

A WYOMING PAIN CLINIC, PC

Mailing and Business Address

3100 West Lakeway Road, Ste 3

Gillette, WY 82718

Phone 307-696-2996

Welcome to A Wyoming Pain Clinic, PC. We are honored that you and your provider have chosen us to consult regarding your pain. Our goal is to provide the highest quality of care for all our patients in a timely and respectful manner.

We will do our best to provide you with information and care on your pain, both interventional and medication management. To best serve you we will need the following information for your appointment.

Prior to your appointment – **THIS NEEDS TO BE IN OFFICE TWO BUSINESS DAYS PRIOR TO YOUR APPOINTMENT**

- Any current radiology such as X-Rays, MRI's, CT's
- Any previous procedure notes from other providers related to the pain we will be seeing you for
- A completed CURRENT medication list
- A completed new patient packet to our office

Day of Appointment:

- Please come at least 15 minutes early to your appointment, late arrivals will be rescheduled
- Bring a photo ID such as your driver's license
- Bring your insurance card
- We do require all patients to perform a drug screen, please come with a full bladder
- Any coinsurance, co-pay or deductible must be paid prior to being seen by the physician

If we do not have your information for our records prior to your appointment we will reschedule the appointment for a later date.

If you need to cancel for any reason, please call at least 24 hours before your appointment time. If 24 hour notice is not given you will be charged \$50.00 for a no show fee that will need to be paid prior to rescheduling for another visit.

If you are being seen in Casper Clinic our office location is at 6600 East 2nd Street, "Medical Office Building"

Please do not send any correspondence to this address.

Your appointment date is _____ @ _____

A Wyoming Pain Clinic, PC
Powder River Pain Clinic Platte River Pain Clinic

Patient Legal Name _____
(First) (Middle) (Last)

Mailing Address _____
(Box or Street) (City) (State) (Zip)

Physical Address _____
(Street) (City) (State) (Zip)

Home Phone _____ Cellphone _____

Personal Email Address _____

Preferred method of Contact (please circle) Email Cellphone Can we leave a text message? Yes No Home Phone

Primary Language _____ Race _____

Social Security Number _____ Date of Birth _____

Marital Status _____ Referred By _____ Primary Care Physician _____

Name of Employer _____ Phone _____

Address of Employer _____
(Street) (City) (State) (Zip)

Name of Spouse/Parent _____

Spouse/Parent Employer _____

Spouse Social Security # _____ Date of Birth _____

Emergency Contact _____ Relationship _____

Home Phone _____ Cellphone _____

Primary Insurance

Name _____
Policy (ID) # _____
Group # _____
Cardholder Name _____
Date of Birth _____
Social Security # _____
Relationship to patient _____

Secondary Insurance

Name _____
Policy (ID) # _____
Group # _____
Cardholder Name _____
Date of Birth _____
Social Security # _____
Relationship to patient _____

Is this a work related injury? YES NO In what state did this occur? _____

Case # _____ Date of Injury _____

Covered Injury Site _____

All initial appointments are for a consultation only. Do not expect to receive any opioid pain medications or other controlled medications at your first visit. The physician will determine your care plan after evaluation.

TREATMENT AGREEMENT

Patient Name: _____ DOB: _____

A treatment agreement is established for both the safety of the patient and the safety of our staff. We require that the following guidelines be followed. Failure to comply with these guidelines may result in being discharged from A Wyoming Pain Clinic, PC.

I understand that the failure to follow the care plan recommended and ordered by the physician may result in a discharge from A Wyoming Pain Clinic PC.

I understand that any physical or verbal abuse of the staff will not be tolerated and will result in a discharge from A Wyoming Pain Clinic, PC.

I understand that failure to use the medications as they are prescribed, use of illicit substances or receiving prescriptions from other physicians (excluding emergency at night or on weekends) will result in our clinic no longer being able to write medications for me or may result in a discharge from A Wyoming Pain Clinic, PC.

I understand that any medication prescribed by A Wyoming Pain Clinic, PC need to be brought to **EVERY** appointment in the original bottles with the labels intact, even if they are empty. A Wyoming Pain Clinic, PC will not fill any prescriptions without the presence of the bottle and medication, if any left.

I understand that all opioid prescriptions require a 30 day follow up with the physician at A Wyoming Pain Clinic, PC. It is the patients' responsibility to schedule a follow up appointment prior to the prescription running out. Opioid prescriptions will **NOT** be refilled without an appointment. It is not uncommon that our physician is booked out for numerous weeks. Please plan ahead and make your appointments early.

I understand that if prescribed any opioids it is my responsibility to keep them safe, secure and out of the reach of children. If medication is lost or stolen, I understand it will not be replaced until my next scheduled appointment, and may not be replaced at all.

I understand that any refills on non-controlled substances must be called into your pharmacy or requested through the patient portal. Please allow three (3) business days to process your request.

NO REFILL REQUESTS WILL BE ACCEPTED ON FRIDAYS.

I understand that if an appointment is cancelled or missed an opioid prescription can't be refilled.

I understand that I will be charged \$50.00 for any no show appointments. This must be paid prior to any further appointments being scheduled.

I understand that I have to have a current appointment for any workers compensation forms or disability forms to be completed. A Wyoming Pain Clinic, PC is not able to complete all forms. This will be at the physician's discretion.

I understand that A Wyoming Pain Clinic, PC will not order or prescribe any durable medical equipment for patients.

Printed Name: _____

Signature: _____ Date: _____

FINANCIAL AGREEMENT

Patient Name: _____ DOB: _____

A Wyoming Pain Clinic, PC is dedicated to defining the standard of patient care through a commitment to excellence, innovation and learning. A Wyoming Pain Clinic, PC has a responsibility to operate in a financially prudent manner to allow us to continue our mission. This includes collecting amounts due prior to rendering services. Amounts due include personal obligations such as past due balances, co-pays, deductibles, coinsurance or any non-covered service. These amounts will be based on eligibility at the time of service and determined by the clinic.

I understand that it is my responsibility to know my insurance benefits and plan coverage. My insurance may or may not cover the services provided at A Wyoming Pain Clinic, PC. To obtain the most accurate information, please check with your insurance carrier to discuss the benefits provided by your medical plan prior to your visit to fully understand your anticipated out of pocket costs.

I understand it is my responsibility to obtain information from my insurance plan to verify that the physician I am seeing is in network with my insurance.

I understand that payment of past due balances, co-pays, coinsurance, deductibles or any non-covered services are to be paid at or before the time of service. I also understand that the fees discussed at that time are an estimate only and additional money may be due after insurance processing. A Wyoming Pain Clinic, PC accepts most forms of payments, please ask staff if you have any questions. You may also pay your bill using the online portal payment section.

I understand that any past due balances that are not paid within 30 days of service are subject to collections, which may include telephone calls, correspondence or contact from an outside collection agency. I also understand that no additional appointments will be made until account is current.

I understand that if I am unable to pay past due balance, co-pay, coinsurance or deductible at time of service my appointment or procedure will be rescheduled until such time that payment can be made.

I understand that any bounced checks will be subject to a \$35.00 fee and account will be placed on a cash basis only after fee and balance are paid.

I understand that I will cancel appointments 24 hours in advance on a scheduled appointment to prevent my account being charged a \$50.00 no show fee.

I acknowledge that I am responsible for all charges for services provided, including any amount not paid by my health insurance plan. I understand that A Wyoming Pain Clinic, PC will assist me in obtaining preauthorization for office visits or procedures, however, if authorization is not obtained I will be financially responsible for services rendered. I authorize A Wyoming Pain Clinic, PC to submit to my insurance any medical records necessary to obtain payment of claim. I also assign all benefits to be paid to A Wyoming Pain Clinic, PC.

Printed Name: _____

Signature: _____ Date: _____

Drug Screens

Patient Name: _____ DOB: _____

A Drug Screen is required for all New Patient visits including consultations. This will be performed in our office prior to seeing the physician. If a drug screen is refused by the patient, A Wyoming Pain Clinic, PC reserves the right to not see the patient.

Random drug screens are required for all continuing clinic patients, even if they are not on an opioid medication. A Wyoming Pain Clinic does perform these randomly in-house, which is usually sufficient in determining that a patient is compliant with the use of their medication and to monitor if a patient is utilizing other medications or drugs. However, if there are questions or unexpected results, A Wyoming Pain Clinic, PC reserves the right to send a specimen to an outside lab for verification. The financial responsibility for this test will be the patient's responsibility, either by self-pay or by insurance.

A random draw is performed monthly and the patient is required to come in to complete the drug screen. If a clinic patient has unexpected results or refuses the random drug screen, the physician may refuse to prescribe any further medications or discharge patient from the clinic. Verification of results may be sent out at physician's discretion or patient's request.

A drug screen is a covered expense by most insurance plans. However, some insurance plans specifically exclude this test. Please check your plan or call your insurance with any coverage questions regarding this test. Regardless of insurance a patient is required to participate and they are also responsible for the reimbursement of this test to A Wyoming Pain Clinic, PC.

I understand that if I have any questionable results or the physician needs verification on a result or upon my request, the sample will be sent to an outside laboratory. I also understand that my insurance will be billed for those services and that I will be responsible to pay the outstanding balance to an outside laboratory of A Wyoming Pain Clinic, PC's choosing.

I understand that if my insurance does not cover this service, I will be responsible for the full balance.

Printed Name: _____

Signature: _____ Date: _____

PRIVACY & DISCLOSURE ACKNOWLEDGEMENT

Patient Name: _____ DOB: _____

By signing below, I acknowledge that I have received the Notice of Privacy Practices of A Wyoming Pain Clinic, PC which explains its legal duties and privacy practices with respect to my protected health information.

I hereby agree that A Wyoming Pain Clinic, PC may disclose any and all of my protected health information to the following individuals, all of whom are involved in my care for any purpose related to my treatment or the payment of my care.

My preferred method of contact is _____

Physician and staff can leave a detailed message with protected health information Yes No

Name

Relationship

Name

Relationship

Name

Relationship

Printed Name: _____

Signature: _____ Date: _____

PORTAL INFORMATION

Due to the large volume of phone calls within a pain clinic we have introduced the patient portal to better access and communicate quickly with our staff. You can message the physician with prescription refill requests, questions or concerns, message the staff with appointment questions or to make an appointment or use to verify or update your information. Office visits are available within the portal for easy access of your records. Unfortunately at this time, procedures done at outside facilities are unavailable but we will update you as this changes. Our URL is www.awyomingpainclinic.com. Please contact staff if you have any questions or need help setting up this process.

Patient Name _____ Date of Birth _____

What pharmacy do you use? _____

Who is your primary care physician? _____

Do you have any allergies? Yes No Please list them and what reaction you have to them.

Medication allergy	Reaction	Medication allergy	Reaction

Have you ever had an allergic reaction to Iodine Contrast Latex Numbing Medication

Please list your current medication and doses that you currently take.

Medication	Dosage	Medication	Dosage
1		8	
2		9	
3		10	
4		11	
5		12	
6		13	
7		14	

Are you currently taking any of the following medications?

Coumadin/Warfarin Aspirin Plavix Aggrenox Ticlid Brilinta Xarelto Eliquis

FAMILY HISTORY

Do you have a family history of the following?

Alcohol abuse Yes No if yes, please indicate relationship to you _____

Illegal drug abuse Yes No if yes, please indicate relationship to you _____

RX drug abuse Yes No if yes, please indicate relationship to you _____

Diabetes Yes No if yes, please indicate relationship to you _____

Heart disease Yes No if yes, please indicate relationship to you _____

Hypertension Yes No if yes, please indicate relationship to you _____

Stroke Yes No if yes, please indicate relationship to you _____

Cancer Yes No if yes, please indicate relationship to you _____

What type of cancer? _____

Other _____

Do you have an advanced directive? Yes No

SOCIAL HISTORY

Smoking Status Former Never Current how much in a day? _____
Chewing tobacco Former Never Current how much in a day? _____
Alcohol intake Former Never Current how much in a day? _____
Caffeine intake Former Never Current how much in a day? _____
Illicit drug use Former Never Current type of drug? _____
Occupation Retired Disabled Currently working (type) _____
Do you currently live alone Yes No with others Yes No

SURGICAL/TREATMENT HISTORY

Type of Surgery	Year	Surgeon	City

Has you or a family member had a reaction to anesthesia? Yes No

Prior treatments (procedures) please only mark the type of treatment you had in the past, **otherwise leave blank**

Injections Better Worse No change

Type:

Epidural Steroid Injection

Medial Branch Blocks

Rhizotomy/ablations

Nerve Root Blocks

Physical therapy Better Worse No change

TENS Unit Better Worse No change

Heat/Ice Better Worse No change

Chiropractor Better Worse No change

Acupuncture Better Worse No change

Massage Better Worse No change

Psychology Better Worse No change

PAST PERSONAL MEDICAL HISTORY

AIDS/HIV Yes No Thyroid disease Yes No Preadolescent Sexual Abuse Yes No

Ulcers Yes No Hepatitis (a,b,c) Yes No Kidney/Liver Disease Yes No

Diabetes Yes No Anxiety disorder Yes No Attention Deficit Disorder Yes No

Bipolar Disorder Yes No Schizophrenia Yes No Obsessive Compulsive disorder Yes No

Depression Yes No Stroke Yes No Hypertension Yes No

Substance abuse Yes No Heart Disease Yes No Gout Yes No

Asthma Yes No COPD Yes No Cancer Yes No

Arthritis Yes No Fibromyalgia Yes No Headaches Yes No

Head Trauma/Injury Yes No

CURRENT PAIN

Which body part(s) are we seeing you for?

Neck Arm R L Shoulder R L
Back Leg R L Knee R L
Face/Head Hip R L Other_____

Was this from an accident or injury? Yes No

Please describe what happened:

Have you had any imaging in the last year for this pain? Yes No if yes, where? _____

How long have you had this pain? _____ Have you had this pain before? Yes No

How would you describe your pain?

Dull/Aching Sharp/Stabbing Throbbing Tightness Burning Electric Pressure
Other_____

What would you rate your pain at its **worst** in the last month?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst

What would you rate your pain at its **best** in the last month?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst

Please complete if you have Neck Pain

Looking down towards ground Worse Better No Effect
Looking up towards the ceiling Worse Better No Effect
Turning head left or right Worse Better No Effect
Working on computer/tv Worse Better No Effect
Coughing/Sneezing Worse Better No Effect
Driving Worse Better No Effect
Overhead activities (w/arms) Worse Better No Effect

Please complete if you have Back Pain

Bending forward Worse Better No Effect
Leaning Back Worse Better No Effect
Sitting Worse Better No Effect
Standing Worse Better No Effect
Walking Worse Better No Effect
Lying Flat Worse Better No Effect
Lying with knees bent Worse Better No Effect

What activities are most bothersome?_____

What helps the most to improve your pain?_____

How far can you walk before feeling like you need to rest?_____

ASSOCIATED SYMPTOMS

Do you have any of the following symptoms? And, if so, please describe

Numbness/tingling Yes No Where_____

Weakness in the arm or leg Yes No Describe_____

Muscle Spasms Yes No Where_____

Bladder/Bowel incontinence Yes No If yes, is this a change? Yes No

Joint Swelling or stiffness Yes No Which joints?_____

Sleep interrupted by pain Yes No

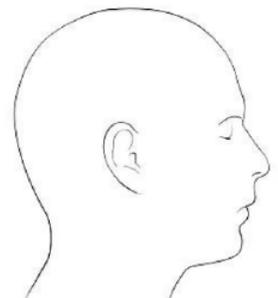
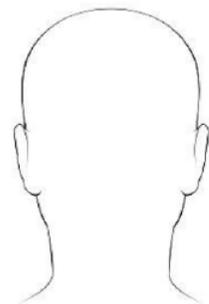
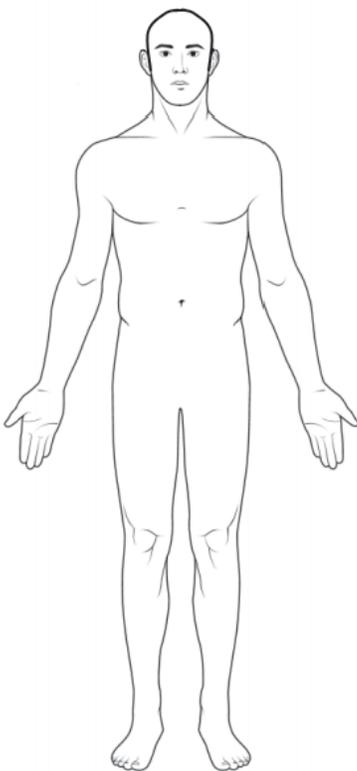
Headaches Yes No

Fever or chills Yes No

Activities or hobbies limited due to pain?_____

Using the appropriate symbol, mark the area(s) on your body where you feel each of the following

sensations	Numbness	Pins & Needles	Burning	Aching	Stabbing
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REVIEW OF SYSTEMS

General

- Loss of appetite Yes No
Recent weight loss/gain Yes No
Fever or chills Yes No

Respiratory

- Shortness of breath Yes No
Chronic cough Yes No

Kidney/Bladder/Urine

- Painful urination Yes No
Blood in urine Yes No
Kidney problems Yes No

Gastrointestinal

- Nausea or vomiting Yes No
Blood in stool Yes No
Heartburn Yes No
Constipation Yes No

Neurological

- Headaches Yes No
Seizures Yes No
Dizziness Yes No

Hematological/Lymphatic

- Easy bruising Yes No
Easy bleeding Yes No

Have we failed to ask anything that you believe is important for us to know? Yes No

Endocrine

- Thyroid disease Yes No
Heat/Cold intolerance Yes No

Cardiovascular

- Chest pain Yes No
Palpatations Yes No

Eyes

- Blurred Vision Yes No
Double vision Yes No
Loss of vision Yes No

Skin

- Frequent rashes Yes No
Skin ulcers Yes No
Lumps Yes No

Head/Ears/Nose/Throat

- Hoarseness Yes No
Trouble swallowing Yes No
Hearing loss Yes No

Psychiatric

- Depression Yes No
Drug/Alcohol addict Yes No
Suicidal thoughts Yes No

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient Name _____

Patient Signature _____ Date _____