

UNIVERSITY PAIN CONSULTANTS New Patient Welcome Packet

Please bring your photo ID and insurance card. No checks accepted for co-pays.

Section A - Patient Information (complete once)

A1. Patient

First Name		Middle	Last Name		Date of Birth
Cell Phone		Home Phone		Email	
Street Address			City	State	ZIP
Sex	Social Security No. (optional)		Preferred Language		Race / Ethnicity (optional)
Emergency Contact - Name		Relationship		Phone	
Referring Physician	Phone		Primary Care Physician	Phone	

A2. Insurance

· No insurance · I am a cash patient *(if checked, skip to A3)*

Primary Insurance	Secondary Insurance
Carrier: _____ · HMO · PPO ID#: _____ Grp#: _____ If HMO, PCP: _____	Carrier: _____ · HMO · PPO ID#: _____ Grp#: _____ If HMO, PCP: _____

Complete only if the patient is NOT the policyholder:

Subscriber Name	Birthdate	Relationship to patient	Subscriber Phone
Employer Name	Employer Phone	Employer Address / City / State / ZIP	

A3. Accident / Injury / Legal (complete only if your pain is related to an accident, work injury, or claim)

Is this due to a motor vehicle accident? · No · Yes
 Is there any litigation involved with your pain? · No · Yes
 Is there a personal injury lawsuit? · No · Yes
 Is this a Worker-s Comp injury? · No · Yes
 Do you have an attorney for this claim? · No · Yes

A4. Social History

Marital status: · Single · Married · Separated · Divorced · Widowed · Other

Who do you live with?	Occupation	Employer
Highest level of education		

Tobacco: · Never · Current · Former How much / how long: _____

Alcohol: · No · Yes Type & how often: _____

Recreational / illegal drugs: · No · Yes Type & how often: _____

Section B · About Your Pain

Reason for visit (e.g., back pain, neck pain)	When did the pain start?
Was there an event or injury that caused it? If so, describe	

Describe the pain (check all that apply):

- Sharp · Dull · Aching · Burning · Electrical · Stabbing · Throbbing · Deep
- Cramping · Numb · Tingling · Pins & needles · Shooting · Lancinating · Swelling · Other:

How often do you have the pain?

- Rarely · Occasionally · Intermittently · Continuously

Average pain over the past week (circle): 0 1 2 3 4 5 6 7 8 9 10 (*0 = no pain, 10 = worst possible*)

What makes the pain WORSE? (check)	What makes the pain BETTER? (check)
<ul style="list-style-type: none"> · Sitting · Standing · Walking · Driving · Lifting · Lying down · Bending/twisting · Exercise · Weather changes Other: _____ 	<ul style="list-style-type: none"> · Sitting · Standing · Walking · Driving · Lifting · Lying down · Bending/twisting · Exercise · Weather changes Other: _____

B1. Treatment History

Previous pain physician (name, dates seen, and why you stopped):

Previous treatments · check any you have tried and whether it helped:

· Acupuncture Helped? · Y · N	· Epidural injections Helped? · Y · N
· Chiropractic Helped? · Y · N	· Facet injections Helped? · Y · N
· Physical therapy Helped? · Y · N	· Radiofrequency ablation Helped? · Y · N
· Psych / behavioral therapy Helped? · Y · N	· Spinal cord stimulator / pump Helped? · Y · N
· Cortisone (by mouth) Helped? · Y · N	· Surgery Helped? · Y · N
· Cortisone (injection) Helped? · Y · N	· TENS unit Helped? · Y · N
· Nerve blocks Helped? · Y · N	· Other Helped? · Y · N

B2. Medical History

Other medical problems (e.g., diabetes, heart disease, depression):

Surgeries you have had (and approximate year):

B3. Medications & Allergies

Medication allergies (medication · reaction):

Current medications you take specifically for pain. Note dose and how often:

Medication name	Dose & how often

Current NON-pain medications. Note dose and how often:

Medication name	Dose & how often

Pain medications you have tried before and stopped (name · reason stopped):

Do you take any blood thinners? · No · Warfarin · Plavix · Eliquis/Xarelto · Heparin · Aspirin · Other

B4. Review of Systems

Do you currently have problems in any of these areas? (check any that apply)

- Breathing / respiratory · Chest pain / shortness of breath · Digestive system · Kidney / urinary
- Mood / depression / anxiety · Bleeding / bruising easily · Numbness or weakness · None of the above

Please explain any boxes you checked:

Section C · Financial Agreement & Assignment of Benefits

I authorize University Pain Consultants· billing staff to file all claims for services rendered and direct my insurer/payor to pay benefits directly to the practice, up to the amount of my bill plus any legally allowed interest and penalties. I will receive a statement after my carrier processes the claim and agree to pay the balance in full within 30 days. For any balance of \$150 or more that I cannot pay in full, I will call the billing office at 951-784-7111 immediately upon receiving the statement. Failure to pay, or to arrange and follow a payment plan, may result in collection action · including follow-up calls, appeals, arbitration, or civil suit as allowed by law. If payment is made jointly or directly to me, I will ensure the provider receives all amounts due.

I am responsible for any balance due because of: co-insurance or co-pays, deductibles, no referral from primary, non-covered or out-of-network services, terminated coverage, exhausted auto benefits, denied Worker-s Comp, failure to respond to carrier correspondence or coordination-of-benefits inquiries, failure to provide current insurance, or no/inaccurate coverage.

No-shows or late cancellations = \$50 per failure to show or cancel.

My information may be released to other providers coordinating my care, to an adjuster or my employer for work or auto injuries, to an attorney in litigation, and to my insurer for audit and payment. Staff will verify my identity before releasing any information by phone. The office is not responsible for disclosures it makes at my request, and I hold the practice harmless for disclosures outside its control.

By my signature, I have read, understand, and agree to this Authorization and Release.

Signature (patient/guardian): _____ Print name: _____ Date: _____

Section D · Communication Preferences & Authorization to Release Health Information

How may we contact you? (appointment reminders are automated)

Home phone · voicemail: · Yes · No message with others: · Yes · No

Cell phone · voicemail: · Yes · No message with others: · Yes · No

Information sharing: · None at this time · Password-protect my account Password: _____

To allow us to speak with someone other than you (spouse, partner, child) about appointments, conditions, treatment, or financials:

Representative: _____ Relationship: _____ Phone: _____ POA on file · Yes · No

Release ALL information to that person EXCEPT (check any): · Appointments · Medication list · Conditions/diagnoses · Treatment/procedures · Financials · Drug/alcohol or behavioral health

This authorization is valid: · Single use only · One year from today · Until revoked in writing

I acknowledge that I have received and understand the Notice of Privacy Practices for University Pain Consultants and have completed the above of my own accord.

Signature (patient/guardian): _____ Print name: _____ Date: _____

Section E · Medical Records Release (complete only if transferring records)

Re-enter your name and date of birth so this page can be sent to another provider on its own.

Patient Name	Date of Birth	Date of Request
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Request type: · Account ledger · Claim copies · Medical records **Format:** · Electronic · Paper

To be used for: · Personal · Medical evaluation / treatment

Request information FROM	Send information TO
Provider / entity: _____ Address: _____ Phone: _____ Fax: _____	Provider / entity: _____ Address: _____ Phone: _____ Fax: _____

Scope of records · please send or retrieve:

- All records for the referral/treatment: notes, op reports, radiology (CT/X-ray/MRI), labs, insurance demographics
- All information and care received between _____ and _____
- Other (specify): · Notes · X-rays · MRI · CT · Labs · Operative reports

I have received a copy of my request in hardcopy form, in person.

Signature (patient/guardian): _____ Print name: _____ Date: _____

Section F · Opioid Medication Policy

University Pain Consultants is a comprehensive pain management clinic that uses many treatment approaches. If you currently take an opioid medication (e.g., morphine, oxycodone, hydrocodone, methadone, hydromorphone, fentanyl), our physicians will assess whether continuing it is appropriate.

Having an appointment with one of our doctors does NOT obligate them to continue prescribing these medications.

If your physician determines an opioid is appropriate, the following may be required first: (1) agreeing to our opioid contract; (2) a blood or urine drug screen if necessary; (3) allowing us to discuss your case with your prior providers; and (4) a psychological or psychiatric evaluation if necessary.

By signing below, I agree to and understand these terms.

Signature (patient/guardian): _____ Print name: _____ Date: _____