NEW PATIENT PAIN FORM

PATIENT NAME: _____ DATE: _____

① ✱PAIN INTENSITY

Please place a mark on the line corresponding to your level of pain for ~ the last 1-2 weeks

✱NECK, SHOULDER, UPPER-BACK, UPPER EXTREMITY:

- *AVERAGE PAIN* — *no pain* |----------| *worst possible pain*
- *AT YOUR BEST* — *no pain* |----------| *worst possible pain*
- *AT YOUR WORST* — *no pain* |----------| *worst possible pain*

• *Do you experience arm-hand pain (upper extremity/UE - pain radiating below elbow)?* ☐ Yes ☐ No

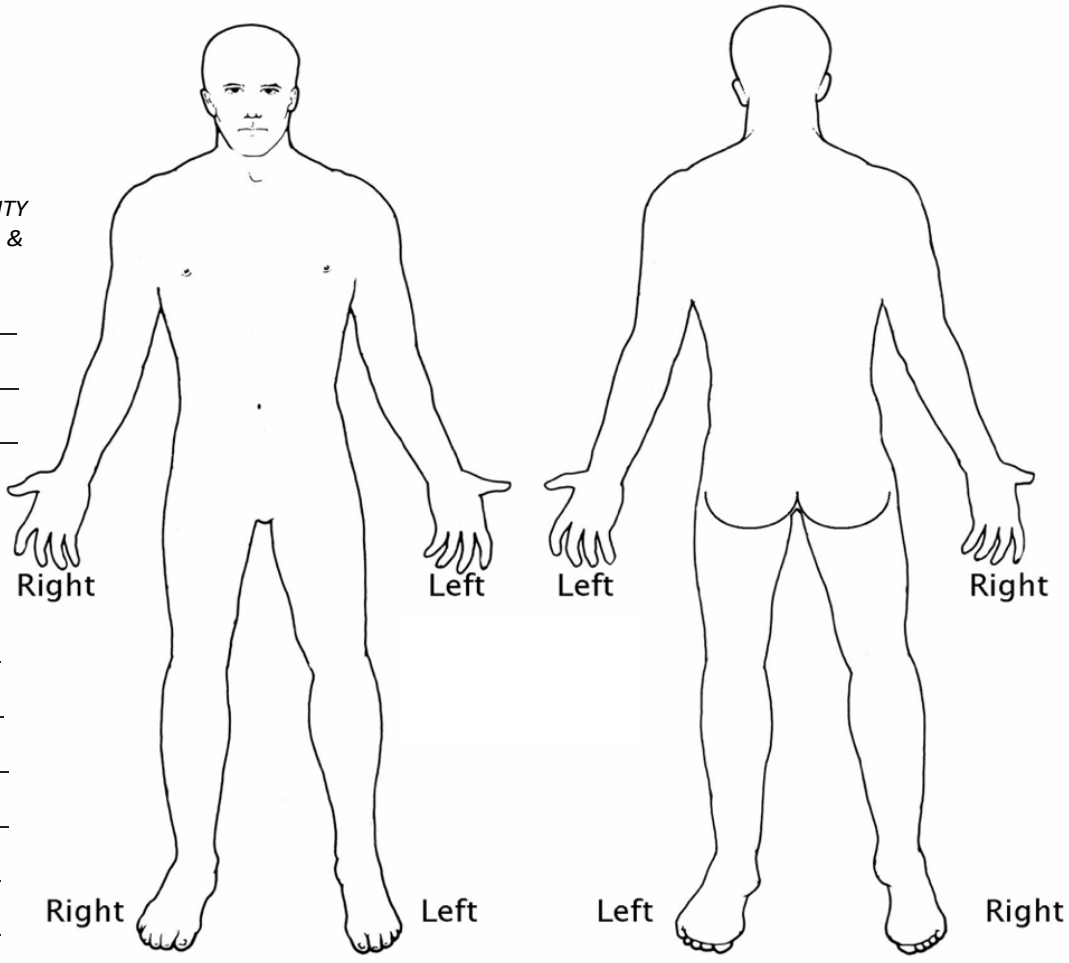
✱LOW-BACK, BUTTOCKS, MID-BACK, LOWER EXTREMITY:

- *AVERAGE PAIN* — *no pain* |----------| *worst possible pain*
- *AT YOUR BEST* — *no pain* |----------| *worst possible pain*
- *AT YOUR WORST* — *no pain* |----------| *worst possible pain*

• *Do you experience leg pain (pain radiating below knee)?* ☐ Yes ☐ No

② ✱PAIN LOCATION

To the right, please draw the location of your pain, including headache pain.



③ ✱PAIN DESCRIPTION

DESCRIBE: *•PATTERN (focus/spread) •QUALITY •DAILY TIMING •AGGRAVATING (worsening) & ALLEVIATING (improving) FACTORS, etc.*

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NEW PATIENT OSWESTRY FORM

- *PLEASE ANSWER THE FOLLOWING QUESTIONS:*

PAIN INTENSITY	❍ I have no pain at the moment ❍ The pain is mild at the moment ❍ The pain is moderate at the moment ❍ The pain is severe at the moment ❍ The pain is very severe at the moment ❍ The pain is the worse imaginable at the moment
PERSONAL CARE WASHING, DRESSING, ETC.	❍ I can look after myself normally without causing extra pain ❍ I can look after myself normally, but it causes extra pain ❍ It is painful to look after myself and I am slow and careful ❍ I need some help but can manage most of my personal care ❍ I need help every day in most aspects of self-care ❍ I do not get dressed. Wash with difficulty and stay in bed
LIFTING	❍ I can lift weight without extra pain ❍ I can lift weight, but it gives me extra pain ❍ Pain prevents me from lifting weights off floor, but can manage if conveniently placed, e.g. on a table ❍ Pain prevents me from lifting weights, but can manage light-medium weights if conveniently placed. ❍ I can only lift very light weights ❍ I cannot lift or carry any significant weight
WALKING	❍ Pain does not prevent me walking ❍ Pain prevents me from walking more than 1 mile ❍ Pain prevents me from walking more than 0.5 mile ❍ Pain prevents me from walking more than 0.25 mile ❍ I can only walk using a cane, a walker or crutches ❍ I am in bed most of the time
SITTING	❍ I can sit as long as I want without extra pain ❍ I can only sit in my favorite or certain chair as long as I like ❍ Pain prevents me from sitting more than 1 hour ❍ Pain prevents me from sitting more than 30 minutes ❍ Pain prevents me from sitting more than 10 minutes ❍ Pain prevents me from sitting at all
STANDING	❍ I can stand as long as I want without extra pain ❍ I can stand as long as I want, but it gives me extra pain ❍ Pain prevents me from standing for more than 1 hour ❍ Pain prevents me from standing for more than 30 minutes ❍ Pain prevents me from standing for more than 10 minutes ❍ Pain prevents me from standing at all
SLEEPING	❍ My sleep is not disturbed by pain ❍ My sleep is occasionally disturbed by pain ❍ Because of pain, I have less than 6 hours of sleep ❍ Because of pain, I have less than 4 hours of sleep ❍ Because of pain, I have less than 2 hours of sleep ❍ Pain prevents me from sleeping at all
SOCIAL LIFE	❍ My social life is normal and gives me no extra pain ❍ My social life is normal but can increase the degree of pain ❍ Pain limits my more energetic interests, e.g. sports, dancing, etc… ❍ Pain has restricted my social life and I do not go out as often ❍ Pain has restricted my social life to the point that I mostly stay home ❍ I have no real social life at this point, mostly due to pain
SEX LIFE	❍ My sex life is normal and causes no extra pain ❍ My sex life is normal, but causes some extra pain ❍ My sex life is nearly normal, but is painful ❍ My sex life is severely restricted by pain ❍ My sex life is nearly absent because of pain ❍ Pain prevents any sex life at all
TRAVELING	❍ I can travel without pain ❍ I can travel, but it can give me extra pain ❍ Traveling gives me pain, but I manage journeys up to two hours ❍ Pain restricts me to journeys of less than one hour ❍ Pain restricts me to short, necessary journeys under 30 minutes ❍ Pain prevents me from traveling any more than I have to.

DESCRIBE THREE THINGS THAT ARE IMPORTANT TO YOU THAT HAVE BEEN AFFECTED BY THE PAIN:

1. _____
2. _____
3. _____

INJURY SOLUTIONS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations within the parameters of the Notice of Privacy Practices.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices. Our Notice provides a description of our treatment, payment activities, healthcare operations, other uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read our Notice of Privacy Practices brochure carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting Injury Solutions:

Telephone: 720-282-4707
Email: Info@InjurySolutions.md
Mailing Address: 7350 E Progress Place Suite 201 Greenwood Village, CO 80111

Phone Contact: We may utilize phone numbers you have provided us to contact you as necessary. It is:
☐ Okay ☐ Not Okay to leave messages on my answering machine.
☐ Okay ☐ Not Okay to leave messages with any other person.

Name: _____

E-Mail Contact: We may utilize email addresses you have provided us to contact you as necessary. It is:
☐ Okay ☐ Not Okay to contact me via email _____

Fax Contact: We may utilize a fax number you have provided us to contact you as necessary. It is:
☐ Okay ☐ Not Okay to contact me via fax _____

Additions: Is there anyone else involved in your care, or payment of your care with whom we may share your information?
☐ Yes ☐ No

If Yes.: _____
Name: Phone:

Exclusions: Is there someone that you specifically DO NOT want us to share information with?
☐ Yes ☐ No

If Yes: _____
Name: Phone:

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact persons stated above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation. Please understand that we may decline to continue to treat you or to continue treating you if you revoke this consent.

I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent, I am giving my consent to use and disclose of my protected health information to carry out treatment, payment activities and health care operations.

☐ I have received a copy of the offices Notice of Privacy Practices.

☐ I decline a copy of the Notices of Privacy Practices.

Signature: _____ Date: _____

Revised 02.07.2022

INJURY SOLUTIONS

POLICY AND DISCLOSURE FOR NEW PATIENTS

Patient Name:_____ Date of Birth: _____

We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our policy that we require you to read and sign prior to any treatment.

INSURANCE

If you are a party injured in an accident, you may need to sign our Lien Agreement for payment. If you are not a lien patient, we will bill your insurance company directly if you have provided us with all the necessary information to do so. This will include your automobile Medpay policy. Your contract for insurance is between you and your insurance company. We are not a party to that contract. The services that you receive, and the bill is an agreement between you and Injury Solutions. It is ultimately your responsibility to see that your bill is paid in full. Agreements with insurance companies vary greatly and it is your responsibility to know what is their portion and what is yours. Any remaining money unpaid by your insurance company will be your responsibility to pay in a timely manner. You will be notified by mail of the balance due on your account, and you may request a statement of account if necessary. It will reflect what your insurance company, upon verification, told us is your portion to pay. This payment needs to be received within 15 days. In the event a check is returned for any reason, a minimum $25.00 charge will be added to your account.

Many insurance companies require a referral to a specialist prior to any appointment. It is your responsibility to ensure that this referral is obtained prior to all scheduled appointments. To obtain a referral you will need to contact your physician and request one. Failure to have a referral on file prior to your appointment may require payment in full at the time of service, or for the appointment to be rescheduled.

Regarding Insurance Plans where we are a participating provider: All co-pays and deductibles are due prior to treatment. If you do not pay your co-pay at the time of service, a $5.00 rebill charge will be added. In the event that your insurance coverage changes to a plan where we are not participating providers, you maintain your responsibility of payment for services. If you receive payment made out to both Injury Solutions and you, please endorse the check and forward to us. And if the insurance company sends a payment directly to you, please let us know at once to make arrangements to have that payment delivered to us so that your account can be properly credited.

Our practice is committed to providing the best treatment for our patients and our charges are the usual and customary for our area. You are responsible for payment regardless of any insurance company's interpretation of usual and customary rates. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurances.

PAYMENT FOR SERVICES

Payment is due in full at the time of service for those without insurance coverage or a signed Lien Agreement. On occasion, certain procedures may not be reimbursed by your insurance company. If it is expected that insurance will not cover a particular service, payment is due at the time of service and an Advanced Beneficiary Notice will need to be signed. In the unlikely event that your account is turned over for collections, those collection fees, plus court costs, reasonable attorney fees, and/or returned check fees are the responsibility of the adult person(s) named on the account. A $45 per form fee will be charged for completion of forms that you request. This must be paid in cash or check due when the form is picked up. Forms may include: Disability, Work forms, FLMA, other miscellaneous forms.

DISCLOSURE:

Dr. Allan has a small ownership interest in Cherry Hills Surgery Center. This is a Colorado licensed outpatient surgical center where Dr. Allan preforms many of his interventional pain management procedures.

NO SHOW & LATE CANCELLATION

Please be advised that you are expected to arrive 15 minutes prior to your appointment in order to allow for check in and completion of paperwork. If you arrive later than 15 minutes after your schedule appointment time, you might be asked to re-schedule.

If you are unable to attend, YOU MUST NOTIFY THE CLINIC AT LEAST ONE DAY IN ADVANCE and reschedule.

It is the policy of Injury Solutions to charge the patient the following fees if they have an appointment and do not call within 24 hours to cancel.

1st no show $50.00, 2nd no show $75.00, 3rd no show $100.00, Procedure no show $250. This fee is not payable by any insurance company, and remains the responsibility of the patient. This is due in full prior to your next appointment. You will be considered for termination from the practice once you have accumulated 3 no-show appointments. It is certainly our hope that it does not reach that point.

PRESCRIPTION REFILLS

It is our policy that prescription refill requests are responded to within 24-48 hours from the time of the request. Please understand prescription refills might not be authorized by the provider and refills will not be done after hours. Controlled substances are exempt from this policy.

CONSENT & DISCLOSURE

I voluntarily consent to treatment for myself and/or my dependent(s) with Injury Solutions and its associated medical groups.

I fully understand all of the above policies and agree to these terms and conditions by signing below.

Signature: _____ Date: _____

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INJURY SOLUTIONS

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

PATIENT	☑ RELEASE TO:
Name: _____	Name: INJURY SOLUTIONS
DOB: _____	Address: 7350 E. PROGRESS PLACE, SUITE 201
	GREENWOOD VILLAGE, CO 80234
	Phone 720-282-4707
	Fax: 303-539-7467
	Email: MEDICALRECORDS@INJURYSOLUTIONS.MD

I authorize Injury Solutions and its affiliated entities to receive or release to the party listed above the following information:

INFORMATION REQUESTED
- ☐ Complete health record
- ☐ Abstract
(i.e., Face-sheet, H&P, D/C Summary, Consults)
- ☐ Provider notes
- ☐ Procedure notes
- ☐ Psychotherapy Notes

☐ Other _____

PURPOSE FOR AUTHORIZATION
- ☐ At my request
- ☐ Continuity of Care

☐ Other (specify) _____

Please send medical records in electronic format only. Prior approval is needed for all charges relating to medical records requested.

I understand the following:

1. This authorization is voluntary and I can refuse to sign this authorization. My signature is required to validate this authorization. If I do not sign this form, my health care, the payment for my health care or my ability to enroll for benefits will not be affected.
2. This authorization will expire, without my express revocation, 365 days from the signing, or if I am a minor, on the date I become an adult according to law.
3. I may revoke this authorization in writing at any time, except to the extent that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
4. I understand that once the office discloses health information, the person or organization that receives it might re-disclose it. Privacy laws may no longer protect it.

_____ _____
Patient / Guardian / Power of Attorney Signature Date

_____ _____
Printed Name if signed on behalf of patient Relationship to patient

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