Follow-up Visit **Name**: **Date**:

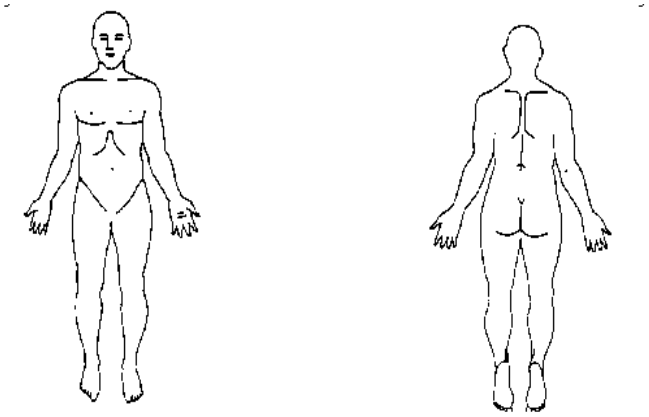
What is your main focus today? Medication refill Discuss Injections New Pain _____

Any new medications, allergies, medical conditions, or doctors? Please list below:

_____

_____

One the diagram, shade the areas where you feel pain. Put an "X" on the area that hurts the most.



Current level of pain 1 -10 (10 is worst) _____

- Describe your level of pain over the last week:

  Circle one: Improved Worse No change Resolved
- Describe the frequency of your pain:

  Circle one: Intermittent Constant Occasional Rare
- How would you describe your pain? Circle all those that apply.

  Ache Burning Dull Numb Sharp Shooting Stabbing Throbbing
- What makes your pain worse? Circle all those that apply.

  Movement Sitting Standing Walking Stress Other: _____
- What relieves your pain? Circle all those that apply.

  Exercise Heat Ice Injections Medication Physical Therapy Rest Sitting Other: _____

Please rate your pain by circling the **ONE** number that best describes your pain at its **worst** in the **last week.**

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst pain imaginable

Please rate your pain by circling the **ONE** number that best describes your pain at its **least** in the **last week.**

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst pain imaginable

Please rate your pain by circling the **ONE** number that best describes your pain on **average.**

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst pain imaginable

Please list and **NEW** medications, doses, and any side effects you are experiencing since your last visit:
(Note: If all medication information is the same, write NO CHANGES)

Name	Dose	Times Taken Per Day	Prescribing MD	Side Effects

Circle the number that describes how during the **past week, pain has interefere with your:**

A. General Activity:

0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes

B. Mood:

0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes

C. Walking ability:

0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes

D. Normal work:

0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes

E. Relations with other people:

0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes

F. Sleep:

0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes

G. Enjoyment of life:

0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes

WK RIVER CITIES INTERVENTIONAL PAIN SPECIALISTS

TREATMENT POLICY

If you are receiving narcotics from our office, please remember that you have signed a written agreement to follow certain safeguards. The purpose of the narcotic treatment agreement that you sign is to help us maintain a safe, controlled treatment plan for you. You must remember:

1. I agree not to receive any pain medications or narcotics from any other physician besides Dr. Brewer, Dr. Noles, or Dr. Germany. We monitor your pharmacy records periodically and if discovered that you have obtained narcotics from another provider, it will result in immediate discharge from the practice. NO EXCEPTIONS.
2. I agree to use to use the same pharmacy to fill prescriptions prescribed by Dr. Brewer, Dr. Noles or Dr. Germany.
3. I agree to take my medication exactly as instructed. I will not change dosage amounts or take more than I am prescribed without permission from a nurse or healthcare provider at Dr. Brewer's office.
4. If I ask for a medication change, I agree to bring my un-used medicine to my appointment to be wasted.
5. I agree to keep all regular follow-up appointments.
6. I agree to keep my medication in a safe location and understand that lost or stolen prescriptions will not be replaced.
7. I agree that I will not sell or give my medications to another individual.
8. I agree to and will comply with possible random drug screens and pill counts.
9. I understand that certain medications are "habit forming" or "addictive" and if I develop intense cravings, medication-induced "highs" or other psychic effects that I will immediately seek medical and psychiatric attention.
10. I will abstain from the use of any illegal substances.
11. I agree that my prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists and other professionals who provide your healthcare for purposes of maintaining accountability.
12. I agree to notify RCIPS before I undergo <u>ANY surgical treatment</u> for a condition that I am treated for by this office.
13. I understand that it is my responsibility to make sure that I have enough medication to make it through the weekend or after hours. Medication refills will not be called in or refilled by the doctor on call after hours or on weekends.
14. I understand that failure to comply with these terms and the terms of my opioid treatment agreement will result in discharge from care.

_____ _____

Patient Signature Witness Signature

_____

Date of Birth

WILLIS-KNIGHTON HEALTH SYSTEM

Clinic Patient Information Record

Patient Name/Last:	First:	Middle:	SSN:
Residence Address:	City:	State:	Zip:
Mailing Address: (Check here if same as above)☐			
Home Telephone Number:	Cell Phone Number:	Email Address:	
Date of Birth/Month: Day: Year:	☐ Male ☐ Female	Race:	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Employer's Name:	Work Telephone Number:		Ext:
Language: ☐English ☐ Spanish ☐ Other	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced		
Communication Needs			
Responsible Party: (check here if same as above)☐			
Name/Last: First:	Middle:	Responsible party's SSN:	Date of birth:
Mailing Address:	City:	State:	Zip:
Home Telephone Number:	Relationship to Patient:		
Employer's Name:	Work Telephone Number:		Ext:
Responsible Party's Spouse's Name (if applicable):	SSN:		
In Case of an Emergency, who may we notify (other than someone living with you)	Relationship to Patient:		
Name:	Telephone Number:		
Address: City:	State:	Zip:	
Who refferred you to our office?	Telephone Number:		
Insurance Coverage	Is your Illness/injury due to an Auto/Work Accident? Yes ☐ No ☐		
Insurance #1 Name of Insurance Company:			
Policy Number	Group Number:		
Employer:	Guarantor:		
Insurance # 2 Name of Insurance Company:			
Policy Number	Group Number:		
Employer:	Guarantor:		
Insurance # 3 Name of Insurance Company:			
Policy Number	Group Number:		
Employer:	Guarantor:		
Preferred Pharmacies:			

FS0005

WILLIS-KNIGHTON HEALTH SYSTEM

1. Hospital Care Consent: I/we consent to hospital services, treatment and diagnostic procedures by the hospital as may be deemed necessary or advisable by my physician and/or consultants selected by my physician. The consent to hospital care includes permission for x−ray examinations, laboratory procedures, I.V. treatments, hepatitis test administration of blood and blood products, injections, medications, recording, filming or video monitoring for internal purposes only, and hospital services rendered the patient under the general and special instruction of doctors. The patient acknowledges responsibility for any or all of these procedures. It is the hospital policy that the patient has the opportunity to discuss surgery and procedures with the patient's doctor before hand. The patient has the right to consent to surgery and procedures. Except in emergencies or unusual circumstances, the hospital does not allow its facilities to be used without this discussion and patient's consent. I voluntarily give my consent to hospital care and accept the condition of hospitalization listed.

2. Authorizations for Release of Information: The employees and agents of this hospital and copy services and electronic claims processing services under contract with this hospital and any third party billing agents for this hospital or any of its staff physicians involved with patient care are given permission to release any and all information relating to the patient, including but not limited to the medical record of the patient's hospitalization, to another healthcare provider if the patient was transferred to that facility from this hospital and to any and all insurance companies or other third−party paying or obligated to pay, in whole or in part, the charges incurred by the patient in this hospital; and they are also given permission to release the above described information to any agent or firm working for or with the above described insurance companies or other third−party payors for the purpose of performing pre−certification, concurrent and/or retrospective review and/or other utilization review of any kind.

3. Valuables: I understand and acknowledge that the hospital assumes no responsibility for personal possessions including cash, jewelry, bridgework, eyeglasses or any other personal possession which I choose to keep in my room. I have been advised that such valuables should be placed in the care of my family or deposited in the hospital vault located in the Business Office.

4. Safety Code for Hospital: Safety Codes for hospitals issued by the National Fire Protection Association prevent the use in the hospital of any electrical equipment or accessories until they have been safety checked by the hospital's electrical engineer. Exceptions to this rule are hair and blow dryers, curling irons, hot rollers, radios, clocks, electric razors, shavers, contact lens sterilizers, electric toothbrushes and calculators.

5. Payment Guaranty and Assignment of Insurance Benefits: I, the undersigned patient, guardian, and/or guarantor (hereinafter "Debtor") hereby promise to pay in full Willis−Knighton Health System (WKHS) customary charges for the goods and services rendered to the patient identified on the reverse side hereof during this period of hospitalization (hereinafter "Indebtedness''). Debtor acknowledges and agrees that, unless waived in full by WKHS as set forth below, the Indebtedness accruing during this hospitalization is due and payable in such amounts and at such times during this hospitalization as WKHS may, in its sole discretion, determine, that the entire Indebtedness is due and payable in full at discharge. I acknowledge that, upon proof of acceptable insurance coverage, WKHS, in its sole discretion, may reduce the amount of indebtedness due and payable during this hospitalizations and the balance due at discharge. In such event, I understand that all deductibles, co−insurance, non−covered charges and other items not paid by insurance or other third−party payors shall be due and payable during this period of hospitalization and upon discharge as set forth hereinabove. I acknowledge and agree that in the event that WKHS, in its sole discretion, accepts proof of insurance coverage, claims for payment for benefits will be filed on behalf of the Debtor and/or the insured and that these benefits will be considered by WKHS in determining the amounts due as set forth herein above. I understand and agree that WKHS will accept payments from third−party payors and insurers on behalf of the Debtor and apply such payment to the indebtedness to the extent that they are received. I acknowledge and agree that the filing of such insurance and other third−party claims is performed as a service by WKHS and in no way relieves me of the obligation to pay the Indebtedness as agreed herein above.

Patient hereby appoints WKMC as Patient's authorized representative to file any necessary claim appeal(s) on Patient's behalf. In consideration for this appointment. WKMC agrees only to collect only applicable copayments, deductibles, and coinsurance for covered benefits from the Patient and waives any right to collect any other payments related to those covered benefits from the Patient.

Debtor hereby absolutely assigns to WKHS all insurance benefits on all policies of insurance under which Debtor is an insured, whether hospital, medical, or liability insurance, and also hereby absolutely assigns to WKHS the proceeds of any judgment or settlement of any claim against any third party and any and all other amounts which may be determined in any manner to be payable to Debtor in connection with any injury suffered by patient which gives rise to the Indebtedness incurred during this period of hospitalization. I hereby authorize WKHS to obtain any information or copies of any accident reports or other documents with regard to such injuries and agree to cooperate with WKHS in connection with the procurement of any information or documents it deems in its sole discretion, necessary or appropriate in connection with the assignment made pursuant to this paragraph. I hereby authorize and direct that all such payments and proceeds shall be made directly to WKHS under the terms of this assignment. To the extent that WKHS receives such proceeds and/or payments, such receipt shall constitute payment of the Indebtedness, but shall not relieve Debtor of the obligation to pay when and as due that portion of the Indebtedness not satisfied by such proceeds and/or payments. I acknowledge and agree that, to the extent that the Indebtedness has not been satisfied by such payment, that portion of the Indebtedness for which payment has been deferred pursuant to the preceding paragraph shall be due and payable in full on the thirtieth day following the date of discharge. In the event that WKHS receives proceeds and/or payments in excess of the Indebtedness, WKHS may apply such excess payment to any outstanding Indebtedness of Debtor to WKHS arising out of any other period(s) of hospitalization and any attorneys' fees and expenses for which I may be liable.

hereunder. In the event that all Indebtedness has been paid in full, then WKHS will within ninety days of such receipt, refund to the Debtor any such excess payment. Notwithstanding anything herein to the contrary, the assignments made hereby shall remain in full force and effect until the entire Indebtedness and any and all attorneys' fees and expenses for which I may be liable for hereunder have been paid in full. In the event that the Indebtedness is not paid when and as due as determined by WKHS hereunder, and the Indebtedness is placed in the hands of an attorney for purposes of collection, Debtor agrees to pay reasonable attorneys' fees, which are hereby acknowledged to be one−third (1/3) of the amount of the Indebtedness at the time the matter is placed in the hands of an attorney, plus any and all court costs and other expenses incurred in connection with the collection of the Indebtedness. ©

Financial assistance is available to all patients who meet the requirements of our charity care policy. Patients are encouraged to contact the Business Office if they have any concerns or need assistance in paying their bills. Our charity care policy is limited to hospital charges and does not include physician, anesthesiologist or professional charges that are not billed by the hospital. In addition, financial assistance is not offered for cosmetic, elective, experimental or other treatments and all hospital services must be ordered by your physician.

6. Assignment to Physicians: I understand that my physician as well as other physicians who treat me or otherwise involved in my care while a patient at the hospital are not employees or agents of the hospital and the hospital is not responsible for their actions. I further understand that my physician or other physicians will send me a separate bill for their services, in addition to the hospital bill. I hereby assign to all physicians who treat me the benefits due to me for these services covering medical and/or surgical expenses. I agree that should be the amount be insufficient to cover the entire medical/surgical expense, I will be responsible to said physicians for payment of the entire bill.

7. Medicare Consent: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act (SSA) is correct. I authorize Willis−Knighton Health System (WKHS) to provide (SSA) or its intermediaries with access to my medical/hospital record for the purpose of processing the Medicare claim for this or a related Medicare claim. I further request that WKHS provide such copies thereof as may be requested. Copies may be made by WKHS or its agents or contractors providing copy service and electronic claims processing services and said third party billing agents for hospital and staff physicians involved with patient care.

8. Champus/Medicare Notice: Champus/Medicare will not pay for private rooms unless medical justified, personal convenience items, diagnostic admissions or test or hospital stays not medically necessary. My signature below acknowledges my receipt of this information regarding Champus/Medicare from the hospital on the date indicated.

9. Willis−Knighton Health System (and our Medical Staff) will use and disclose your personal health information to treat you, to receive payment for the care we provide and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website and have copies available for distribution. I acknowledge that I have received a copy of the Notice of Privacy Practices. This form has been fully explained to me. My signature reflects my understanding of the information contained herein. I further understand and acknowledge that all references to myself as the patient shall be deemed to apply as if rewritten in their entirety to a dependent for whom I am responsible for and/or who is unable to consent on their behalf for reasons indicated below.

I acknowledge that I have been informed of my rights and obligations as a patient.

Signature of Patient/Guardian	Date/Time	Guarantor	Date/Time	Witness	Date/Time

Print Name	Print Name	Print Name

If Patient/Guarantor is unable to sign, I, _____, do hereby state that I have been given the authority to sign for

_____, either expressed or implied and that he or she is fully aware of this authority.

Signature of Authorized Party	Authorized Party's Relationship to the Patient	Date/Time	Witness	Date/Time