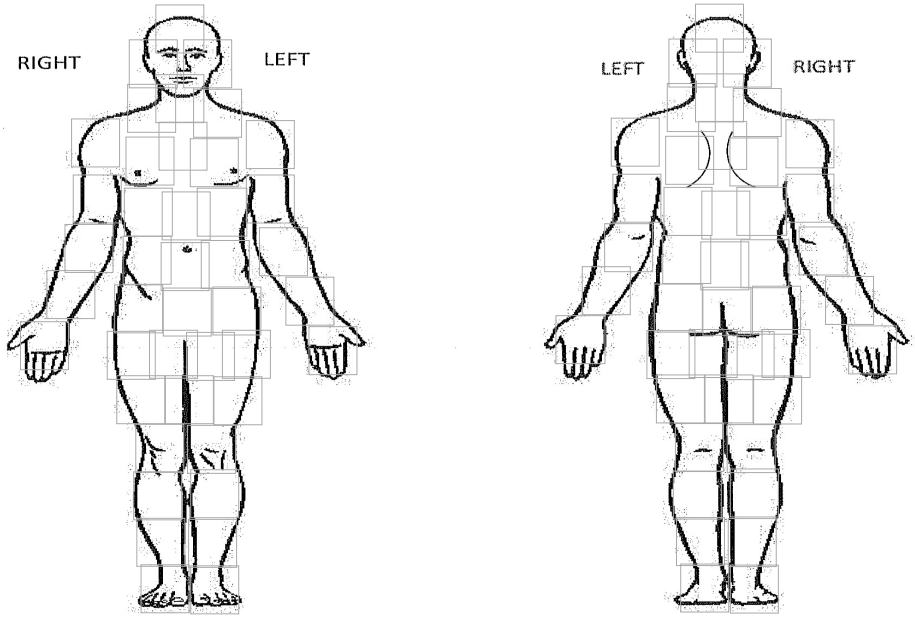
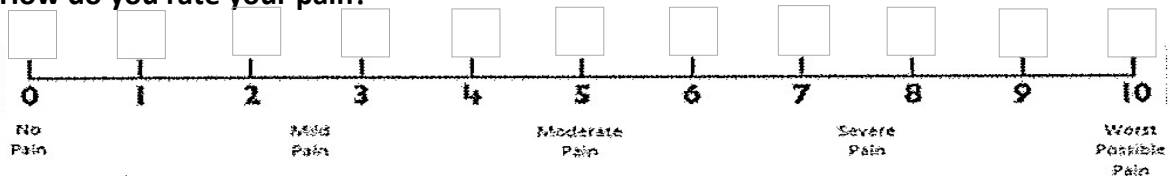
Patient Name:_____ Date: _____ DOB: _____

Please check the parts of the body where you have pain



How do you rate your pain?



Please (CHECK) your answers:

Describe your pain:
- Aching
- Burning
- Deep, Diffuse
- Discomforting
- Dull
- Electrical
- Localized
- Piercing, Sharp
- Shooting
- Stabbing
- Superficial
- Throbbing

Timing of your pain:
- Continuous and Constant
- Continuous, but variable intensities
- Intermittent
- Progressive
- Variable
- Daily

Do you have these symptoms:
- Numbness
- Tingling
- Weakness
- Pain with coughing or having a BM
- Loss of bowel or bladder control

Aggravated by:
- Any activity
- Stairs
- Daily activities
- Driving
- Exercise
- 1st steps in the morning
- Leaning back
- Leaning forward
- Physical activity
- Sitting
- Standing
- Walking

Relieved by:
- Brace
- Heat
- Ice
- Injections
- Leaning back
- Leaning forward
- Lying Down
- Medications
- Procedures
- Sitting
- Standing
- Walking

Have you had physical therapy? _____ How long did you participate?_____ Did it help?_____
Activities of Daily Living : Not affected or Unable to perform (Specify: _____)
Difficulty sleeping? Yes or No (If yes, is it because of pain? Yes or No)
Procedure _____ and _____% relief
Are you on blood thinners? Yes or No **(if yes, list: _____)**
Are you currently working? Yes or No **Is your blood pressure controlled?** Yes or No

Patient Name:_____ Date: _____ DOB: _____

OSWESTRY DISABILITY INDEX

This questionnaire is designed to give us information as to how your pain affects your ability to manage in everyday life. Please answer ***every*** *section*. Check ***one box only in each section*** that most closely describes you ***today*.**

Section 1 – Pain Intensity

☐ I have no pain at the moment.

☐ The pain is very mild at the moment.

☐ The pain is moderate at the moment.

☐ The pain is fairly severe at the moment.

☐ The pain is very severe at the moment.

☐ The pain is the worst imaginable at the moment.

Section 2 – Personal Care (washing, dressing, etc.)

☐ I can look after myself normally without causing extra pain.

☐ I can look after myself normally but it is very painful.

☐ It is painful to look after myself and I am slow and careful.

☐ I need some help but 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.

Section 3 – Lifting

☐ I can lift heavy weights without extra pain.

☐ I can lift heavy weights but it gives extra pain.

☐ Pain prevents me from lifting heavy weights off the floor but I can manage if conveniently positioned (i.e. on a table).

☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if conveniently positioned.

☐ I can lift only very light weights.

☐ I cannot lift or carry anything at all.

Section 4 – Walking

☐ Pain does not prevent me walking any distance.

☐ Pain prevents me walking more than one mile.

☐ Pain prevents me walking more than 100 yards.

☐ I can only walk using a cane, crutches or walker.

☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

☐ I can sit in any chair as long as I like.

☐ I can sit in my favorite chair as long as I like.

☐ Pain prevents me from sitting more than 1 hour.

☐ Pain prevents me from sitting for more than half an hour.

☐ Pain prevents me from sitting for more than 10 minutes.

☐ Pain prevents me from sitting at all.

Section 6 – 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 I hour.

☐ Pain prevents me from standing more than half an hour.

☐ Pain prevents me from standing more than 10 minutes.

☐ Pain prevents me from standing at all.

Section 7 – Sleeping

☐ My sleep is never 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.

Section 8 – Sex Life (if applicable)

☐ 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 very 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.

Section 9 – Social Life

☐ My social life is normal and causes me no extra pain.

☐ My social life is normal but increases the degree of pain.

☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. sports, etc.

☐ Pain has restricted my social life and I do not go out as often.

☐ Pain has restricted my social life to home.

☐ I have no social life because of pain.

Section 10 – Traveling

☐ I can travel anywhere without pain.

☐ I can travel anywhere but it gives extra pain.

☐ Pain is bad but I manage journeys over 2 hours

☐ Pain restricts me to journeys of less than 1 hour.

☐ Pain restricts me to short journeys under 30 minutes

☐ Pain prevents me from traveling except to receive treatment.

REVIEW OF SYSTEMS

Patient Name: _____ **Date:** _____ **DOB:** _____

Are you CURRENTLY experiencing any of the following symptoms

Constitutional:

o No	o Yes	Fever
o No	o Yes	Weight Gain
o No	o Yes	Weight Loss
o No	o Yes	Other:_____

Head, Eyes, Ears, Nose & Throat:

o No	o Yes	Ear Drainage
o No	o Yes	Nasal Drainage
o No	o Yes	Sinus Pressure
o No	o Yes	Sore Throat
o No	o Yes	Other:_____

Respiratory:

o No	o Yes	Chronic Cough
o No	o Yes	Cough
o No	o Yes	Known TB Exposure
o No	o Yes	Shortness of Breath
o No	o Yes	Wheezing
o No	o Yes	Other:_____

Cardiovascular:

o No	o Yes	Chest Pain
o No	o Yes	Swelling
o No	o Yes	Palpitations
o No	o Yes	Other:_____

Gastrointestinal:

o No	o Yes	Constipation
o No	o Yes	Diarrhea
o No	o Yes	Nausea
o No	o Yes	Vomiting
o No	o Yes	Other:_____

Genitourinary:

o No	o Yes	Painful Urination
o No	o Yes	Blood in Urine
o No	o Yes	Urinary Retention
o No	o Yes	Other:_____

Reproductive:

o No	o Yes	Erectile Dysfunction
o No	o Yes	Other:_____

Integumentary:

o No	o Yes	Brittle Hair
o No	o Yes	Brittle Nails
o No	o Yes	Hair Loss
o No	o Yes	Itching
o No	o Yes	Rash
o No	o Yes	Other:_____

Neurological:

o No	o Yes	Dizziness
o No	o Yes	Extremity Numbness
o No	o Yes	Extremity Weakness
o No	o Yes	Trouble Walking
o No	o Yes	Headache
o No	o Yes	Memory Loss
o No	o Yes	Seizures
o No	o Yes	Tremors
o No	o Yes	Other:_____

Psychiatric:

o No	o Yes	Anxiety
o No	o Yes	Depression
o No	o Yes	Insomnia
o No	o Yes	Other:_____

Musculoskeletal:

o No	o Yes	Back Pain
o No	o Yes	Joint Pain
o No	o Yes	Joint Swelling
o No	o Yes	Muscle Weakness
o No	o Yes	Neck Pain
o No	o Yes	Other:_____

Hematologic/Lymphatic:

o No	o Yes	Easy Bleeding
o No	o Yes	Easy Bruising
o No	o Yes	Other:_____

Southern Pain AND Neurological

Paul J. Hubbell, III, MD
Donald E. Richardson, MD
Melanie Mire, PA-C
Brooke Vincent, PA-C

Southern Pain AND Anesthesia Consultants, LLC

OPIOID SAFETY SURVEY

Because there is an addiction risk with opioid medicines, we must understand your history before we set a treatment plan for you. Please circle "Yes" or "No" in the chart below as the case applies to you today or in the past.

PATIENT NAME: _____ DOB: _____

DATE: _____ (M / F)

Circle YES or NO for each question		
Do YOU have a history of substance abuse of any of the following?		
Alcohol	YES	NO
Illegal Drugs	YES	NO
Prescription Drugs	YES	NO
Do you have a FAMILY history of substance abuse of any of the following?		
Alcohol	YES	NO
Illegal Drugs	YES	NO
Prescription Drugs	YES	NO
Are you between 16-45 years old?	YES	NO
Were you sexually abused as a child?	YES	NO
Have you ever been diagnosed with any of the following mental health conditions?		
ADD, OCD, bipolar, schizophrenia	YES	NO
Depression	YES	NO

Southern Pain and Neurological

Were you exposed to anyone with a positive COVID 19 test? Yes ☐ No ☐

Have you been tested for COVID 19? Yes ☐ No ☐

When were you tested? _____

Did you test positive? Yes ☐ No ☐

If positive, have you had a negative test recorded? Yes ☐ No ☐

Do you have any symptoms today? Yes ☐ No ☐

Have you previously had any symptoms? Yes ☐ No ☐

Symptoms: Cough ☐ Shortness of breath or difficulty breathing ☐

Chills ☐ Muscle Pain ☐ Headaches ☐

Sore Throat ☐ NEW loss of taste or smell ☐

Fever: When _____ Temp _____

Any other symptoms, please list:

Today's Temp: _____ Date: _____

Patient Name: _____ DOB: _____

Patient Signature:_____

7/28/2020

Southern Pain AND Neurological

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504-887-7207 (Phone) 504-889-1868 (Fax)
1200 Pinnacle Pkwy, Suite 7, Covington, LA 70433
985-643-4144 (Phone) 985-643-3603 (Fax)
1849 Barataria Blvd, Suite B, Marrero, LA 70072
504-887-7207 (Phone) 504-889-1868 (Fax)

PAIN ASSESSMENT TOOL

Today's Date_____

Name_____ **Gender** _____

Date of Birth_____ **Age**_____ **Height** _____ **Weight** _____

Referring Physician_____

Pain Problem / Reason for medical visit _____

_____

Goals for Therapy _____

PAIN QUALITY

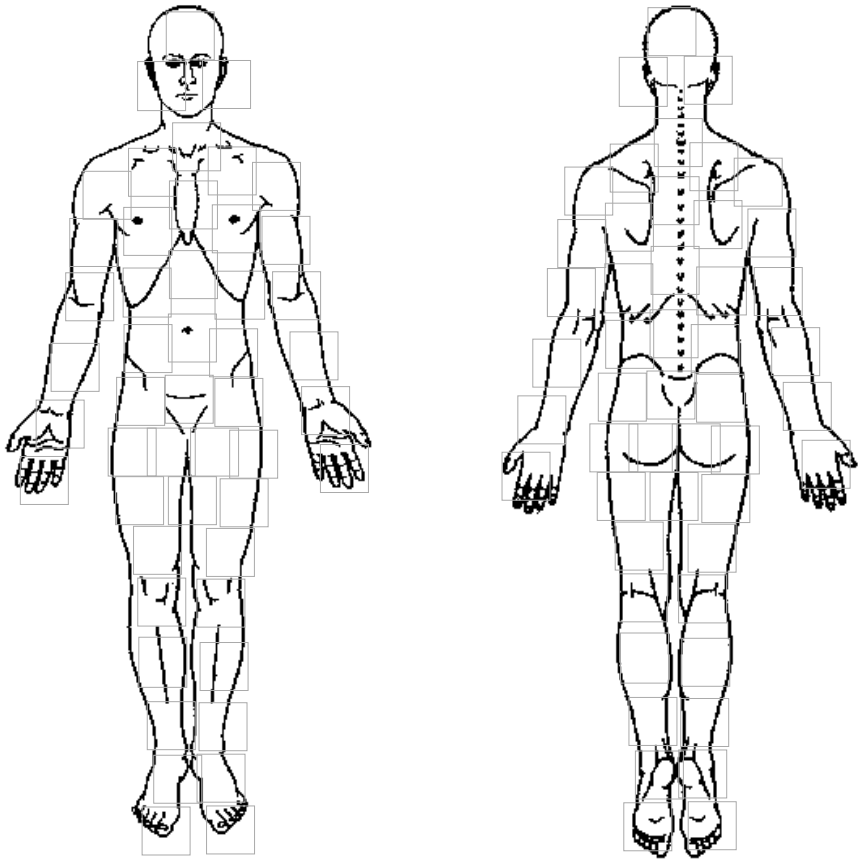
Please describe your pain by

CHECKING

all that apply

- ☐ Aching
- ☐ Burning
- ☐ Deep
- ☐ Diffuse
- ☐ Discomforting
- ☐ Dull
- ☐ Electrical
- ☐ Localized
- ☐ Piercing
- ☐ Sharp
- ☐ Shooting
- ☐ Stabbing
- ☐ Superficial
- ☐ Throbbing

CHECK the exact location(s) of your pain on the following diagram



Onset of pain was (Please check one) □ Sudden □ Gradual □ Unsure

Approximate date of onset: _____

Did any of the following cause your pain? (Check all that apply)

□ Change in Medication
□ Direct Impact
□ Fall
□ Increased Activity
□ Lifting an Object
□ Twisting Motion
□ Medical Procedure/Surgery
□ Motor Vehicle Accident
□ Multiple Causes
□ New Medication
□ Repetitive Motion
□ Other _____
□ Skin Rash
□ Injury
□ Illness
□ Pregnancy
□ Unknown

Timing of pain (Please check ONE)

□ Intermittent
□ Inconsistent
□ Variable
□ Continuous but of variable intensity

Frequency of pain (Please check ONE)

□ Daily
□ Several times per week
□ Weekly
□ Monthly

Status of pain (Please check ONE)

□ Unchanged
□ Fluctuating
□ Improving
□ Better
□ Stable
□ Other _____
□ Worse
□ Resolved

Severity of pain (Please check ONE)

□ Mild
□ Mild/Moderate
□ Moderate
□ Moderate/Severe
□ Severe

Pain symptoms are AGGRAVATED by (Please check all that apply)

□ Daily Activities
□ Driving
□ Emotional Stress
□ First Steps While Awake
□ Kneeling
□ Leaning Back
□ Leaning Forward
□ Lifting
□ Lying Down
□ Movement
□ No Specific Activity
□ Physical Activity
□ Physical Therapy
□ Pulling
□ Pushing
□ Rotation
□ Sitting
□ Squatting
□ Standing
□ Walking
□ Weather Changes
□ Work Activity
□ Other _____

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

Pain symptoms are RELIEVED by (Please check all that apply)

□ Brace	□ Massage	□ Soaks
□ Elevation	□ No Specific Activity	□ Splint
□ Exercise	□ NSAIDs	□ Standing
□ Heat	□ OTC Medication	□ Stretching
□ Ice	□ Pain Medicine	□ Urination
□ Injections	□ Physical Activity	□ Walking
□ Leaning Back	□ Physical Therapy	□ Work Activity
□ Leaning Forward	□ Rest	□ Other _____
□ Lying Down	□Sitting	

What is your current sleep pattern? (Please check ONE)

□ Normal □ Abnormal-Insomnia □ Abnormal-Pain disturbs sleep

How are you dealing with the pain? _____

_____

When did you first see a medical professional regarding your pain? _____

_____

Who have you seen regarding your pain? _____

_____

Have you had any of the following tests? (Check all that apply)

X-rays	Date _____	Where_____
EMG/NCV	Date _____	Where_____
MRI Scan	Date _____	Where_____
Myelogram	Date _____	Where_____
Bone Scan	Date _____	Where_____
CT scan	Date _____	Where_____

Have you tried any of the following to improve your pain problem?

Trigger Point Injection	Date _____	□ Helpful	□ Not Helpful
Physical Therapy	Date _____	□ Helpful	□ Not Helpful
Acupuncture/Acupressure	Date _____	□ Helpful	□ Not Helpful
Psychological Treatment	Date _____	□ Helpful	□ Not Helpful
TENS Unit	Date _____	□ Helpful	□ Not Helpful
Epidural Steroid Injection	Date _____	□ Helpful	□ Not Helpful
Radiofrequency/Rhizotomy	Date _____	□ Helpful	□ Not Helpful
Spinal Cord Stimulation	Date _____	□ Helpful	□ Not Helpful
Chiropractic Treatment	Date _____	□ Helpful	□ Not Helpful
Pain Pump Implant	Date _____	□ Helpful	□ Not Helpful
Facet/Medial Branch Block	Date _____	□ Helpful	□ Not Helpful
Other _____	Date _____	□ Helpful	□ Not Helpful

Patient Name: _____ Date of Birth: _____

Have you ever been diagnosed with any of the following? (Check all that apply)

□ Alzheimer's disease
□ Anemia
□ Angina (Chest Pain)
□ Arthritis
□ Asthma
□ Cancer (See Below)
□ Congestive Heart Failure
□ COPD
□ Coronary Artery Disease
□ Crohn's Disease
□ Deep Venous Thrombosis
□ Degenerative Joint
□ Disease
□ Depression
□ Diabetes
□ Drug Abuse
□ Fibromyalgia
□ Fracture
□ Gout
□ Headache, migraine
□ Hepatitis/Liver Disease
□ High Cholesterol
□ Hypertension
□ Inflammatory Bowel Disease
□ Lyme disease
□ Lupus
□ Heart Attack
□ Obesity
□ Osteoporosis
□ Parkinson's disease
□ Peptic Ulcer Disease
□ Psoriasis
□ Renal Disease
□ Scoliosis
□ Seizure Disorder
□ Sleep Apnea
□ Spinal Stenosis
□ Stroke
□ Thyroid Disease
Other_____
_____

Cancer: Type / Year Diagnosed _____ (Radiation/Chemo)

SURGICAL HISTORY

Procedure	Approximate Date	Surgeon
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY

What is your highest level of education? _____
Marital Status (Please check ONE)
□ Married □ Divorced □ Widowed □ Separated □ Single
Do you have any children? □ Yes (how many _____) □ No
Do you use illicit drugs? □ Yes □ No
If yes, please explain _____
Do you drink alcohol? □ Yes □ No □ Formerly
What type of alcohol? _____
How many glasses? _____ Per: □ Day □ Week □ Month
Age started _____ Age Stopped _____

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

Do you use tobacco? □ Yes □ No □ Formerly

Type of tobacco □ Cigarette How many packs? _____ per: □ Day □ Week □ Month
□ Cigar How many? _____ per: □ Day □ Week □ Month
□ Pipe How many? _____ per: □ Day □ Week □ Month
□ E-Cigarette How many? _____ per: □ Day □ Week □ Month

Do you consume caffeine? □ Yes □ No □ Formerly

What type? □ Coffee □ Tea □ Soda □ Energy Drinks
How many glasses? _____ per: □ Day □ Week □ Month
Age Started _____ Age Stopped _____

OCCUPATION/WORK STATUS

What is your current occupation? _____

What is your current work status? (Please check ONE)

□ Full Time □ Part Time □ Disabled
□ Unemployed □ Retired □ Other _____
Retirement/Disability Date _____

Is your pain related to a worker's compensation claim/injury? □ Yes □ No

If yes, date of injury _____
If yes, current work status □ Not working □ Working w/ restrictions
□ Working without restrictions
If you are a **TriWest** patient, is this a service related injury? □ Yes □ No

Are you currently involved in litigation? (Is a lawyer involved because of the injury?)

□ Yes □ No

Attorney Name _____
Attorney Address _____
Phone _____ Fax _____

FAMILY HISTORY

To the best of your knowledge, did either parent suffer from any of the following?

	Mother	Father		Mother	Father
High Blood Pressure	□	□	ADD/ADHD	□	□
Mental Illness	□	□	Alcoholism	□	□
Muscle Disease	□	□	Drug Abuse	□	□
Osteoporosis	□	□	Arthritis	□	□
Parkinson's disease	□	□	Coronary Artery Disease	□	□
Stroke	□	□	Depression	□	□
Cancer	□	□	Diabetes	□	□

Type of Cancer _____

Patient Name: _____ Date of Birth: _____

PROVIDER LIST

Please list all of your treating physicians

	Physician	Phone Number
Cardiologist		
PCP/Internist		
Pulmonologist		
Endocrinologist		
Oncologist		
Neurosurgeon		
Orthopedist		
Other		
Other		
Other		

PREFERRED FACILITIES:

If you have a facility preference, please list below.

	Preferred Facility Name	Phone Number
Imaging (MRIs, CTs)		
Physical Therapy		
Labwork		

Patient: _____ Date: _____ Date of Birth: _____

Revised 04/21

CURRENT MEDICATIONS AND ALLERGIES

Please list ***ALL*** of the medications you are ***CURRENTLY TAKING***. This includes both medication for pain and all other medications taken. This information is important so we know your medication history and also can detect possible medication interactions. Please make sure to also include over the counter and herbal medications/supplements.

Medication Name	**Strength/ Dose**	**Directions**	**Reason for taking**
ex: Lisinopril	*10mg*	*1 tablet my mouth once daily*	*High Blood Pressure*

ALLERGIES

Allergen	***Reaction***
ex. Tape (Adhesive)	*Rash*

Patient Name: _____ Date of Birth: _____

Check **ALL** medications you have taken to try to improve your pain

Circle "Y" if it was helpful Circle "N" if it was NOT helpful

Anti-Inflammatory Meds			*Antidepressant/anti-anxiety*			*Pain Medication*		
Tylenol (acetaminophen)	Y	N	Elavil (amitriptyline)	Y	N	Lortab	Y	N
Aleve (naprosyn)	Y	N	Doxepin (sinequan)	Y	N	Lorcet	Y	N
Daypro (oxaprozin)	Y	N	Pamelor (nortriptyline)	Y	N	Vicodin	Y	N
Feldene (piroxicam)	Y	N	Effexor (venlafaxine)	Y	N	Norco	Y	N
Lodine (Etodolac)	Y	N	Paxil (paroxetine)	Y	N	Percocet	Y	N
Voltaren	Y	N	Prozac (fluoxetine)	Y	N	Percodan	Y	N
Ansaid	Y	N	Zoloft (sertraline)	Y	N	oxycodone	Y	N
Relafen (nabumetone)	Y	N	Seroquel	Y	N	Roxicodone	Y	N
Arthrotec	Y	N	Buspar (buspirone)	Y	N	hydrocodone	Y	N
Celebrex	Y	N	Celexa (citalopram)	Y	N	tramadol	Y	N
Mobic (meloxicam)	Y	N	Lexapro (escitalopram)	Y	N	Tylenol #3	Y	N
Advil (ibuprofen)	Y	N	Wellbutrin (bupropion)	Y	N	Tylox	Y	N
Motrin	Y	N	Cymbalta (duloxetine)	Y	N	Darvocet (propoxyphene)	Y	N
Oruvail (ketoprofen)	Y	N	Remeron (mirtazapine)	Y	N	Demerol	Y	N
Clinoril (sulindac)	Y	N	Trazodone (desyrel)	Y	N	Morphine	Y	N
aspirin	Y	N	Fetzima	Y	N	OxyContin	Y	N
Dolobid	Y	N	Pristiq	Y	N	MS Contin	Y	N
Salsalate	Y	N	Klonopin	Y	N	MSIR	Y	N
diclofenac	Y	N	***Nerve Pain Medication***			Duragesic (fentanyl)	Y	N
Toradol (ketorolac)	Y	N	Neurontin (gabapentin)	Y	N	Dilaudid	Y	N
Luvox	Y	N	Topamax (topiramate)	Y	N	Kadian	Y	N
Migraine Medication			Gabitril	Y	N	Avinza	Y	N
Imitrex	Y	N	Zonegran	Y	N	Methadone	Y	N
Axert	Y	N	Lamictal (lamotrigine)	Y	N	Xodol	Y	N
Relpax	Y	N	Tegretol	Y	N	Tylenol #4	Y	N
Amerge	Y	N	Dilantin	Y	N	Actiq	Y	N
Maxalt	Y	N	Lyrica (pregabalin)	Y	N	Ultracet	Y	N
Zomig	Y	N	Horizant	Y	N	Ultram	Y	N
Cafergot	Y	N	Gralise	Y	N	Opana	Y	N
Midrin	Y	N	***Muscle Relaxers***			Fioricet	Y	N
Depakote (valproic acid)	Y	N	Soma (carisoprodol)	Y	N	Fiorinal	Y	N
Topamax	Y	N	Robaxin (methocarbamol)	Y	N	Talacen	Y	N
Sleep Aids			Flexeril (cyclobenzaprine)	Y	N	Vicoprofen	Y	N
Ambien (zolpidem)	Y	N	Skelaxin (metaxalone)	Y	N	codeine	Y	N
Sonata	Y	N	Zanaflex (tizanidine)	Y	N	Butrans	Y	N
Lunesta	Y	N	baclofen (Lioresal)	Y	N	Exalgo	Y	N
Rozeram	Y	N	Dantrium (dantrolene)	Y	N	Hysingla	Y	N
Chloral hydrate	Y	N	Parafon Forte (chlorzoxazone)	Y	N	Nucynta	Y	N
Restoril (temazepam)	Y	N	Norflex (orphenadrine)	Y	N	Zohydro	Y	N
Ativan	Y	N	Valium (diazepam)	Y	N	Suboxone	Y	N
Doxepin	Y	N	Quinine	Y	N	Xtampza	Y	N
Vistaril	Y	N	***Benzodiazepine Meds***					
Halcion	Y	N	Ativan (lorazepam)	Y	N			
			Valium (diazepam)	Y	N			
			Xanax (alprazolam	Y	N			

Name:_____ Date:_____ Date of Birth:_____

SOUTHERN PAIN & NEUROLOGICAL

REGISTRATION FORM
(Please Print)

Today's date:	Race:	Ethnicity:
Referring Physician :	PCP:	

PATIENT INFORMATION

Last Name:	Firs Name:	Middle:	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Social security number:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street Address:	City:	State:	Zip Code:

Cell Phone Number: ( )	Home Number: ( )	Email Address:

Occupation:	Employer:	Employer phone no.: ( )

LIST PERSON WE MAY SPEAK WITH REGARDING YOUR HEALTH

Named Person:	Relationship to patient:	Birth date: / /	Phone number: ( )

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Please indicate primary insurance ❑ Commercial ❑ Medicare ❑ Workmans Comp ❑ Attorney

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Named Person:	Relationship to patient:	Date of Birth: / /	Phone number: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature ***Date***

NOTICE OF PRIVACY PRACTICES
(MEDICAL)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical exam.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 15, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new Notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Southern Pain & Anesthesia Consultants, LLC
Paul J. Hubbell, III, M.D.
2701 Lake Villa Dr. Ste. A
Metairie, La 70002

For more information about HIPAA or to file a complaint:

The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202)619-0257
(877)696-6775

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Southern Pain & Anesthesia Consultants, LLC
Paul J. Hubbell, III, M.D.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address listed above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: _____

Initials: _____

Reason: _____

Patient: _____ Date: _____ Date of Birth: _____

Chapter 69. Prescription, Dispensation and Administration of Medications
Subchapter B. Medications Used in Treatment of Non-Cancer-Related Chronic or Intractable Pain
§6915. Scope of Subchapter
A. The rules of this Subchapter govern physician responsibility for providing effective and safe pain control for patients with noncancer-related chronic or intractable pain.
AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(A)(1), 1270(B)(6) and 1285(B).
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners LR 23:727 (June 1997), amended LR 26:693 (April 2000)
A. As used in this Subchapter, unless the content clearly states otherwise, the following terms and phrases shall have the meanings specified.
Board- the Louisiana State Board of Medical Examiners.
Chronic Pain- pain which persists beyond the usual course of a disease, beyond the expected time for healing from bodily trauma, or pain associated with a long term-incurable or intractable medical illness or disease.
Controlled Substance- any substance defined, enumerated, or included in federal or state statute or regulations 21 C.F.R. §1308. 11-15 or R.S. 40:964, or any substance which may hereafter be designated as a controlled substance by amendment or supplementation of such regulations and statute.
Diversion- the conveyance of a controlled substance to a person other than the person to whom the drug was prescribed or dispensed by a physician.
Intractable Pain- a chronic pain state in which the cause of the pain cannot be eliminated or successfully treated without the use of controlled substance therapy and, which in the generally accepted course of medical practice, no cure of the cause of pain is possible or no cure has been achieved after reasonable efforts have been attempted and documented in the patient's medical record.
Noncancer-Related Pain- that pain which is not directly related to symptomatic cancer.
Physical Dependence- the physiological state of neuroadaptation to controlled substance which is characterized by the emergence of a withdrawal syndrome if the controlled substance use is stopped or decreased abruptly, or if an antagonist is administered. Withdrawal may be relieved by re-administration of the controlled substance.
Physician- physicians and surgeons licensed by the Board.
Protracted Basis- utilization of any controlled substance for the treatment of noncancer-related chronic or intractable pain for a period in excess of 12 weeks during any 12-month period.
Substance Abuse **(may also be referred to by the term *Addiction*)-**a compulsive disorder in which an individual becomes preoccupied with obtaining and using a substance, despite adverse social, psychological, and/or physical consequences, the continued use of which results in a decreased quality of life. The development of controlled substance tolerance or physical dependence does not equate with substance abuse or addiction.
Tolerance- refers to the physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect, or a reduced effect is observed with a constant dose. Controlled substance tolerance refers to the need to increase the dose of the drug to achieve the same level of analgesia. Controlled substance tolerance may or may not be evident during controlled substance treatment.
§6919. General Conditions/Prohibitions
A. The treatment of noncancer-related chronic or intractable pain with controlled substances constitutes legitimate medical therapy when provided in the course of professional medical practice and when fully documented in the patient's medical record. A physician duly authorized to practice medicine in Louisiana and to prescribe controlled substances in this state shall not, however, prescribe, dispense, administer, supply, sell, give, or otherwise use for the purpose of treating such pain, any controlled substance unless done in strict compliance with applicable state and federal laws and the rules enumerated in this Subchapter.
AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(A)(1), 37:1270(B)(6) and 37:1285(B).
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners LR 23:727 (June 1997), amended LR 26:694 (April 2000)
§6921. Use of Controlled Substances, Limitations
A. Requisite Prior Conditions. In utilizing any controlled substance for the treatment of noncancer-related chronic or intractable pain on a protracted basis, a physician shall comply with the following rules.
1. Evaluation of the Patient. Evaluation of the patient shall initially include relevant medical, pain, alcohol and substance abuse histories, an assessment of the impact of pain on the patient's physical and psychological functions, a review of previous diagnostic studies, previously utilized therapies, an assessment of coexisting illnesses, diseases, or conditions, and an appropriate physical examination.

2. Medical Diagnosis. A medical diagnosis shall be established and fully documented in the patient's medical record, which indicates not only the presence of noncancer-related chronic or intractable pain, but also the nature of the underlying disease and pain mechanism if such are determinable.

3. Treatment Plan. An individualized treatment plan shall be formulated and documented in the patient's medical record which includes medical justification for controlled substance therapy. Such plan shall include documentation that other medically reasonable alternative treatments for relief of the patient's noncancer-related chronic or intractable pain have been considered or attempted without adequate or reasonable success. Such plan shall specify the intended role of controlled substance therapy within the overall plan, which therapy shall be tailored to the individual medical needs of each patient.

4. Informed Consent. A physician shall ensure that the patient and/or his guardian is informed of the benefits and risks of controlled substance therapy. Discussions of risks and benefits should be noted in some format in the patient's record.

B. Controlled Substance Therapy. Upon completion and satisfaction of the conditions prescribed in §6921. A, and upon a physician's judgment that the prescription, dispensation, or administration of a controlled substance is medically warranted, a physician shall adhere to the following rules.

1. Assessment of Treatment Efficacy and Monitoring. Patients shall be seen by the physician at appropriate intervals, not to exceed 12 weeks, to assess the efficacy of treatment, assure that controlled substance therapy remains indicated, and evaluate the patient's progress toward treatment objectives and any adverse drug effects. Exceptions to this interval shall be adequately documented in the patient's record. During each visit, attention shall be given to the possibility of decreased function or quality of life as a result of controlled substance treatment. Indications of substance abuse or diversion should also be evaluated. At each visit, the physician should seek evidence of under treatment of pain.**2.** Drug Screen. If a physician reasonably believes that the patient is suffering from substance abuse or that he is diverting controlled substances, the physician shall obtain a drug screen on the patient. It is within the physician's discretion to decide the nature of the screen and which type of drug(s) to be screened.

2. Drug Screen. If a physician reasonably believes that the patient is suffering from substance abuse or that he is diverting controlled substances, the physician shall obtain a drug screen on the patient. It is within the physician's discretion to decide the nature of the screen and which type of drug(s) to be screened.

3. Responsibility for Treatment. A single physician shall take primary responsibility for the controlled substance therapy employed by him in the treatment of a patient's noncancer-related chronic or intractable pain.

4. Consultation. The physician should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those pain patients who are at risk for misusing their medications and those whose living arrangements pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder may require extra care, monitoring, documentation, and consultation with or referral to an expert in the management of such patients.

5. Medications Employed. A physician shall document in the patient's medical record the medical necessity for the use of more than one type or schedule of controlled substance employed in the management of a patient's noncancer-related chronic or intractable pain.

6. Treatment Records. A physician shall document and maintain in the patient's medical record, accurate and complete records of history, physical and other examinations and evaluations, consultations, laboratory and diagnostic reports, treatment plans and objectives, controlled substance and other medication therapy, informed consents, periodic assessments, and reviews and the results of all other attempts at analgesia which he has employed alternative to controlled substance therapy.

7. Documentation of Controlled Substance Therapy. At a minimum, a physician shall document in the patient's medical record the date, quantity, dosage, route, frequency of administration, the number of controlled substance refills authorized, as well as the frequency of visits to obtain refills.

C. Termination of Controlled Substance Therapy. Evidence or behavioral indications of substance abuse or diversion of controlled substances shall be followed by tapering and discontinuation of controlled substance therapy. Such therapy shall be reinitiated only after referral to and written concurrence of the medical necessity of continued controlled substance therapy by an addiction medicine specialist, a pain management specialist, a psychiatrist, or other substance abuse specialist based upon his physical examination of the patient and a review of the referring physician's medical record of the patient.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(A)(1), 37:1270(B)(6), and 37:1285(B).
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:727 (June 1997), amended LR 26:694 (April 2000)

§6923. Effect of Violation

A. Any violation of or failure of compliance with the provisions of this Subchapter, §§6915-6923, shall be deemed a violation of R.S. 37: 1285.A(6) and (14), providing cause for the board to suspend or revoke, refuse to issue, or impose probationary or other restrictions on any license held or applied for by a physician to practice medicine in the state of Louisiana culpable of such violation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(A)(1), 37:1270(B)(6), and 37:1285(B).
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 23:728 (June 1997), amended LR 26:695 (April 2000)

I have read and understand this document. A signed copy of this document has been given to me.

_____ _____

Patient Signature **Date**

_____ _____

Witness Signature **Date**

Patient: _____ Date: _____ Date of Birth: _____

SOUTHERN PAIN and NEUROLOGICAL

CONTROLLED SUBSTANCE AGREEMENT

I understand that in order to receive any controlled substances from Southern Pain and Neurological I must comply with the following terms and conditions:

If any of the physicians associated with Southern Pain and Neurological prescribe a controlled substance, included but not limited to tramadol, Lyrica or any other pain medications, I can no longer accept prescriptions of controlled substances for pain from any other physician. I am responsible for my medications and early refills will not be issued because of theft, loss or misuse of my medications. I will not take medication that was not prescribed to me and I will not sell or trade my medications. I will follow all directions given to me, by the physician or the pharmacy, as it pertains to the safe use of the medications I am given. I will take my medications as prescribed and if I feel that a change needs to be made I will contact the office for instructions. I understand that random blood or urine drug tests may be performed, without prior notification, to ensure compliance with medications and to screen for any illegal drug use. Evidence of medication misuse, illegal drug use or refusal to submit for the blood or urine drug testing will result in discontinuation of medications and a psychological evaluation by a pain psychologist. If requested, I will bring my medications to the office for a pill count. I will be courteous and respectful to the office staff.

I understand that if I fail to comply with this agreement it may result in termination of my relationship with Southern Pain and Neurological.

I agree to the above terms and conditions and I will receive a copy of this agreement for my records once it is signed.

_____

Patient Date

_____

Witness Date

I decline the above agreement and understand that I will not be able to receive any controlled substances from Southern Pain and Neurological until this agreement is accepted and signed, but I can still receive treatment by way of interventional procedures.

_____

Patient Date

_____

Witness Date

OFFICE USE ONLY

Copy Given to Patient Initials: _____ Date: _____

Patient: _____ Date: _____ Date of Birth: _____

SOUTHERN PAIN and NEUROLOGICAL

MEDICATION/PHARMACY AGREEMENT

This agreement applies to prescriptions for ANY medications

Primary Pharmacy: Name: _____

Address: _____

Phone #: _____

Secondary Pharmacy: Name: _____

Address: _____

Phone #: _____

If you choose to change your pharmacy please notify the office as soon as possible.

PRESCRIPTION REFILL PHONE # 1-800-419-0462

Prescriptions will only be refilled Monday – Thursday from 8am – 4pm. Prescriptions will not be refilled after hours, or on Friday, Saturday, Sunday and holidays. Calls for refills will be taken Monday – Friday from 8am – 4pm. **Please call one week (7 days) in advance for your refill.** Failure to call one week (7 days) in advance for your refill may result in a delay in receiving your prescription. ALL prescriptions will be sent directly to your pharmacy through escribe software. **Please call your PHARMACY to assess if the prescription is ready for pickup.** The pharmacy will allow you to pick up the medication when it is due to start taking the medication.

_____

Patient Date

_____

Witness Date

Office Use Only

Copy Given to Patient Initials: _____ Date: _____