FRONT RANGE PAIN MEDICINE

George Girardi, MD
Matthew Pouliot, DO
Michael Brown, DO
Colin Carpenter, MD
Deb Dennis, PA-C
Kelli McKee, PA-C

Name:_____ Date:_____
Time: _____

THIS APPOINTMENT IS FOR AN OFFICE VISIT

Please fill out forms and bring them to your appointment. Attached you will find:

Office Location and Map (On the back of this page)

Demographic Information
Please fill this form out completely, including your primary care and referring physician information. It is important that we have emergency contact information. Also, please bring a **photo ID** with you.

Insurance Information and Financial Policy
Please bring your insurance card to your appointment (to be scanned into our system). Workman's Comp and auto accident patients MUST supply us with complete billing information, including: claim number, date of injury, adjuster name, and phone number. It is the patient's responsibility to make sure there is a current insurance referral in place (if required) before your first scheduled appointment, as well as future appointments. This referral originates from your primary care provider. Any procedures performed will be preauthorized by our office. **We will collect your co-pay at the time of your visit**, and we accept VISA, MasterCard, American Express, checks, and cash.

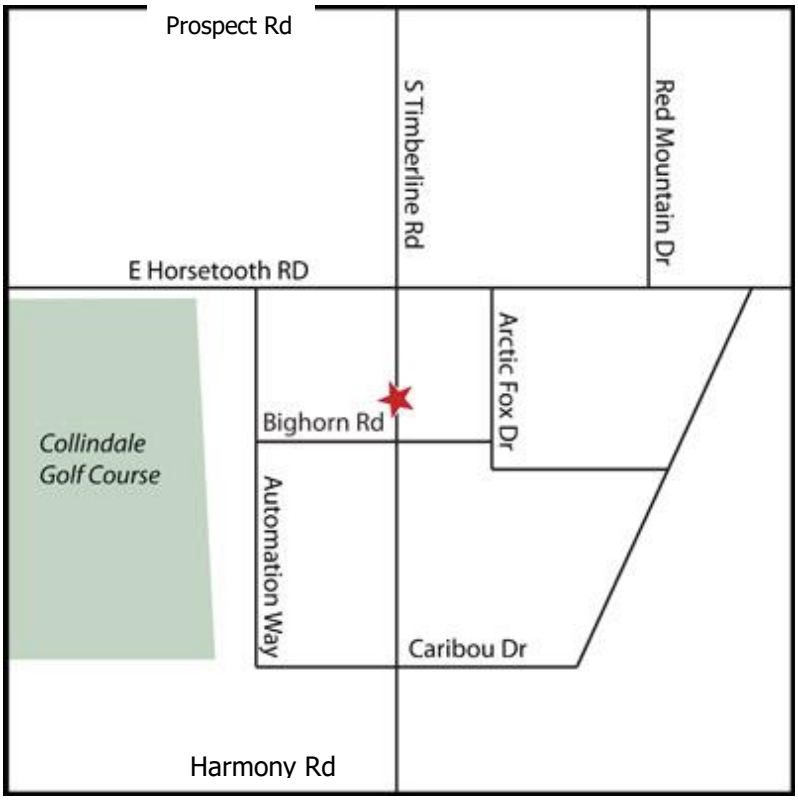
Notice of Privacy Practices
This allows us to release your office visit and procedure notes to your referring doctor. Also this form will allow our office to release any information to family members. The Notice of Privacy Practices will be available for you to view when you come to the office.

Medical History Questionnaire
It is very important that you fill out all pages of this questionnaire completely. This will assist the provider during your visit with us.

Narcotic Contract
This only applies if we prescribe any medication for you. We will have you review this and sign at your appointment.

PLEASE CHECK IN AT LEAST 15 MINUTES BEFORE YOUR SCHEDULE APPOINTMENT
If you are unable to keep this appointment, or if you have any questions, please call us.

3744 South Timberline Road, Suite 102 Fort Collins, CO 80525
1605 Foxtrail Drive, Loveland, CO 80538
555 Prospect Ave. Estes Park, CO 80517
4108 Laramie Street, Cheyenne, WY 82001
(970)495-0506



LOCATION:

- **We are located on Timberline Road, just one block South of Horsetooth Road**
- **You will turn East off Timberline Rd on to Bighorn Road**
- **Take an immediate left turn into our parking lot**

FROM I-25

- **From the South: Exit on Harmony Road, go West until you get to Timberline Road – turn right (North) and proceed as above.**
- **From the North: Exit on Prospect Road, go West until you get to Timberline Road – turn left (South) and proceed as above.**

Front Range Pain Medicine
3744 S. Timberline Road, Suite 102
Fort Collins, CO 80525
Phone: (970) 495-0506
The Cheyenne, Loveland, and Estes Park are satellite offices and have limited availability.

INFORMATION (Please Print)

Name: _____
First Middle Last

Address: _____
Street Apt. # City State Zip

Email: _____

Home Phone:( ) _____ Cell Phone:(___)_____Social Security#:_____
Date of Birth: _____ Sex: M F Marital Status: S M W D
Race/Ethnicity: C-Caucasian B-Black H-Hispanic A-Asian N-Native American O-Other N-Refuse to Answer
Employer: _____ Work Phone: _____ Occupation: _____
Primary Insurance: Insurance Company: _____
Address: _____ Name of Policy Holder: _____
ID#: _____Group #: _____
Secondary Insurance:(if any) Insurance Company: _____
Address: _____Name of Policy Holder: _____
ID#: _____ Group #: _____

Worker's Compensation? ___ **Auto Accident?** ____ Date of Injury _____ State_____
Insurance/Worker's Compensation Carrier: _____ Adjuster's Name: _____
Address: _____Phone #: _____Claim #: _____
I authorize the release of any medical information necessary to process my insurance claim.
Signature: _____ Date: _____
Referring Physician: _____ Phone #: _____City: _____ State: _____
Family Physician: _____ Phone #: _____City: _____State:_____

EMERGENCY CONTACT: Name: _____Phone#: _____
Relationship to patient: _____
FINANCIAL POLICY: Please understand that the credit and collection policies of Front Range Pain Medicine are necessary part of assuring the financial resources needed to maintain this medical office for our patients and the community. We do not want financial circumstances to limit our care for you. If an unusual situation should make it impossible to meet our credit terms, please discuss the matter with our billing department. If you have health insurance: This is an agreement between you and your insurance company to pay certain amounts for medical care. Our relationship is with you, not with your insurance company; therefore, all charges are ultimately your responsibility, regardless of your insurance status. We strive to assist patients in this process as much as possible. As a service to you, we submit insurance claims on your behalf, including secondary and supplements. You, in turn, must provide us with complete information about your insurance carrier and the insured party.

- Your co-pay, as well as any previous balance, will be collected at check-in on the day of your office visit. We accept VISA, MasterCard, American Express, checks, and cash.
- After 60 days, you will be expected to pay any unpaid insurance portions and arrange with your insurance for reimbursement.

If you do NOT have health insurance: You are expected to pay for all services as they are rendered. Accounts 90 days past due are referred to a collection agency or attorney. Reasonable fees, cost and expenses, including attorney's fees incurred in this process by the agency assigned to collect your account, will be added to your account.
I certify that I have read and understand the above. The signature below is that of the patient (or the person duly authorized by the patient) who agrees to the terms and obligations in this statement
If you are unable to keep an appointment please give us a 24 hour notice, if our office does not hear from you, you will be charged a $35 cancellation fee for office visits and $100 for procedures.

_____ _____
YOUR SIGNATURE **DATE**

Authorization for Release of Information to Family

_____ Ok to leave information on voicemail at: □ Home □ Work □ Cell Phone
_____ Give information to: _____.
(Spouse or family member)

Description of information to be released:
_____ Appointment Reminders _____ Medical Information
_____ Financial Information _____ Information results from tests or x-rays.
_____ Other information as described: _____.

Rights of the Patient: I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to **FRONT RANGE PAIN MEDICINE, LLC.** I understand that a revocation is not effective in cases where the information has already been disclosed, but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization. This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

NOTICE OF PRIVACY PRACTICES: Front Range Pain Medicine has a Notice of Privacy Practices, copies of which are located in the front office. I understand that I will be given the opportunity to review this document at the time of my appointment, if I so desire.

_____ Date_____
Signature of Patient or Personal Representative

_____
Description of Personal Representative's Authority (attach necessary documentation)

FOR OFFICE USE ONLY: We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
_____individual refused to sign; _____prohibited by communication barriers; _____emergency situation;
_____other (please explain): _____

NAME:_____
DATE:_____

To assist our physician in determining your diagnosis and treatment plan, please complete this form in its entirety:

BRIEF HISTORY OF INITIAL PAIN (when pain started and progression of pain today):_____

_____

LOCATION OF PAIN AND RADIATION OF PAIN:_____

_____

DESCRIPTION OF PAIN (sharp, tingling, burning, numbness, stabbing, constant, intermittent):_____

_____

PAIN IS WORSENED BY:_____

_____

PAIN IS BETTER BY:_____

_____

PLEASE CIRCLE A NUMBER FROM 1 TO 10 THAT MOST CLOSELY MEASURES THE LEVEL OF PAIN ON A <u>GOOD DAY</u>:

0 1 2 3 4 5 6 7 8 9 10

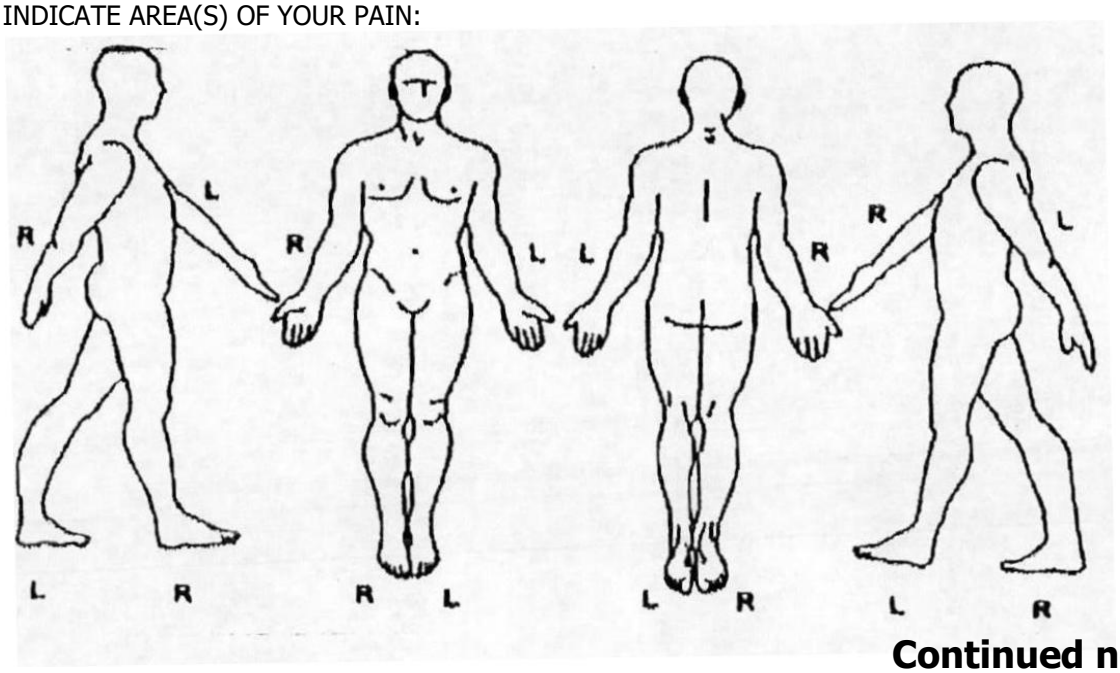
No pain, annoying, nagging — Distressing, miserable, Agonizing, gnawing — Excruciating, unbearable, Torturing, crushing, tearing

PLEASE CIRCLE A NUMBER FROM 1 TO 10 THAT MOST CLOSELY MEASURES THE LEVEL OF PAIN ON A <u>BAD DAY</u>:

0 1 2 3 4 5 6 7 8 9 10

No pain, annoying, nagging — Distressing, miserable, Agonizing, gnawing — Excruciating, unbearable, Torturing, crushing, tearing

PLEASE INDICATE AREA(S) OF YOUR PAIN:



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Front Range Pain Medicine

MEDICAL HISTORY	YES	NO	COMMENTS
LUNG PROBLEMS ASTHMA, EMPHYSEMA, COPD, SLEEP APNEA			
ARTHRITIS			
BLEEDING DISORDER			
BOWEL/BLADDER PROBLEMS			
CANCER			
DIABETES			
HEADACHES			
HEART DISEASE			
HYPERTENSION			
HIATAL HERNIA/HEARTBURN			
ULCERS			
KIDNEY PROBLEMS			
LIVER DISEASE/HEPATITIS			
NEUROLOGICAL PROBLEMS STROKE, SEIZURES			
PSYCHIATRIC PROBLEMS			
ALCOHOL CONSUMPTION			
TOBACCO USE CIGARETTES, SMOKELESS			
MARIJUANA			
COCAINE OR OTHER STREET DRUGS			
THERAPIES PHYSICAL, MASSAGE, ACUPUNCTURE			

FAMILY HISTORY	MATERNAL	PATERNAL
HEART DISEASE		
CANCER		
LUNG DISEASE		
LIVER/KIDNEY DISEASE		
DEPRESSION		
DRUG/ALCOHOL ABUSE		

SURGICAL HISTORY	DATE

NAME:_____
DATE OF BIRTH:_____

DRUG ALLERGIES:_____

_____

CURRENT MEDICATIONS (Prescription and Over-the-Counter):

Drug Name	**Dose**	**Times per Day**
MEDICATIONS/ THERAPIES (Tried and Failed):		
Name	**Dose**	**Times per Day**

Do you take a blood thinner (such as Coumadin, Heparin, Aspirin, Plavix, Lovenox, anti-inflammatory)?
Yes____ No____If yes, which one?_____ Dose:_____

Do you take Tylenol or medication with acetaminophen?
Yes ____ No____If yes, which one? _____ Dose:_____

Global Pain Scale

NAME_____

Your Pain:

My current pain is ..... No Pain: 0 1 2 3 4 5 6 7 8 9 10 Extreme pain

During the past week,
the best my pain has been is..... No Pain: 0 1 2 3 4 5 6 7 8 9 10 Extreme pain

the worst my pain has been is ..... No Pain: 0 1 2 3 4 5 6 7 8 9 10 Extreme pain

my average pain has been .....No Pain: 0 1 2 3 4 5 6 7 8 9 10 Extreme pain

During the past 3 months,
my average pain has been **.....**No Pain: 0 1 2 3 4 5 6 7 8 9 10 Extreme pain

Your Feelings: During the past week I have felt:

Afraid .....**Strongly Disagree: 0 1 2 3 4 5 6 7 8 9 10 Strongly Agree**

Depressed .....**Strongly Disagree: 0 1 2 3 4 5 6 7 8 9 10 Strongly Agree**

Tired .....**Strongly Disagree: 0 1 2 3 4 5 6 7 8 9 10 Strongly Agree**

Anxious .....**Strongly Disagree: 0 1 2 3 4 5 6 7 8 9 10 Strongly Agree**

Stressed .....**Strongly Disagree: 0 1 2 3 4 5 6 7 8 9 10 Strongly Agree**

Your Clinical Outcomes: During the past week:

I had trouble sleeping .....**Strongly Disagree: 0 1 2 3 4 5 6 7 8 9 10 Strongly Agree**

I had trouble feeling comfortable .....**Strongly Disagree: 0 1 2 3 4 5 6 7 8 9 10 Strongly Agree**

I was less independent .....**Strongly Disagree: 0 1 2 3 4 5 6 7 8 9 10 Strongly Agree**

I was unable to work
(or perform normal tasks) .....**Strongly Disagree: 0 1 2 3 4 5 6 7 8 9 10 Strongly Agree**

I needed to take more medication .....**Strongly Disagree: 0 1 2 3 4 5 6 7 8 9 10 Strongly Agree**

Your Activities: During the past week I was **NOT** able to:

Go to the store .....**Strongly Disagree: 0 1 2 3 4 5 6 7 8 9 10 Strongly Agree**

Do chores in my home .....**Strongly Disagree: 0 1 2 3 4 5 6 7 8 9 10 Strongly Agree**

Enjoy my friends and family .....**Strongly Disagree: 0 1 2 3 4 5 6 7 8 9 10 Strongly Agree**

Exercise (including walking) .....**Strongly Disagree: 0 1 2 3 4 5 6 7 8 9 10 Strongly Agree**

Participate in my favorite hobbies .....**Strongly Disagree: 0 1 2 3 4 5 6 7 8 9 10 Strongly Agree**