PHONE: (937) 252-2000
FAX: (937) 252-3700

DAYTON OUTPATIENT CENTER

PAIN MANAGEMENT

WELCOME NEW PATIENT

Dear:_____

Your appointment at Dayton Outpatient Center with_____ is

scheduled for _____ at our _____location.

PLEASE REMEMBER TO BRING YOUR PHOTO ID & INSURANCE CARDS WITH YOU

LOCATIONS & DIRECTIONS

Woodman Drive

1010 Woodman Drive, Suite 200
Dayton, OH, 45432
(Park in the back of the building, Office on the 2nd Floor)

From the North: Take I-75 South to OH-35 East towards Xenia (Via Exit 52-B). After 4.7 miles you will take the Woodman Drive Exit off OH-35. Turn Left onto Woodman Drive and we are located .25 miles on the right hand side of the road.

From the South: Take I-75 North to I-675 North towards Columbus (Via Exit 43). Remain on I-675 for 6.05 miles and merge onto OH-35 West towards Dayton (Via Exit 13-B). After 1.3 miles you will take the Woodman Drive Exit off OH-35. Turn Right onto Woodman Drive and we are located .25 miles on the right hand side of the road.

Dayton Mall

8210 Springboro Pike
Miamisburg, OH 45342
(Next to Red Lobster, in back of Urgent Care)

From the North: Take I-75 South toward Dayton to OH-725 exit towards Centerville/ Miamisburg (Via Exit 44). Turn Left onto OH-725/ Miamisburg-Centerville Road and after 0.47 miles turn Right on Springboro Pike/OH-741. After 0.48 miles we are located on the left hand side.

From the South: Take I-75 North towards Dayton to OH-725 towards Centerville/ Miamisburg (Via Exit 44). Merge onto OH-725/ Miamisburg/Centerville Road towards Centerville. Take the second right onto Springboro Pike/OH-741. After 0.48 miles we are located on the left hand side of the road.

Huber Heights

6229 Troy Pike
Huber Heights, OH 45424
(Open MRI Sign)

From the North: Take I-75 South to I-70 East towards Columbus (Via Exit 61). After 3.1 miles you will take the OH-202 exit towards Old Troy Pike/Huber Heights (Via Exit 36). Turn Right on Troy Pike/OH-202, after 1.61 miles the office will be located on the right side of the road.

From the South: Take I-75 North towards Dayton to Stanly Ave (Via Exit 56). Keep right to take Stanley Ave Ramp and Merge onto Stanley Ave. After 0.67 miles turn Left onto Troy Pike/OH-202. Continue on OH-202 for 4.55 miles and we are located on the left side of the road.

Springfield

1301 West First Street
Springfield, OH 45504
(Located inside the Hometown Urgent Care)

From the North: Take I-75 South and merge onto I-70 East (Via exit 61-A). After 13.1 miles merge on OH-4 towards Enon/ Springfield (Via exit 47). Continue for 1.47 mi and merge onto US-68 North towards Urbana. Turn Right on West 1st Street, then take the second Right on Hillcrest and an immediate Left on West 1st St.

From the South: Take I-75 North and merge onto I-70 East (Via exit 61-A). After 13.1 miles merge on OH-4 towards Enon/ Springfield (Via exit 47). Continue for 1.47 mi and merge onto US-68 North towards Urbana. Turn Right on West 1st Street, then take the second Right on Hillcrest and an immediate Left on West 1st St.

Troy

1430 West Main Street
Troy, OH 45373
(In Trojan Plaza in back of Hometown)

From the North: Take I-75 South towards OH-41 towards Covington/Troy (Via Exit 74). Turn left off the exit onto West Main Street and continue for 0.44 miles. Our office is located on the right side of the road directly behind Taco Bell in the same Building as the Hometown Urgent Care. (Separate entrance on the side).

From the South: Take I-75 North towards OH-41 towards Covington/Troy (Via Exit 74). Turn Right off the exit onto West Main Street and continue for 0.25 miles. Our office is located on the right side of the road directly behind Taco Bell in the same Building as the Hometown Urgent Care.

Greenville

1403 Wagner Ave
Greenville, OH 45331
(Located in back of the Access MD Urgent Care)

From the North: Depending on your exact location there are multiple routes that can be taken. We advise using a GPS system if available or www.mapquest.com online. You can call our office as well and we will be glad to assist with any directions.

From the South: Take I-75 North Towards I-70 W (Via Exit 61). Continue for 10.34 miles and take OH-49 North toward Phillipsburg/Greenville (Via Exit 24). Stay straight on OH-49 for 19.7 miles and merge on US-127 North. After 3.98 miles turn left onto Kruckeburg Road, after .84 miles turn Right on Wagner Ave. Office located .14 miles on the right side of the road.

PLEASE ARRIVE 15 MINUTES EARLY WITH THIS PACKET COMPLETED

DAYTON OUTPATIENT CENTER

PATIENT DEMOGRAPHIC FORM

(THIS FORM MUST BE UPDATED EVERY CALENDAR YEAR OR WHEN ANY INFORMATION CHANGES)

PATIENT NAME (LAST, FIRST)	**M.I.**	**DATE OF BIRTH**	**SOCIAL SECURITY**
RACE □ CAUCASIAN □ HISPANIC □ AFRICAN AMERICAN □ ASIAN □ OTHER _____	**MARITAL STATUS** □ SINGLE □ MARRIED □ DIVORCED □ LEGALLY SEPARATED □ WIDOWED □ DOMESTIC PARTNER		
GENDER □ MALE □ FEMALE □ _____	**LEGAL SEX** MALE □ FEMALE □		**PERFERRED LANGUAGE** □ ENGLISH □ OTHER
ADDRESS	**PREFERRED PRONOUNS** □ HE/HIM □ SHE/HER □ THEY/THEM		**PREFERRED NAME**
ADDRESS (CONTINUED)	**APT/UNIT**	**CITY**	**STATE** / **ZIP CODE**
HOME PHONE	**CELL PHONE**		**WORK PHONE + EXT**
EMAIL ADDRESS □ CONSENT TO PORTAL ACCESS AND RECORD SHARING			**CONSENT TO TEXT** □ YES □ NO
EMPLOYER	**EMPLOYER ADDRESS**		
EMPLOYMENT STATUS □ FULL TIME □ PART TIME □ RETIRED □ DISABLED □ FULL-TIME STUDENT	**JOB TITLE**		
PRIMARY CARE PHYSICIAN □ NONE	**LOCAL PHARMACY/PHONE NUMBER**		

PRIMARY INSURANCE □NONE		**SECONDARY INSURANCE** □NONE	
ID#	**GROUP#**	**ID#**	**GROUP#**
SUBSCRIBER □SAME AS PATIENT	**RELATIONSHIP**	**SUBSCRIBER** □SAME AS PATIENT	**RELATIONSHIP**
SUBSCRIBER'S SOCIAL SECURITY NO	**SUBSCRIBER'S DOB**	**SUBSCRIBER'S SOCIAL SECURITY NO**	**SUBSCRIBER'S DOB**

EMERGENCY CONTACT		**DO YOU HAVE POWER OF ATTORNEY** □ YES □ NO IF YES, COMPLETE BELOW	
NAME	**RELATIONSHIP**	**NAME**	**RELATIONSHIP**
PHONE	**ALT PHONE**	**PHONE**	**ALT PHONE**

The above subscriber hereby authorizes their insurance company to issue indemnity checks to the above listed medical provider for services provided.

AUTHORIZATION

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services and authorize such physician or organization to submit a claim to my insurance carrier or Medicare for payment. I authorize any holder of medical and other information about me to release to insurance carriers or the Health Care Financing Administration and its agents or the Social Security Administration or its intermediaries or any agency, group or person(s) necessary to secure payment any information needed for this or related Medicare claim. For and in consideration of services rendered and to be rendered by the above listed medical provider, I hereby guarantee payment of all charges incurred for this account. The patient or his/her representative recognizing the need for healthcare, consents to the above listed medial provider rendering services ordered by the physicians, including medical or surgical treatment, laboratory procedures, X-ray examinations or other services rendered under the general and specific instructions of the physicians. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct

. * Privacy policy DOC Pain Management and its Affiliates do not share or sell your email address information. If you do not wish to receive e-mail correspondence from Dayton Outpatient Center or its affiliates please check this box. □

FINANCIAL POLICY

Patients are responsible for all co-pays, deductible and any other charges for the services performed by us and not paid by patient's insurance. Patients are responsible to verify with their insurance if we, the provider of medical services, are covered medical provider and also to find the benefits available to patient for our services. Patients are responsible to arrange the referral from their PCP and/or any other authorization, if required by the patient's insurance. Our staff is available to assist patient in this regard or to answer any question the patient might have. Co-payment and deductibles are expected at the time of service. We accept cash, checks, and credit cards. Self-pay patients are required to pay their charges on the date of service. If at any time the patient defaults on this agreement resulting in collection proceedings, the patient understands that he/she shall be responsible for any and all of the a) interest, b) collection costs including but not limited to third-party collection fees and costs, and c) all legal fees and court costs.

PATIENT SIGNATURE _____ DATE _____

revised 12/18 RED

DAYTON OUTPATIENT CENTER

Pain Management

No Show Policy

1. Dayton Outpatient Center requires at least 24 hours notice to cancel an appointment in order to allow our staff to reschedule another person in need for that time slot.
2. Our staff will perform a reminder call the day before your appointments. A message will be left on the answering machine to the best number we have on our records that you have provided.
3. Every no show event will be documented in the chart and you will be assessed a fee payable prior to your next office visit, $50 for office visits & $100 for procedures.
4. At the next scheduled appointment after each no show, the Doctor/PA will discuss with you the reason for the no show, the importance of keeping scheduled appointments and review our no show policy. Your treatment plan may be adjusted accordingly based on any information obtained during this discussion.
5. After 3 no shows (consecutive or non-consecutive), no additional appointments will be scheduled for you. You will need to pay for all no shows before you can be scheduled for an appointment. If you report a need for an appointment that appears to be urgent or emergent, you will be transferred to the Doctor/PA for a telephone interview.

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

_____
Patient Name

_____ _____
Signature of Patient or Legally Responsible Person Date

DAYTON OUTPATIENT CENTER
Pain Management

CONSENT TO NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), 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 healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- For judicial & administrative proceedings according to specific requirements.

I have been informed by you of *your Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that the Notice of Privacy Practices covers all entities of Dayton Outpatient Center practices such as Pain Clinic, Ambulatory Surgery Center, Physical Therapy, Counseling, Pharmacy, Dental Clinic, Family Medicine, Occupational Medicine and any other service areas). I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. 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 above to obtain a current copy of the *Notice of Privacy 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.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Unless there is an objection we may do any of the following:

- **Call patients to confirm an appointment and may leave a message**
- **Call regarding an account (at the phone # provided by the patient)**
- **Call and/or leave a message regarding treatment/test results.**

We are only permitted to return calls left by our patients. *We will not return calls left by a spouse, family member, or friend.*

Patient Name: _____ SSN: _____

Patient Signature: _____ Date: _____

Representative Name: _____ Relationship to Patient: _____

Representative Signature: _____ Date: _____

DAYTON OUTPATIENT CENTER
PAIN MANAGEMENT

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 compliancy 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 could result in a $50-$100 fee depending on if this is for an office visit or for a procedure in our ambulatory surgery center.

13. You cannot request to change to another of our physicians if you have been discharged. All doctors are within one practice. If your 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

DAYTON OUTPATIENT CENTER

PAIN MANAGEMENT

- 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 #: _____

DAYTON OUTPATIENT CENTER

PAIN MANAGEMENT

CLINIC 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

DAYTON OUTPATIENT CENTER

Pain Management

PATIENT HISTORY FORM

(Must be filled out by new patients before seen by Physician)

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST)	M.I.	DATE OF BIRTH	SOCIAL SECURITY NUMBER

LEGAL SEX □ MALE □ FEMALE	AGE	ORIENTATION □ HETEROSEXUAL □ HOMOSEXUAL □ BISEXUAL □ SOMETHING ELSE _____ □ CHOOSE NOT TO DISCLOSE

EMPLOYMENT STATUS □ FULL TIME □ PART TIME □ RETIRED □ DISABLED □ FULL-TIME STUDENT	JOB TITLE / DATE LAST WORKED

PRIMARY CARE PHYSICIAN □ NONE	PHONE NUMBER

PREVIOUS PAIN DOCTOR □ NONE	PHONE NUMBER

CAUSE OF PAIN

DATE PAIN STARTED	LOCATION OF PAIN	PAIN LEVEL /10	CONSTANT □ YES □ NO	PAIN WORSE □ AM □ PM □ None

WORK INJURY □ YES □ NO	BWC □ YES □ NO	CLAIM #	ACTIVE □ YES □ NO	ATTORNEY NAME / PHONE NUMBER

AUTO ACCIDENT □ YES □ NO	DATE OF ACCIDENT	ATTORNEY NAME / PHONE NUMBER

OTHER ACCIDENT □ YES □ NO	TYPE	ATTORNEY NAME / PHONE NUMBER

Any previous testing? □ YES □ NO □ MRI □ CT scan □ Xray □ EMG/NCV □ OTHER

Where was testing done? _____ Date of testing: _____

Are you having trouble sleeping due to pain? □ YES □ NO Trouble staying asleep? □ YES □ NO

Activities that worsen pain □ Lifting □ Bending □ Twisting □ Sitting □ Standing □ Other_____

Does stress affect your pain? □ YES □ NO Source of stress: _____

Things that help your pain? □ YES □ NO What helps? _____

TYPE OF PAIN

MARK YOUR AREAS OF PAIN ON THE DRAWINGS BELOW

DESCRIBE PARTS OF THE BODY

STABBING _____

BURNING _____

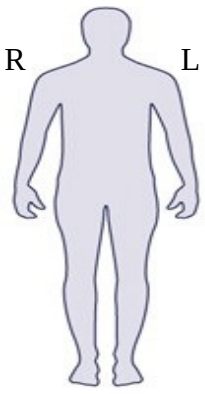
ACHING _____

NUMBNESS _____

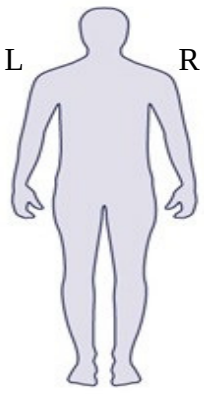
PINS & NEEDLES _____

JOINT PAIN _____

FRONT OF BODY



BACK OF BODY



DAYTON OUTPATIENT CENTER

Pain Management

MEDICAL HISTORY

PATIENT NAME (LAST, FIRST)	M.I.	DATE OF BIRTH	SOCIAL SECURITY NUMBER

HEIGHT	WEIGHT	TOBACCO USE □ YES □ NO	ALCOHOL USE □ YES □ NO
		How much? PPD YRS.	How much?

Please list your past surgeries with dates or provide list _____

_____

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

- □ Angina
- □ Arthritis
- □ Blood disorders
- □ Cancer
- □ CHF
- □ COPD/Emphysema
- □ Coronary Heart Disease
- □ Diabetes
- □ Heart Attack
- □ Hepatitis
- □ High blood pressure
- □ Intestinal Issues
- □ Kidney stones
- □ Liver Disease
- □ Seizures
- □ Stroke
- □ Thyroid Disease
- □ Ulcers/Gastritis

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

- □ Head (history of trauma)
- □ Bloody stool
- □ Skin rash
- □ Painful joints
- □ Allergies
- □ Chest pain
- □ Passing out
- □ Bloody Urine
- □ Upset stomach/nausea
- □ Swelling
- □ Depression/Anxiety
- □ Hearing loss
- □ Diarrhea/Constipation
- □ Shortness of breath
- □ Weakness/Loss of strength
- □ Dizziness
- □ Eyesight changes
- □ Alcohol/Substance abuse

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

- □ Trigger point injections
- □ SI joint injections
- □ Accupuncture
- □ Aquatic/Pool Therapy
- □ Epidural steroid injections
- □ Spinal Cord Stimulator
- □ Chiropractor
- □ Addiction Counseling
- □ Facet joint injections
- □ Morphine/Intrathecal pump
- □ Physical therapy
- □ 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

0 1 2 3 4 5 6 7 8 9 10

MOOD

0 1 2 3 4 5 6 7 8 9 10

NORMAL WORK (INCLUDING WORK OUTSIDE THE HOME AND HOUSEWORK)

0 1 2 3 4 5 6 7 8 9 10

RELATIONSHIPS WITH FAMILY, FRIENDS AND CO-WORKERS

0 1 2 3 4 5 6 7 8 9 10

ABILITY TO SLEEP

0 1 2 3 4 5 6 7 8 9 10

QUALITY OF LIFE (Hobbies, Sex or Any Daily Activities)

0 1 2 3 4 5 6 7 8 9 10

DAYTON OUTPATIENT CENTER

Pain Management

MEDICAL HISTORY
MEDICATIONS

PATIENT NAME (LAST, FIRST)	M.I.	DATE OF BIRTH	SOCIAL SECURITY NUMBER

Please list all your Allergies

_____

_____

Please list your current PAIN medications _____

_____

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

_____

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

_____

_____

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

Are you concerned about your use of pain medications? ☐ YES ☐ NO

Have you ever used marijuana, cocaine or any other illegal drugs in the past? ☐ YES ☐ NO

Do you have any history of substance abuse? ☐ YES ☐ NO (check any that apply)

☐ Alcohol ☐ Illegal Drugs ☐ Prescription Drugs

Any family history of substance abuse? ☐ YES ☐ NO (check any that apply)

☐ Alcohol ☐ Illegal Drugs ☐ Prescription Drugs

Any history of psychological disorders in the past or present? ☐ YES ☐ NO (check any that apply)

☐ Attention Deficit Disorder ☐ Bipolar ☐ Schizophrenia

☐ Depression ☐ Anxiety

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

Patient Signature _____ Date _____

DAYTON OUTPATIENT CENTER

Pain Management

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____, do hereby authorize the release of my protected health information (PHI), as indicated herein; between the following parties:

FROM: _____

_____

_____

_____

TO: **DOC Pain Management**
1010 Woodman Drive
Dayton, Ohio 45432
Fax:937-252-3700
Phone:937-252-2000

I authorize the use or disclosure of the following PHI: (Please list dates of service, condition or event for releases)

I request these records to be released for the following purpose:

Pain Management Treatment

I authorize this release effective for 180 days from the date of my signature below. If not specified, this authorization shall be effective for one (1) year. I understand, as set forth in the provider's Notice of Privacy Practices, I have the right to revoke this authorization, in writing at any time. I understand revocation is not effective to the extent the provider has relied on this authorized release.

I also make the following qualification: If the information specified above contains information related to treatment for drug and/or alcohol abuse or HIV test results; I understand I have the right to inspect or copy my PHI and I have the right to refuse to sign this authorization

Patient Name _____ Date of Birth _____ SSN _____

Patient Signature or Guardian, or Durable Power of Attorney _____ Date _____

Patient unable to sign due to: _____ Relationship to Patient _____

OFFICE USE ONLYDO NOT WRITE BELOW THIS LINE**

FOR OFFICE USE ONLY: (Make sure only minimum necessary information is released)

☐**Surgery Records** ☐**Pain Clinic Records** ☐ **Imaging Records** ☐**Testing Records**

Indicate PHI released by checking boxes below

☐ Face Sheet	☐ Operative Reports	☐ Physician Orders
☐ H&P	☐ Radiology Reports	☐ Therapy Reports
☐ Discharge Summary	☐ Office Notes	☐ Emergency treatment
☐ Consultation Reports	☐ Pathology Reports	☐ Other:_____
☐ Laboratory Reports	☐ Physician Progress Notes	

Medical Record Clerk Signature _____ Date _____

*** PLEASE READ CAREFULLY AS PAYMENT PLANS HAVE CHANGED***

EFFECTIVE 4/1/2018 ALL PATIENTS WITH A BALANCE UNDER $500 WILL NEED TO PAY AT LEAST $75 ON THEIR ACCOUNTS EVERY MONTH.

EFFECTIVE 4/1/2018 ALL PATIENTS WITH A BALANCE OVER $500 WILL NEED TO PAY AT LEAST $100 ON THEIR ACCOUNTS EVERY MONTH.

THANK YOU FOR YOUR UNDERSTANDING IN THIS MATTER

_____ _____

PATIENT SIGNATURE DATE