NAME: (F) (M) (L)

DATE OF BIRTH: SEX: MARITAL STATUS:

SOCIAL SECURITY NUMBER:

ADDRESS: CITY: STATE: ZIP:

CONTACT INFORMATION (PLEASE CIRCLE PREFERRED CONTACT NUMBER)

HOME PHONE: WORK PHONE: MOBILE:

EMPLOYER: ADDRESS: CITY:

STATE: ZIP: EMPLOYER PHONE:

EMAIL ADDRESS:

EMERGENCY CONTACT PERSON NAME: _____ RELATIONSHIP: _____

EMERGENCY CONTACT PERSON PHONE: _____

File with _____ (Insurance Company Name)

Insured's Name: _____ Insured's Date of Birth_____

Is this visit Workers Compensation? Yes No

Is this visit Auto Accident? Yes No

State of MVA, Accident or Injury:_____ Date of injury or accident:_____

Carrier Name: _____ Attorney Name: _____

Case Manager/Adjuster: Attorney Address:

Claims Address: City, State, Zip:

Phone #: Phone #:

Claim #: Employer at time of injury:

Authorization: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or the party who accepts assignment. I authorize payment of medical benefits to Southeastern Spine, Brain & Joint for medical services rendered to me. I understand that by signing this, I am taking full responsibility for any unpaid medical expenses that are not covered by my insurance company including copays, deductible or my failure to obtain a referral from my primary care physician. I will be responsible for any collection charges, interest or added expense for my failure to pay any balance due.

Patient/Insured Signature: Date:

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT INFORMATION

Last name:	First name:	SSN:	Date of birth:

AUTHORIZATION INFORMATION

I request and authorize Southeastern Spine, Brain & Joint to noted below ☐ request ☐ release the information from my medical records to:

☐ Medical Provider ☐ Parent/Guardian ☐ Myself ☐ Other_____

Entity:	Address:

Phone:	Fax:	Email:

☐ Fax to number above ☐ Mail to address above ☐ Email to address above ☐ Picked up by patient

INFORMATION TO BE RELEASED (select one)

☐ All medical records to include all chart entries, diagnostics, test results and reports

☐ All records related to visits on the following date(s)_____

☐ All records related to the following diagnosis/symptoms_____

☐ All medical records **EXCEPT**_____

☐ Test results only from the following date(s)_____

☐ Other _____

I authorize and request for my sole benefit the release of medical information which is part of my file at Southeastern Spine, Brain & Joint. This does not constitute blanket permissions for release of such information for an infinite period of time, but is limited to this instance only.

I agree that a copy of this release, electronic or faxed submission of this release shall be valid as this original release. I understand that if I authorized Southeastern Spine, Brain & Joint to fax or email the information, that there are inherent privacy risks with these methods.

_____ _____

Patient signature Date

FOR OFFICE USE ONLY

Copied: Initial _____ Date:_____ SENT: Mailed Picked-up Faxed Emailed

Initial:_____ Date:_____

Disclosure of Protected Health Information

According to our policy, test results or the release of medical information will be provided to the patient only. Please specify below whom information may be released to other than you. Please complete the information and sign below to verify your permission. Please circle all that apply and fill in the blanks:

Do we have permission to leave messages on your voicemail? Yes No

Do we have permission to discuss medical information with a family member? Yes No *If yes, please list below.

Emergency contact name: _____ Relationship: _____

Phone: _____ Alternate Phone: _____

Alternate contact name: _____ Relationship: _____

Phone: _____ Alternate Phone: _____

Advanced Directives

It is the right of every adult citizen in Tennessee (18 years and over) to sign a living will, as well as a Durable Power of Attorney for Healthcare that empowers an individual of your choosing to see that your wishes are carried out. It is important to decide whether or not you wish to sign a Living Will now when you are fully competent to make your own decision. The choices that you make in your Living Will will be binding on doctors, hospitals, and other healthcare providers in the event you become incapable of telling them your wishes. If you have signed either document, please make sure that your provider has a copy for your file.

Authorization

I authorize Southeastern Spine, Brain & Joint to release any insurance company, managed care organization, state or federal agencies, centers for Medicare and Medicaid services. Third Party Administrators, and/or Workers' Compensation (or its' agents) any information needed to process my claim and/or determine benefits payable for related services. I also authorize Southeastern Spine, Brain & Joint to utilize a fax machine to transmit any/all of the above medical records pertaining to my medical care or insurance reimbursement. I acknowledge that faxing my medical records may increase the risk of accidental disclosure of my medical records. I grant permission to Southeastern Spine & Neurosurgery to release all or part of my medical record to any consulting entity that may be involved in my medical care. This includes, but is not limited to, testing facilities, consulting physicians, and outpatient facilities. I request that payment of Medicare, MediGap, Medicaid, Managed Care Organization, Third Party Administrators, Commercial insurance, Worker's Compensation, Liability, and/or any other benefits made on my behalf to Southeastern Spine & Neurosurgery. I permit a copy of this authorization to be used in place of the original. Regulations pertaining to medical assignment benefits apply.

Patient or Guarantor Signature_____ Date_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

By signing below, I hereby acknowledge receipt of Southeastern Spine, Brain & Joint, PLLC Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how DPS may use and disclose my protected health information.

By signing below, I acknowledge that I understand that Southeastern Spine, Brain & Joint, PLLC has reserved the right to change its privacy practices that are described in the Notice of Privacy Practices. By signing below, I acknowledge that I also understand that any revisions to the Notice of Privacy Practices will be provided to me or made available to me.

_____
Signature

_____
Print Name

_____
Date

If you are not the patient, please specify your relationship to the patient: _____

SOUTHEASTERN SPINE, BRAIN & JOINT MEDICATION AGREEMENT

1. I understand that I need to give 24 hrs notice when requesting a refill on any medication. Walk-in requests for medication or appointments will not be accepted.
2. I agree to take all medication exactly as instructed. I am not allowed to change the dosage or time schedule without speaking to my provider first.
3. I understand that no medication will be changed or called in after hours or on the weekend.
4. I understand that a follow-up visit may be required from my provider in order to obtain a refill and I must keep all recommended appointments.
5. I understand that Urine Drug Screens will be required at my provider's discretion as long as I am receiving opioid medication. I understand that my medication may be stopped or changed at the provider's discretion, based upon the results of the Drug Screen or the TN prescription monitoring data base.
6. Southeastern Spine, Brain & Joint will not refill lost or stolen medication. **These are your responsibility once you leave our office.**
7. I will not trace, sell or give away the medications that are prescribed for me. I will also not take any medication that is prescribed to someone else.
8. I am aware that while I am on medications that treat my pain, I am prohibited from driving or using heavy machinery. I understand that driving while taking opioid medication could result in a DUI change.
9. I understand that verbal abuse and argumentative behavior towards the staff will not be tolerated and could result in discharge from the practice.
10. I will not use multiple pharmacies when filling my prescriptions.
    The pharmacy I use is: _____ Phone#: _____
11. The following are conditions for immediate discharge from the practice:
    a. Obtaining opioid prescriptions from other physicians while receiving medications from our providers.
    b. Altering or forging a prescription in any way. This is a felony and will be reported.
    c. Non-compliance with any of the above statements.

I HAVE READ, UNDERSTAND AND AGREE WITH THE ABOVE POLICIES, AND I UNDERSTAND THAT IF I DO NOT SIGN, MY PHYSICIAN MAY REFUSE TO PRESCRIBE PAIN MEDICATIONS TO ME.

NAME:_____DATE:_____

PATIENT SIGNATURE:_____

DR. JAY JOLLEY
DR. DAVID WILES
DR. MATTHEW BERNARD
REBECCA PAYNE, FNP-BC
NATHAN WOODY, ARNP, CNP
JESSICA SCOTT, PAC
MARY HUBBARD, MSN, APRN, FNP-C

Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management.

Sex (circle one): Female Male

Mark appropriate box beside each question	Yes	No
Do you have a *family history* of any of the following?		
Alcohol Abuse		
Illegal Drug Abuse		
Prescription Drug Abuse		
Do you have a *personal history* of any of the following?		
Alcohol Abuse		
Illegal Drug Abuse		
Prescription Drug Abuse		
Are you between 16—45 years old?		
Do you have a history of preadolescent sexual abuse?		
Do you have a personal history of ADD, OCD, bipolar, schizophrenia		
Do you have a personal history of depression?		
Scoring totals		

**A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Questionnaire developed by Lynn R. Webster, MD to asses risk of opioid addiction. Adapted for use by Southeastern Spine, Brain & Joint.

Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk too. Pain Med. 2005; 6 (6) : 432

SOUTHEASTERN SPINE • BRAIN • JOINT

Oswestry Disability Index v1.4

Directions: *This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every section, and mark in each section only one statement which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the one which most closely describes your problem.*

01. Pain Intensity *(Mark only one)*

- ◯ I can tolerate the pain I have without having to use pain medication.
- ◯ The pain is bad, but I can manage without having to take pain medication.
- ◯ Pain medication provides me with complete relief from pain.
- ◯ Pain medication provides me with moderate relief from pain.
- ◯ Pain medication provides me with little relief from pain.
- ◯ Pain medication has no effect on my pain.

02. Personal Care (e.g., Washing, Dressing) *(Mark only one)*

- ◯ I can take care of myself normally without causing increased pain.
- ◯ I can take care of myself normally, but it increases my pain.
- ◯ It is painful to take care of myself, and I am slow and careful.
- ◯ I need help, but I am able to manage most of my personal care.
- ◯ I need help every day in most aspects of my care.
- ◯ I do not get dressed, wash with difficulty, and stay in bed.

03. Lifting *(Mark only one)*

- ◯ I can lift heavy weights without increased pain.
- ◯ I can lift heavy weights, but it causes increased pain.
- ◯ Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (e.g., on a table).
- ◯ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ◯ I can lift only very light weights.
- ◯ I cannot lift or carry anything at all.

04. Walking *(Mark only one)*

- ◯ Pain does not prevent me from walking any distance.
- ◯ Pain prevents me from walking more than 1 mile. (1 mile = 1.6 km)
- ◯ Pain prevents me from walking more than 1/2 mile.
- ◯ Pain prevents me from walking more than 1/4 mile.
- ◯ I can only walk with crutches or a cane.
- ◯ I am in bed most of the time and have to crawl to the toilet.

05. Sitting *(Mark only one)*

- ◯ I can sit in any chair as long as I like.
- ◯ I can only sit in my favorite chair as long as I like.
- ◯ Pain prevents me from sitting for more than 1 hour.
- ◯ Pain prevents me from sitting for more than 1/2 hour.
- ◯ Pain prevents me from sitting for more than 10 minutes.
- ◯ Pain prevents me from sitting at all.

06. Standing *(Mark only one)*

- ◯ I can stand as long as I want without increased pain.
- ◯ I can stand as long as I want, but it increases my pain.
- ◯ Pain prevents me from standing more than 1 hour.
- ◯ Pain prevents me from standing more than 1/2 hour.
- ◯ Pain prevents me from standing more than 10 minutes.
- ◯ Pain prevents me from standing at all.

Please continue on next page

07. Sleeping *(Mark only one)*

◯Pain does not prevent me from sleeping well. ◯

I can sleep well only by using pain medication.

◯Even when I take pain medication, I sleep less than 6 hours.

◯Even when I take pain medication, I sleep less than 4 hours.

◯Even when I take pain medication, I sleep less than 2 hours.

◯Pain prevents me from sleeping at all.

08. Social Life *(Mark only one)*

◯My social life is normal and does not increase my pain.

◯My social life is normal, but increases my level of pain.

◯Pain prevents me from participating in more energetic activities (e.g., sports, dancing).

◯Pain prevents me from going out very often.

◯Pain has restricted my social life to my home.

◯I have hardly any social life because of my pain.

09. Traveling (*Mark only one)*

◯I can travel anywhere without increased pain.

◯I can travel anywhere, but it increases my pain.

◯My pain restricts my travel over 2 hours.

◯My pain restricts my travel over 1 hour.

◯My pain restricts my travel to short necessary journeys under 1/2 hour.

◯My pain prevents all travel except for visits to the physician/therapist or hospital.

10. Employment/Homemaking *(Mark only one)*

◯My normal homemaking/job activities do not cause pain.

◯My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.

◯I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (e.g., lifting, vacuuming).

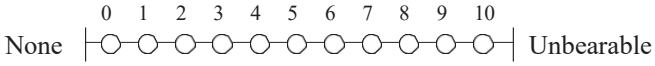
◯Pain prevents me from doing anything but light duties.

◯Pain prevents me from doing even light duties.

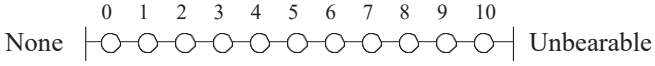
◯Pain prevents me from performing any job or homemaking chores.

VAS Pain Scales

11. On a scale from 0 to 10, mark the intensity of your <u>back pain</u> during the past week, with 0 being 'None' and 10 being 'Unbearable pain'. *(Mark only one)*



12. On a scale from 0 to 10, mark the intensity of your <u>left leg pain</u> during the past week, with 0 being 'None' and 10 being 'Unbearable pain'. *(Mark only one)*



13. On a scale from 0 to 10, mark the intensity of your <u>right leg pain</u> during the past week, with 0 being 'None' and 10 being 'Unbearable pain'. *(Mark only one)*