Patient Registration

Account #
Chart #

PATIENT INFORMATION		
Last Name:	First Name:	MI:
SSN:	Date of Birth: _______/_______/_______	
Sex: ☐ M ☐ F	Preferred Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them	
Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Never Married		
Address:	Apt/Unit:	
City:	State:	Zip:
Mobile Phone:	Home Phone:	Work Phone:
Email:		
Primary Care Provider:	Primary Care Provider Phone:	
Primary Care Provider Address:		

PRIMARY INSURANCE INFORMATION	SECONDARY INSURANCE INFORMATION
Is the patient covered by insurance? ☐ Y ☐ N	Does patient have secondary insurance? ☐ Y ☐ N
Insurance Co:	Insurance Co:
ID #:	ID #:
Group #:	Group #:
Name of Insured: ☐ Same as patient	Name of Insured: ☐ Same as patient
**If not same as patient fill out below:*	**If not same as patient fill out below:*
Insured SSN:	Insured SSN:
Relation to Patient:	Relation to Patient:
Date of Birth: _______/_______/_______	Date of Birth: _______/_______/_______
Employer:	Employer:

WORK OR ACCIDENT RELATED INJURIES		
Are you here for Work-Related Injury?: ☐ Y ☐ N	If yes, BWC: ☐ Y ☐ N	Claim #:
Active: ☐ Y ☐ N	Date of Work-related Injury:	
Are you here for an auto-accident related injury?: ☐ Y ☐ N		
Are you here for non-auto accident related injury?: ☐ Y ☐ N	Type:	Date of Accident:
Attorney Name:	Phone number:	

EMERGENCY CONTACT	
Contact Name:	Contact Name:
Phone:	Phone:
Alternate Phone:	Alternate Phone:
Relation to Patient:	Relation to Patient:

Please bring the following to your first appointment:

- ☐ Photo identification
- ☐ Health insurance card(s)
- ☐ Medications or a list of the medications you are currently taking
- ☐ A list of known allergies
- ☐ Patient Registration forms (if you've filled them out in advance)

Patient Registration

AUTHORIZATION AND RELEASE

By signing this consent form I acknowledge that I have read, understand, voluntarily consent to and authorize the following:

Authorization of Treatment:

I authorize examination, diagnosis and general treatment (including, but not limited to, the use of x-rays, diagnostic tests and non-invasive/minimally invasive procedures to be performed by physicians and staff at Dayton Outpatient Center (DOC). I realize that if surgery is required, I will be given additional information.

Guarantee of Payment:

INSURED: Assignment of Benefits: I authorize payment directly to Dayton Outpatient Center and its entities for all benefits otherwise payable to me. I understand that I am financially responsible for all charges not covered by insurance. I authorize Dayton Outpatient Center and its entities to submit claims to my insurance carrier(s), as well as medical records required to evaluate these claims for payment.

SELF-PAY/UNINSURED: Current self-pay rates apply and are due prior to or at the time of service, before leaving our facility.

Communications:

I consent to receive healthcare alerts from DOC and its entities via text, email, and patient portal.

Receipt of Privacy Practices:

By signing this consent form, I acknowledge that a copy of the Notice of Privacy Practices has been offered to me. I understand that the notice covers all entities of Dayton Outpatient Center including DOC Pain Management, DOC Vein Management, DOC Imaging Services, DOC Physical Therapy, Miami Vally Ambulatory Surgery Center, Access Surgery Center of Ohio, Dayton Anesthesia Associates, AccessMD Urgent Care and Meta Medical Research Institute. Meta Medical Research Institute may use data for screening purposes if you chose to participate in a clinical trial. I understand that DOC reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by requesting a copy from the office manager.

Release of Medical Records:

I authorize Dayton Outpatient Center and its Affiliates to release verbally, electronically and/or in writing confidential medical information obtained during the course of my examination and/or treatment to any person or entity including my insurance carrier, employer (if treatment is related to employment), and/or other healthcare provider(s) for purposes of treatment, payment of charges, quality assurance and utilization review. I understand that should I choose not to release my medical records to a specific entity and/or person(s) I must specifically state so in writing for inclusion in my medical record.

Patient Signature: ____ Date: ____________________

Responsible Party: ____ Date: ____________________

No-Show and Cancellation Policy

1. If cancellation is necessary, we require that you contact our office at least 24-hours in advance for office visits and procedures to avoid a potential cancellation fee

2. A “no-show” or missed appointment without 24-hour notification may be charged a fee of $50 for Office Visits or $100 for Procedures and Diagnostic Testing (incl. Ultrasounds). These fees are not billable to your insurance company and will be patient’s responsibility.

3. Repeated missed appointment may result in the termination of the physician/patient relationship

4. If you are 15 or more minutes late for your appointment, the appointment may be canceled and rescheduled

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Patient Responsibility

Below fees are not billable to your insurance company and will be patient’s responsibility.

Deductibles:
Is the amount you have to pay for healthcare services before your insurance plan starts to pay. You are responsible for the full amount of office visits, diagnostic testing, and procedures until the deductible amount is met each year.

Co-Pays:
Based on your agreement with your insurance plan, a copay is required to be paid at time of service before your insurance will pay. After we file a claim to your insurance plan(s) after your visit and any procedures performed, if there is any remaining amount left after your insurance pays, we will send you a statement for the balance.

Co-Insurance:
A percentage you pay for covered health care services (for example 20% of the allowed amount). Your insurance plans will determine the amount they will allow as payment for a certain item or service, where a set percentage of that “allowed amount” will be the patient’s responsibility.

Patient Account Balances:
If you accumulate a balance on your account, DOC requires that you settle your balance within 30 days before your balance transfers to a debt collection agency. If you are unable to do so, DOC policy requires you to create a clear payment plan with our Patients Account team before seeing the doctor.

**Your signature below indicates that you have read this policy,
understand it and agree to comply with its requirements.**

Patient Name: ____

Patient/Legally Responsible Person Signature: ______________________ Date: ______________

Medical History

PATIENT INFORMATION	
Height:	Weight:
Tobacco Use: ☐ Y ☐ N How much? ______ PPD; ______ Yrs.	
Alcohol Use: ☐ Y ☐ N How much?	

Please list your past surgeries with dates or provide list:

Past Surgery 1:	Surgery Date:
Past Surgery 2:	Surgery Date:
Past Surgery 3:	Surgery Date:
Past Surgery 4:	Surgery Date:
Past Surgery 5:	Surgery Date:
Past Surgery 6:	Surgery Date:
Past Surgery 7:	Surgery Date:

Please list your current Medications or provide list:

Medication 1:

Medication 2:

Medication 3:

Medication 4:

Medication 5:

Medication 6:

Medication 7:

Please list your current Allergies or provide list:

Allergy 1:

Allergy 2:

Allergy 3:

Allergy 4:

Allergy 5:

Allergy 6:

Allergy 7:

Have you ever been diagnosed with any of these? (check any that apply)

☐ Angina	☐ Coronary Heart Disease	☐ Kidney Stones
☐ Arthritis	☐ Diabetes	☐ Liver Disease
☐ Blood Disorders	☐ Heart Attack	☐ Seizures
☐ Cancer	☐ Hepatitis	☐ Stroke
☐ CHF	☐ High blood Pressure	☐ Thyroid Disease
☐ COPD/Emphysema	☐ Intestinal Issues	☐ Ulcers/Gastritis

Have you ever had any of the following happen to you? (check any that apply)

☐ Head (history of trauma)	☐ Passing Out	☐ Diarrhea/Constipation
☐ Bloody Stool	☐ Bloody Urine	☐ Shortness of Breath
☐ Skin Rash	☐ Upset Stomach/Nausea	☐ Weakness/Loss of Strength
☐ Painful Joints	☐ Swelling	☐ Dizziness
☐ Allergies	☐ Depression/Anxiety	☐ Eyesight Changes
☐ Chest Pain	☐ Hearing Loss	☐ Alcohol/Substance Abuse

Medication History

PATIENT INFORMATION			
Patient Name (Last, First):	MI:	DOB:	SSN:

Please list all your allergies:

____

Please list your current PAIN medications:

____

Have you tried other pain medications in the past? If so, what?:

☐ Y ☐ N ____

Please list any other medications you take currently or provide a list:

____

Do you have any side effects from current medications? If so, what?

☐ Y ☐ N ____

Are you concerned about your use of pain medications?: ☐ Y ☐ N

Have you ever used marijuana, cocaine or any other illegal drugs in the past?: ☐ Y ☐ N

Do you have any history of substance abuse?: ☐ Y ☐ N
(check any that apply) ☐ Alcohol ☐ Illegal Drugs ☐ Prescription Drugs

Any family history of substance abuse?: ☐ Y ☐ N
(check any that apply) ☐ Alcohol ☐ Illegal Drugs ☐ Prescription Drugs

Any history of psychological disorders in the past or present?: ☐ Y ☐ N
(check any that apply) ☐ Attention Deficit Disorder ☐ Bipolar ☐ Schizophrenia ☐ Depression ☐ Anxiety

Have you ever had any pain treatments? (check any that apply)

☐ Trigger Point Injections	☐ Epidural Steroid Injections	☐ Facet Joint Injections
☐ SI Joint Injections	☐ Spinal Cord Stimulator	☐ Morphine/Intrathecal Pump
☐ Acupuncture	☐ Chiropractor	☐ Physical Therapy
☐ Aquatic/Pool Therapy	☐ Addiction Counseling	☐ Psychological Counseling

Circle a number the best describes how your pain interferes with the following activities
(0 is the lowest with no interference and 10 indicates complete interference)

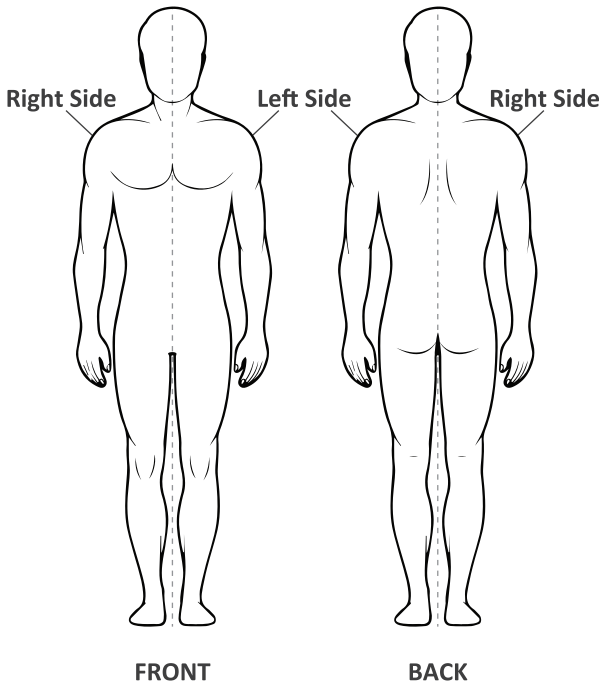
GENERAL ACTIVITY:	1	2	3	4	5	6	7	8	9	10
MOOD:	1	2	3	4	5	6	7	8	9	10
NORMAL WORK (including work outside the home and housework):	1	2	3	4	5	6	7	8	9	10
RELATIONSHIPS WITH FAMILY, FRIENDS AND CO-WORKERS:	1	2	3	4	5	6	7	8	9	10
ABILITY TO SLEEP:	1	2	3	4	5	6	7	8	9	10
QUALITY OF LIFE (Hobbies, Sex or Any Daily Activities):	1	2	3	4	5	6	7	8	9	10

I certify all my answers are true and are answered to the best of my knowledge.

Patient Signature: ______________________________ Date: ______________

Pain History

Are you experiencing pain?: ☐ Y ☐ N **If you marked "Yes" please fill the below information.*		
CAUSE OF PAIN		
Date Pain Started:	Location of Pain:	
Pain Level: _____ /10	Constant: ☐ Y ☐ N	Pain Worse: ☐ AM ☐ PM ☐ None
Any previous testing?: ☐ Y ☐ N	Type: ☐ MRI ☐ CT Scan ☐ Xray ☐ EMG/NCV ☐ Ultrasound	
Where was your testing?:	Date of Testing:	
Are you having trouble sleeping due to pain?: ☐ Y ☐ N	Trouble staying asleep?: ☐ Y ☐ N	
Activities that worsen pain: ☐ Lifting ☐ Bending ☐ Twisting ☐ Sitting ☐ Standing ☐ Other:		
Does stress affect your pain?: ☐ Y ☐ N	Source of Stress:	
Does anything help your pain?: ☐ Y ☐ N	What Helps?:	
MARK DRAWING BELOW ACCORDING TO WHERE YOU HURT		



Part of Body

Stabbing: ______________________________

Burning: ______________________________

Aching: ______________________________

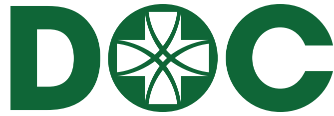
Numbness: ______________________________

Pins & Needles: ______________________________

Joint Pain: ______________________________

I certify all my answers are true and are answered to the best of my knowledge.

Patient Signature: ______________________________ Date: ______________

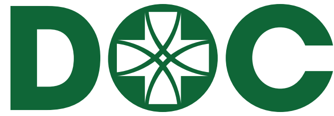


Controlled Substance (Narcotic) Agreement

The successful management of chronic pain involves many modalities including, but not limited to, physical therapy (PT), surgical consultation, injection therapy, behavioral counseling and oral medications. Occasionally, upon the mutual agreement of the patient and the pain management physician, it may be necessary to institute long-term opiate administration to achieve satisfactory pain control.

Because these drugs have the potential for abuse, strict accountability is necessary when prolong use is required. For this reason, the following policies are agreed upon by you as the patient and your Physician and/or Physician Assistant.

1. You may not share, sell, trade or exchange your medications. You agree to keep these medications in a secure place. Medications will not be replaced if they are lost, misplaced, stolen or destroyed. **No exceptions will be made.**
2. You agree that you will use your medication at a rate no greater than the prescribed rate unless it is discussed directly with a Pain Management prescriber.
3. Early refills will not be given.
4. Changes in prescriptions can only be made during scheduled appointments and not via phone.
5. You agree that continued refill of medications may be contingent upon compliance with any chronic pain treatment modalities recommended by your Physician and/or Physician Assistant such as Physical Therapy, Psychological Therapy and Pain injections.
6. At any time, a request could be made at random by a Pain Management Physician to present the original dispensed container of medications to the office at each visit to document compliance and to prevent overuse.
7. You agree not to attempt to get pain medications from any other health care provider without telling them that you are currently under treatment by a pain management physician. If you are prescribed pain medications from another provider, you must notify us immediately with the information so we can document this in your chart as well as inform you as to whether or not you can take the medicine.
8. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacies or other professionals who provide your health care.
9. Unannounced, random urine or serum toxicology screens may be requested by your Pain Management Provider to determine compliance with this agreement and your regimen of pain control medications. Tests may include screens for any illegal substances. Your cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorders. Refusal of such testing may subject you to an abrupt rapid wean schedule in order for the medication to be discontinued or prompt termination of our care.
10. Unannounced, random pill counts may also be requested by your Pain Management Provider to determine compliance with medication regimen and compliance of this agreement. You may be asked to bring all current medications to the office so that a staff member can verify the quantity of medications remaining. A time frame will be given to report to the office. Failure to show up for a pill count may result in the discontinuation of medications or prompt termination of our care.



11. You agree not to use any illegal substances (cocaine, heroin, marijuana, crystal meth, ecstasy, ketamine, etc.) while being treated with controlled substances. Violation of this will result in the cessation of the prescribing of any controlled substances and termination of care at PMA effective immediately.

12. You will keep all scheduled appointments in the Pain Management Clinic. No-shows or late cancellations (within 24 hours) may result in a $50-$100 fee determined upon the type of visit.

13. You may not request to change to another of our physicians if you have been discharged from our practice. All of our doctors are within one practice. If our physician has discharged you and referred you to an Addictionologist; it is highly recommended you are compliant and complete a rehabilitation and/or counseling program. Please remember that just because you do actually go through a program, does not mean our pain physicians will take you back as a patient.

Narcotic Therapy - Possible Side Effects, Risks and Complications

The patient understands that narcotic analgesics may result in physical dependence that ultimately may require slow weaning once the pain condition improves. Immediate discontinuation of this medication is not advised and severe life threatening conditions may occur.

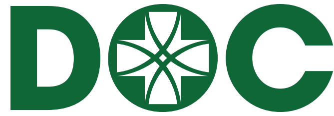
Tolerance to the medication may develop after long-term usage which means that ultimately these medications may become less effective.

Other side effects may include the following which could be life threatening if not taken as instructed:

- Respiratory depression resulting in respiratory arrest and/or death, as well as resultant cardiac arrest and/or death
- Tolerance and/or physical dependence
- Withdrawal phenomenon with abrupt discontinuation of the medication causing significant side effects such as heart palpitations, sweating, elevated pulse and blood pressure
- Disorientation, resulting in falls and resultant significant injury
- Constipation, bowel obstruction or difficulty urinating
- Allergic and/or anaphylactic reactions to the medications resulting in low blood pressure, fast heart rate, arrhythmias, excessive itching, rash, throat swelling, respiratory or cardiac arrest and death
- **(Males Only)** may cause low testosterone levels
- **(Females Only)** Narcotic analgesics should not be used during pregnancy. Possible birth defects or physical opiate dependence could occur

Precautions and/or contraindications:

- Patients taking anticoagulants (blood thinners: Plavix, Coumadin)
- Extremes of age
- Patients with significant other medical problems
- Patients taking sedative medications or central nervous system depressants (Valium, Soma, Xanax, Ativan, etc.)



- Narcotic analgesics should not be used during pregnancy
- Patients on multiple other medications

Recommendations as to what to avoid while taking narcotics until you see how you respond:

- Any kind of activity where judgment is required - i.e. signing legal documents, caring for the sick, the elderly or the very young
- Driving
- Operating heavy machinery.
- Working in high-risk areas (i.e. construction sites, elevated work sites, working with power tools, etc.).
- Drinking alcohol is prohibited while on narcotics due to potent and unpredictable enhancement of central nervous system depression of these two substances when taken together.

I have read this form or have had it read to me. I understand all of it and have had a chance to have my questions regarding this treatment answered to my satisfaction. I am signing this form voluntarily. I give my consent for the treatment for my pain with possible narcotic pain medications. I am aware of the many potential risks versus benefits and will make every effort to follow these guidelines during my pain management. I also understand that should this agreement be broken by non-compliance on my part that I may be discharged from the practice.

________________________________ ________________

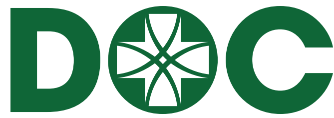
Signature of Patient | Date

________________________________ ________________

Witness | Date

Name of Pharmacy: ________________________________

Pharmacy Phone #: ________________________________



Clinical Policies

In order to better serve our patients, we have found it necessary to put some long-standing "unwritten rules" on paper. It is our hope that by doing so, our patients will better understand the rationale behind these rules. This is a brief overview of policies; the narcotic agreement goes into further detail about some important and common issues not allowed.

Narcotic Agreement:

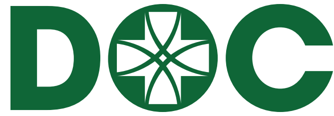
1. This is a contract between you and your doctor in which you need to review and sign. The purpose of the contract is not to convey mistrust, intimidate or make us appear inflexible. It is used by our office to help us efficiently monitor and treat your pain.

2. Patients are not to increase their medications on their own. Any increase or decrease has to be done with the consent of the Doctor/PA. Patients are not allowed to obtain any pain medications from other Doctors, ER, etc. once they are under our care.

Clinic Policies:

1. We have designed a program that requires input from different specialties like Psychological Services and Physical Therapy. We rely on these services to aid in our assessment and treatment of your pain. We understand that some of you may come to us having already attempted some of these services and may have had less than desirable outcomes. However, we are confident in our referral and ask that you comply with our recommendations. NOTE: Matters discussed with Psychological Services are confidential. We are provided a report from them that addresses only your pain issues.

2. There are certain behaviors and/or actions that will not be tolerated at our office:
    a. Do not use any threatening or curse words. Our "zero tolerance" policy states theses are grounds for immediate dismissal from this practice.
    b. We can understand that problems, concerns and question come up which require our attention. We ask that if you call the office, you leave only one message and allow up to 24 hours for a return call, multiple telephone calls within one day will not change our response time. Messages are answered as quickly as possible and in order of severity.
    c. Please, do not stop in to speak with a staff member without an appointment, as this will delay our interactions with patients scheduled for that day.
    d. Paperwork is to be brought to scheduled office visits, this way the doctor may discuss any pertinent information needed to fill out the paperwork. Some paperwork does require a fee and will not be filled out until the fee is collected. Please allow enough time for completion of all paperwork.



Primary Care Physician (PCP) Requirement:

1. DOC is a referral based service only; therefore, it is mandatory that you have a primary care physician (PCP) or other specialist prior to your first appointment at our clinic. We will inform your referring physician of our treatment recommendations after your initial evaluation and of your progress thereafter.
2. At the time of your discharge from our service, your care will be referred back to your PCP or referring doctor.

Medication Management Policy:

1. The number of telephone calls received daily regarding medications can be overwhelming. Please read the following before calling the office. The main goal of treatment with narcotic medications is to improve your ability to function and/or work.
   a. You must help yourself by following a healthy way of life including exercise, weight control, and limiting/ceasing the use of alcohol and tobacco.
   b. It is important to take your medication exactly as prescribed. If you have any questions about medications, please discuss these with your physician at your next scheduled office visit. If your medications are taken other than as directed and you run out early, we will not be able to honor early refills.
   c. Medications will not be refilled if you “no show,” cancel, or do not schedule a follow up appointment. Refills of narcotic medications will not be made as an “emergency” because you suddenly realize you will run out of medications before your next appointment. Please plan accordingly, taking holidays and weekends into consideration.
   d. **NARCOTIC PRESCRIPTIONS ARE NOT FAXED, MAILED, “CALLED IN”, OR OTHERWISE DELIVERED TO YOUR PHARMACY.**
   e. Medication changes (switching from one to another) will not be made over the telephone except in a dire emergency. Please wait until your next appointment to discuss these changes.
   f. You should allow up to 2 weeks if your doctor prescribed a new medication for you to see maximum affect.
   g. Violation of the above conditions can lead to termination of your association with our clinic. If the violation includes obtaining controlled substances from another practitioner, we may also report this action to other healthcare providers or authorities.

I have thoroughly read, understand, and accept all of the above. Any questions I had regarding this information has been answered to my satisfaction by a DOC staff member. I understand that I will be held accountable as I progress through my pain management treatment.

______________________________	______________
Signature	Date
______________________________	______________
DOC Staff Member	Date