CYPRESS POINTE
PAIN MANAGEMENT

New Patient Medical Questionnaire And Authorization

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Date: _____ **Patient Full Name:** _____ **Date of Birth:** _____

How did you hear about us? _____ **SS#:**_____

Please list your physical address & P.O. Box: _____

Please list 2 contact phone numbers: _____/_____

Can we communicate with you via: Voicemail- ☐ YES ☐ NO **Email-** ☐ YES ☐ NO

Physical Activity? ☐ Vigorous ☐ Moderate ☐ Sedentary

Race: ☐ African American/ Black ☐ Caucasian/ White ☐ Hispanic/ Latino ☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Other _____

Relationship: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Education: ☐ High School Diploma ☐ Some College ☐ Associate Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ GED- Last grade attended _____

Employment: Are you currently employed? ☐ Yes ☐ No If not why? _____

Occupation___ _____ If you are disabled and/or retired, list your prior occupation.

Have you ever been treated by another pain management clinic/provider?

☐ YES ☐ NO If so, who & when? _____

Prescription Drug Abuse: Have you ever abused prescription medications, such as amphetamines, benzodiazepines, barbiturates, codeine, Demerol, or Morphine? ☐ Yes ☐ No

Are you currently in or have you ever attended a substance abuse program? ☐ Yes ☐ No

Alcohol Use: Check one- ☐ Daily ☐ Weekly ☐ Monthly ☐ Socially ☐ Very infrequently

☐ I Do Not drink Have you ever abused Alcohol? ☐ Yes ☐ No

Tobacco Use: ☐ Chew/Dip ☐ Cigarettes ☐ None

How much? _____ **How often?** _____ **How many years?** _____

Illegal Drug Use: Do you use or have you ever used any of the following illegal drugs?

Drug	Currently Using	Drug	Currently Using
Marijuana	YES NO	LSD	YES NO
Heroin	YES NO	PCP	YES NO
Cocaine	YES NO	Ecstasy	YES NO
Inhalants	YES NO	Methamphetamines	YES NO
Crack	YES NO	Crank	YES NO

Patient Initials:_____

<u>Medications</u>- Please list all of the prescriptions, herbal supplements and vitamins that you are presently taking:

Medication Name	Dosage	How many times do you take this daily?	When did you take your last dose?

<u>Medications Allergies</u>- Please list ALL medication names and reaction that occurred:

_____ _____ _____

_____ _____ _____

Height: _____ft. _____inches Weight: _____#

<u>Medical History</u>- Check the following that apply now or have occurred in the past:

_____ High Blood Pressure/ Hypertension
_____ Diabetes
_____ High Cholesterol
_____ Heart Disease
_____ Liver Disease
_____ Seizure/Epilepsy
_____ Thyroid Disease
_____ Headaches/Migraines
_____ Cancer, what kind? _____
_____ Stroke
_____ Peptic Ulcer Disease (PUD)
_____ Hepatitis C
_____ Anxiety
_____ Depression
_____ Irregular Heart Beat
_____ Parkinson's Disease
_____ Arthritis
_____ Kidney Disease
_____ HIV/AIDS
_____ Asthma
_____ COPD
_____ Multiple Sclerosis
_____ Alzheimer's/ Dementia
_____ Degenerative Disc Disease
_____ GERD
_____ Acid Reflux
Other: _____

Patient Initials:_____

<u>Family History</u>- Please indicate which family member each applies to, use the abbreviations as follows (M-Mother, F-Father, S-Sister, B-Brother, GP-Grandparent)

_____ High Blood Pressure/ Hypertension
_____ Diabetes
_____ Heart Disease
_____ Seizure/Epilepsy
_____ Headaches/Migraines
_____ Cancer (List Type)
_____ Stroke
_____ High Cholesterol
_____ Heart Disease
_____ Alzheimer's Dementia
_____ Multiple Sclerosis
_____ Parkinson's Disease
_____ Muscular Dystrophy
_____ Muscular Dystrophy

<u>Surgical History</u>- Please list all of your past surgeries and the approximate date/year:

SURGERY NAME/DESCRIPTION	DATE/YEAR

How many children have you given birth to? _____

<u>Prior Treatment</u>: Please fill in the blanks ONLY for the treatments you have had performed for this pain problem. If a treatment performed is not listed, please add it:

Treatment	What Doctor Performed this?	Date/Year Performed	Outcome (check one) Improved	Not Improved
Nerve Block				
Epidural Steroid Injection				
TENS Unit				
Physical Therapy				
Traction				
Acupuncture				
Chiropractic Care				
Psychiatrist/Psychologist				
Hypnosis/Biofeedback				
Alternative Treatments				

Patient Initials:_____

- **Appointment Policy**: I understand that no showing for more than **TWO** scheduled appointments or procedures is grounds for patient discharge. Office visit cancellations must be made with at least a **24-hour** notice and procedure cancellations must be made with at least a **72-hour** notice. If this policy is not followed, I may be subject to a **$25 fee per office visit** & **$100 fee per procedure**. **NSF check fee- $25**.
- When leaving **voicemails**, I understand that it may take **24 business hours** for the office to respond with an appropriate answer from my provider. Leaving multiple voicemails about the same concern is not necessary and will only delay my response time.
- I acknowledge that I have received a copy of the **Notice of Privacy Practices** for Cypress Pointe Pain Management. CPPM reserves the right to modify the privacy practices outlined in the notice.
- I consent to receive calls/text from CPPM for my protected health care and other services at the phone numbers I have listed, including my wireless phone number. I understand that I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.
- I have read and understand my rights and responsibilities as a patient.
- I understand that I have the right to choose a personal representative.

Release of Information:

CPPM will not be held liable for releasing protected health information to the listed persons, in the event that I fail to report any changes to the above list. Persons whom I give permission to disclose any medical or billing information regarding my care (spouse, family, friends, etc.):

Full Name of Person _____Relationship_____

Full Name of Person _____Relationship_____

Full Name of Person _____Relationship_____

I, the undersigned, authorize the physicians of CPPM to disclose any or all of the information in my medical records to any person, other healthcare provider, pharmacy, reimbursing agency, law enforcement, or other state/federal corporation or agency which is or may be liable for all or part of CPPM's charge or who may be responsible for determining necessity of health maintenance. I understand that my records may contain diagnosis, toxicology screening results, prescription information, or my history of communicable disease. I understand that it is my sole responsibility as a patient of CPPM to report any changes to this authorization in writing, and it shall remain in effect until revoked by me. A photocopy of this authorization is considered as valid as the original. I understand that I am responsible for any unpaid charges, regardless of insurance coverage, as well as any additional expenses incurred in the collection of this account. I hereby understand and agree with the terms of this agreement, and I was given the opportunity to ask any pertinent questions. I give my consent for evaluation & treatment at CPPM.

Patient/Representative Signature: _____ Date: _____

*If the patient is physically or legally unable to sign and a guardian signed in place of the patient, please list:

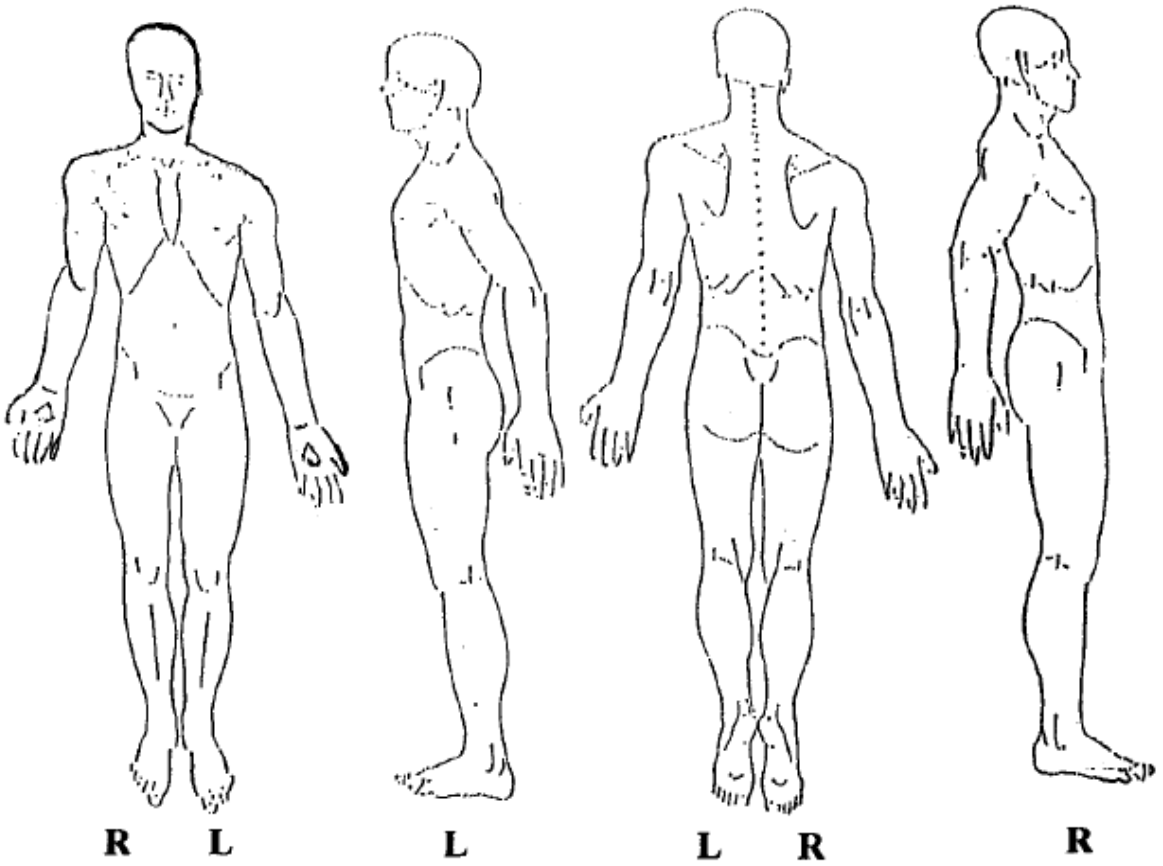
Representative Full Name: _____ Relationship to Patient: _____

Witness Signature: _____

CYPRESS POINTE
PAIN MANAGEMENT

PAIN DRAWING:

Ache	Burning	Numbness	Pins & Needles	Stabbing	Other
^^^^	- - - - -	0000	. . . . .	//////////	XXXX
^^^	- - -	00	. . . . .	/////	XXX



Patient Initials:_____

Patient Full Name: _____ **Date of Birth:** _____

Current Opioid Misuse Measure (COMM)®

Please answer each question as honestly as possible. Keep in mind that we are only asking about the past 30 days. There are no right or wrong answers. If you are unsure about how to answer the question, please give the best answer you can.

Please answer the questions using the following scale:	**Never**	**Seldom**	**Sometimes**	**Often**	**Very Often**
	0	1	2	3	4
1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?	O	O	O	O	O
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments)	O	O	O	O	O
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e., another doctor, the Emergency Room, friends, street sources)	O	O	O	O	O
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?	O	O	O	O	O
5. In the past 30 days, how often have you seriously thought about hurting yourself?	O	O	O	O	O
6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?	O	O	O	O	O
7. In the past 30 days, how often have you been in an argument?	O	O	O	O	O
8. In the past 30 days, how often have you had trouble controlling your anger (e.g., road rage, screaming, etc.)?	O	O	O	O	O
9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?	O	O	O	O	O
10. In the past 30 days, how often have you been worried about how you're handling your medications?	O	O	O	O	O

Patient Initials:_____

Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
11. In the past 30 days, how often have others been worried about how you're handling your medications?	O	O	O	O	O
12. In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?	O	O	O	O	O
13. In the past 30 days, how often have you gotten angry with people?	O	O	O	O	O
14. In the past 30 days, how often have you had to take more of your medication than prescribed?	O	O	O	O	O
15. In the past 30 days, how often have you borrowed pain medication from someone else?	O	O	O	O	O
16. In the past 30 days, how often have you used your pain medicine for symptoms other than for pain (e.g., to help you sleep, improve your mood, or relieve stress)?	O	O	O	O	O
17. In the past 30 days, how often have you had to visit the Emergency Room?	O	O	O	O	O

Add the numbers together for each question selection: Total= _____

Circle One: Positive Negative

A score of 9 or greater = Positive (High Risk)

A score of 9 or less = Negative (Low Risk)

Patient Initials:_____

CYPRESS POINTE
PAIN MANAGEMENT

Patient Full Name (PRINT):_____ **Date of Birth**:_____

Pain Management Treatment Agreement

The goal of this agreement is to establish and maintain a safe and controlled treatment plan. We strive to make your life as pain-free as possible, so you can return to the activities you enjoy.

Benefits:

- We provide diagnostic and therapeutic services for pain.
- We apply the latest advances in medicine to relieve pain.
- We strive to improve function and increase quality of life.
- We organize multidisciplinary approaches to manage other issues accompanying pain, if indicated.
- We provide education on the disease of pain, while providing cost-effective care.

Potential Side Effects of Opioid/Narcotic Medications:

- While all medications have possible side effects, opioid medications are potentially more dangerous with respect to side effects and/or risks. To ensure safe usage and pain control, proper monitoring through drug testing is required. The following stipulations are mandatory for all patients to receive opioid pain management treatment from CPPM.
- Potential side effects of opioid/narcotic medications include: Addiction; Appetite decrease or loss; Balance and/or coordination disruption; Confusion and/or difficulty thinking, concentrating, and focusing clearly; Constipation; Increased drowsiness/sleepiness; Respiratory depression (slowed breathing); Psychological dependence; Tolerance (needing increased amounts of medication over time).

PATIENTS RECEIVING OPIOID (NARCOTIC) TREATMENT *MUST AGREE* TO ALL OF THE FOLLOWING STATEMENTS.

OFFICE POLICIES:

☐ I will keep and arrive in a timely manner for my scheduled appointments. No-showing for more than **two** scheduled appointments or procedures is grounds for patient discharge. I must provide at least **24-hour** notice to cancel an office-visit appointment and at least **72-hour** notice to cancel an appointment for a procedure.

☐ I, and any family members or representatives communicating on my behalf, will be courteous and respectful to all office staff and will not yell, use profanity, or engage in other threatening behavior, whether in person or on the telephone or in other media, when communicating with CPPM staff.

☐ I understand that when leaving a voicemail, CPPM may require **24 business hours** to return my phone call. Leaving multiple voicemails with the same concern is unnecessary.

MEDICATIONS:

☐ I am not and will not be involved in any way in the sale, illegal possession, diversion, or transport of prescribed controlled substances.

☐ I do not have a problem with substance abuse or medication dependence.

☐ I will not use or abuse addictive or potentially addictive substances, illegal or legal (Cocaine, Alcohol, Narcotics, Marijuana, etc.). Moderate use of nicotine and caffeine are an exception to this restriction.

Patient Initials:_____

☐ I will not use **any** mood-modifying medication, including tranquilizers and medications for ADHD and the like, from **any** other prescriber without first discussing this with my CCPM physician, and I will not abuse such medication.

☐ I will obtain all prescriptions for opioids/Narcotics **only** from CPPM. I will only take these medications as directed.

☐ I will not **share, give, lose, or allow others to consume** my medications. I understand that CPPM does **not** replace lost or stolen medications.

☐ I understand that the physicians at CPPM do not write prescriptions for Soma, Xanax, Valium, or Ativan.

☐ I understand that stopping controlled substances suddenly may result in withdrawal symptoms that can lead to possible heart attack and seizures.

☐ I understand that my medication treatment may be discontinued if my CPPM physician feels that opioids are ineffective in relieving my pain or improving my functionality.

☐ Pharmacy: _____ I agree to use **only** one pharmacy to obtain opioid medications. I will notify CPPM immediately if I or my representatives use another pharmacy for any reason.

☐ I understand that I am required to follow Federal and State guidelines for medication disposal. I will consult with CPPM before **disposing** of any unused medications. CPPM will instruct me how to properly dispose of these unused medications. Medication changes **will not** be made unless I comply with this policy.

☐ I will be **subject to** random pill counts and random drugs screens and must arrive at the clinic within **24 hours** of a request by CPPM for a pill count or drug test.

ADDITIONAL TREATMENT:

☐ I will actively participate in other, additional pain therapies as recommended by my CPPM physician. I understand that treatment can include physical therapy, minimally invasive procedures, psychological services, and may or may not include prescription strength medication.

☐ I will participate in a chemical dependency program if my CPPM physician identifies a problem.

☐ I accept responsibility to gradually increase my daily activities as recommended by my physician.

☐ I understand that CPPM utilizes Mid-Level providers for follow up office visits.

OTHER MEDICAL CONDITIONS AND OTHER PROVIDERS:

☐ I will immediately notify my CPPM physician if I am or plan to become pregnant.

☐ I will not obtain or seek controlled substances from any other physicians, including dentists or emergency room physicians. If I receive medical treatment for pain for any reason, I will notify my CPPM physician immediately.

☐ I will not seek emergency treatment for the pain condition my CPPM physician is treating.

☐ I will notify any/all of my other providers of my opioid treatment by my CPPM provider. I will not accept any **pain medication** from any other provider.

PATIENT RESPONSIBILITY:

☐ I assume responsibility in making any important decisions, legal or otherwise, while taking controlled substances, as controlled substances can decrease mental function.

☐ I assume responsibility for operating any type of automobile, vehicle, machinery, or any potentially hazardous task while taking controlled substances that are prescribed by my physician.

PRESCRIPTION REFILL POLICY:

☐ I understand that opioid prescriptions **are not refilled** without an office visit. Prescriptions for opioid refills are available only through a scheduled visit during regular office hours.

☐ I take responsibility to plan ahead, arrive for office visits as scheduled, take my medications as prescribed, and to know when my refills are due to prevent running out of medication prior to my

Patient Initials:_____

next scheduled appointment.

PATIENT DISCHARGE/TERMINATION FROM CARE OR OPIOID TREATMENT DISCHARGE MIGHT RESULT IF ANY OF THE FOLLOWING OCCURS:

- I refuse or fail to respond to a random pill count or random drug screen by arriving at the clinic within **24 hours** of a request by CPPM.
- My CPPM physician feels that opioids or other treatment is ineffective in relieving my pain or improving my functionality.
- I share/give/sell/lose my medications or allow them to be stolen or used by others.
- I fail to take my medications as directed, or fail to actively participate in other treatments and programs recommended by my CPPM physician, or otherwise fail to follow my CPPM treatment plan and recommendations.
- I abuse other substances, legal or illegal (alcohol, cocaine, marijuana, narcotics, etc.), or take mood-altering medications not discussed and approved by my CPPM physician.
- I obtain opioid medications from sources other than the **one** pharmacy identified above, and as prescribed by my CPPM physician.
- I or my representative yell, use profanity, or engage in other threatening behavior or communications with CPPM staff.
- My CPPM physician believes I have falsely stated my compliance with this agreement or that I am not complying with the terms of this agreement.
- I terminate this agreement at any time.
- If this agreement is terminated, the patient/physician relationship will end on the date I terminate the agreement, or the date stated in CPPM's notice of termination. CPPM's notice will provide me with a written explanation of why the discharge occurred, a list of referral resources to find a new physician, and instructions for transfer of records to a new physician. During the notice period, CPPM will provide emergency treatment for the condition then under treatment by CPPM.
- If I am discharged, I cannot and will not be treated by another physician associated with CPPM.

IF I REFUSE TO SIGN THE TREATMENT AGREEMENT, I UNDERSTAND THAT I WILL NOT BE TREATED WITH OPIOIDS FOR PAIN MANAGEMENT AT CYPRESS POINTE PAIN MANAGEMENT.

I, the undersigned, attest that I have been informed, fully understand, and have had the opportunity to ask any questions about my Pain Management Treatment Agreement. I agree to all of the conditions and requirements, and I understand that failure to comply with the Treatment Agreement, as outlined by my CPPM physician, indicates I no longer agree with it, which may result in my discharge from this practice.

Patient/Guardian Signature: _____ Date: _____

*If the patient is physically or legally unable to sign and a guardian signed in place of the patient, please list:

Guardian Full Name: _____ Relationship to Patient: _____

Physician Signatures: **Date: _____**

Mailing Address: 76 Starbrush Circle
Covington, LA 70443
Phone: (985) 892-8934
Fax: (985) 892-8937 - Covington
Fax #2: (985) 345-3379 - Hammond
www.cppain.com

CYPRESS POINTE
PAIN MANAGEMENT

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Full Name: _____ Date of Birth: _____ Phone #: _____

Authority to Release Protected Health Information

I hereby authorize _____, to **release** the information indicated below to:
(Doctor or Mid-Level Name)

Physician Office/Requesting Facility: _____ Provider: _____

Address: _____

Phone #: _____ Fax #: _____

Covering the Periods of Health Care

I authorize the release of the health records indicated below that cover the period of health care from (date) _____ to (date) _____.

Type of Information to be Released

☐ My complete health record, OR

☐ **Only** the following information:

☐ Diagnosis & treatment codes	☐ Discharge summary	☐ History & physical exam
☐ Consultation reports	☐ Progress Notes	☐ MRI reports
☐ X-ray reports	☐ CT reports	
☐ Other, specify: _____		

I understand that my health record may include information about mental health diagnosis or treatment; alcohol, drug, and/or controlled substance abuse, diagnosis, or treatment; or HIV/AIDS diagnosis or treatment. **Only initial one on each line below:**

I do _____ /do not ____ authorize the release of information pertaining to mental health.

I do _____ /do not ____ authorize the release of information pertaining to alcohol or drug abuse.

I do _____ /do not ____ authorize the release of information pertaining to HIV/AIDS.

Patient Initials:_____

Purpose of the Requested Disclosure

I am authorizing the release of my Protected Health Information for the following purposes:

☐Medical Care ☐Insurance ☐At the request of patient
☐Other (specify)_____

Time Period for this Authorization

This Authorization will expire on the following date, event or condition _____, or within one (1) year of the below date of this Authorization, whichever occurs first.

Revocation of This Authorization

I understand that I have the right to revoke this Authorization at any time to prohibit future release of my information. To revoke this Authorization, I must send written notice to Cypress Pointe Pain Management, to the attention of the office manager, at the address indicated above. I understand that my revocation of this Authorization applies to future disclosures only and will not have any effect on any disclosures of Protected Health Information made before receiving the revocation.

Redisclosure

I understand that my Protected Health Information disclosed pursuant to this Authorization may be redisclosed by the recipient identified above, and may no longer be protected from disclosure to others by federal or state law.

Waiver

I hereby expressly waive any claim of privilege or privacy with respect to the released information. I release and forever discharge Cypress Pointe Pain Management and its agents, servants, or employees from all liability or claims, of any kind or character, in any way arising out of the disclosure of the requested information, including disclosures made in good faith.

Voluntary

I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

Signature of Patient/Patient's Representative: **Date:**

_____ _____

Print Name of Patient's Representative: **Relationship to Patient:**

_____ _____

Patient Initials:_____