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 $25.00 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			

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

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 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.

PRS
PAIN AND REHABILITATION SPECIALISTS OF ST. LOUIS

NOTICE of DOCTOR'S LIEN

PATIENT NAME _____ Date of Birth _____

PRS PROVIDER ☐ Helen M Blake, MD ☐ Kaylea M Boutwell, MD Date of Accident/Injury _____

I do hereby authorize Pain & Rehabilitation Specialists (PRS) to furnish you, my attorney, with a full report of my medical records in regard to the injuries I sustained as a result of the above-referenced accident/injury.

I hereby authorize and direct you, my attorney, to pay said doctor/entity, directly, all monies owed them in consequence of this accident/injury, as well as any other settlement made in this case prior to disbursement to any other individual or entity.

This Lien does not supplement my own responsibilities for outstanding medical bills, but is given as protection to said doctor/entity and in consideration of their willingness to await payment for services rendered. I understand that payment for all outstanding fees to said doctor are payable upon demand and are not contingent on the receipt of the award through settlement, judgment or verdict. In the event there is no recovery on my accident claim, I understand that I am responsible for those services rendered by the doctor.

I agree to promptly notify said doctor/entity of any change or addition of attorney(s) used by me in connection with this accident and I instruct my attorney to do the same and to promptly deliver a copy of this Lien to any such substituted or added attorney(s).

Please acknowledge this Lien by Signing below and returning this document to the doctor's office.

I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable

_____ _____

Signature of Patient Date Signed

The undersigned, being Attorney of Record for the above patient, does hereby agree to observe all the terms of the above Lien and agrees to withhold such sums from any settlement, judgment or verdict, as may be necessary to adequately protect and fully compensate said doctor/entity above named. Attorney further agrees that in the event this Lien is litigated, that the prevailing party will be awarded attorney's fees and costs. Attorney further waives deliver of the Notice by registered mail with return receipt requested as required by R.S. MO 430.240.

_____ _____

Signature of Attorney of Record Date Signed

_____ _____

Signature of PRS Provider/Provider's Representative Date Signed

Please date, sign and return one copy to the doctor's office. Keep one copy for your personal records.

14825 North Outer Forty Road Suite 360 Chesterfield, MO 63017

Office Phone: 314-336-257 Fax: 314-336-2571

Patient Name: _____ Date: _____

PAIN AND REHABILITATION SPECIALISTS OF ST. LOUIS
NEW PATIENT COMPREHENSIVE PAST MEDICATIONS LIST

PLEASE **CAREFULLY** REVIEW ALL LISTED MEDICATIONS TO ENSURE THE QUALITY AND SAFETY OF THE CARE WE OFFER YOU WITHIN OUR CLINIC.

Please circle ALL medications you have previously taken. For EACH selected, describe when/why it was prescribed, as well as your response to the medication, in the space provided on the last page of this form:

Fibromyalgia:

Cymbalta (Duloxetine) Lyrica (Pregabalin) Savella (Milnacipran)

Migraine:

Fioricet Fiorinal Imitrex Inderal Maxalt Midrin Propranolol Relpax Stadol

Sumatriptan Topamax (Toprimate) Valproic Acid Zomig

Muscle Relaxants:

Amrix Baclofen Chlorzoxazone Cyclobenzaprine (Flexeril) Fexmid Lorzone Metaxalone(Skelaxin)

Methocarbamol (Robaxin) Norflex(Orphenadrine) Parafon Forte Soma (Carisprodol) Zanaflex (Tizanidine)

Narcotic/Opioid Analgesics:

Actiq (Transmucosal Fentanyl) Avinza (Morphine) Buprenex (Buprinorphene) Butorphanol

Butrans (Transdermal Buprinorphine) ConZip (Tramadol) Darvon Demerol (Meperidine)

Darvocet (Propoxyphene/Acetaminophen) Dilaudid (Hydromorphone) Duragesic (Transdermal Fentanyl)

Endocet (Oxy/ Acetaminophen) Fioricet (Butalbital/Acetaminophen/Caffeine/Codeine)

Hydrocodone Ibudone (Hydrocodone/Ibuprofen) Lorcet (Hydrocodone/Acetaminophen)

Lortab (Hydro/Acetaminophen) Magnacet(Oxycodone/Acet) MS Contin (ER Morphine)

Methadone (Dolophine) Morphine Sulfate Nalbuphine (Nubain) Nucynta (Tapentadol)

Norco (Hydro/Acetaminophen) Opana (Oxymorphone) Oramorph SR (Morphine)

Oxecta (Oxycodone) Oxycodone OxyContin OxyFast Percodan (Oxycodone/Aspirin)

Panlor (Acetaminophen/Caffeine/Dihydrocodeine) Percocet (Oxycodone/Acetaminophen)

Pentazocine/Acetaminophen Primalev (Oxy/Acetaminophen) Reprexain (Hydrocodone/Ibuprofen)

Roxicet (Oxy/Acetaminophen) Roxanol (Morphine) Roxicodone (Oxycodone) Rybix ODT (Tramadol)

Ryzolt (Tramadol) Tylenol + Codeine (T#3, T#4) Ultracet(Tramadol/Acetaminophen)

Ultram (Tramadol) Vicodin (Hydro/Acetaminophen) Vicoprofen (Hydro/Ibuprofen)

NSAIDs (Non-Steriod Anti-Inflammatory Drugs):

Advil (Ibuprofen) Aleve (Naproxen) Anaprox Ansaid (Flurbiprofen)

Arthrotec (Diclofenac/Misoprostol) Celebrex (Celecoxib) Cambia/Cataflam (Diclofenac Potassium)

Daypro (Oxaprozin) Diclofenac Duexis (Ibuprofen/Famotidine) Toradol(Etodalac)(Sprix)(Lodine)

Feldene (Piroxicam) Flector (Diclofenac Patches) Indocin (Indomethacin) Ketoprofen

Ketorolac Mobic (Meloxicam) Midol Motrin (Ibuprofen) Naprelan (Naproxen)

Pennsaid (Diclofenac Topical) Relafen (Nabumetone) Vimovo (Naproxen/Esomeprazole)

Voltaren (Diclofenac Topical Gel) Zipsor (Diclofenac Potassium)

Other Pain Classes/Medications of Interest:

Neuropathic Pain Agents: Clonidine Neurontin (Gabapentin) Cymbalta (Duloxetine)

Lyrica (Pregabalin) Carbatrol (Carbamazepine) Tegretol (Carbamazepine) Gralise

Requip (Ropinirole) Amitriptyline (Elavil) Nortriptyline (Pamelor) Valproic Acid

Lidoderm (Lidocaine Pain Patches)

Gout: Zyloprim (Allopurinol) Colcrys (Colchicine)

ADHD: Concerta Ritalin Vyvanse Strattera ProCentra Adderall

Topical Pain Medications: Biofreeze Other?

Anxiolytics/Sedative Hypnotics:

Ambien (Zolpidem) Atarax (Hydroxyzine) Ativan (Lorazepam) Benadryl (Diphenhydramine)

BuSpar (Buspirone) Clonazepam (Klonopin) Doxepin Halcion Intermezzo (Zolpidem)

Librium (Chlordiazepoxide) Lunesta (Eszopiclone) Restoril (Temazepam) Serax (Oxazepam)

Sonata (Zaleplon) Trazodone Valium (Diazepam) Vistaril (Hydroxyzine) Xanax (Alprazolam)

Anti-Depressants:

Remeron (Mirtazapine) Wellbutrin (Buproprion)

SNRI's: Effexor (Venlafaxine) Pristiq (Desvenlafaxine) Cymbalta (Duloxitine)

SSRI's: Celexa (Citalopram) Prozac (Fluoxetine) Paxil (Paroxetine) Luvox (Fluvoxamine)

Lexapro (Escitalopram) Viibryd (Vilazodone) Zoloft (Sertraline)

Over the Counter and/or Alternative Medicines:

_____

Description of Previous Medication Use:

Medication #1

_____

Medication #2

_____

Medication #3

_____

Medication #4

_____

Medication #5

_____

Medication #6

_____

Medication #7

_____

Medication #8

_____

Medication #9

_____

Medication #10

_____

Medication #11

_____

Medication #12

_____

PAIN AND REHABILITATION SPECIALISTS OF SAINT LOUIS

PATIENT NAME:_____ DATE:_____
HEIGHT:_____ WEIGHT:_____ DATE OF BIRTH: _____
CHIEF PAIN COMPLAINT :_____
DATE OF INJURY, IF ANY:_____ IS THE INJURY WORK RELATED? Y N
BRIEFLY DESCRIBE THE PROBLEM, ACCIDENT, OR ILLNESS:

_____

_____

WHAT THERAPY HAVE YOU HAD (MEDICATIONS, PT, INJECTIONS, CHIROPRACTIC, ETC) _____

_____

_____

WHAT WAS YOUR RESPONSE?_____
PREVIOUS IMAGING/ STUDIES? (X-RAY, CT, MRI, EMG, etc)_____
IF YES, WHEN/WHERE? _____

_____

ARE YOU CURRENTLY DISABLED? _____ WHEN DID YOUR DISABILITY BEGIN? _____
WHAT IS YOUR OCCUPATION?_____
FOR WHOM/WHAT COMPANY DO YOU WORK? _____
WHAT IS YOUR CURRENT WORK STATUS? _____
HOW LONG HAVE YOU HELD/DID YOU HOLD THIS POSITION? _____

PAST MEDICAL HISTORY (CIRCLE YOUR PAST OR PRESENT MEDICAL ISSUES):

DIABETES	HEART DISEASE	KIDNEY DISEASE
HIGH BLOOD PRESSURE	CANCER	LIVER DISEASE
HIV or HEP B/C Positive	OTHER _____	

MEDICATION ALLERGIES _____
IF YES, WHAT WERE THE REACTIONS? _____

_____

SOCIAL HISTORY:

DO YOU USE TOBACCO PRODUCTS? Y N HOW MUCH_____FOR HOW LONG? _____
IF QUIT, WHEN? _____
ARE YOU: SINGLE MARRIED DIVORCED WIDOWED (please circle one)
DO YOU HAVE CHILDREN? _____ HOW MANY? _____AGES? _____
DO YOU DRINK ALCOHOL: DAILY WEEKLY MONTHLY RARELY HOW MUCH _____

HAVE YOU EVER USED/DO YOU USE ANY RECREATIONAL DRUGS? Y N WHAT_____

_____

WHAT ARE YOUR HOBBIES/INTERESTS_____

PAST SURGICAL HISTORY: (PLEASE LIST ALL PREVIOUS SURGERIES) AND THE YEAR YOU HAD THEM

_____

_____

LIST ANY MEDICATIONS, INCLUDING DOSAGES THAT YOU CURRENTLY TAKE: _____

_____

_____

_____

PATIENT SIGNATURE: _____**DATE:** _____
NAME:_____DATE: _____

Name: _____ Date: _____

WHERE IS YOUR PAIN?

PLEASE MARK **WHERE** YOUR PAIN IS, USING THE SYMBOLS TO INDICATE THE **TYPE OF PAIN** YOU EXPERIENCE IN EACH AREA.

ACHING	NUMBNESS	PINS & NEEDLES	BURNING	STABBING
ΔΔΔΔΔ	========	OOOOOOO	XXXXXX	/////////

Staff Use Only

HEIGHT _____

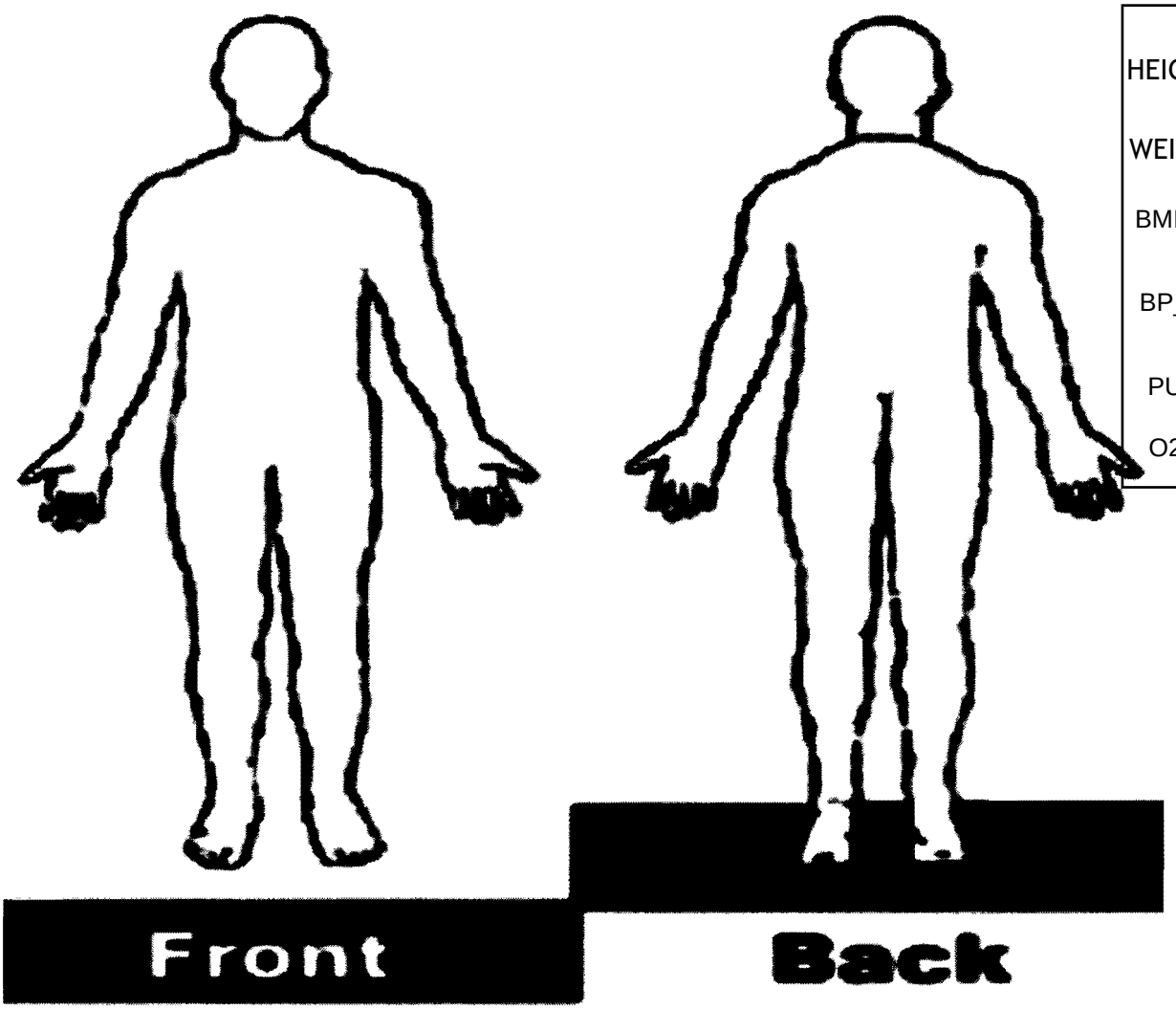
WEIGHT_____

BMI _____

BP_____

PULSE_____

O2_____



PAIN SCALE: (NO PAIN) 0__1__2__3__4__5__6__7__8__9__10 (WORST IMAGINABLE PAIN)

1. **At this moment, my pain is a: 1 2 3 4 5 6 7 8 9 10**
2. **At my best, my pain is a: 1 2 3 4 5 6 7 8 9 10**

My pain improves with/when I: _____

_____

3. **At my worst, my pain is a: 1 2 3 4 5 6 7 8 9 10**

My pain worsens with/when I: _____

_____