

Patient Demographic Information

Please print:

Patient Name:		Social Security #:		Birthdate:	Age:
Mailing Address: Street:			City: <input type="checkbox"/> Lewiston <input type="checkbox"/> Clarkston Other City:		
			State:		Zip Code:
Home Phone:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Other	Employment:	Employer Name: Address: City/State/Zip:	
Cell Phone:			<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Not employed <input type="checkbox"/> Retired		
Work Phone:			<input type="checkbox"/> Student full time <input type="checkbox"/> Student part time		
Spouse Name:			Spouse's Employer:		
Spouse's Social Security #:		Spouse's Birthdate:			
In Case of Emergency, Please Contact: Name:			Emergency Contact outside the home: Name:		
Phone:	Cell:	Phone:			Cell:
Address:			Address:		
Relationship:			Relationship:		
Referring Physician:			Primary Care Physician:		

Does this visit pertain to an injury or accident that we will bill to Worker's Compensation or other insurance? Yes No **If yes, complete the following accident / injury information:**

<input type="checkbox"/> Auto Accident	If Auto Accident, Date of Injury: _____ State: _____	
	Claim #: _____	Insured Name: _____
<input type="checkbox"/> On the Job Injury	If on the Job Injury, Date of Injury: _____ State: _____	
	Name of Employer: _____	Industrial Insurance Co: _____
<input type="checkbox"/> Other Accident	Claim #: _____	
	If other Injury, Date of Injury: _____ State: _____	
Describe What and How Injured: _____		

Insurance / Financial Information:

Do you have medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, do you agree to: <input type="checkbox"/> regular monthly payments by check <input type="checkbox"/> regular monthly payments by credit card <input type="checkbox"/> automatic bank draft	
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If you have medical insurance, please list: We need this information regardless of whether or not it was accident.

Primary Insurance Name:	Policy #:	Group #:
Name of Policy Holder:	Policy Holder Birthdate:	Policy Holder Employer:

Secondary Insurance Name:	Policy #:	Group #:
Name of Policy Holder:	Policy Holder Birthdate:	Policy Holder Employer:

Third Insurance Name:	Policy #:	Group #:
Name of Policy Holder:	Policy Holder Birthdate:	Policy Holder Employer:

Medicare Patients Only: Please complete the following information:

How are you enrolled in Medicare?

- based on age
- based on disability
- based on ESRD (end stage renal disease)

Is Medicare your primary or secondary insurance plan?

- primary
- secondary

Yes	No			
		1. Are you receiving Black Lung (BL) Benefits? If yes, date benefits began:		
		2. Are your services at the Pain Clinic to be paid by a government program such as a research grant?		
		3. Are your services at the Pain Clinic to be paid by the Dept of Veterans Affairs (DVA)?		
		4. Are you currently employed?		
		5. Is your spouse currently employed?		
		6. Do you have group health coverage based on your own or a spouse's current employment?		
	<table border="1"> <tr> <td>Yes</td> <td>No</td> </tr> </table>	Yes	No	7. If you answered yes to #6, does the employer that sponsors your group health coverage employ 20 or more employees?
Yes	No			

INTERVENTIONAL PAIN CONSULTANTS, P.A.

Acknowledgement of Financial Responsibility: I hereby authorize my insurance benefits to be paid directly to the physician. I am financially responsible for all fees incurred in my treatment and services. I also authorize the doctor or insurance company to release any information required for this claim.

Two Bills: I understand that should I have procedures or services at IPC Surgical Center, I will receive 2 bills: 1 for the physician fees from Interventional Pain Consultants and one for the facility fees (IPC Surgical Center).
_____ (initial)

Consent for Treatment: I hereby give my consent for the authorized personnel of Interventional Pain Consultants, P.A. (IPC) to evaluate and, if appropriate; render subsequent treatment in accordance with the plan of care authorized by my physician (if applicable) or by my personal authorization.

Consent for Minor: As the above named minor's parent or legal guardian, I hereby give my consent for the authorized personnel of Interventional Pain Consultants, PA. to evaluate and, if appropriate, render subsequent treatment in accordance with the plan of care authorized by patient's physician (if applicable) or by my personal authorization.

Privacy Notice Confirmation: I understand that by signing below, I am certifying that I have been offered the Notice of Privacy. I understand that I have the right to review the notice prior to initialing. I understand that the IPC reserves the right to change their notice and practices and will publish any changes in the lobby. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations. I understand, that unless I object, IPC may disclose protected health information to a member of my family, relative, close friend, or other person who is involved in my healthcare or payment of my healthcare. IPC will limit the disclosure to the protected health information relevant to that person's involvement in my healthcare or payment.

Advanced Directives: I understand that I am responsible for letting IPC know of my advanced directives status and updating them if/when the status changes.

- I have an advanced directive, but do not have a copy with me and understand that my wishes cannot be honored until I provide you with a copy.
- I have an advanced directive and have a copy with me for my record.
- I do not have an advanced directive.
 - I would like more information about advanced directives.

Prescription Pick-up Authorization: I hereby give permission for the following person(s) to pick up my written prescriptions from Interventional Pain Consultants on my behalf: _____

I acknowledge that I am solely responsible for my prescription medication and will not allow it to remain in the possession of anyone other than myself. I also acknowledge that if my prescription is lost or stolen while in possession of another person, it may not be replaced.

Patient Signature: _____ Date _____

Witness: _____ Date _____

IPC SURGICAL CENTER, L.L.C

Acknowledgement of Financial Responsibility: I hereby authorize my insurance benefits to be paid directly to IPC Surgical Center, LLC (Center). I am financially responsible for all fees incurred in my treatment and services. I also authorize the Center or insurance company to release any information required for this claim.

Two Bills: I understand that should I have procedures or services at IPC Surgical Center, I will receive 2 bills: 1 for the physician fees from Interventional Pain Consultants and one for the facility fees. _____ (initial)

Consent for Treatment: I hereby give my consent for the authorized personnel of IPC Surgical Center L.L.C. to evaluate and, if appropriate; render subsequent treatment in accordance with the plan of care authorized by my physician (if applicable) or by my personal authorization.

Consent for Minor: As the above named minor’s parent or legal guardian, I hereby give my consent for the authorized personnel of IPC Surgical Center L.L.C. to evaluate and, if appropriate, render subsequent treatment in accordance with the plan of care authorized by patient’s physician (if applicable) or by my personal authorization.

Ownership / Financial Interest: I understand that the Center is owned by Craig Flinders, M.D., Gary Haas, D.O. and Lyndal Stoutin, M.D. I acknowledge that I was informed of this information in advance of the date of the procedure. _____ (initial)

Semi-Private Area: I understand that I will be admitted to a semi-private area and if I am uncomfortable with this, I will notify my nurse.

Privacy Notice Confirmation: I understand that by signing below, I am certifying that I have been offered the Center’s Notice of Privacy. I understand that I have the right to review the notice prior to initialing. I understand that the Center reserves the right to change their notice and practices and will publish any changes in the lobby. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations. I understand, that unless I object, IPC may disclose protected health information to a member of my family, relative, close friend, or other person who is involved in my healthcare or payment of my healthcare. IPC will limit the disclosure to the protected health information relevant to that person’s involvement in my healthcare or payment.

Patient Rights and Responsibilities: I understand my rights and responsibilities. I acknowledge that I was provided this information, both verbal and written, in advance of the date of the procedure. _____ (initial)

Advanced Directives: I acknowledge receipt of information regarding Center’s policy for advance directives. I acknowledge that I was informed of this information in advance of the date of the procedure. _____ (initial)

I understand I am responsible for letting the Center know of my advanced directives status and updating them if/when the status changes.

- I have an advanced directive, but do not have a copy with me and understand that my wishes cannot be honored until I provide you with a copy.
- I have an advanced directive and have a copy with me for my record.
- I do not have an advanced directive.
 - I would like more information about advanced directives.

Patient Signature: _____ Date _____

Witness: _____ Date _____

IPC Surgical Center LLC

IPC Surgical Center is a Medicare-approved surgery center specializing in the treatment and diagnosis of acute and chronic pain. This Center credentials and uses only physicians specializing in anesthesia and pain management.

Ownership / Financial Interest

The Center is owned by Craig Flinders, M.D., Gary Haas, D.O. and Lyndal Stoutin, M.D.

Patient Rights and Responsibilities

Your Rights as a Patient

You have the right to:

- Be treated with respect, consideration, and dignity,
- Appropriate personal privacy,
- Receive care in a safe setting,
- Have patient disclosures and patient records treated confidentially, and except when required by law, to have the opportunity to approve or refuse the release of your records
- Have complete information concerning your diagnosis, evaluation, treatment, and prognosis,
- Be fully informed about a treatment or procedure and the expected outcome before it is performed.
- Participate in decisions involving your health care, except when such participation is contraindicated for medical reasons
- Have information available regarding patient rights, patient conduct and responsibilities, services available here at IPC, provisions for after-hours and emergency care, fees for services, payment policies, patient's right to refuse to participate in experimental research, advance directives, as required by state or federal law or regulations, and credentialing of health care professionals.
- Change your physician should you desire. If you request to change to a different IPC physician, we must request approval from that physician.
- Appropriate marketing or advertising regarding the competence and capabilities of the organization,
- Exercise your rights without being subjected to discrimination or reprisal.
- Voice grievances regarding treatment or care that is (or fails to be) furnished.
- Be free from all forms of abuse or harassment,
- Talk with a nurse, the Clinical Nurse Coordinator, or Administrator if you have a suggestion or a complaint.
- Submit a complaint to Idaho Department of Health and Welfare, Bureau of Facility Standards, 3232 Elder Street, Boise, ID 83720, (208) 334-6626 or the Office of the Medicare Beneficiary Ombudsman at www.cms.hhs.gov/center/ombudsman.asp.

As a patient it is your responsibility to:

- Keep your appointment or notify the Center if you are unable to do so,
- Be accurate and complete, as much as possible, in giving your medical history, medications, over-the-counter products and dietary supplements, and any allergies or sensitivities,
- Follow your treatment plan and discharge instructions as provided,
- Provide a responsible adult to drive you home and stay with you after the procedure,
- Keep us informed of the presence of a living will, medical power or attorney, or other directive that may affect your care,
- Accept personal financial responsibility for any charges not covered by your insurance. Pay your bill promptly and notify us if there is a hardship.
- Be respectful of all health care providers and staff, as well as other patients
- Let us know if you do not understand any part of your treatment. Ask questions and take part in your health care decisions,
- Regard other patients' medical information as confidential,
- Respect the Center's property and equipment.

Advanced Directive Policy

It is the policy of IPC SURGICAL CENTER to comply with the rules and regulations for advanced health care directives promulgated in the Medical Consent and Natural Death Act of July 1, 2007. According to the Idaho Statute, a POST form is "appropriate in cases where a patient has an incurable or irreversible injury, disease, illness or condition, or where a patient is in a persistent vegetative state. A POST form is also appropriate if such conditions are anticipated."

The Statute allows that a health care provider to disregard the POST form or identification device if: (1) they believe the POST has been revoked; (2) to avoid oral or physical confrontation; or (3) if so ordered by the attending physician. "Any authentic expression of a person's wishes with regard to health care should be honored."

Allergies (include what type of reaction you have):

Current medications

Please attach a list of current medications.

Past Medical History: Please mark all that apply.

- | | | |
|--|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Other - describe: |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Glaucoma | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart disease | |
| <input type="checkbox"/> Defibrillator | <input type="checkbox"/> Macular degeneration | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pacemaker | |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Stroke | |
| | <input type="checkbox"/> | |

Past Surgeries: Please mark all that apply.

- | | | |
|--|--|---|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Hip replacement ___left ___right | <input type="checkbox"/> Back surgery – describe: |
| <input type="checkbox"/> Gall bladder | <input type="checkbox"/> Knee replacement ___left ___right | |
| <input type="checkbox"/> Hernia repair | <input type="checkbox"/> Shoulder surgery ___left ___right | |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Other – describe: | <input type="checkbox"/> Neck surgery – describe: |
| <input type="checkbox"/> Defibrillator | | |
| <input type="checkbox"/> Pacemaker | | |
| <input type="checkbox"/> Stent | | |

Review of Systems: Please mark the health problems you have had or currently have. Explain as needed.

- | | | |
|---|---|--|
| Yes | Yes | Yes |
| <i>Constitutional</i> | <i>Gastrointestinal</i> | <i>Infectious Illness</i> |
| <input type="checkbox"/> Recent high fever | <input type="checkbox"/> Heartburn / reflux / ulcers | <input type="checkbox"/> Hepatitis. Type _____ |
| <input type="checkbox"/> Recent weight loss | <input type="checkbox"/> Prolonged constipation | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Recent weight gain | <input type="checkbox"/> Vomited blood / coffee ground material | <input type="checkbox"/> AIDS or HIV (optional) |
| <input type="checkbox"/> Thyroid disorder | <i>Genitourinary</i> | <i>Skin</i> |
| <input type="checkbox"/> Autoimmune disorder | <input type="checkbox"/> Recurrent bladder or kidney infections | <input type="checkbox"/> Recent bruising easily |
| <i>Eye, Ear, Nose, & Throat</i> | <input type="checkbox"/> Recent loss of bowel function | <input type="checkbox"/> Delayed healing of cuts/incisions |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Recent loss of bladder function | <i>Psychological</i> |
| <input type="checkbox"/> Glaucoma | <i>Muscular and Skeletal</i> | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Macular degeneration | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Recent visual changes | <input type="checkbox"/> Swollen or painful joints | <input type="checkbox"/> Bipolar disorder |
| <i>Heart & Circulation</i> | <input type="checkbox"/> Gout | <input type="checkbox"/> PTSD |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Fractures/broken bones | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Osteoporosis (soft bones) | <input type="checkbox"/> Other mental health problem |
| <input type="checkbox"/> Palpitations/fluttering of heart | <i>Neurology</i> | |
| <input type="checkbox"/> Pacemaker or defibrillator | <input type="checkbox"/> Frequent headaches | |
| <i>Lungs</i> | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Chronic or frequent cough | <input type="checkbox"/> Loss of consciousness | |
| <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Sudden weakness/numbness | |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Difficulty with walking / balance | |

Explanations:

Family History: Please check if a family member has (had) a disease listed below

	Mother	Father	Brother	Sister	Grandparent	
Cancer						Type of cancer:
High blood pressure						
Arthritis						
Chronic pain problems						Type of problem:
Heart disease						
Diabetes						
Alcohol abuse						
Drug abuse						

Social History:

Occupation _____

Education elementary school high school / GED some college bachelor's degree or higher

Marital Status: Married Single Divorced Widowed

Disability or worker's compensation? Yes No Pending lawsuit? Yes No

Do you smoke or chew tobacco? Yes No If yes, how much? _____ how long? _____

did you quit? Yes No if yes, when? _____

Do you drink alcohol? Yes No If yes, how much? _____

Do you or have you used illegal drugs? Yes No If yes, date of last use: _____

For nurse to complete: **(Dear patient, please continue to page 4)**

Height: Weight: Temp: Pulse: Resp: BP: Pain Level:

ASA Status: ASA I ASA II ASA III ASA IV

Psychology and Chronic Pain

Psychological treatment is an important component of pain management. Often pain can be reduced using mental techniques including relaxation training, imagery, biofeedback, and medical hypnosis. All of these options are available to you at the Pain Clinic.

A second use of psychological treatment is counseling for issues surrounding chronic pain. As many as half of all chronic pain patients suffer from depression. Many have to cope with anxiety, anger, or high levels of stress. All of these negative emotions make suffering worse. The following questionnaire assesses how chronic pain has affected your life.

For the following, circle the number that best describes your feeling or situation.	Totally disagree	Strongly disagree	Mildly disagree	Neutral	Mildly agree	Strongly agree	Totally agree
I am under a lot of stress and this seems to make my pain worse.	1	2	3	4	5	6	7
I feel overwhelmed by my condition.	1	2	3	4	5	6	7
I have problems with thoughts I cannot control.	1	2	3	4	5	6	7
I find myself reliving frightful experiences over and over.	1	2	3	4	5	6	7
I have attacks of anxiety or panic.	1	2	3	4	5	6	7
I am troubled by worry or anxiety.	1	2	3	4	5	6	7
I have had thoughts of killing myself.	1	2	3	4	5	6	7
I feel sad and can't seem to snap out of it.	1	2	3	4	5	6	7

If you answered any item at a 6 or 7 this indicates that you will benefit from adding a psychological approach to your ongoing program of pain management. We highly recommend that you try this option. (Sign up below.)

Even if stress or emotions are not a factor in your chronic pain, you may still find psychological techniques such as relaxation training, imagery, or biofeedback helpful in managing pain. If you wish to take advantage of these tools, sign up below.

Name

Telephone

Best time to call

THE OSWESTRY PAIN DISABILITY QUESTIONNAIRE

Name: _____

Today's Date: _____

Please read carefully: This questionnaire is designed to enable us to understand how much your pain has affected your ability to manage your every day activities. Please circle the LETTER that most closely describes your situation.

1. Pain Intensity

- A. The pain comes and goes and is very mild.
- B. The pain is mild and does not vary much.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain comes and goes and is severe.
- F. The pain is severe and does not vary much.

2. Personal Care

- A. I do not have to change my way of washing or dressing in order to avoid pain.
- B. I do not normally change my way of washing or dressing even though it causes some pain.
- C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
- D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- E. Because of the pain, I am unable to do some washing and dressing without help.
- F. Because of the pain, I am unable to do any washing or dressing without help.

3. Lifting

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights but it gives me extra pain.
- C. Pain prevents me from lifting heavy weights off the floor.
- D. Pain prevents me from lifting heavy weights, but I can manage if they are conveniently positioned, e.g., on a table.
- E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- F. I can only lift very light weights, at the most.

4. Walking

- A. Pain does not prevent me from walking any distance.
- B. Pain prevents me from walking more than 1 mile.
- C. Pain prevents me from walking more than ½ mile.
- D. Pain prevents me from walking more than ¼ mile.
- E. I can only walk using a cane or crutches.
- F. I am in bed most of the time and have to crawl to the toilet.

5. Sitting

- A. I can sit in any chair as long as I like without pain.
- B. I can only sit in my favorite chair as long as I like.
- C. Pain prevents me sitting more than 1 hour.
- D. Pain prevents me sitting more than ½ hour.
- E. Pain prevents me sitting more than 10 minutes.
- F. Pain prevents me from sitting at all.

6. Standing

- A. I can stand as long as I want without pain.
- B. I have some pain while standing, but it does not increase with time.

- C. I cannot stand for longer than 1 hour without increasing pain.
- D. I cannot stand for longer than ½ hour without increasing pain.
- E. I cannot stand for longer than 10 minutes without increasing pain.
- F. I avoid standing because it increases pain right away.

7. Sleeping

- A. I get no pain in bed.
- B. I get pain in bed, but it does not prevent me from sleeping well.
- C. Because of my pain, my normal night's sleep is reduced by less than one-quarter.
- D. Because of pain, my normal night's sleep is reduced by less than one-half.
- E. Because of my pain, my normal night's sleep is reduced by less than three-quarters.
- F. Pain prevents me from sleeping at all.

8. Social Life

- A. My social life is normal and gives me no pain.
- B. My social life is normal, but increases the degree of my pain.
- C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- D. Pain has restricted my social life and I do not go out very often.
- E. Pain has restricted my social life to my home.
- F. I have hardly any social life because of the pain.

9. Traveling

- A. I get no pain while traveling.
- B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
- C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- D. I get extra pain while traveling which compels me to seek alternative forms of travel.
- E. Pain restricts all forms of travel.
- F. Pain prevents all forms of travel except that done lying down.

10. Changing Degree of Pain

- A. My pain is rapidly getting better.
- B. My pain fluctuates, but overall is definitely getting better.
- C. My pain seems to be getting better, but improvement is slow at present.
- D. My pain is neither getting better nor worse.
- E. My pain is gradually worsening.
- F. My pain is rapidly worsening.

Examiner: _____