INNOVATIVE
PAIN & SPINE SPECIALISTS

7121 Stephanie Lane, Suite 102
Lincoln, NE 68516

Phone: 402.413.5010
Fax: 402.413.5009
Web: innovativepainlincoln.com

Important Information About Your Visit

Even though we at Innovative Pain and Spine Specialists are committed to compassionate care, we must exercise proper due diligence when prescribing opioid analgesics for chronic pain. Prescription drug abuse has reached epidemic proportions in our society. Therefore, our clinic policy is that an appropriate workup must be completed prior to the dispensing of an opioid prescription. This workup will include review of previous pharmacy/clinic records, evaluation by diagnostic and laboratory tests, and acceptable completion of a urine drug screen yielding expected results. Common examples of opioid analgesics include hydrocodone, morphine, oxycodone, fentanyl, and methadone. Prescriptions for these medications will not be given at an initial visit.

- Please bring your driver's license and insurance cards along with your completed new patient paper work to your scheduled appointment. Payment for services are expected at the time of service (co-pays, co-insurance, private pay). We accept cash, check, money order, and credit cards (Visa, American Express, MasterCard, and Discover).

- If you have been instructed to obtain imaging reports and/or films by our staff, please bring them to your appointment. Our office requires these as part of your consultation. If we do not have your films at the time of your appointment, you may be rescheduled.

- Your initial visit at Innovative Pain and Spine Specialists is a consultation. If a doctor referred you for an injection, you must be seen for an office visit first. Procedures are scheduled after the initial consultation.

- If English is your second language, please make arrangements for someone to accompany you to your visit who can translate in order to provide you with the best healthcare service. We want you to fully understand your diagnosis and prognosis, and have any questions you may have answered.

We wish to make your visit as comfortable as possible, so please do not hesitate to contact us if you have any questions at the number listed above.

MEDICATION CONTRACT

The following outline is medication contract between the patient and the Innovative Pain and Spine Specialists (IPSS) concerning the usage of opioid analgesics. Examples of opioid analgesics include hydrocodone, oxycodone, fentanyl, and morphine. Opioid analgesics may not completely relieve pain symptoms. If the physicians of IPSS feel that you are not responding to the therapy by showing substantial improvement in function, your medications will be tapered. The following statements are relevant concerning opioid analgesics:

1. There are risks associated with chronic opioid therapy including but not limited to constipation, itching, addiction, physical dependence, sexual dysfunction, nausea, vomiting, and drowsiness, and overdose, resulting in death.

2. IPSS recommends that **ALL** patients on chronic opioids not participate in the operating of motor vehicles or machinery. If the patient chooses to engage in these activities, IPSS bears no responsibility for the outcome of such events.

3. The patient will use only **ONE PHARMACY** and will notify us with the name of the chosen pharmacy.

4. Unannounced urine drug screenings will happen during the course of treatment and you are expected to comply. Positive results of illicit drugs, excessive alcohol or negative results of prescribed drug may result in termination from the clinic. If unable to provide us a urine sample, we have salivary test kits available.

5. Additionally, random pill counts may be requested. This would require that you to bring in your pill bottles within 24 hours of notification by the clinic to monitor for compliance.

6. In addition, opioid analgesics will **NOT** be prescribed on your initial visit because an acceptable urine screen and review of pharmacy records must occur prior to starting these medications.

7. Our clinic must be notified **THREE BUSINESS DAYS** prior to anticipated refill date.

8. You will only call **once** per refill request.

9. Lost or stolen medications **WILL NOT** be replaced for **ANY REASON** including partial refills. In addition, refills will not be given for any reason after hours or on weekends.

10. Early refills will only be given if authorized by physician and may require a follow up visit prior to refill.

11. Patients will not seek opioid analgesic from any other physicians for treatment of their chronic condition. This policy in no way prevents a patient from seeking acute care for acute problems. If patients receive opioids for an acute pain condition from another provider, they must notify our clinic who prescribed them, what they prescribed, how many they prescribed, and the reason.

12. If you are coming in for an early office visit, you will need to bring all unused opioids to your appointment.

13. By signing this contract, you are giving your medical provider permission to speak to family or members of your household about your medication usage and activity if the provider has reason to believe that medications are not being used appropriately or are not working.

The patient acknowledges that he/she has read this contract and agrees to abide by its regulations.

____ **Patient Signature**

____________________ Date

____ **Witness (IPSS Employee)**

CLINIC POLICIES

INITIAL EACH to indicate agreement:

____________ Payment is due at the time services are rendered. I understand that if I have insurance that I am the responsible party, and that having insurance does not guarantee payment of the services rendered to me. I authorize submission of my claim to my insurance.

____________ If you are unable to make an appointment, please call 24 hours prior to your appointment time to reschedule. If you fail to notify our office prior to missing your scheduled appointment, you will be charged a NO SHOW fee of $25 for an office visit and $50 for a procedure. *Frequent NO SHOWS may result in a release from the practice.

____________ Permission for treatment: I hereby authorize physician and assistants for the care of the patient named on this record to administer treatment as may be deemed necessary including examinations of treatments that may be ordered to be performed by the clinical personnel. I acknowledge that no guarantees have been made to me to the result of examinations or treatments to be performed.

Acknowledgement of Review of Notice of Privacy Practices (HIPAA)

I have reviewed this office's notice of privacy practices (located at the front desk), which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____

Patient Signature

____________________ Date

____

Witness (IPSS Employee)

NEW PATIENT INFORMATION

NAME: ______________________________ DATE OF BIRTH: ________________ GENDER: _________

ADDRESS: ____

CITY: ____________________________ STATE: _______________________ ZIP: _________________

HOME PHONE: _______________ CELL PHONE: ________________ WORK PHONE: _______________

SSN: ________________________________

ETHNICITY: HISPANIC/LATINO: _____ NON-HISPANIC/LATINO: _____

PREFERRED LANGUAGE/DIALECT: _______________________

RACE: AMERICAN INDIAN: ______ ASIAN: ______ BLACK OR AFRICAN AMERICAN: ______

NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER: ______ WHITE: ______ OTHER: ______

Highest Level of Education: ________________________ OCCUPATION: _________________________

EMAIL: ____________________________________ MARRIED: __ WIDOWED: __ SINGLE: __ DIVORCED: __

PREFERRED METHOD OF COMMUNICATION? HOME PHONE: ____ CELL PHONE: ____ WORK PHONE: ____ E-MAIL: ____

REFERRING PHYSICIAN: _____________________ PRIMARY CARE PHYSICIAN: ____________________

OTHER PHYSICIANS: ____

PHARMACY/LOCATION: ____

EMERGENCY CONTACT: _________________________________ RELATIONSHIP: __________________

EMERGENCY PHONE: _________________________________ PHONE TYPE: _____________________

Please provide the front desk with an I.D. and all insurance, work compensation, car accident, or attorney information.

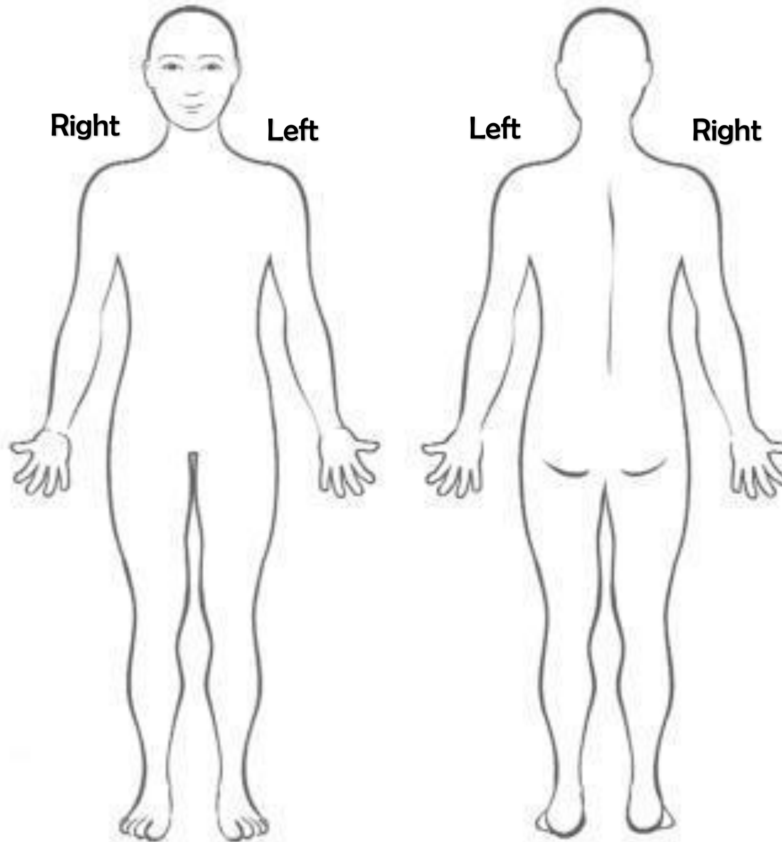
Please list the name of any person(s) you wish to have access to your medical information, including portal access:

Name: _________________________________ Relationship: ______________________

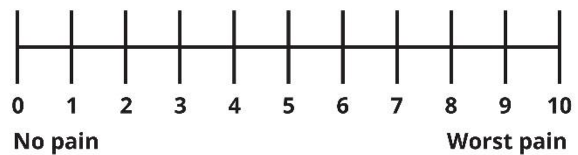
Name: _________________________________ Relationship: ______________________

Name: _________________________________ Relationship: ______________________

Location of Pain (circle the area of pain) **Initials: __________**



Rate your pain



On a scale of 0 to 10 (0= no pain and 10= severe pain) how bad is your pain *today*?

Circle the pain characteristics that you are experiencing:

Numbness Pins & Needles Burning Aching Stabbing

Constant Intermittent Deep Superficial

Over the past 30 days, what was your average pain score? _____________

About Your Health

Initials: ___________

In the past few months, have you had any of the following symptoms or difficulties? If you have any difficulty that bears further explanation, please indicate so and explain in the additional notes section.

GENERAL:
- [ ] Loss of Appetite
- [ ] Fever
- [ ] Chills
- [ ] Recent Weight Loss
- [ ] Low Energy/Fatigue

EYES:
- [ ] Blurred Vision
- [ ] Loss of Vision
- [ ] Double Vision
- [ ] Eye Pain

HEAD/EARS/NOSE/THROAT:
- [ ] Hoarseness
- [ ] Trouble Swallowing
- [ ] Hearing Loss
- [ ] Ear Pain

CARDIOVASCULAR:
- [ ] Chest Pain
- [ ] Leg Swelling
- [ ] Varicose Veins
- [ ] Palpitations
- [ ] Shortness of Breath (while lying flat)

RESPIRATORY:
- [ ] Shortness of Breath
- [ ] Wheezing
- [ ] Chronic Cough

GASTROINTESTINAL:
- [ ] Nausea or Vomiting
- [ ] Blood in Stool
- [ ] Change in Bowel Habits
- [ ] Heartburn
- [ ] Constipation
- [ ] Hemorrhoids

KIDNEY/BLADDER/URINE:
- [ ] Painful Urination
- [ ] Frequent Urination
- [ ] Blood in Urine
- [ ] Change in Urinary Pattern

MUSCLES and JOINTS:
- [ ] Significant Pain/Stiffness

SKIN:
- [ ] Rash
- [ ] Frequent Rashes
- [ ] Itching

NEUROLOGICAL:
- [ ] Tremor
- [ ] Seizures
- [ ] Dizziness
- [ ] Tingling

PSYCHIATRIC:
- [ ] Depression
- [ ] Drug/Alcohol Addiction
- [ ] Difficulty with sexual activities
- [ ] Suicidal Thoughts
- [ ] Trouble Sleeping (Insomnia)

ENDOCRINE:
- [ ] Thyroid Disease
- [ ] Heat/Cold Intolerance

HEMATOLOGICAL/LYMPHATIC:
- [ ] Easy Bruising
- [ ] Easy Bleeding

IMMUNOLOGIC:
- [ ] Enlarged/Swollen Lymph Glands

ADDITIONAL NOTES:

____

____

Initials: ___________

PAST MEDICAL HISTORY

Please indicate if you have suffered any of the following medical conditions.
Also, state the year when these occurred (if it is not a current condition)

____ AIDS or HIV
____ Arthritis
____ Asthma
____ Bipolar
____ Cancer
____ Chronic Skin Disease
____ Depression
____ Diabetes
____ Emphysema
____ Fibromyalgia
____ Gallbladder
____ Gonorrhea
____ Gout
____ Headaches/Migraines
____ Heart Disease
____ Heart Attack
____ Heart Failure
____ Heart Murmur
____ Hepatitis
____ Herpes Infection
____ High Blood Pressure
____ Hormone Problems
____ Insomnia
____ Irregular Heart Beat
____ Jaundice
____ Kidney Disease
____ Kidney Stones
____ Liver Disease
____ Lupus
____ Menopause
____ Multiple Sclerosis
____ Nervous Breakdown
____ Other Blood Abnormality
____ Other Venereal Disease
____ Panic Attacks
____ Peptic Ulcer Disease
____ Peripheral Vascular Disease
____ Pneumonia
____ Prostate Enlargement
____ Rheumatic Heart
____ Schizophrenia
____ Seizures/Convulsions
____ Shingles
____ Stroke
____ Syphilis
____ Thyroid
____ Tuberculosis
____ Urinary Infection
____ Other: ________________

____

____

PAST SURGICAL HISTORY

- ______________________________
- ______________________________
- ______________________________
- ______________________________
- ______________________________

FAMILY HISTORY

List any medical conditions in your **IMMEDIATE FAMILY**.

- ______________________________
- ______________________________
- ______________________________

ALLERGIES:

☐ No known allergies

I am allergic to: ☐ Latex ☐ Iodine ☐ Contrast Dye ☐ Adhesive/Bandages

Other Allergies: ____

SOCIAL HISTORY:

Do you smoke? _______________ How many a day? _________ Years: ___________

Drink Alcohol? ______________ If yes, how often? ____________________________

Do you use any other drug (Marijuana, Cocaine, etc.)? __________________________

If yes, which? ____

PAIN EVALUATION -for Muscle and Joint Pain

Initials: __________

Locations of pain? ____

When did it start? (month/day/year) ____

Where is the worst area of pain? ____

How did your pain begin? (car accident, fall, nothing, etc.) ___________________________

What **aggravates** your pain? (circle all that apply)

Standing	Lying Down	Climbing Upstairs
Sitting	Leaning Forward	Going Downstairs
Bending	Leaning Back	
Walking	Coughing/Sneezing	

What makes your **pain better**? (circle all that apply)

Standing	Leaning Forward	Stretching
Sitting	Leaning Back	Rest
Bending	Coughing/Sneezing	Heat
Walking	Climbing Upstairs	Cold
Lying Down	Going Downstairs	Medication

PAIN EVALUATION -for Migraines/Headaches

Headache Location: ____

Pain Description: ____

Associated Symptoms: ____

Headache Frequency: ____

Duration of Headaches: ____

Headache Triggers: ____

Current Headache Medications: ____

Previously Tried Treatments: ____

Additional Comments: ____

Initials: _______

CURRENT MEDICATIONS- -include doses (or you can provide the nurse with a list)

Do you take any blood thinning medications? ☐ Yes ☐ No
If so, which one? ______________________________

Past Treatment for Pain

☐ Physical Therapy ☐ Aquatic Therapy

When: ______________________ Duration: ___________________________ Did it Help? ________

☐ Chiropractor

When: ______________________ Duration: __________________________ Did it Help? ________

☐ Home Exercises

How often? ____ (how many days per week, per day)

Which daily activities has your pain affected? (examples: sleep, work, household chores, etc.)

____

Other Treatments:

☐ Braces ☐ TENS/Electrical Stimulator ☐ Acupuncture ☐ Psychological Counseling

☐ Massage ☐ Ice/Heat packs ☐ Biofeedback ☐ Hypnosis

Did you receive any relief from any of the above?

Explain: ____

____

Please list any injections or surgery you've had for the pain, what kind, how many, when, and if it helped:

____

____

Circle any medications that you have tried:

Gabapentin Tramadol Cymbalta/Duloxetine Hydrocodone Oxycodone Fentanyl Morphine

Lyrica NSAIDS Cyclobenzaprine Nortriptyline Belbuca Nucynta Other: ____________________

Did any medication help, if so which ones? ____

7121 Stephanie Lane Suite 104 Lincoln, Nebraska 68516

FINANCIAL DISCLOSURE NOTICE TO PATIENTS

This is a notice informing you that Innovative Pain & Spine Specialists, LLC has an ownership interest in Pharma Innovations Pharmacy and will receive remuneration for securing or soliciting patients for prescriptions you have filled at this entity or any items or services you may purchase or receive.

Innovative Pain & Spine Specialists, LLC has begun this venture for the convenience of our patients and wish to create a more holistic approach to helping our patients manage their medications.

As a patient, you have the right to obtain these items or services from a pharmacy or provider of your choice. You always have a choice in pharmacies and are in no way obligated to use our pharmacy.

By signing below, you are acknowledging that you have received notice of the information provided above.

____ ____________________
Signature of Patient or Authorized Representative Date