention Deficit/Hyperactivity Disorder (ADD/ADHD)
- ❑ Obsessive-Compulsive Disorder (OCD)
- ❑ Personality Disorder
- ❑ Schizophrenia

Do you have a personal history of physical, emotional, or sexual abuse or other trauma? ❑ Yes ❑ No

If 'Yes' please discuss with your provider.

Preventative Medicine: Falls Risk Screening: If you are 65 or older, please check all that apply to you.

Have you had any falls in the last year?

- ❑ No falls in the past year
- ❑ One fall with injury in the past year
- ❑ Two or more falls with injury in the past year
- ❑ 1 fall without injury in the past year
- ❑ 2 or more falls without injury in the past year

Medical History and Consent for Treatment

I certify that the above information is accurate, complete and true. I authorize MD Pain and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness. I give my consent for MD Pain to retrieve and review my medication history. I understand that this will become part of my medical record. I acknowledge that I have had the opportunity to review the Notice of Privacy Practices of MD Pain, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records. I authorize the MD Pain to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize MD Pain to release any information required in obtaining procedure authorization or the processing of any insurance claims. I understand that MD Pain will not release my Protected Health Information to any other party (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at its facility and on its website. In the event that I am asked to provide a urine, saliva and/or blood sample, **I voluntarily seek laboratory services and hereby consent to provide a urine, saliva and/or blood sample as requested.** I have the right to refuse specific tests, but understand this may impact my pain management treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked. I hereby assign to the Laboratory my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare or Medicaid in my name or in my behalf. I further authorize payment of benefits directly to the Laboratory. I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance. I also acknowledge that the Laboratory may be an out-of-network provider with my insurer. Payment in full is expected 30 days of being notified of any balance due. Please note that in the event that you fail to make payment when due, this account will be referred to a collection agency for collections. In that event, the contingency fee assessed by the collection agency will be added to the principal and interest due. You will be additionally liable for attorney fees. Both collection agency fees and attorney fees will increase the balance you owe.

Signature: _____ **Date:** _____

(Patient, guardian or patient representative)

Printed name of patient or other person signing: _____

Patient Name_____ DOB:_____

SOAPP-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

		Never	Seldom	Sometimes	Often	Very Often
1	How often do you have mood swings?	0	1	2	3	4
2	How often have you felt a need for higher doses of medication to treat your pain?	0	1	2	3	4
3	How often have you felt impatient with your doctors?	0	1	2	3	4
4	How often have you felt that things are just too overwhelming that you can't handle them?	0	1	2	3	4
5	How often is there tension in the home?	0	1	2	3	4
6	How often have you counted pain pills to see how many are remaining?	0	1	2	3	4
7	How often have you been concerned that people will judge you for taking pain medication?	0	1	2	3	4
8	How often do you feel bored?	0	1	2	3	4
9	How often have you taken more pain medication than you were supposed to?	0	1	2	3	4
10	How often have you worried about being left alone?	0	1	2	3	4
11	How often have you felt a craving for medication?	0	1	2	3	4
12	How often have others expressed concern over your use of medication?	0	1	2	3	4
13	How often have any of your close friends had a problem with alcohol or drugs?	0	1	2	3	4
14	How often have others told you that you had a bad temper?	0	1	2	3	4
15	How often have you felt consumed by the need to get pain medication?	0	1	2	3	4
16	How often have you run out of pain medication early?	0	1	2	3	4
17	How often have others kept you from getting what you deserve?	0	1	2	3	4
18	How often, in your lifetime, have you had legal problems or been arrested?	0	1	2	3	4
19	How often have you attended an AA or NA meeting?	0	1	2	3	4
20	How often have you been in an argument that was so out of control that someone got hurt?	0	1	2	3	4
21	How often have you been sexually abused?	0	1	2	3	4
22	How often have others suggested that you have a drug or alcohol problem?	0	1	2	3	4
23	How often have you had to borrow pain medications from your family or friends?	0	1	2	3	4
24	How often have you been treated for an alcohol or drug problem?	0	1	2	3	4

I acknowledge that I have provided you with the most accurate and complete information about my medical history to the best of my ability.

_____

Patient/Guardian Signature Date

MD PAIN

SPORT, SPINE, AND PAIN MANAGEMENT

Chronic Pain Management
Review of Systems Form

Patient Name: _____ Today's Date: _____

Please mark only the following symptoms that you have experienced during the last 30 days.

Body System	Symptoms
Constitutional	❑ Fatigue ❑ Fever ❑ Night sweats/Chills ❑ Unexplained weight loss ❑ Weight gain
Eyes	❑ Blurred vision ❑ Double vision ❑ Vision loss
Ears, Nose, Throat	❑ Ringing in the ears ❑ Hearing loss ❑ Sore throat ❑ Difficulty swallowing
Cardiovascular	❑ Chest pain ❑ Palpitations ❑ Fainting ❑ Swelling of the feet ❑ Leg pain with walking
Respiratory	❑ Cough ❑ Wheezing ❑ Shortness of breath ❑ Blood in sputum/phlegm
Skin	❑ Rashes ❑ Lumps ❑ Skin color changes ❑ Hair and nail changes
Gastrointestinal	❑ Constipation ❑ Diarrhea ❑ Heartburn/Reflux ❑ Vomiting ❑ Dark and tarry stools ❑ Bloody stools ❑ Bowel incontinence
Genitourinary	❑ Blood in urine ❑ Unable to urinate ❑ Frequent urination ❑ Urinary incontinence
Neurological	❑ Headache ❑ Dizziness ❑ Seizure ❑ Weakness ❑ Numbness ❑ Tingling ❑ Tremor
Psychiatric	❑ Depressed mood ❑ Anxious ❑ Thought of hurting yourself ❑ Thoughts of hurting others
Endocrine	❑ Heat or cold intolerance ❑ Sweating ❑ Excessive appetite ❑ Excessive thirst ❑ Frequent urination ❑ Change in energy level
Hematologic	❑ Easy bruising ❑ Easy bleeding ❑ Frequent infections ❑ History of blood transfusion
Allergy/Immunology	❑ Frequent sneezing ❑ Itchy/Teary eyes ❑ Swollen lymph nodes

Reviewed by: _____ Date: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	
TOTAL:				

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

Opioid Therapy Statement 2021

Welcome to MD Pain. This document contains the Opioid and Controlled Medications Agreement/Contract, the Informed Consent for the Treatment of Chronic Pain with Opioid Pain Medications, and the Opioid Therapy Statement. If you plan to ask for an opioid or other controlled substance for the treatment of your pain, then please read all three of these documents carefully and sign or initial where indicated. If you have any questions, please do not hesitate to ask a provider or staff member.

At MD Pain, it is the goal of our physicians and staff to help give you your life back by reducing your pain and improving your daily functioning. We accomplish these goals with customized, safe, comprehensive and effective treatment plans that reduce risks and maximize benefits.

To protect our patients from the significant risks associated with opioid therapies including addiction, we follow recommendations and applicable guidelines from the Drug Enforcement Agency (DEA), Colorado state regulatory agencies and the Colorado Medical Board regarding the safe and responsible prescribing of these medications. We first try non opioid medications and other treatments before progressing to treating pain with opiates. Furthermore, we only prescribe opioid medications if, after thorough screening, risk stratification from the forms you fill out, and after through history and physical, we determine that a patient's pathology warrants their use, they meet specific criteria, and other treatment options, including alternative non-opioid pain medications, have failed to achieve satisfactory results.

The opioid therapy statement and patient agreement serve to document that both you and your clinician agree on a care plan so that controlled substances are used in a way that is safe and effective in treating your pain.

MD Pain takes a conservative approach to opioid therapy. Depending on a patient's specific situation, these medications may not be prescribed at all, may be prescribed at a lower dose, or changed to a safer, more appropriate alternative opioid. Research results continue to demonstrate conflicting evidence for the long-term use of opioid medications for chronic non-cancer pain. High doses or ever-escalating doses can result in a greater risk of physical dependence, tolerance addiction, and increased pain (opioid induced hyperalgesia). The lowest effective dosage of opioids used in conjunction with non-opioid medications in concert with pain management procedures, physical therapy, mental health therapy and other conservative treatments have been shown to produce the best long-term, effective results.

We track our treatment outcomes to do our best to ensure that our patients are being helped. We are proud of our results and believe that if you suffer from chronic pain we can help you. We provide a multidisciplinary approach to pain management that is safe, minimally invasive and clinically proven to be effective.

Side Effects of opioid Medications

I understand that the medication I will be taking may cause side effects to include, but not limited to: sleepiness or drowsiness, constipation, inability to urinate, nausea, vomiting, dizziness, an allergic reaction, immune suppression, hormone deficiencies, sexual problems, lack of coordination, kidney or liver disease, and bone thinning/weakness. Furthermore, the medication may cause my reflexes and reaction time to slow down. Finally, the medication may cause my breathing to become shallow and slower, leading to decreased oxygen supply to my body, which may lead to permanent neurological, mental, cognitive and physical deficits and possibly death.

I have read, understand, and acknowledge the MD Pain Opiate Therapy Statement.

Printed Name _____

Signature _____ Date _____

Opioid and Controlled Substances Provider-Patient Agreement

Consent for Treatment

I, _____, understand and voluntarily agree that:

Identification of Alternative Treatment Options: I am aware that my physician and his staff have discussed the possible benefits and risks of other treatments that do not include opioid therapy. These treatments include, but are not limited to, non-opioid medications, injections, physical therapy, mental health therapy and surgery, among others.

I understand my condition and I voluntarily request that my physician/ provider and his/her staff treat my condition. I further authorize my provider to administer or write prescriptions of controlled substances/ opioids/ "pain killers" to me for the purpose of treating my chronic pain. I am in agreement with taking these medications and in no way did my provider require me or talk me into taking these medications.

I understand all controlled substances can be addictive and can lead to death.

I understand the side effects of opioids listed in the Opioid Therapy Statement and will ask questions if needed.

I will participate in all other types of treatment that I am asked to participate in within reason

I will be responsible for my medicines and will keep the medicine safe, secure, locked, and out of the reach of children.

I will not sell my medicine or share it with others. I understand that if I do, my treatment will be stopped and authorities may be called.

If my medicine is lost or stolen, I understand it will not be replaced until my next appointment, and may not be replaced at all.

I will not take anyone else's medicine.

I will not increase my medicine until I speak with my doctor or MD pain clinical staff.

I will bring the pill bottles with any remaining pills of this medicine to each clinic visit. I will authorize MD pain staff to count my pills if necessary

I will take my medication as instructed and not change the way I take it without first talking to the doctor or other member of the treatment team.

If I see another doctor who gives me a controlled substance medicine (for example, a dentist, a doctor from the Emergency Room or another hospital, etc.) I must bring this medicine to Primary Care in the original bottle, even if there are no pills left.

I will keep (and be on time for) all my scheduled appointments with the doctor and other members of the treatment team

I will not call between appointments, or at night or on the weekends looking for refills and I understand that no early or emergency refills may be made.

I understand that prescriptions will be filled only during scheduled office visits with the treatment team. I will make sure I have an appointment for refills.

I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

I will tell the doctor all other medicines that I take, and let him/her know right away if I have a prescription for a new medicine.

I will not obtain any non-opioid pain medicines or other prescription medicines for treatment of anxiety or pain, from other providers without permission from my MD Pain provider. If taken with opiates, I know these drugs, such as benzodiazepines (Klonopin/ clonazepam, Xanax, and valium/ diazepam) or stimulants (Ritalin, amphetamine), can be addictive, and dangerous to my health, or even causing death.

I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment may be stopped.

I will come in for drug testing and counting of my pills within 24 hours of being called (random testing). I understand that I must make sure the office has current contact information in order to reach me, and that any missed tests will be considered positive for drugs.

I will keep up to date with any bills from the office and tell the doctor or member of the treatment team immediately if I lose my insurance or can't pay for treatment anymore. I understand that I may lose my right to treatment in this office if I break any part of this agreement.

Provider communication consent: I authorize my provider to talk with my other providers, pharmacists, attorneys, when appropriate for my care. I give them permission to discuss my opioid use as it pertains to my care. I know my provider or MD Pain staff will review the CO-PDMP and I will sign a release form to let the doctor speak to all other doctors or providers that I see.

I will use only one pharmacy to get all on my medicines: [Pharmacy name/phone#] and I will notify the practice in writing if I wish to change pharmacies.

Right to Discontinue Treatment or Medication

I understand that I may discontinue using my medication at any time and I agree to notify physician and/or his staff immediately upon discontinuing the use of my medication. I understand that I may be provided supervision if needed by my physician and/or his staff if I choose to discontinue my medication. In this situation alternative care by other pain or addiction providers will be suggested and you would then be released of this agreement
I know that these opioid and controlled medications will be stopped by the MD Pain providers if any of the following occurs:

- I trade, sell, give away, misuse, or abuse these medications;
- MD Pain finds that I have broken any part of this agreement;
- I do not present immediately for a blood, urine or saliva test, or pill count when requested by MD Pain;
- My blood, urine, or saliva tests show the presence of controlled or non-controlled medications that have not been previously reported to MD Pain, the presence of illegal drugs or fail to show opioid and other controlled medications that I am being prescribed by MD Pain;
- I receive prescriptions for opioid and controlled medications from sources other than MD Pain, unless arranged and discussed previously with my MD Pain physician or provider;
- Any member of the professional staff at MD Pain feels that it is in my best interest, from a safety or accountability standpoint, that opioid and controlled medication treatment be discontinued;
- I demonstrate ANY aggressive, belligerent, or unacceptable behavior toward any physician, provider, patient, or staff member at MD Pain;
- I consistently miss scheduled appointments at MD Pain, including office visits and procedures scheduled at MD Pain or any other facility utilized by MD Pain.
- Illicit Drug use ie: cocaine, methamphetamine, heroin
- Misrepresenting or lying about medical history including not disclosing risks to addiction such as family history of abuse, prior abuse of drugs or alcohol, prior military experience.

My signature indicates that I understand and agree to abide by each issue displayed on this page and I understand that if I fail to abide to any issue displayed on this page, I may be discharged from this clinic.

Printed Name _____

Signature _____ Date _____

I attest that I have explained each issue displayed on this page to said patient and said patient indicated their understanding of each issue by affixing their initials next to each issue and signing the bottom of each page:

_____ _____

Staff Signature Date

MD PAIN

SPORT, SPINE, AND PAIN MANAGEMENT

6950 E Belleview Ave Suite 300 Greenwood Village CO 80111

Giancarlo Checa, MD Christopher Huser, MD
Jonathan Bernardini, MD
Neelam Gala, PA-C Adrian Sutter, PA-C
Rachel Spady, PA.-C Karissa Hoeme, PA-C
Ashley Vanderjagt, PA-C Erica Watson PA-C
Phone: 303-750-810D
Fax: 303-974-3804

CANCELLATION and NO-SHOW POLICY

We understand that situations may arise which makes it necessary to cancel your appointment. Accordingly, we request that you provide at least 24-hour notice of cancellation. This will enable the physicians to offer that time slot to other patients who need to be seen. Appointments with our specialists are in high demand, and your early cancellation will give another person access to timely medical care.

Cancellation Fee: Office appointments, which are cancelled with less than a **24-hour** notification, are subject to a **$25.00** cancellation fee.

All procedure appointments (done outside of office), NOT cancelled 48 hours prior to scheduled appointment are subject to cancellation fee of $100.00.

Patients who do not show up for their appointment and who do not call to cancel or reschedule, will be considered a **No-Show** and are also subject to a **No-Show** fee. Patients who **"No Show",** for 2 or more appointments in a 12-month period may be dismissed from the practice. **The Cancellation and No-Show fees are the sole responsibility of the guarantor and cannot be billed to the insurance company.**

Please sign that you have read and are aware of the above Cancellation and No-Show Policy.

All appointments not cancelled 24 hours prior are subject to $25.00

No Show Fees

$50.00 New Patient

$40.00 Established Patients

$100.00 Surgical procedures (performed outside office)

Payments can be made directly to our billing office at 303-422-9438 or our office at 303-750-8100

Please sign that you have read and are aware of the above Cancellation and No-Show Policy.

PATIENT NAME (Please Print): _____

Patient or guardian name _____

Patient or guardian signature_____

Date_____

CREDIT CARD INFORMATION_____

YOUR CREDIT CARD WILL ONLY BE CHARGED FOR CO PAYS AND OUTSTANDING BALANCES

MDPAIN Management

METRO DENVER PAIN MANAGEMENT PLLC TELEMEDICINE INFORMATION AND CONSENT FORM

Because of your existing relationship with Metro Denver Pain Management PLLC and its physicians, medical professionals, associates and staff (the "Practice"), you have asked the Practice to provide medical services (the "Services") through telemedicine consultation.

Telemedicine involves the use of real-time, two-way electronic communications to enable.

health care providers at different locations to share individual patient medical information for the purpose of improving patient care. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

Patient medical records
Medical images
Live two-way audio and video Output data from medical devices and sound and video files

The Practice contemplates that the use of telemedicine will afford its patients the ability to remain in their homes and receive the Services without any risks entailed in traveling to the Practice.

location or being in that location; allow for efficient remote medical evaluation and management; and permit more prompt consultation. The Practice will use its best efforts through network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

By signing this form, I understand the following:
1 The Practice will use telemedicine to perform the Services in order to assess and treat my medical condition.

2 The telemedicine consult will be done through a two-way, real-time video link-up by which the physician or other healthcare provider with the Practice can see my image on the screen and hear my voice. Currently, a cell phone, tablet or laptop that enables such a two-way interactive video link may be used. However, unlike a traditional medical consult, the physician or other health provider does not have the use of the other senses such as touch or smell, and it may not be equal to a face-to-face visit.

3 Since the Practice's telemedicine consultant providers practice in a different location and do not have the opportunity to meet with me face-to-face, they must rely on information provided by me. The Practice and its providers cannot be responsible for advice, recommendations and/or decisions based on incomplete or inaccurate information provided by me or others.

4. can and am encouraged to ask questions and seek clarification of the procedures and telemedicine technology.

5. I can ask that the telemedicine exam and/or videoconference he stopped at any time.

6. If an emergency occurs during a telemedicine encounter, I should call 911 and stay on the video connection of applicable) until help arrives.

7. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.

8. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

9. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction and may receive copies of this information for a reasonable fee

10. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. The Practice has explained the alternatives to my satisfaction,

11.I understand that the consultation may be viewed by medical and non-medical persons for evaluation, informational, research, educational, quality, or technical purposes.

12 understand that the examination may be videotaped for internal quality review or as might be required by my health coverage plan; until and unless I withdraw approval. I authorize the video images to be used only for those purposes.

13 I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. These people will all maintain confidentiality of the information obtained, I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history physical examination that ure personally sensitive to me, (2) ask non-medical personnel to leave the room and or (3) terminate the consultation at any time.

14. I understand that it is my duty to inform the Practice of electronic interactions regarding my care that I may have with other healthcare providers. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

16 I understand that the Practice will use third party technology to provide the Services through telemedicine, that the Practice may have no control over that technology, and that the Practice will not and cannot be liable for any errors or issues caused by that technology.

17. I know and acknowledge that there are potential risks with the use of this new technology. These include but are not limited to:
Interruption of the audio/video link ;
Disconnection of the audio/video link: A picture that is not clear enough to meet the needs of the consultation.

Electronic tampering:
Information transmitted may not be sufficient (e.g poor resolution of images) to allow for appropriate medical decision making by the Practice's providers:
Delays in medical evaluation and treatment failures of the equipment:
could occur due to deficiencies or in very rare instances, security protocols could fail, causing a breach of privacy of personal medical information:

In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors If any of these risks occur, the transmission and consultation and treatment might need to
be stopped.

18. Payment Agreement/Assignment of Benefits. I agree to be responsible for any co-payments, deductibles, or other charges from the Practice and its providers that are not covered or paid by insurance or other third-party payors - except as prohibited by any state or federal law. or any agreement between my insurance company and the Practice. I authorize the Practice to file any claims for payment of any portion of the patient bills and assign all rights and benefits payable for health care services to the provider or organization furnishing the services. I agree, subject to state and federal law, to pay all costs, attorney fees, expenses, delinquent charges, and interest in the event the Practice has to take action to collect the same because of my failure to pay all incurred charges in full. It is my responsibility to know what providers and telehealth services are covered under my insurance plan. I understand that I may be billed and agree to pay all bills submitted by the Practice and its providers involved with the provision of telemedicine services.

19. Consent to be Contacted (Telephone Consumer Protection Act): Unless and until I notify the Practice in writing, including email and text message, by providing a telephone number (landline or cellular) or other wireless device, I agree that in order for the Practice to service my account(s) (including contacting me about appointment reminders, surveys, obtaining potential financial assistance for my account(s)), or to collect any amounts I may owe, the Practice Metro Denver Pain Management PLLC Telemedicine Information and Consent Form

Name:_____ Date:_____