PRS
PAIN AND REHABILITATION SPECIALISTS OF ST. LOUIS

PRACTICE INFORMATION

Because we value open communication and mutual respect, we created this Practice Information Guide to help make your visits here convenient, pleasant, and beneficial.

Office Hours

- Our office is open from 8:00 until 5:00, Monday through Thursday and from 8:00 until 4:30 on Friday.
- The office phone number is: 314-336-2570; we accept telephone calls beginning at 8:00 until 4:00 each day.

Appointments

- We strive to minimize wait times and to spend as much time as needed to address your medical concerns. For this reason, we see our patients by appointment and strongly discourage walk-in visits.
- We room patients in appointment-time order. Expect the doctor to treat the primary reason for the scheduled office visit; we may ask you to schedule another appointment to address concerns other than the primary reason for your visit.
- If you arrive LESS than 15 minutes before your scheduled appointment time, we will do our best to assist you; however, we may ask you to reschedule.

Medication Refills

- We make every effort to process prescription refill requests as quickly as possible. Please allow 48-72 hours for our staff to process your refill request.
- To ensure you do not run out of medication, please ask your pharmacy to fax the refill request to 314-336-2571 no less than three (3) days before you need it.
- Dr. Blake and Dr. Boutwell will authorize prescriptions for narcotic medications only during office hours and she may ask you to come for an office visit before she authorizes your refill request.

Personal Health Information

- Our physicians reserve the right to determine the type of medical-care-related forms she will complete and sign.
- The standard fee for completion of forms (for example, FMLA, disability, etc.) is $50.00 to complete forms, payable when you present the form to the office. We must receive payment, either in person or by credit card over the phone, for all requests received by fax or by mail.
- Our practice partners with HealthPort Technologies to process requests for medical records. We must have a signed, HIPAA-compliant authorization to release copies of your medical records. Please allow no less than ten (10) business days from the date we receive the request to process these requests.
  If the request is for your personal use HealthPort may charge you a fee for copying those records. We do not charge for records transferred to another physician or medical facility for the purpose of continued care.

Registration / Insurance

- Please review insurance information with our staff *prior* to receiving care. Come to each visit with your insurance card and valid photo ID.
- Please tell the staff member at check-in if you have any change in insurance, contact information, address or pharmacy information.

After Hours an Emergency Care

- If you experience a life-threatening medical condition after office hours, call 911 or go immediately to the nearest Emergency Department, even if you are out of town.
- If you have an urgent medical concern that cannot wait until regular office hours, you may reach our doctors through our answering services**: 314-865-6009.**

PAIN and REHABILITATION SPECIALISTS

PATIENT REGISTRATION

FIRST NAME	MIDDLE NAME/INITIAL	LAST NAME

Preferred Name	Date of Birth	Social Security Number	Gender: Male Female

Primary Care Doctor	Name	Address	Phone	Fax
Referring Provider	**Name**	**Address**	**Phone**	**Fax**

DEMOGRAPHIC INFORMATION

Home Address	Zip code

Home Phone	Area code	Number	Work Phone	Area code	Number	Extension

Cell Phone	Area code	Number	Preferred Phone	Home Work Cellular

Email Address	Preferred communication	Phone Mail Email

Mailing Address *(if different from home address)-*	Zip code

Whom shall we contact in an emergency?	Relationship to patient?	Phone number

Race	Ethnicity: Hispanic/Latino Non Hispanic/Latino Unreported/Refused

Preferred Language English Spanish Other	Do you need an interpreter? Yes No What type of interpreter?

Marital Status Single Married Divorced Widowed Domestic Partner

Employment Full-Time Part Time Not Employed Student	Employer

PRIMARY INSURANCE

Insurance Plan Name		Effective Date	

Subscriber ID		Group Number	
Insured's Name		Date of Birth	
Relationship to Patient Self Spouse Parent Partner		Social Security #	

SECONDARY INSURANCE

Insurance Plan Name		Effective Date	

Subscriber ID		Group Number	
Insured's Name		Date of Birth	
Relationship to Patient Self Spouse Parent Partner		Social Security #	

ASSIGNMENT OF BENEFITS

- I understand I am financially responsible for all charges and services provided to me, including the balance remaining after payment of potential insurance benefits. I authorize payment of medical insurance benefits to PAIN and REHABILITATION SPECIALISTS for professional services rendered.
- I authorize the release of any information necessary to process this claim.
- I certify that all the above information is true and correct to the best of my knowledge. I give my permission to the Provider and/or medical staff to administer and perform such procedures deemed necessary in the diagnosis and/or treatment of my medical condition(s).

Signature of Patient / Legal Guardian/Representative	**Relationship**	**Date**

EXTENDED INFORMATION

Date of Injury	
How were you injured?	
If you were involved in a Motor Vehicle Accident, in what state did it occur?	

WORKERS' COMPENSATION INFORMATION	
Insurance Company Name	
Claim Number	

Case Adjuster	
Office Phone	
Office Fax	
Email Address	
Mailing Address	
City / State / Zip	

Case Manager	
Office Phone	
Office Fax	
Email Address	
Mailing Address	
City / State / Zip	

ATTORNEY			
Attorney's Name			
Name of Firm			
Mailing Address			
City / State / Zip			
Office Phone		Office Fax	
Email Address			

PATIENT FINANCIAL AGREEMENT

We strive to maintain a strong physician-patient relationship. Sharing our Financial Policy in advance allows for a good flow of communication and enables us to achieve our goal. If you have any questions, do not hesitate to ask a member of our staff.

Health Insurance

- Deductibles, copayment and co-insurance payments are your responsibility.
- We file claims with our contracted insurance plans only. Since the insurance contract is an agreement between you and your insurance company. It is your responsibility to understand your insurance plan benefits with regard to a covered service, if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure. If you have more than one insurance policy, it is your responsibility to inform the office which policy is **Primary** (first) coverage and which policy is **secondary** or **Tertiary**. With each policy, we require the name, birth date, address, phone number, and social security number of the individual who carries the policy.

We expect our patients to pay at time of service any copayment, co-insurance, or deductible required by the insurance company. Because this is an insurance requirement, we cannot bill the patient for these amounts.

Patient/Responsible Party Initial _____

I agree to provide a copy of my insurance card(s) at each visit with the name, address, phone number, date of birth and social security number of the individual who carries the insurance.

Patient/Responsible Party Initial _____

I agree to provide a valid authorization/referral. I understand that if I do not have a valid referral, the staff may ask me to reschedule or pay for the visit in full at check in.

Patient/Responsible Party Initial _____

General Financial Information

Returned Checks: We charge a $30.00 fee for any check returned by the bank. We expect payment by cash, credit card, or money order within 14 days of the notice that your check was returned.

Patient/Responsible Party Initial _____

Past Due Balances: We offer monthly payment plans tailored to each individual's circumstances. If your account becomes delinquent, we reserve the right to take all steps necessary to collect this debt, including referral of your account to a collection agency and/or collection attorney. If such action becomes necessary you assume responsibility for any and all related fees.

Patient/Responsible Party Initial _____

Workers' Compensation: If your employer has pre-approved treatment, we will file claims and you should not expect to have any financial liability. If your employer has not approved treatment and **you choose to receive care by our** physician, you assume full financial responsibility for costs associated with that treatment.

Patient/Responsible Party Initial _____

Personal Injury: If you are receiving treatment as part of a personal injury claim or lawsuit, we require verification from your attorney **prior to your initial visit**. In addition to this verification, we require that you allow us to bill your personal health insurance, if available. We will require you to sign a Notice of Doctor's Lien. In the absence of insurance, other financial arrangements may be available. **Payment of all charges remains the patient's responsibility. We cannot bill your attorney for charges incurred due to your personal injury.**

Patient/Responsible Party Initial _____

Completion of Forms: We charge a fee of **$50.00** to complete any forms not related to health insurance claims (disability, FMLA, injury, for example). Payment is due each time you deliver a form for completion. For forms received by fax or mail, we must receive your payment prior to returning the form to the requestor. We cannot bill you for this service.

Patient/Responsible Party Initial _____

By signing initialing and signing this form, I agree to all of the terms and conditions herein and the agreement will be in full force and effect. I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Signature of Patient / Guardian / Legal Representative	Relationship to Patient	Date

AUTHORIZATION FOR MEDICAL TREATMENT and RELEASE OF INFORMATION

I authorize my physician and his/her employees, to provide the medical care, tests, procedures, medications, services and supplies considered advisable by my physician. These services may include pathology, radiology, emergency and other special services. In consenting to treatment, I have not relied on any statements as to results. In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance that are capable of transmitting disease and I am unable to consult timely with my physician prior to testing, I consent to limited testing to determine the presence, if any of antibodies to hepatitis A, B, and C and HIV.

STORAGE AND RELEASE OF INFORMATION

I consent to the electronic storage and transmission of patient health information. I hereby authorize my treating physician, to release by electronic means or otherwise any medical and/or billing information concerning my care, including copies of my medical records to:

a. Any governmental or other entity as required by law for purposes of reporting or for purposes of determining the eligibility in government sponsored benefit programs.
b. The supplier of any blood or blood products which may be administered to me for the purposes of quality control and recipient monitoring.
c. Any continuing care, residential or long-term care facility, or home health agency for the purposes of providing services for my care.
d. Another health care provider that prescribes medication electronically to provide continuity of care and quality of care issues regarding prescriptions.
e. I also authorize my physician to obtain information from other providers regarding my care and treatment including obtaining my electronic medication and prescription history from whatever source for the purpose of my continuing care and treatment.

Signature of Patient/Legal Guardian/Representative	Relationship	Date

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name _____
Last First MI Maiden

Date of Birth _____ Social Security Number _____

I Authorize and Request: _____

_____

_____

_____ _____
Office Phone Office Fax

To Release to: **Pain and Rehabilitation Specialists**
14825 N Outer 40 Road, Suite 360
Chesterfield, MO 63017
Office Phone: 314-336-2570
Office Fax: 314-336-2571

Medical Records covering the periods of health care from _____ to _____
Date Date

Please check, and initial, the types of records you <u>do not</u> want released.

☐ HIV Testing/Treatment Records ☐ Substance Use/Abuse History ☐ Psychiatric Evaluation

☐ Other (please specify) _____

The Medical Information is needed for: _____

ATTENTION: Once this information has been released pursuant to the Authorization, it may no longer be protected by Federal, and/or State law/regulations and may no longer be deemed "confidential."

I understand that neither Pain and Rehabilitation Specialists, or any of its affiliated healthcare providers can make me sign this Authorization as a condition to getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan, unless the Federal Privacy Regulations allow it. I agree that I have received a signed copy of this Authorization, if so requested.

I understand that I may revoke the Authorization at any time except to the extent that prior action has been taken in reliance on this Authorization. This Authorization will **expire one (1) year** from the date it is signed if I do not cancel it in writing prior to the expiration date. I understand that if I want to cancel/revoke this Authorization, I must mail, fax, or bring a letter in person stating that I want to cancel this Authorization. I understand that I need to mail, fax or bring the letter to the address or fax number at the top of the page.

If you are signing on behalf of a patient for whom you are the legal guardian or personal representative, you must attach a certified copy of your appointment as legal guardian or personal representative. If you are signing on behalf of a patient who is deceased, you must attach a certified copy of the patient's Death Certificate.

_____ _____ _____
Signature of Patient (if the patient is incompetent, of his guardian or other) ***Relationship*** ***Date***

_____
Printed name of person authorized under State Law to act in the patient's behalf, if the patient is deceased, or his personal representative or if none, of his child, parent or sibling.

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PAIN MANAGEMENT
NEW PATIENT QUESTIONNAIRE

DATE _____

Patient Name _____ **DOB** _____ **Gender** M ☐ F ☐

How did you hear about our practice? _____ If MD, Phone # _____

Reason for today's visit _____

_____

How did this Pain begin?
☐ Auto Accident ☐ At Home ☐ Following an Illness
☐ At Work ☐ Following Surgery ☐ Other/Unknown

Please briefly describe how your Pain began. _____

_____

_____

When did the Pain begin? _____

What was the date of your Injury? _____

Have you ever had this Pain before? ☐ NO ☐ YES How long ago? _____

Since the Pain began, my symptoms have: ☐ Gotten Worse ☐ Stayed the Same ☐ Improved

How often do you have the Pain?
☐ Constant (100% of the time) ☐ Intermittent (50% of the time)
☐ Frequent (75% of the time) ☐ Occasional (25% of the time)

Have you ever seen any other physician, or had other treatment, for this Pain? ☐ NO ☐ YES

If **YES**, what is the Physician's name? _____ Specialty _____

If **YES**, what treatment did you receive? _____

Have any Legal Claims been filed related to your Pain? ☐ NO ☐ YES

If **YES**, what is the Attorney's name? _____ Phone# _____

Have you had any of the following Imaging Studies to evaluate the Pain?

☐ MRI ☐ X-Ray ☐ CT Scan ☐ Bone Scan
☐ Myelogram ☐ Discogram ☐ EMG/NCV ☐ Other _____

What Treatments have you previously tried for the Pain?

- ☐ Steroid/Cortisone Injection
- ☐ Acupuncture
- ☐ Chiropractic Visits
- ☐ Biofeedback
- ☐ Rest/Activity Modification
- ☐ Heat Therapy
- ☐ Physical Therapy
- ☐ Psychotherapy
- ☐ Electrical Stimulation (TENS)
- ☐ Nerve Block
- ☐ Massage Therapy
- ☐ Other _____

What Medications have you previously tried for the Pain?

- ☐ Gabapentin (*Neurontin*)
- ☐ Ibuprofen (*Advil*)
- ☐ Opioid/Narcotic *Type* _____
- ☐ Pregablin (*Lyrica*)
- ☐ Acetaminophen (*Tylenol*)
- ☐ Antidepressant *Type* _____
- ☐ Oral Steroids (*Medrol Dose-Pak*)
- ☐ Naproxen (*Aleve*)
- ☐ Other *Type* _____

Do you have any of the following symptoms? ☐ NO ☐ YES

If **YES**, check all that apply.

- ☐ Numbness
- ☐ Bladder Incontinence
- ☐ Weakness in Arm/Leg
- ☐ Tingling
- ☐ Bowel Incontinence
- ☐ Joint Swelling

What makes the Pain better? (Check all that apply.)

- ☐ Walking
- ☐ Leaning Forward
- ☐ Relaxation
- ☐ Heat
- ☐ Lying Flat
- ☐ Lying with Hips/Knees Bent
- ☐ Rest
- ☐ Medication _____

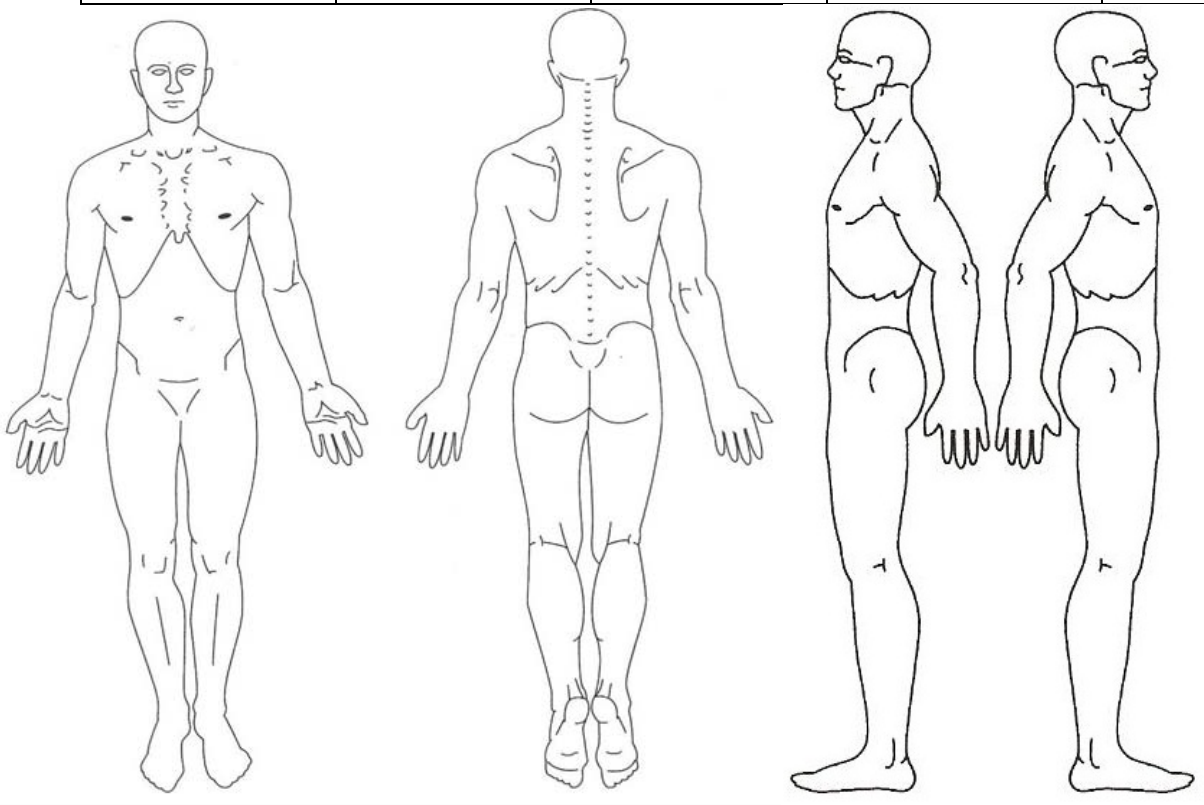
What makes the Pain worse? (Check all that apply)

- ☐ Standing
- ☐ Laying Down
- ☐ Bowel Movements
- ☐ Sitting
- ☐ Lifting
- ☐ Coughing/Sneezing
- ☐ Getting up out of bed
- ☐ Bending Forward
- ☐ Damp Weather
- ☐ Walking
- ☐ Bending Backward
- ☐ Rising out of a chair
- ☐ Cold
- ☐ Urination
- ☐ Exercise _____

Patient Name: _____ DOB _____ Date of Visit _____

Please mark **WHERE** you feel The Pain. Use the symbols to indicate **THE TYPE OF PAIN** you experience in each area.

Aching	Burning	Numbness	Pins and Needles	Stabbing
ΔΔΔΔΔΔΔ	XXXXXXXX	=========	ooooooo	/////////



In the past 30 DAYS, please indicate your Pain Level based on the scale below:

TODAY	0	1	2	3	4	5	6	7	8	9	10
At its BEST	0	1	2	3	4	5	6	7	8	9	10
At its WORST	0	1	2	3	4	5	6	7	8	9	10

Scale
0 = No Pain
1 = Very Mild Pain: You are aware of the pain but it doesn't bother you
2 = Mild Pain that you can tolerate without taking medication
3 = Mild to Moderate pain that requires medication to tolerate
4-5 = Moderate Pain that sometimes is not controlled and causes you to feel antisocial
6 = Fairly Severe Pain that Interferes with daily life.
7-9 = Intensely Severe Pain
10 = Worst Pain Imaginable

Patient Name: _____ DOB _____ Date of Visit _____

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PAIN MANAGEMENT: HEALTH HISTORY

Date of Visit _____

Name _____ DOB _____ Gender ☐ M ☐ F

Email address _____ Height _____ Weight _____

Spouse _____ Are you pregnant? ☐ No ☐ Yes ☐ Unknown

Primary Care Physician _____ Phone _____

Preferred Pharmacy _____ Phone _____

For Office Use Only: **HT** _____ **WT** _____ **BP** _____/_____ **P:** _____

PAST MEDICAL HISTORY: *Please check if you have now, or have had in the past, any of these medical conditions.*

☐ **NO PAST MEDICAL PROBLEMS**	☐ Coronary Artery Disease	☐ Kidney Disease
☐ Acid Reflux	☐ Dental Disease	☐ Osteoarthritis
☐ Adverse Reaction to Anesthesia	☐ Depression	☐ Osteoporosis
Describe _____	☐ Diabetes	☐ Pneumonia
☐ Alzheimer's/Significant Memory Loss	☐ Emphysema	☐ Psychiatric Disorder
☐ Anemia	☐ Epilepsy/Seizures	☐ Rheumatoid Arthritis
☐ Angina or Chest Pain	☐ Fibromyalgia	☐ Sickle Cell
☐ Asthma	☐ Gout	☐ Sleep Apnea
☐ Atrial Fibrillation/Erratic Heartbeat	☐ Hemophilia/Excessive Bleeding	☐ Use CPAP Machine
☐ Bladder Problems	☐ Hepatitis or Liver Disease	☐ Stroke (CVA)
☐ Bleeding Ulcer	☐ Hypertension	☐ Thyroid Disease
☐ Blood Clot	☐ High Cholesterol	☐ Other (Explain)
☐ Legs ☐ Lungs ☐ Other	☐ HIV or AIDS	
☐ Cancer Type: _____	☐ Infections: _____	
☐ Congestive Heart Failure	MRSA? ☐ Yes ☐ No	

Have you ever passed out/lost consciousness at the time of a blood draw, IV or medical procedure?

☐ NO ☐ YES Briefly explain. _____

Do you have a FAMILY history of any of these conditions?

☐ Alcohol Abuse	☐ Illegal Drug Use	☐ Prescription Drug Abuse
☐ Father	☐ Father	☐ Father
☐ Mother	☐ Mother	☐ Mother
☐ Sibling	☐ Sibling	☐ Sibling
☐ Child	☐ Child	☐ Child

Do you have a PERSONAL history of any of these conditions?

☐ Alcohol Abuse ☐ Illegal Drug Use ☐ Prescription Drug Abuse

Did you seek Professional Treatment or Detoxification? ☐ NO ☐ YES

Do you have a PERSONAL Diagnosis of any of these conditions?

☐ ADD / ADHD ☐ OCD ☐ Bipolar

☐ Schizophrenia ☐ Depression ☐ Other:

Are you taking medication for any of the above conditions?

☐ NO ☐ YES What medication? _____

Are you allergic to any of the following?

☐ Iodine ☐ Shellfish ☐ Latex

Are you CURRENTLY Taking any of the following medications?

☐ *Coumadin* (Warfarin) ☐ *Plavix* (Clopidogrel) ☐ Aspirin ☐ *Brillinta* (Ticagrelor)

☐ *Pradaxa* (Dabigatran) ☐ *Lovenox* (Enoxaprin) ☐ *Aggrenox* ☐ *Ticlid* (Ticlopidine)

☐ *Xarelto* (Rivaroxaban) ☐ Other Blood Thinning medication?

Why are you taking this medication? _____

What is the Prescribing Physician? _____

Contact phone number? _____

SURGICAL HISTORY: *Please check if you have had any of these surgeries.*

☐ **NO PREVIOUS SURGERY**

☐ Abdominal Surgery
Type: _____

☐ Aneurysm

☐ Angioplasty/Stents

☐ Artery Bypass of Arm or Leg

☐ Bone/Joint Surgery
Type _____

☐ Back/Neck Surgery
- ☐ Cervical (neck) Level(s) _____ When? _____
- ☐ Thoracic Level(s) _____ When? _____
- ☐ Lumbar (low back) Level(s) _____ When? _____

☐ Breast Surgery
Type _____

☐ Carotid Surgery

☐ Colon Surgery

☐ Coronary Bypass (CABG)

☐ Heart Valve Replacement

☐ Hysterectomy

☐ Pacemaker/Defibrillator

☐ Prostate Surgery

☐ Other (explain)
_____
_____
_____
_____
_____
_____

☐ Implanted Devices *(If YES, check all that apply.)*
- ☐ Screws, Pins, Plates ☐ Pacemaker ☐ IUD ☐ Venous Access
- ☐ Aneurysm Clip(s) ☐ AICD ☐ Breast Implant ☐ Spinal Cord Stimulator
- ☐ Intrathecal Pump

Patient Name: _____ DOB _____ Date of Visit _____

FAMILY HISTORY:

*Please check below if any immediate relatives have had any of these conditions: **F**–father, **M**–mother, **S**-sibling, **C**-child.*

☐ **NO FAMILY HISTORY TO REPORT**	☐ Cancer	☐ Osteoarthritis
☐ **I AM ADOPTED**	☐ Depression	☐ Osteoporosis
☐ Aneurysm	☐ Diabetes	☐ Other (Explain)
☐ Adverse Reaction to Anesthesia	☐ Heart Disease	_____
☐ Bleeding Disorders	☐ Hypertension	_____
☐ Blood Clots/ Pulmonary Embolism	☐ Stroke (CVA)	_____

SOCIAL HISTORY:

Marital Status ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widow/Widower

Hobbies _____

Please indicate your employment status

☐ Unemployed because of my Pain	☐ On Disability	☐ Employed, Part Time
☐ Unemployed, currently looking	☐ Retired	☐ Employed, Full Time
☐ Homemaker	☐ (Other) _____	

Smoking ☐ Never Smoked ☐ Former Smoker ☐ Current Smoker? How may packs /day? _____

Do you dip or chew tobacco? ☐ No ☐ Yes How much per day? _____

Do you drink alcoholic beverages? ☐ No ☐ Yes How many drinks per week? _____

Do you use recreational drugs ☐ No ☐ Yes What and how often? _____

REVIEW OF SYSTEMS: *Please check if you have now, or recently experienced any of these medical conditions.*

☐ Leg Swelling	☐ Skin Wounds/ Rash	☐ Seizures
☐ Weight Gain	☐ Shortness of Breath	☐ Psychological Problems
☐ Weight Loss	☐ Abdominal Pain	☐ Depression
☐ Fever/Chills/Night Sweats	☐ Black, Tarry Stools	☐ Anxiety
☐ Vision Problems	☐ Arm/Leg Pain	☐ Easy Bleeding/Bruising
☐ Dental Problem	☐ Urinating at Night	☐ Swollen Glands
☐ Chest Pain	☐ Incontinence	☐ Irregular Heart Beat

MEDICATION ALLERGIES

☐ **NO KNOWN MEDICATION ALLERGIES**			
Are you allergic to Contrast Dye?	☐ NO	☐ YES	Reaction?
Are you allergic to Latex?	☐ NO	☐ YES	Reaction?
Are you allergic to Tape?	☐ NO	☐ YES	Reaction?
Other			Reaction?
Other			Reaction?
Other			Reaction?

CURRENT MEDICATION: *Please include herbal and over-the-counter medications. List all medications with dosage.*

☐ NOT CURRENTLY TAKING ANY MEDICATIONS-PRESCRIPTION OR OVER-THE-COUNTER, OR HERBAL SUPPLEMENTS

DRUG	DOSAGE		DRUG	DOSAGE

Patient Name: _____ DOB _____ Date of Visit _____