Advance Pain Management

Date: _____

First Name: _____

Last Name: _____

Address: _____

Address Line 2 (Apt., Ste., etc.): _____

City, State: _____, _____ Zip Code: _____

Phone Number: (_____) _____

Email: _____

Social Security: _____ - _____ - _____

Date of Birth: _____/_____/_____ Age: _____ Marital

Status: Married ◯ Single ◯ Divorced ◯ Separated ◯ Widow ◯

Emergency Contact Name: _____

Emergency Contact Phone Number: (_____) _____

Relationship to Patient: _____

Insurance Information

Insurance Name: _____

Policy Number/Member ID: _____

Group Number: _____

Health Questionnaire

(Select the answer and fill out blanks if necessary)

1. Are you allergic to any medications?
    a. No ☐
    b. Yes, ☐ _____
    _____
    _____

2. Do you smoke any form of tobacco?
    a. No ☐
    b. Yes ☐
        i. If yes, how many packs per day? _____
        ii. If yes, how many years have you been smoking? _____

3. Do you drink alcohol?
    a. No ☐
    b. Yes ☐
    c. I consume _____ (number) of drinks per week

4. Do you currently have a Medical Marijuana Card?
    a. No ☐
    b. Yes ☐
        i. If yes, when is the expiration date? _____

5. Do you have any history of illegal drug use?
    a. No ☐
    b. Yes ☐
        i. If yes, what drug(s)? _____
        ii. If yes, when did you quit? _____
        iii. If yes, how long did you use it for? _____(years)

6. Have you ever been incarcerated due to illegal drug use:
    a. No ☐
    b. Yes ☐
        i. If yes, explain: _____

7. Do you have any history of domestic violence?
    a. No ☐
    b. Yes ☐
        i. If yes, how long ago? _____ (years)

8. Do any of the following apply to a blood relative? If so, who?(Select all that apply)

Addiction ☐	Depression ☐	Neuropathy ☐
Alcoholism ☐	Fibromyalgia ☐	Osteoporosis ☐
Anxiety ☐	Gallbladder ☐	Pancreatitis ☐
Arthritis ☐	Head Injury ☐	Peripheral Nerve ☐
Asthma ☐	Heart Arrhythmia ☐	Disease ☐
Blood Disorders ☐	Heart Attack ☐	Reflux ☐
Bowel Disease ☐	Hepatitis ☐	Seizures ☐
Lung Disorder ☐	High Blood Pressure ☐	Sleep Apnea ☐
Cancer ☐	High Cholesterol ☐	Stroke ☐
Cirrhosis ☐	HIV ☐	Tuberculosis ☐
Coronary Artery Disease ☐	Kidney Disorder ☐	Ulcers ☐
Diabetes ☐	Migraine ☐	
	Multiple Sclerosis ☐	

9. Do you have any health concerns that you wish to disclose at this moment?

a. No ☐
b. Yes ☐
   i. If yes, what? _____

10. Have you ever been treated for any of the following problems? (Mark all that apply)

- Asthma ☐
- AIDS ☐
- Hepatitis ☐
- Cancer ☐
- Congestive Heart Failure ☐
- Diabetes ☐
- Diverticulitis ☐
- Depression/Anxiety ☐
- ED ☐
- GERD ☐
- Gout ☐
- Skin Lesions/Rashes ☐
- Visual Impairment or Loss ☐
- Breast Lesions ☐
- Dizzy Spells/Blackouts ☐
- Seizures ☐
- Diabetes ☐
- Arthritis ☐
- Vomiting Blood ☐
- Hearing Impairment or Loss ☐
- Stomach Ulcers ☐
- Drug Addiction ☐
- Ear/Sinus Infections ☐
- Blood in Stools ☐
- Anorexia ☐
- Anemia ☐
- Dizziness ☐
- High Blood Pressure (Hypertension) ☐
- Heart Attack ☐
- Headache ☐
- High Cholesterol ☐
- Eczema ☐
- Kidney Disease ☐
- Liver Disease ☐
- Lupus ☐
- Seizures ☐
- Sleep Apnea ☐
- Stroke ☐
- Urinary Tract Infections (UTI) ☐
- Blood in Urine ☐
- Thyroid Disease ☐
- Arrhythmia/Palpitation ☐
- Bladder and/or Bowel Movement Issues ☐
- Anemia/Bleeding Problems ☐
- Tuberculosis ☐

1. Where is the main area of your pain today? (Select all that apply)

Head ☐
Neck ☐
Chest ☐
Abdomen ☐
Upper Back ☐
Middle Back ☐

Lower Back	☐	Legs (Left, Right, or Both)	☐
Shoulders (Left, Right, or Both)	☐	Hands (Left, Right, or Both)	☐
Hips (Left, Right, or Both)	☐	Feet (Left, Right, or Both)	☐
Arms (Left, Right, or Both)	☐		

Other:_____

2. How would you rate the pain on a scale from 1-10? (Please select) 10

3. How would you describe the pain? (Please select all that apply)

Aching	☐	Numbness	☐
Burning	☐	Tingling	☐
Stabbing	☐	Soreness	☐
Shooting	☐	Throbbing	☐
Sharp	☐	Pressure	☐
Electricity	☐		

Other: _____

4. What relieves the pain? (Please select all that apply)

Rest	☐	Medication	☐	Changing Positions	☐
Ice	☐	Lying Down	☐	Meditation	☐
Heat	☐	Stretching	☐	Physical Therapy	☐
Relaxation	☐	Injections	☐	Tens Unit	☐

Other: _____

5. What increases the pain? (Please select all that apply)

Stress	☐	Standing	☐	Lifting	☐
Activity	☐	Pushing on Area	☐	Bending	☐
Walking	☐	Movement	☐		
Sitting	☐	Cold Weather	☐		

Other: _____

6. Are you pregnant or planning on becoming pregnant? (Select One) Yes ☐ or No ☐

7. Are you on blood thinners? (Select One) Yes ☐ No ☐
If yes, Please list them _____

8. Will you be requesting pain medication at today's visit? (Select One) Yes ◯ or No ◯

Please check off any surgeries/procedures that you may have had:

• Epidural Injection ☐	• Tubal Ligation ☐
• Spinal Cord Stimulator ☐	• Vasectomy ☐
• Cortisone Injections ☐	• Cholecystectomy ☐
• Appendectomy ☐	• Mastectomy ☐
• Cardiac Cath ☐	• Breast Lumpectomy ☐
• Stress Test ☐	• Carotid Endarterectomy ☐
• Stent ☐	• C-section ☐
• T & A ☐	• LE Bypass Surgery ☐
• Hernia Repair ☐	• Hip Surgery ☐
• CABG ☐	• Back Surgery ☐
• Hysterectomy ☐	• Tonsil/Adenoid ☐
• Ear Tubes ☐	• Pacemaker ☐
• Circumcision ☐	

Risk Assessment

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.

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 feel that your pain is “out of control?”	0
2. How often do you have mood swings?	4
3. How often do you do things that you later regret?	4
4. How often has your family been supportive and encouraging?	4
5. How often have others told you that you have a bad temper?	4
6. Compared with other people, how often have you been in a car accident?	4
7. How often do you smoke a cigarette within an hour after you wake up?	4
8. How often have you felt a need for higher doses of medication to treat your pain?	4
9. How often do you take more medication than you are supposed to?	4
10. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	4
11. How often have any of your close friends had a problem with alcohol or drugs?	4
12. How often have others suggested that you have a drug or alcohol problem?	4
13. How often have you attended an AA or NA meeting?	4
14. How often have you had a problem getting along with the doctors who prescribed your medicines?	4
15. How often have you taken medication other than the way that it was prescribed?	4
16. How often have you been seen by a psychiatrist or a mental health counselor?	4
17. How often have you been treated for an alcohol or drug problem?	4
18. How often have your medications been lost or stolen?	4
19. How often have others expressed concern over your use of medication?	4
20. How often have you felt a craving for medication?	4
21. How often has more than one doctor prescribed pain medication for you at the same time?	4

22. How often have you been asked to give a urine screen for substance abuse?	4
23. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	4
24. How often, in your lifetime, have you had legal problems or been arrested?	0

For office use only

Score: 84

- **Low 0-6**
- **Moderate 6-12**
- **High 12+**

MEDICATION LIST

Name:_____DOB: _____
Drug Allergies:_____

Medication	Strength	How Often?	Comments

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____
Address:_____
Birth Date:_____Phone Number:_____

INFORMATION TO BE SENT: Please Check One

- **All**
- **Other (Be Specific)_____**

PLEASE RELEASE A COPY OF MY MEDICAL RECORDS TO:
(THIS INFORMATION IS REQUIRED FOR RELEASE OF YOUR INFORMATION):

ADVANCE PAIN MANAGEMENT
2950 STONE HOGAN CONNECTOR RD. BLDG A, STE B
ATLANTA, GEORGIA 30331
PHONE: 404-781-2800 FAX: 833-897-2947

Medical records may include confidential information related to HIV, communicable disease, alcohol or drug abuse and mental health diagnosis and treatment.
I understand that I can refuse the release of this type of information.
(PLEASE INITIAL): _____

I understand:

- I may revoke this authorization except to the extent that it has already been acted upon.
- Treatment will not be conditioned on me providing this authorization unless this provision of healthcare is solely for the purpose of creating protected health information for disclosure to a third party.
- Once this information is released it may be re-disclosed by the recipient and may no longer be protected information.
- I may have a signed copy of this authorization.

Patient's Signature:_____ Date:_____

MISSED APPOINTMENTS

It's the responsibility of the patient to call at least 24 hours in advance of their scheduled appointment if the patient is unable to make their appointment.

If a patient “no shows” an appointment, there will be a **$50 fee for office appointments, $100 fee for EMG appointments, and $150 fee for procedure appointments.** This fee will be billed to the patient, not the insurance company, and will be due in full at their next scheduled appointment.

It is the responsibility of the patient to keep track of their appointment date and time,and to contact the office if unable to keep the appointment.

Patient Signature:_____ Date:_____

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT

Name: _____ DOB: _____ Date:_____

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug after knowing the risk and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to use the drug(s) recommended to you by me, as your physician. For the purpose of this agreement the use of the word “physician” is defined to include but not only my physician but also my physicians’s authorized associates, technical assistants, nurse, staff, and other health care providers as might be necessary or advisable to treat your condition.

CONSENT TO TREATMENT AND DRUG THERAPY: I voluntarily request my physician, Geetha Manchireddy MD, to treat my condition which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent for my physician to administer or write prescription(s) for dangerous and/or controlled drugs (medication)as an element in the treatment for my chronic pain.

It has been explained to me that these medication(s) include opioid/narcotic drug(s), which can be harmful without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results.The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medications.

THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT HAVE BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT (THIS IS SOMETIMES REFERRED TO AS “OFF LABEL” PRESCRIBING). MY DOCTOR WILL EXPLAIN HIS TREATMENT PLAN(S) FOR ME AND DOCUMENT IT IN MY MEDICAL CHART.

I have been informed and understand that I will undergo medical tests and examinations before and during my treatment. Those tests include random, unannounced checks for drugs and psychological evaluation if and when it is deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances may result in me being discharged from your care.

For female patients only:

To the best of my knowledge **I AM NOT PREGNANT.**
If I am not pregnant, I will use appropriate contraception/birth control; during my course of treatment. I accept that it is **MY RESPONSIBILITY** to inform my physician immediately if I become pregnant.
IF I AM PREGNANT OR AM UNCERTAIN, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY.
All of the above possible side effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics to assure complete safety to unborn child(ren). With full knowledge of this, I consent to it's use and hold my physician harmless for injuries to the embryo/fetus/baby.

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention(inability to urinate), orthostatic hypotension(low blood pressure), arrhythmias(irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression(slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities including work.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medication(s) for the treatment of my chronic pain.

The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and active life. I realize that I may have chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s) at any time and that I will notify my physician of any discontinued use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

I understand that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition.The long-term use of medications to treat

chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

I UNDERSTAND AND AGREE TO THE FOLLOWING:
That this pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called “narcotics, painkillers’, and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). **Therefore, medication(s) will only be provided so long as I follow the rules specified in this Agreement.**

My physician may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior:

- My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the **medication(s) may be discontinued.**
- I will disclose to my physicians **ALL** medication that I take at any time, prescribed by any physician.
- I will use the medication(s) **exactly as directed by my physician.**
- I agree **not to** share, sell, or otherwise permit others, including my family and friends, to have access to these medications.
- I will **not allow or assist in the misuse/diversion of my medication; nor will I give or sell them to anyone else.**
- All medication(s) must be obtained at **one pharmacy, when possible.** Should the need arise to change pharmacies, my physician must be informed. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement.
- I authorize my physician to release my medical records to my pharmacist as needed.
- I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money. If either are lost or stolen, they may not be replaced.
- Refill(s) **will not be ordered before the refill date.** However, early refill(s) are allowed when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.

- I will receive medication(s) **only from ONE physician** unless it is for an emergency or the medication(s) that is being prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.
- If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then **my physician may try alternative medication(s) or may taper me off all medication(s).** I will not hold my physician liable for problems caused by the discontinuance of medication(s).
- I **agree to submit to urine, saliva, and/or blood screens** to detect the use of non-prescribed medication(s) at any time without prior warning. If I test positive for illegal substance(s), such as marijuana, speed, cocaine, etc., treatment for chronic pain may be terminated. Also, a consultation with, or referral to, an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an addictionologist or a physician who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.
- I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize **that my active participation** in the management of my pain is extremely important. I agree to **actively participate in all aspects of the pain management program** recommended by my physician to achieve increased function and improved quality of life.
- I agree that **I shall inform any doctor** who may treat me for any other medical problem(s)that I am enrolled in a pain management program, since the use of other medication(s) may cause harm
- I hereby give my physician **permission** to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medication(s) prescribed by my other physician(s).
- I must take the medication(s) as instructed by my physician. **Any unauthorized increase** in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.
- I must **keep all follow-up appointments** as recommended by my physician or my treatment may be discontinued.

I certify and agree to the following:

1. I am **not currently using illegal drugs or abusing prescription medication(s)** and I am not undergoing treatment for substance dependence(addiction) or abuse. I am reading and making this agreement

while in full possession of my faculties and not under the influence of any substance that might impair judgment.

2. I have **never been involved** in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.).
3. **No guarantee or assurance has been made** as to the results that may be obtained from chronic pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life.
4. I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain. **I fully understand the explanations regarding the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.**

Patient Signature_____

Physician Signature_____

Pharmacy _____

Phone Number_____

Address_____

ADVANCE. PAIN MANAGEMENT

OFFICE POLICY ON MEDICATION & URINE DRUG SCREEN

Please initial on each line after reading

All opioids and muscle relaxant medications are prescribed through Advanced Pain Management and cannot be obtained from any other provider including emergency rooms, urgent cares, dentists, and hospitals.

_____Refills are done on a month to month basis only. Refills require a follow up visit before prescriptions are e-prescribed. Refills cannot be called into the pharmacy. Refills or medication changes cannot, and will not be prescribed before they are due.

_____If your medications are lost, stolen or destroyed, they will not be replaced even if you have a police report.

_____If you have difficulty with a medication that has been prescribed to you, please call the office to report the problem and make an appointment to be evaluated.

_____We strongly urge patients to make your next monthly follow up visit for medications at the time of your last visit. Please do not wait until your medication is out or a few days before due to limited availability for appointment.

_____If you "no show" an appointment there is a $50.00 charge.

_____Drug screens are required for all patients receiving opioid prescriptions. You must provide an adequate sample. No opioids will be prescribed until you are able to. If unable to provide a sample within designated time, you will not receive a prescription that day and will need to reschedule your appointment. If you are unable to provide a sample by 4:00 pm, you will not receive a prescription that day and will need to reschedule your appointment. Once you have been notified you are due for a drug screen sample, you cannot leave the office. Doing so will result in your appointment being rescheduled. If you are scheduled at 4:00 pm or 4:15 pm and you are unable to go you will only be given until 4:30 pm, to provide a sample. If you are still unable to provide a sample you will be asked to reschedule your appointment.

_____You can face discharge of opioid therapy if you test positive on your urine drug screen for alcohol, any illegal substances, or other opioid not prescribed by this office, or test negative for medication you are prescribed by our office.

_____I am consenting to, and aware that Advanced Pain Management will be searching each month for pharmacy reports to insure compliance of our policies, misuse of medications etc. Failure to consent to these searches each month will result in no medications being provided during my care as per the policy of our practice. Injections and physical therapy would still be offered to patients.

_____We are an interventional pain management facility. We do not provide medications for patients unless they are completing the intervention treatments prescribed for them. If you are scheduled for an injection/treatment, and cancel or "no show" 3 times, you are subject to being weaned off opioid medications and/or candidate for discharge from our practice.

_____I understand that I may be prescribed potentially dangerous medication and that, if taken improperly, it may lead to excess sedation, respiratory depression and DEATH.

_____If you have a MEDICAL MARIJUANA CARD, we will be happy to provide physical therapy and interventional pain treatments to treat your pain. We will NOT prescribe narcotic medications in conjunction with medical marijuana.

_____I will not give, lend, or sell my prescriptions to other people. If misuse or abuse is suspected, I consent to be called in for a pill count.

_____I have read and understand the policies on medication refills and urine drug screens and agree to abide by them.

Print Name_____ Date_____

Signature_____

Dr. Manchireddy_____ Date_____