SUNSHINE SPINE & PAIN, P.A.

WWW.SUNSHINESPINE.COM
Arkam Rehman, M.D.

HISTORY AND PHYSICAL INTAKE FORM

Name: ______________________________________DOB: ____________________Age:______Height: _______ Weight: ________

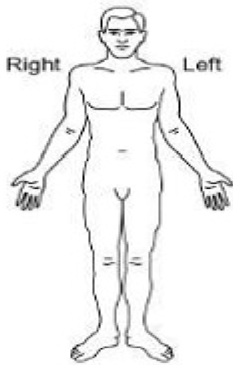
Primary Care Physician: ___________________________________Referring Physician: ___________________________________

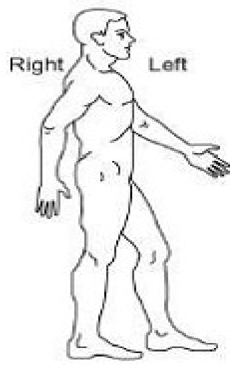
Reason for visit/Area of pain (please specify body part):

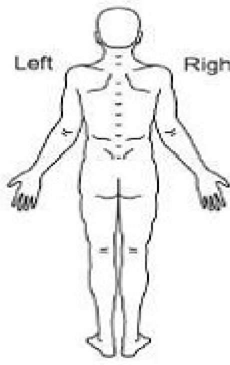
____

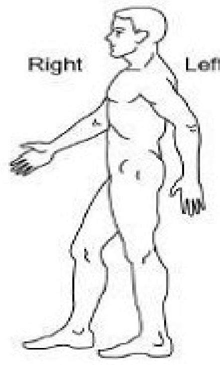
Please **circle** the areas where you are experiencing pain & **rate** the area you are having pain from a 1 out of 10 (**1** being minor and **10** being unimaginable):

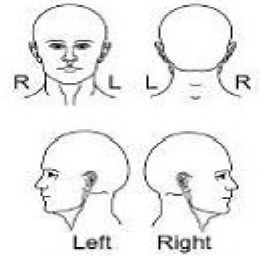
Pain score: ______ ______











Pain score: ______ ______ ______ ______ ______ ______

Current Medications:		**Allergies:**	**Yes**	**No**
Name of Medication	Dosage	No Known Drug Allergies	___	___
_________________________	________	**IV Dye**	___	___
_________________________	________	**Iodine**	___	___
_________________________	________	**Seafood/Shellfish**	___	___
_________________________	________	Latex	___	___
_________________________	________	Adhesive Tape	___	___
		NSAIDS	___	___
_________________________	________	Penicillin	___	___

Pharmacy Name:____ Other:_____________________________________

Pharmacy Address/Location:_________________________________ **Pharmacy Phone #:**__________________________

____

Patient Name:____ **DOB:**______________________________

Past Medical History:	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
High blood pressure	___	___	Hepatitis/liver disease	___	___	Phlebitis/blood clots	___	___
Heart disease	___	___	Kidney problems/Stones	___	___	Stomach Ulcer disease	___	___
Heart attack	___	___	Thyroid disease	___	___	Bleeding disorder	___	___
Irregular heart rhythm	___	___	Diabetes	___	___	Asthma	___	___
Stroke	___	___	Osteoporosis	___	___	Emphysema/COPD	___	___
Seizures	___	___	Rheumatoid Arthritis	___	___	Cancer	___	___
Glaucoma	___	___	Depression	___	___	Trauma	___	___
Fibromyalgia	___	___	HIV positive	___	___	Other: ___________________________		

Surgical History: Check here if none ( )

( ) Low back surgery (When) ____________________ Where ____________________ Surgeon ________________________

( ) Neck surgery (When) ________________________ Where ____________________Surgeon ________________________

( ) Heart surgery (When) ________________________ Where ____________________Surgeon ________________________

( ) Joint replacement (Which) ______________________________ ( ) Cancer surgery (When) __________________________

( ) Appendix ( ) Hernia ( ) Gallbladder ( ) Hysterectomy ( ) OTHER SURGERY ____________________________

Social History: Right Handed **( )** Left Handed **( )**

Alcohol: **( ) YES** ( ) NO ( ) Daily ( ) Few per week ( ) Once per week ( ) Few per month

Illicit Drug Use: **( ) YES** ( ) NO ( ) Type ____________

Drug/Alcohol treatment? **( ) YES** ( ) NO If yes, name of facility: ______________________ Year ________

Past Suicide Attempt? **( )YES** ( ) NO If yes when __________

Active Suicidal Thoughts?**( )YES** ( ) NO If yes do you have an active plan? ___________________________

Smoker: **( ) YES** ( ) NO # packs daily: _____________How many years: _______________

Employment status: ( ) None ( ) Full Time ( ) Part time ( ) Work with limitations (length of time limited): __________ ( ) Retired

If employed type of occupation: _______________________________________ ( ) Light ( ) Sedentary ( ) Heavy duty

Family History:

Mother ( ) Alive ( ) Deceased Age: ___ Cause/medical conditions:____

Father ( ) Alive ( ) Deceased Age: ___ Cause/medical conditions: ____

Family Medical Problems ( ) Diabetes ( ) Heart Disease ( ) Cancer (type): ________________ ( ) Other: __________

Patient Name:____ **DOB:**_______________________

Review of Systems: Possibly pregnant ( ) Yes ( ) No

Have you had a major fall or accident with fracture in painful area(s) recently? ( ) Yes ( ) No

If yes, please explain: ____

Functional status evaluation, does your pain interfere with any of these?

( ) Eating ( ) Bathing ( ) Using the toilet ( ) Dressing ( ) Getting up out of bed/chair

( ) None **General:** ( ) Numbness ( ) Tingling Where? ____________ Old/New: ____________

( ) New incontinence ( ) urine ( ) stool ( ) Coordination/Off balance

( ) None **Constitutional:** ( ) Fever ( ) Weight loss ( ) Tiredness

( ) None **HEENT:** ( ) Blurred vision ( ) Haloes around lights ( ) Double vision ( ) Deafness ( ) Ringing ( ) Dizziness ( ) Vertigo

( ) None **Heart:** ( ) Chest pain ( ) Irregular heart beat ( ) Pounding in chest

( ) None **Lungs:** ( ) Shortness of breath ( ) Wheezing ( ) Cough

( ) None **Abdomen:** ( ) Diarrhea ( ) Constipation ( ) Black stools ( ) Heartburn ( ) Stomach bleeding

( ) None **Urinary:** ( ) Burning ( ) Loss of urine **( ) Saddle anesthesia** ( ) Kidney disease

( ) None **Musculoskeletal:** ( ) Sprains ( ) Swelling ( ) Stiffness

( ) None **Skin/Breasts:** ( ) Rash ( ) Sores ( ) Masses

( ) None **Neurologic:** ( ) Balance problems ( ) Memory problems ( ) Falls

( ) None **Behavioral:** ( ) Depression ( ) Anxiety ( ) Sleep disturbance

( ) None **Endocrine:** ( ) Sleep all the time ( ) Hyperactive ( ) Too cold ( ) Too hot

( ) None **Blood/Lymphatic:** ( ) Easy bruising ( ) Bleeding problems ( ) Anemia

( ) None **Immunologic:** ( ) Itching ( ) Frequent colds/infections

( ) None **Menstrual:** ( ) Regular ( ) Irregular ( ) Severe pain ( ) Post menopausal

I certify that the information given on the Initial Visit Intake is correct to the best of my knowledge. I will not hold my doctor or any member of his staff responsible for any errors or omissions that I may have made in the completion of this paperwork.

____ **Date:** ____________________
Patient/Family/Legal Guardian Signature

MA Initials:__________

Physician Signature: ____________________________ **Date:**__________

SUNSHINE SPINE & PAIN, P.A.

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PATIENT REGISTRATION FORM **Today's Date: ______________**

Patient Information

Name:

Sex: □ Male □ Female

Social Security #:

Date of Birth:

Home Address:

City, State:

Zip Code:

Home Phone:

Cell Phone:

Email Address:

Employer:

Mailing Address (If Different):

Martial Status

Please Check One:

□ Single □ Married □ Divorced □ Widow

If Married Spouse Name:

Spouses Phone #:

Spouse Social Security #:

Date of Birth:

Employer

Health Information

Are you currently here as a result of an **AUTO** accident?

□ Yes □ No

Do you have an **OPEN CLAIM OR CASE** for an auto accident? If yes, please fill out the page titled **AUTO.**

□ Yes □ No

Are you currently here as a result of an accident that happened on the job and is connected to a **WORKERS COMPENSATION** case? If yes, please fill out page titled **WORKERS COMPENSATION**.

□ Yes □ No

Patient Information Continued

Race: (please check one)

□ White □ Black □ Hispanic

□ Asian/Pacific Islander □ Indian

□ Other:_____________________

Language: □ English □ Spanish

□ Other:_____________________________

Ethnicity: □ Latino or Hispanic

□ Not Latino or Hispanic

□ Declined to answer

Emergency Contact:

Emergency Contact Number:

Referring Physician:

Primary Care Physician:

Health Insurance

What is your Primary **Health** Insurance?

Policy/ID #:

Group #:

Policy Holders Name:

Date of Birth:

What is your Secondary **Health** Insurance?

Policy/ID #:

Group #:

Policy Holders Name:

Date of Birth:

It is your responsibility as a patient of Sunshine Spine & Pain, PA to provide us with your accurate insurance information at the time of service. If another party (auto, w/c, legal attorney) is responsible for paying for your treatment, you must give us that information. Otherwise, you will be financially responsible. (Please Note: we only have 30 days in which to file your claim and get reimbursed from auto insurance.)

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CONSENT FOR TREATMENT

I hereby consent and authorize the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment at **SUNSHINE SPINE AND PAIN, P.A.**

PRIVACY NOTICE ACKNOWLEDGEMENT

During the course of your treatment it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared:

- During treatment, we may find it necessary to acquire a laboratory analysis.
- During your treatment, a referral to other services may be necessary.
- During health care operations, we may need a second opinion.
- During the payment process, we may need to release notes and other laboratory results.
- Release information to legal authorities or case workers.

I acknowledge that I have had the opportunity to review a copy of the **SUNSHINE SPINE & PAIN, P.A NOTICE OF PRIVACY PRACTICES**. I understand that I am responsible for reading this notice and for notifying Sunshine Spine and Pain, P.A. in writing of any request for restrictions in the use or disclosure of my individually identifiable health information. I understand that the notice includes electronic access to my medication history. Sunshine Spine and Pain, P.A. has the right to revise this notice at anytime and will post a copy of the current notice in the office in a visible location at all times. Sunshine Spine and Pain, P.A. may also provide me with a copy of its most recent notice upon my request.

CONSENT FOR DISCLOSURES

We understand that at times you may need members of your family or friends to contact the office to make inquiries about your health status, diagnosis, treatment options, schedule, reschedule, cancel appointments or to be contacted in the event of an emergency. To do so, please list the person, or persons you are authorizing to make such inquires or changes. Please be advised that we may require them to confirm personal information to verify their authorization, such as your date of birth.

Our commitment here at Sunshine Spine and Pain, PA is to serve our patients in a professional, courteous, and caring manner. Therefore we ask that all members of your party conduct themselves in that same manner while in the office or on the phone. Any inappropriate behavior and/or rudeness to the staff for any reason, is not tolerated and are grounds for discharge.

Name: ______________________________ Relationship: _________________________ Contact #: _________________________

Name: ______________________________ Relationship: _________________________ Contact #: _________________________

I DO NOT give authorization for medical information, lab work results and any other information regarding my appointments or treatment to be released to anyone __________.

(Your Initials)

SUNSHINE SPINE & PAIN, P.A.

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FINANCIAL POLICY AND AGREEMENT

I understand that in consideration of the services provided to me, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered by Sunshine Spine & Pain, PA. I am responsible for any applicable deductible, co-payments and coinsurance prior to the provision of services. Sunshine Spine & Pain, PA may file ALL claims for payment with my insurance company as a courtesy to me. If the insurance company fails to pay in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts due. Payments may be made in the form of check, Visa, Mastercard, and Discover. Should my account be referred to a collection agency and/or attorney for collection, the undersigned agrees to pay all collection fees and/or attorney fees associated with the collection of this debt.

I hereby authorize and assign all payments, insurance or Medicare benefits for medical services and/or procedures rendered to the me, directly to Sunshine Spine & Pain, PA. I hereby authorize Sunshine Spine & Pain, PA to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by my insurance company or Medicare.

If my insurance company requires me to obtain referrals/authorizations, it is my responsibility to obtain such and if not, then I will be responsible for any unpaid balance.

By signing this agreement, I acknowledge that I have carefully read, understand and agree to the above terms and conditions. I also understand that it is mandatory to tell Sunshine Spine & Pain, PA if another party is responsible for paying for my treatment (i.e. Automobile Insurance, Workers' Compensation, slip and fall). Section 1128B of Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

MEDICAID INSURANCE WAIVER

This notice is to inform all patients that we are **NOT MEDICAID PROVIDERS.** If you decide to seek treatment at Sunshine Spine and Pain, P.A., **you are required to sign this waiver in acknowledgment that you have received this waiver (even if you do not have Medicaid insurance),** and that you will be responsible for any portion of your bill that is not covered by any other insurance.

FEE POLICY

Appointment Cancellation/No Show Fees:

If you do not call within 24hrs of your scheduled appointment to cancel, reschedule, or if you “no show” for a scheduled appointment, the following fees will apply

Follow up = $50.00
Injections = $100.00
Stim Adjustment = $50.00
EMG/Nerve Conduction Study = $100.00
Medical Botox = $150.00
Stim Trial/Radiofrequency = $300.00
Hospital Procedures =$300.00

Medical Records Fees:

If you are requesting a copy of your medical records, a signed authorization to release your records is required before we can process any requests. As a courtesy we will release a copy of your records to a physician of your choice with a signed release form and appropriate forwarding information for that physician free of charge. Any additional requests will be charged a fee (see below) and must be paid in full prior to pick up. Please note the final charge will include postage if you are requesting your records to be mailed. All records are processed out of our Baptist South location and must be picked up at that location. Fees for copies of medical records are as follows:

$1.00 per page for the first 20 pages, $0.25 per page thereafter

Paperwork Fees:

(Disability FMLA, etc.)

It is the patients responsibility to ensure all disability paperwork is provided during their office visit in a timely fashion.

Physician Progress Report $25.00 FEE	2 PAGES $25.00 FEE	3 PAGES OR MORE $40.00 FEE

One page paperwork will be completed at **NO ADDITIONAL CHARGE.** Payment must be collected prior to any forms being completed by your provider. You will need to allow 7-10 business days for the provider to complete these forms. Once the forms are completed, our office will call you to arrange for pick up. You are responsible to ensure that your forms are sent to the appropriate place within the time frame required.

By signing this agreement, I acknowledge that I have carefully read, understand, and agree to the terms and conditions of the Consent for Treatment Agreement, the Privacy Notice Acknowledgment, the Consent for Disclosure, the Financial Policy and Agreement, the Medicaid Insurance Waiver, and the Fee Policy. I have completed these forms accurately and to the best of my knowledge and will be financially responsible if I have failed to provide Sunshine Spine and Pain, P.A. with all of my applicable insurance information.

Patient/Legal Guardian Name (print):____

Patient/Legal Guardian Signature:____ Date:________________

SUNSHINE SPINE & PAIN, P.A.

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NARCOTIC MEDICATION POLICY/CONTRACT

You **MAY** be given narcotic medication for the treatment of your pain. **If you choose to receive medications from our practice, then you are to abide by the terms of this narcotic contract. If you are choosing NOT to receive medication from our practice, you are still required to complete this form in its entirety in acknowledgment of receiving this policy.** Please **read each statement and sign** this contract below. If you have any questions regarding this, please request clarification from the medical staff.

Any medical treatment is initially a trial and continued prescription/s are based on evidence of benefit. I understand that the goal of using narcotics is to decrease my pain, increase my functional level and to improve the overall quality of my life.

I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, lightheaded, dizziness, confusion, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, kidney or liver disease, sexual dysfunction, physical dependence, tolerance to analgesia, addiction, withdrawal and the possibility that the medicine will not provide complete relief. The overuse of narcotic medication can result in serious health risks including respiratory depression or even death. This medication will be strictly monitored and all of my medications should preferably be filled at the same pharmacy.

Patient must initial each statement below and by initialing, the patient acknowledges what is expected of him/her by the physician. With any violation of this contract, the physician has the right to discharge you as a patient from the clinic.

(Initial)

- **PATIENT WILL NOT USE ANY ILLEGAL SUBSTANCE** ____________
- **ABSOLUTELY NO ALCOHOL USE (Including but not limited to beer, wine, liquor etc.)** ____________
- **I agree to use good judgment regarding my ability to drive while taking controlled substances** ____________
- **Patient will not obtain scheduled substances from another provider without notifying physician.**
- **Patient will not change their dose without prior discussion with physician.**
- **Patient will not be given early refills on medications that are being overused/lost/stolen.**
- **Patient will give a RANDOM urine specimen for drug testing when asked.**
- **Patient will not take old prescribed medications as well as take other people's prescribed medications.**
- **I understand that I am required to bring in medications for counting anytime my Provider requests it due to reasons such as suspecting overuse.**
- **I agree to bring in any left over medications for proper disposal if a medication change is to be made.**

Please continue to read each statement below that is also expected of you by the physician.

- I agree to always conduct myself in a courteous manner with staff while in the office or on the phone. It is my responsibility to ensure that all members of my party also conduct themselves in the same manner. I understand that any inappropriate behavior and/or rudeness by me or anyone accompanying me at my appointment is grounds for my discharge from the clinic.

- I will inform Sunshine Spine and Pain, P.A. of any changes in my medical condition, any changes in any prescription and/or over the counter medication that I take and of any adverse affects or problems that I may experiencing from any of the medications that I have been prescribed to me by this clinic or any other clinic.

- I agree to tell Sunshine Spine and Pain, P.A. my complete and honest personal drug / medication usage and history and if I have been in any drug or alcohol rehabilitation programs in order for the physician to make the best clinical decisions for my care.

- "Random" drug screening will be performed to monitor my adherence to/compliance of my treatment plan. I agree to have the random drug screen performed on the day the physician/clinical staff requests it.

- **A "random" drug screen ordered by the physician can consists of either a urine drug test, oral drug screen test that is done on site or a requisition form to a specific lab that must be done within 24 hours of my office visit in order to be compliant. Not completing a random drug screen is a violation of this contract and is grounds for discharge by the physician.**

I will also inform the physician/provider at Sunshine Spine and Pain, P.A., if I have had or begin to have suicidal/homicidal thoughts at any time during my treatment with this clinic. In the event I begin to have these thoughts, I will contact the office immediately.

I agree to advise the physician if there is a confirmed pregnancy by a physician/lab or if I suspect that I may be pregnant. If applicable.

I also understand that in the event I am given a medication warning for violating this narcotic contract that financial hardships and/or previous payment arrangements may be considered null and void and any balances would be due in full.

If, in the sole opinion of the physician, I violate any of the above, I understand that Sunshine Spine and Pain, P.A. will include any and all such violations in my file and shall immediately discharge me as a patient. Sunshine Spine and Pain, P.A., will forward my files and records to a new physician of my choice at my request.

I give my consent to Sunshine Spine and Pain, P.A., and all its employees to make report to or otherwise cooperate with any law enforcement officials or regulatory agencies in any investigation which may arise as a result of my receiving prescriptions as a patient of Sunshine Spine and Pain, P.A. I waive any and all rights of privacy and privilege in this regard and these authorities may be given full access to my records upon written request to Sunshine Spine and Pain, P.A. without order of clerk or court.

By signing this agreement I affirm that I have read, understand and accept all of the terms of this Narcotic Medication Contract.

____ **Date:** ____________________
Patient/Family/Legal Guardian Signature

Physician Signature: ____ **Date:** ____________________

(updated 08/04/16 ac)

SUNSHINE SPINE & PAIN, P.A.

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Arkam Rehman, M.D.

AUTO / WORKERS' COMPENSATION FORM

Patient Name:____ Date of Birth:________________________________

AUTO INFORMATION

If you are requesting treatment for injuries sustained in an auto accident, and have an open auto claim or case, please complete this form. Individuals seeking PIP medical benefits **must receive initial services and care within 14 days** after the motor vehicle accident. Initial services and care are only reimbursable if lawfully provided, supervised, ordered, or prescribed by a licensed physician, licensed chiropractic physician, licensed dentist, or must be rendered in a hospital, a facility that owns or is owned by a hospital, or a licensed emergency transportation and treatment provider. **Follow up services and care requires a referral from such providers and must be consistent with the underlying medical diagnosis rendered when the individual received initial services and care.**

Name of Auto Insurance Carrier:________________________________ Auto Policy # ____________________________
Name of Insured: ____ Claim # _________________________________
Date of Accident: ____ **Date of First Treatment:**__________________
Body Parts Injured: ____ Doctor/Facility Name: ____________________
Adjuster's Name: ____ Phone#/Ext:____________ Fax:______________
Auto Insurance Billing Address: ____
What State Did This Occur In? ____________________________ Do you have an Open Legal Case? □ **Yes** □ **No**
Attorney Firm: ____ Attorney Name: _______________________
Phone #: _________________ Fax #: ____________________________ Legal Case #: ________________________
Date Legal Case was Opened: ____________________________

I ____________________________, hereby authorize and direct _______________ to send to Sunshine Spine & Pain, P.A. An accounting of payouts made under **all claims** submitted for payment under the above referenced policy relating to the auto accident occurring on the above referenced date **as those payouts occurred.**

WORKERS' COMPENSATION INFORMATION

If you are requesting treatments for injuries sustained while at work, have an open workers' compensation claim or case, please complete this form. Please note: We must have authorization from your workers' compensation adjuster before any treatment can be provided.

Employer: ____ Date of Injury: __________________________
Body Parts Injured: ______________________________________ Claim #: _______________________________
Workers' Comp. Insurance Name: ____
Adjuster's Name: ____ Phone#/Ext:___________ Fax:_______________
Claims Mailing Address: ____
Attorney Firm: __ ____ Attorney Name: _______________________
Phone #: ___________________ Fax #: ___________________________ Legal Case #: ________________________
Date Legal Case was Opened: ______________________________

I have completed this form with accurate and truthful information about the above mentioned incident.

Patient/Legal Guardian Signature: ____ **Date:**_________________

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SOAPP Version 1.0-14Q

Name (print): ____ **Date:**____________________

The following are some questions given to all patients receiving pain management care 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 circle your answer to 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 is 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**
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

Patient/Legal Guardian Signature:____