Alturas
Pain & Spine Specialists

Patient Information

Patient

Last Name _____ First Name _____

Middle Name _____ Preferred Name _____

Date of Birth _____ Sex ☐ Female ☐ Male

Mobile phone _____ Home phone _____

Email _____

Mailing Address Street _____

City _____ State _____ Zip _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Referring Provider _____ Primary Care _____

How did you hear about us? _____

Emergency Contact

Name _____ Phone _____

Insurance

Primary Insurance _____ Policy Holder _____ DOB _____

Secondary Insurance _____ Policy Holder _____ DOB _____

Is your pain related to ☐ Auto Accident ☐ Worker's Comp ☐ Not related to auto or work

If auto or work related, provide date of injury _____

Permission to release medical and financial information to the following individuals:

_____ _____

Name/Relationship Name/Relationship

_____ _____

Signature of Patient or Legal Representative Date

Alturas
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Consent to Treat, Authorization of Benefits, and Use of Information

Authorization for Treatment
I consent and authorize Alturas Pain and Spine Specialists to provide medical services as ordered by my provider.

Release of Information
I consent and authorize the release to Alturas Pain and Spine Specialists of any medical information necessary for treatment and/or to process claims for services rendered by Alturas Pain and Spine Specialists. I understand that Alturas Pain and Spine Specialists will use and disclose my identifying and medical information for the purposes of payment, treatment, and day to day operations as described in the Notice of Privacy Practices.

Reimbursement Coverage
I assign to Alturas Pain and Spine Specialists all medical insurance benefits (primary and secondary) or other benefits to which patient may be entitled for any services rendered by Alturas Pain and Spine Specialists. Alturas Pain and Spine Specialists has permission to apply and file for all such benefits on behalf of the patient.

Term
This patient consent and authorization given to Alturas Pain and Spine Specialists as set forth above will remain in full force and effect per episode of care (initial assessment to discharge) until terminated in writing by patient or by an authorized patient representative.

I have been informed of and given the right to review and secure a copy of "Notice of Privacy Practices" which describes the uses and disclosures of my protected health information and my rights under HIPAA.

_____ _____

Signature Date

Payment Policy

YOUR RESPONSIBILITY IS TO KNOW YOUR PLAN:

- Know your yearly deductible and when it resets
- Know whether services provided by our office are covered under your plan
- Know your co-pay
- Follow up on claims submitted to your insurance company when needed

FOR INSURED PATIENTS
For those patients covered by health insurance, we agree to file your initial claims provided we have complete information at the time of service. However, your health insurance contract(s) is between you and the insurance carrier. Because of this relationship, you have primary responsibility to pay for the services and provide follow-up communication with your health insurance carrier(s), if necessary. Should your insurance reject our claim for any reason, you are financially responsible. If your health insurance requires you to pay a co-pay, this amount will be due before service. We will try to give you an estimate of the amount you may owe before your visit upon your request. If we are contracted providers with your plan, you are not eligible for any additional discounts beyond the discount agreed upon with your health insurance carrier.

FOR NON-INSURED PATIENTS
Services must be paid at the time of service. You will receive a fixed discount off the eligible charges. We make every effort to collect fees when you check in or out but ultimately it is your responsibility to pay before leaving the office. Any amounts not paid on the date of the visit will not be eligible for the discount.

There is a $30.00 service charge on all returned checks.

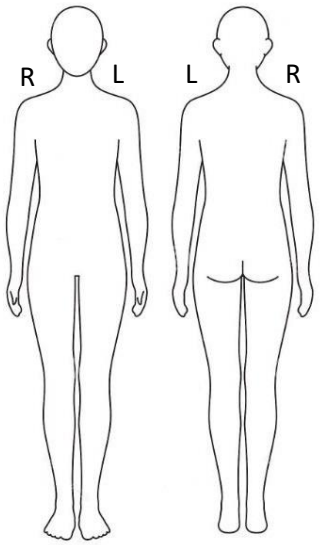
I agree that I am responsible for payment in full at the time of service. As a courtesy my insurance company will be billed for payment. I agree to pay interest at the rate of one and one half percent per month (18% per year) if applicable. I agree if the account is assigned to a collection agency, to pay all attorney fees, court costs, filing fees, including a collection fee of up to 29% which will be added to the outstanding balance with or without suit.

_____ _____

Signature Date

Alturas
Pain & Spine Specialists

Patient History



Front Back

Legal Name _____

Briefly describe the reason for your visit _____

What caused your pain? _____

How long ago did your pain start? _____

Please mark your areas of pain on the person to the right.

How would you describe your pain? Check all that apply.

☐ Sharp ☐ Aching ☐ Burning ☐ Lightning ☐ Cramping ☐ Fire

☐ Throbbing ☐ Tight ☐ Other _____

For the next 3 questions, rate your pain on a scale of 0 - 10 with 0 being no pain and 10 being the most extreme pain you can imagine.

What was your worst pain level over the last week? _____

What was your lowest pain level over the last week? _____

What was your average pain level over the last week? _____

Use the table below to mark what things make your pain better or worse.

	Worse	Better	No Effect	Comment
Walking	☐	☐	☐	
Standing	☐	☐	☐	
Lifting	☐	☐	☐	
Sitting	☐	☐	☐	
Exercise	☐	☐	☐	
Lying Down	☐	☐	☐	
Pressure on area	☐	☐	☐	
Sneeze/cough	☐	☐	☐	

Check all the areas of your life that have been negatively affected by the pain.

☐ Work ☐ Sleep ☐ Mood ☐ Exercise

☐ Self Care ☐ Care of family members ☐ Mobility

Have you seen a medical provider for this pain? If yes, who did you see and what was the provider's specialty?
☐ No ☐ Yes _____

Have you ever seen a pain management provider or pain specialist before? If yes, who did you see?
☐ No ☐ Yes _____

Have you had any imaging related to your pain condition? If yes, what type of imaging and which facility performed the imaging?
☐ No ☐ Yes _____

Use the table below to mark the medications you have used to treat your pain, their effect, and the specific medication names, if you know them.

	Helpful	No help or minimal help	Medication Names/Comments
NSAIDs (ibuprofen, Aleve)			
Muscle Relaxer (Flexeril			
Tramadol			
Hydrocodone (Vicodin)			
Oxycodone			
Morphine			
Long-acting opioid			
Antidepressant (Cymbalta			
Gabapentin/Lyrica			

What kind of treatments have you undergone to treat your pain? List length of treatment and/or number of sessions if applicable.

	Helpful	No help or minimal help	Length of treatment, number of sessions, and comments
Physical Therapy			
Physical Therapy			
Chiropractic care			
Emergency Department			
Brace			
Massage			
Joint injection			
Trigger point injection			
Epidural steroid injection			
Medial branch block			
Radiofrequency ablation			
Spinal cord stimulator			
Surgery for the pain			

Medical and Surgical History

Do you have a history of any of the following conditions?

- ☐ Heart attack
- ☐ Heart failure
- ☐ Heart rhythm problem
- ☐ High blood pressure
- ☐ Asthma
- ☐ COPD
- ☐ Seizures
- ☐ Migraines
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar disorder
- ☐ ADD/ADHD
- ☐ Schizophrenia
- ☐ Obsessive compulsive disorder
- ☐ Hypothyroidism
- ☐ Decreased kidney function
- ☐ Kidney stones
- ☐ Decreased liver function or cirrhosis
- ☐ Hepatitis B or C
- ☐ Acid reflux problem
- ☐ Bleeding stomach ulcer
- ☐ Arthritis
- ☐ HIV/AIDS
- ☐ Bleeding disorder
- ☐ Sleep apnea
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Autoimmune disease (specify)_____
- ☐ Cancer (specify)_____
- ☐ Other Conditions (specify_____

Please list all your major surgeries and the approximate month/year. Please include any heart stents.

Do you have any allergies to medications or contrast dye? If yes, please list. ☐ No ☐ Yes

_____

Are you taking any medications like aspirin, Plavix, Coumadin, Xarelto, or another blood thinner? If yes, please list.
☐ No ☐ Yes _____

Please list your current medications or have staff make a copy of your medication list. Please give the medication name, dose, and how many times per day you take the medicine.

Social History

What is your current employment status? ☐ Employed ☐ Retired ☐ Disabled ☐ Student ☐ Stay at home parent ☐ Unemployed due to pain ☐ Unemployed due to other reason

If employed, what kind of work do you do? If retired, what was your previous work? _____

Do you smoke cigarettes? Vape? If yes, how much? ☐ No ☐ Yes _____

Do you drink alcohol? If yes, how many drinks in one week? ☐ No ☐ Yes _____
Have you ever had a problem with alcohol abuse? ☐ No ☐ Yes

Do you use marijuana products? If yes, how often and in what form? ☐ No ☐ Yes _____

Check if you have ever used any of the following substances? ☐ Methamphetamine ☐ Cocaine ☐ Heroin ☐ Ecstasy ☐ Pills purchased from someone other than a pharmacy provider

Have you ever had a problem with prescription drug abuse? ☐ No ☐ Yes

Do you have a history of preadolescent sexual abuse? ☐ No ☐ Yes

Family History

Have any of your blood relatives had the following problems?

☐ Alcohol abuse
☐ Illegal drug use
☐ Prescription drug abuse
☐ Osteoporosis
☐ Migraines
☐ Neck or back surgery
☐ Depression
☐ Autoimmune Condition

Write the relationship (mother, sibling, uncle, etc.) next to any conditions marked as present in the family.

Review of Symptoms

Please mark any signs or symptoms that you have experienced in the last week.

☐ Fever
☐ Weight loss
☐ Night sweats
☐ Excessive sleepiness
☐ Poor sleep
☐ Swelling of multiple joints
☐ New rashes
☐ Constipation
☐ Nausea
☐ Excessive bleeding
☐ Suicidal thoughts
☐ Weakness
☐ Numbness/tingling
☐ Loss of bladder control
☐ Loss of bowel control

Please share your hopes for this visit and any other information you think would be helpful.