ADVANCED PAIN MEDICINE ASSOCIATES

Wichita, Kansas • 316.942.4519

Providing Hope for Pain Sufferers

Welcome to Advanced Pain Medicine Associates. Your appointment is scheduled for:

Date:_____ Check-In Time:_____

In this packet, you will find all of the patient forms required by Advanced Pain Medicine Associates for your initial appointment. ***Please complete at home and bring with you to your appointment***. (***We may have to reschedule if you have not filled out these forms completely by the time of your appointment.***)

Any missed, rescheduled or canceled appointment with less than 24-hour notice may be charged a $30.00 late cancellation fee

****THE FOLLOWING MUST BE BROUGHT TO YOUR APPOINTMENT****

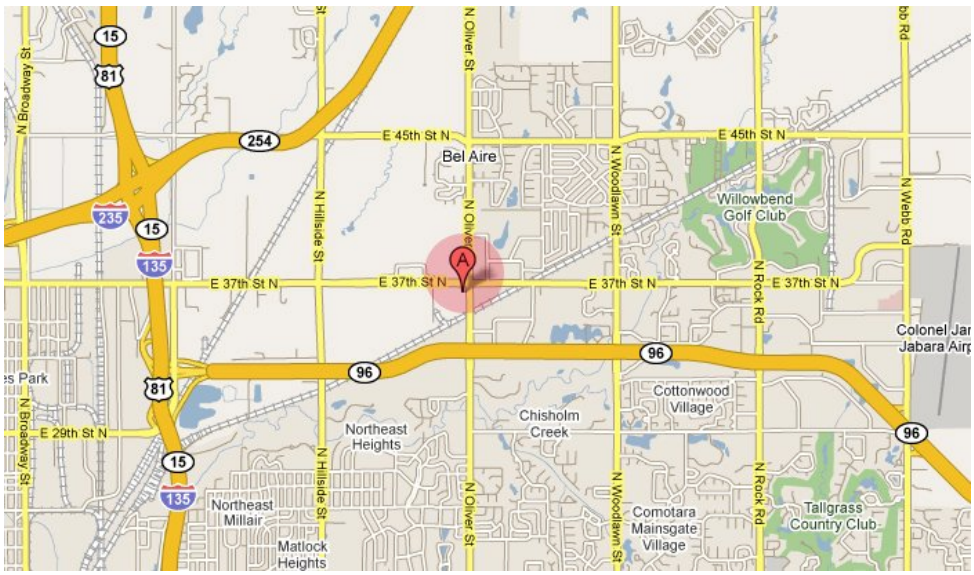
1. **Photo ID and insurance cards (MVA and/or Work Comp information if related).**
2. **Any X-Ray, MRI, or CT scan reports and films that you have.**
3. **All medication that you are currently taking for your pain (in their original bottles).**
4. **Any other information that you think is relevant.**

*****IN REGARDS TO MEDICATION MANAGEMENT, THERE IS NO GUARANTEE THAT YOU WILL BE PRESCRIBED AND/OR KEPT AT YOUR CURRENT DOSING; IT IS CASE BY CASE AND AT THE PROVIDER'S DISCRETION*****

CONTACT INFORMATION:

3715 N. Oliver Wichita, KS 67220

Phone: (316) 942-4519 opt. 4
Fax: (316) 942-4655



From I-35 North/South (Kansas City/Oklahoma City) (Turnpike) – Exit off I-35 at **exit 53** toward KS-96/WICHITA (Turnpike Toll). Merge onto KS-96 W toward HUTCHINSON. Take the OLIVER exit. Turn RIGHT onto N OLIVER ST. Proceed ¼ mile to facility on left. Advanced Pain Medicine Associates is located at the corner of Oliver and 37th street.

From 135 South (South Wichita) – Merge onto KS-96 E via **EXIT 10A**. Take the OLIVER exit. Turn LEFT onto N OLIVER ST. Proceed ¼ mile to facility on left. Advanced Pain Medicine Associates is located at the corner of Oliver and 37th street.

From 135 North (Hutchinson) – Merge onto KS-96 E via **EXIT 10**. Take the OLIVER exit. Turn LEFT onto N OLIVER ST. Proceed ¼ mile to facility on left. Advanced Pain Medicine Associates is located at the corner of Oliver and 37th street.

From 235 South – Merge onto I-135 S/US-81 S/KS-15 S/KS-96 E **via EXIT 16A. Continue .8 Miles** and Merge onto KS-96 E via **EXIT 10**. Take the OLIVER exit. Turn LEFT onto N OLIVER ST. Proceed ¼ mile to facility on left. Advanced Pain Medicine Associates is located at the corner of Oliver and 37th street.

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3715 N. Oliver, Wichita, KS 67220 Tel. 316.942.4519 Fax 316.942.4655
JON C. PARKS M.D. GEORGE. G. FLUTER M.D.
Rita **Simpson P.A.** **Meosha Carr P.A.** **Zachary Castor P.A.**

NEW PATIENT EVALUATION

Today's Date_____

Patient's Full Name_____

Date of Birth_____Age_____Sex_____ □ Married □ Single_____

Who referred you to our practice?_____

Primary Care Physician _____ Phone#_____

Current Medications:

1._____ 6._____

2._____ 7._____

3._____ 8._____

4._____ 9._____

5._____ 10._____

Allergies/Reactions: _____

Previous Surgeries:

Type	*Date*	*Surgeon*
1.		
2.		
3.		

Below, please list other physicians you have seen for your pain. Indicate if this was a consult only or if there was testing or medications prescribed.

Physician	*Date/Year seen*	*Consult only*	*Testing/Medications given*

Patient:_____ Date:_____

MEDICAL HISTORY

			You	Family	Family Relation
Heart Attack	□ No	□ Yes	□	□	
Chest Pain	□ No	□ Yes	□	□	
Heart Murmur	□ No	□ Yes	□	□	
Heart Palpitations	□ No	□ Yes	□	□	
Irregular Heart Beat	□ No	□ Yes	□	□	
Congestive Heart Failure	□ No	□ Yes	□	□	
Shortness of Breath	□ No	□ Yes	□	□	
High Blood Pressure	□ No	□ Yes	□	□	
Low Blood Pressure	□ No	□ Yes	□	□	
Headache	□ No	□ Yes	□	□	
Stroke	□ No	□ Yes	□	□	
Fainting	□ No	□ Yes	□	□	
Scarlet Fever	□ No	□ Yes	□	□	
Rheumatic Fever	□ No	□ Yes	□	□	
Lupus Disease	□ No	□ Yes	□	□	
HIV/AIDS	□ No	□ Yes	□	□	
Hepatitis/Jaundice	□ No	□ Yes	□	□	
Asthma/Emphysema	□ No	□ Yes	□	□	
Bronchitis	□ No	□ Yes	□	□	
Chronic Cough	□ No	□ Yes	□	□	
Lung Disease	□ No	□ Yes	□	□	
Tuberculosis	□ No	□ Yes	□	□	
Pleurisy	□ No	□ Yes	□	□	
Pneumonia	□ No	□ Yes	□	□	
Diabetes	□ No	□ Yes	□	□	
Thyroid Disease/Trouble	□ No	□ Yes	□	□	
Epilepsy/Seizures/Convulsions	□ No	□ Yes	□	□	
Kidney Disease/Dialysis	□ No	□ Yes	□	□	
Cancer/Type_____	□ No	□ Yes	□	□	
Leukemia	□ No	□ Yes	□	□	
Cirrhosis	□ No	□ Yes	□	□	
Swollen/Painful Joints	□ No	□ Yes	□	□	
Phlebitis/Blood Clots	□ No	□ Yes	□	□	
Ulcer	□ No	□ Yes	□	□	
Psychiatric History	□ No	□ Yes	□	□	

Are you: □ Right handed □ Left handed

Domestic Situation:

With whom do you currently reside?_____

Are you currently able to take care of yourself? □ No □ Yes

If no, please give the name and number of your caregiver _____ #_____

Patient:_____Date:_____

Testing/Studies
Please list any recent tests and studies done in relation to your chronic pain.

Test/Studies *Month/Year done*

_____
_____
_____

Legal History
Are you presently involved in a lawsuit related to your pain issue? □ No □ Yes
If yes, please list your attorneys name and phone._____
If Work Comp related please list employer filed against._____

Substance **Use**
Which of the following drugs or substances, if any, have you used in the past?
Next to those that apply to you, indicate if you use [O] Occasionally, [F] Frequently, or [C] Continuously.

□ Alcohol_____ □ Barbiturates_____ □ Cocaine_____
□ Heroin_____ □ Amphetamines_____ □ Marijuana_____
□ Other [be specific]_____
_____

Do you presently smoke cigarettes or use tobacco in any form? □ No □ Yes
If no, have you ever in the past? □ No □ Yes
How many packs do/did you smoke a day?_____ How many years? _____

Pain History
How did your pain begin?

□ Work accident
□ Accident at home
□ At work but *not* an accident
□ Motor vehicle accident
□ Following surgery
□ Following an illness
□ Pain *just* began
□ Other type of accident_____

Date of Injury_____

• Do you experience pain;

[ ] Every day
[ ] 1 to 2 days per week
[ ] 3 to 4 days per week
[ ] 5 to 6 days per week
[ ] Sometimes a week may go by with no pain

• What other things have your tried for your pain?

[ ] Physical/Occupational Therapy
[ ] TENS unit
[ ] Biofeedback
[ ] Anti-inflammatory pills
[ ] Acupuncture
[ ] Narcotic pills
[ ] Chiropractic care

Patient:_____ Date:_____

• Is your pain;

[ ] Constant
[ ] Intermittent

• Is your pain;

[ ] Worse in the morning after getting up
[ ] Worse in the evening after being up all day
[ ] Worse at night when trying to sleep
[ ] No pattern to the pain

• Indicate which of the following describes your usual current quality of pain.

[ ] Sharp
[ ] Dull
[ ] Aching
[ ] Shooting
[ ] Burning

• Indicate your usual level of pain

[ ] Mild
[ ] Uncomfortable
[ ] Distressing
[ ] Very Severe
[ ] Unbearable

• How often are you confined to bed because of your pain?

[ ] Never
[ ] About once a week
[ ] Daily, or more often
[ ] Less than once a week
[ ] Several times per week

• What makes your pain worse?

[ ] Nothing
[ ] Walking
[ ] Bending/Twisting
[ ] Lying down
[ ] Standing
[ ] Sitting
[ ] Cold and Ice
[ ] Medication
[ ] Heat
[ ] Exercise

• Does the pain stop when you quit the above activities?

[ ] Always
[ ] Sometimes
[ ] Never

• What makes your pain better?

[ ] Nothing
[ ] Walking
[ ] Bending/Twisting
[ ] Lying down
[ ] Standing
[ ] Sitting
[ ] Cold and Ice
[ ] Medication
[ ] Heat
[ ] Exercise

Patient:_____ Date:_____

- Do you ever experience any weakness?
  □ No □ Yes If "Yes", please explain_____
  _____

- Have you had in the past or do you currently have any loss of control of your bowel or bladder function?
  □ No □ Yes If "Yes", please explain_____
  _____

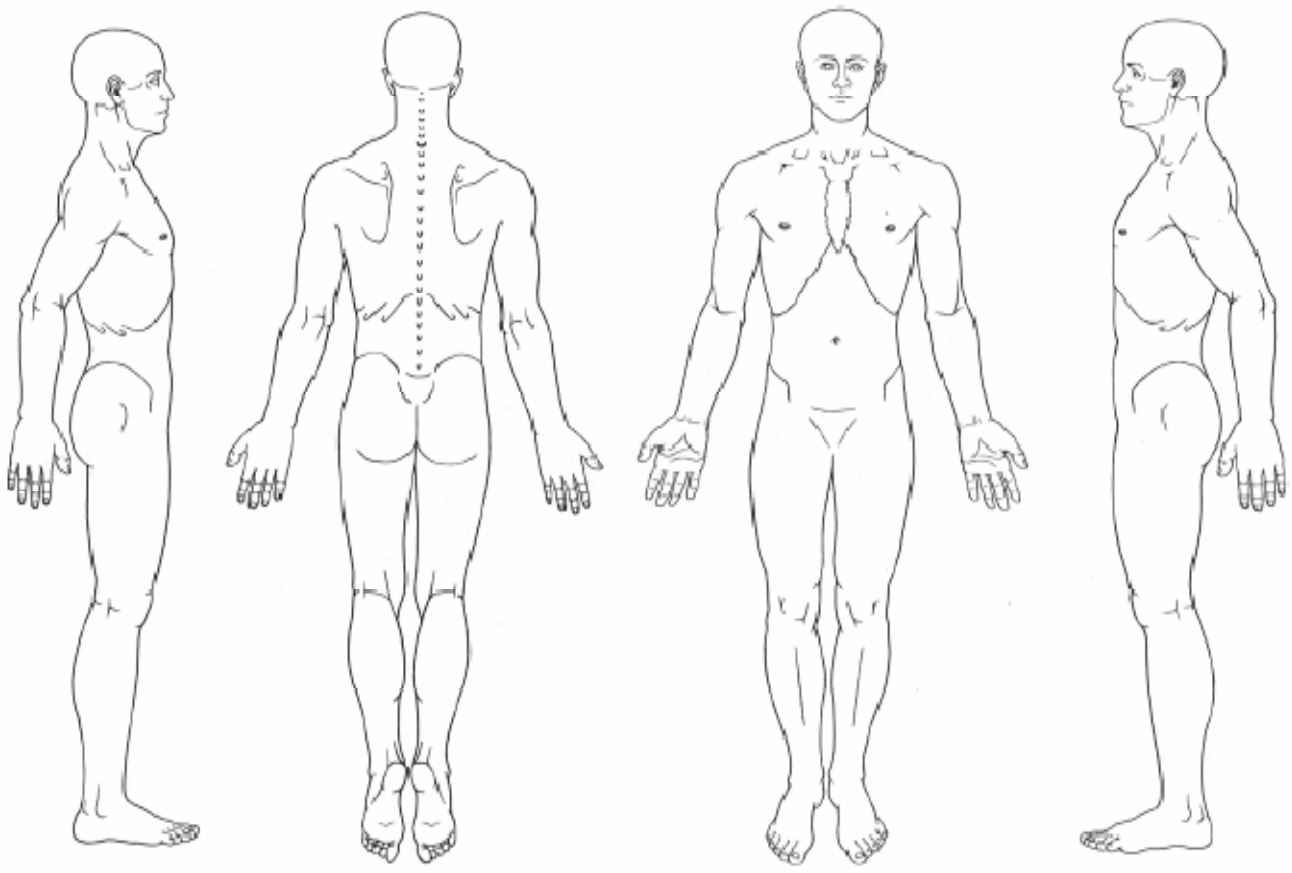
- Do you have any areas of numbness?
  □ No □ Yes If 'Yes", please explain_____
  _____

- Rate your level of pain. "0" is equal to no pain and "10" is equal to the worst pain you have ever experienced.

No Pain- 0 1 2 3 4 5 6 7 8 9 10 Worst Pain-

- Using the symbols below, indicate on the diagram where you have pain.

XXXX = Shooting/Stabbing pain
////// = Numbness
+++++ = Burning Pain
******* = Achy Pain*
0000 = Pins & Needles
= Other Pain



SOAPP® Version 1.0-14Q

Name: _____ Date: _____

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you have mood swings?	0 1 2 3 4
2. How often do you smoke a cigarette within an hour after you wake up?	0 1 2 3 4
3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	0 1 2 3 4
4. How often have any of your close friends had a problem with alcohol or drugs?	0 1 2 3 4
5. How often have others suggested that you have a drug or alcohol problem?	0 1 2 3 4
6. How often have you attended an AA or NA meeting?	0 1 2 3 4
7. How often have you taken medication other than the way that it was prescribed?	0 1 2 3 4
8. How often have you been treated for an alcohol or drug problem?	0 1 2 3 4
9. How often have your medications been lost or stolen?	0 1 2 3 4
10. How often have others expressed concern over your use of medication?	0 1 2 3 4

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

11. How often have you felt a craving for medication?	0 1 2 3 4
12. How often have you been asked to give a urine screen for substance abuse?	0 1 2 3 4
13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0 1 2 3 4
14. How often, in your lifetime, have you had legal problems or been arrested?	0 1 2 3 4

Please include any additional information you wish about the above answers. Thank you.

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PATIENT FINANCIAL POLICY

Advanced Pain Medicine Associates is committed to providing you with the best possible care and will be happy to discuss questions regarding our policies, fees or your responsibilities at any time. A clear understanding of the "Patient Financial Policy" is important for the entire scope of your care.

All patients must complete our "Patient Financial Policy" before seeing a provider. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance, phone changes etc….).

INSURANCE: As a courtesy, we will file your insurance claims. We will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, co-payments, non-covered charges and "usual and customary" charges. We will supply factual information as necessary. Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan. Do not assume that you will not owe anything if you have more than one insurance policy.

REGARDING HMO'S, PPO'S AND MANAGED CARE PROGRAMS: It is your responsibility to obtain referral forms required by your particular insurance company. We will do our best to remind you when a referral is due, but ultimately you are required to keep track of the referrals on hand. If you present to the office without a current referral you will be asked to sign an advanced beneficiary form and you will be responsible for the bill or reschedule the appointment. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100 percent responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment.

CO-PAYS: You are expected to pay your co-pay prior to seeing your provider. If you are unable to pay, you will be required to reschedule your appointment. Refunds of co-pays will not be given.

REGARDING PATIENTS WITH NO INSURANCE (*SELF-PAY PATIENTS*): If you do not have coverage or have insurance that we do not participate in, you will be required to pay for your services prior to seeing the provider or reschedule your appointment.

REGARDING MEDICARE: Our providers all participate with Medicare. We will file all claims with your Medicare and your supplemental insurance, if applicable. If you do not have a supplemental insurance you will be responsible for the co-insurance and/or deductible amount following the processing of your claim.

REGARDING MEDICAID/PROJECT ACCESS: Our providers do not participate in any form of Kansas Medicaid, Kancare program or Project Access. (Above policy regarding patients with no insurance will apply.)

FORM COMPLETION: A charge of **$30.00** is due before the forms will be processed. (Disability, FMLA, Physician statements, etc.)

WORKERS COMPENSATION/AUTO LIABILITY: Our office requires authorization prior to the initial visit. Any Work Comp or MVA information will need to be provided **PRIOR** to you being seen. We will do our best to obtain the authorization prior to the visit. You are also required to provide us with Health Insurance coverage in case your workers' comp or auto denies the service. If you do not have health insurance you may be asked to pay for the service in advance. Any claims paid after we have received your payment will be refunded promptly.

CO-PAYS/CO-INSURANCE/DEDUCTIBLES/GUARANTOR RESPONSIBILITY: Our office requires payment in full for any balance not paid by insurance within three months from the date of service. If you are unable to pay your balance in full it is the patient's responsibility to make arrangements with our business office. If payment is not received, we will enlist a collection agency's help after three months of non-payment. Referral to a collection agency may result in financial dismissal from our practice.

RETURNED CHECKS: There is a **$30.00** returned check fee payable in cash or money order.

NO SHOW APPOINTMENTS: You are expected to show for the appointments made for us to adequately provide care. Failure to provide 24 business hours notice that you will not be keeping your appointment may result in termination from the practice. I understand I may be charged for any appointments missed without giving 24 business hours prior notice.

By signing this form I acknowledge that I have read this policy and understand the terms outlined above. Failure to comply with the financial policy of APMA may result in suspension of services or dismissal from the practice.

_____ _____

Patient Name (please print) **Patient Signature** **Date**