Pain and Spine Specialists
peace restored

**Paul E. Pinson, M.D.**
3917 Georgetown Road, NW
Cleveland, TN 37312

# SOAPP

Signature: _____ DOB: _____ Date: _____

**The following are some questions given to all patients at Pain and Spine Specialists who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment.**

Please answer the questions below using the following scale:

**0 = Never 1 = Seldom 2 = Sometimes 3 = Often 4 = Very Often**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. | How often do you have mood swings? | 0 | 1 | 2 | 3 | 4 |
| 2. | How often do you smoke a cigarette within the first hour after you wake up? | 0 | 1 | 2 | 3 | 4 |
| 3. | How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs? | 0 | 1 | 2 | 3 | 4 |
| 4. | How often have any of your close friends had a problem with alcohol or drugs? | 0 | 1 | 2 | 3 | 4 |
| 5. | How often have others suggested that you have a drug or alcohol problem? | 0 | 1 | 2 | 3 | 4 |
| 6. | How often have you attended an AA or NA meeting? | 0 | 1 | 2 | 3 | 4 |
| 7. | How often have you taken medication other than the way that it was prescribed? | 0 | 1 | 2 | 3 | 4 |
| 8. | How often have you been treated for an alcohol or drug problem? | 0 | 1 | 2 | 3 | 4 |
| 9. | How often have your medications been lost or stolen? | 0 | 1 | 2 | 3 | 4 |
| 10. | How often have others expressed concern over your use of medication? | 0 | 1 | 2 | 3 | 4 |
| 11. | How often have you felt a craving for medication? | 0 | 1 | 2 | 3 | 4 |
| 12. | How often have you been asked to give a urine sample for substance abuse? | 0 | 1 | 2 | 3 | 4 |
| 13. | How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years? | 0 | 1 | 2 | 3 | 4 |
| 14. | How often, in your lifetime, have you had legal problems or been arrested? | 0 | 1 | 2 | 3 | 4 |

**Please include any additional information you wish about the above answers.**

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Cleveland, TN 37312

# Patient Health Questionnaire

Signature: _____ DOB: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle in the appropriate box.

| | **Not at all** | **Several Days** | **More than half the days** | **Nearly every day** |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead, or of hurting yourself | 0 | 1 | 2 | 3 |

Office Staff Only: add columns: _____ + _____ + _____

TOTAL:_____

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

____Not difficult at all ____Somewhat difficult ____Very difficult ____Extremely difficult

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# Patient Registration

Last Name: _____First Name:_____ MI:_____ SSN: _____

Date of Birth: _____ Gender: ____ Marital Status: _____ Race: _____ Ethnicity:_____

Address: _____ City: _____ State: _____ Zip:_____

Home Phone: _____ Cell: _____ Email: _____

Are you residing in a Nursing Facility: _____ Name of Facility: _____

Phone & Address of Nursing Facility: _____

Are you under house arrest (affects insurance coverage)? _____

Primary Care Doctor Name: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Insurance: _____ Secondary Insurance: _____

Policy Holder Information (IF different than Patient) – Relationship to Patient:_____

Name: _____ _____ Phone: _____ _____

Address: _____ City: _____ State: _____ Zip:_____

The pain problem to be addressed today is in the context of a Workers Comp Injury (circle): Y / N

If yes: Date of injury: _____ Claim #: _____

The pain problem to be addressed today is in the context of an accident/lawsuit (circle): Y / N

If yes: Date of injury: _____ Claim #: _____

Provide Insurance Company Involved: _____

Provide Attorney Name: _____ Address: _____

Pharmacy Name: _____ Address: _____ Phone #: _____

Previous Pain Management Doctor: _____

Reason for previous Pain Management Doctor:_____

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# Medical History

Have you experienced any of the following? Please circle Yes or No.

| Constitutional | | | Musculoskeletal | | |
|---|---|---|---|---|---|
| Fever | Yes | No | Muscle Weakness | Yes | No |
| Weight Gain | Yes | No | Back Pain | Yes | No |
| Fatigue | Yes | No | Arthritis | Yes | No |
| Weakness | Yes | No | Carpal Tunnel | Yes | No |
| Insomnia | Yes | No | | | |
| Weigh loss | Yes | No | | | |

| Endocrine | | | Genitourinary | | |
|---|---|---|---|---|---|
| Hair Loss | Yes | No | Blood in urine | Yes | No |
| Menopause | Yes | No | Difficult urination | Yes | No |
| Diabetes | Yes | No | Painful urination | Yes | No |
| Thyroid Disorder | Yes | No | Irregular menstruation | Yes | No |
| High Cholesterol | Yes | No | Abnormal bleeding | Yes | No |
| | | | Erectile dysfunction | Yes | No |
| | | | Kidney stones | Yes | No |

| Respiratory | | | Psychiatric | | |
|---|---|---|---|---|---|
| Cough | Yes | No | Depression | Yes | No |
| Asthma | Yes | No | ADD/ADHD | Yes | No |
| Shortness of breath | Yes | No | Anxiety/Panic Attacks | Yes | No |
| Trouble breathing | Yes | No | Eating Disorder | Yes | No |
| Sputum or Phlegm | Yes | No | Hallucination | Yes | No |
| Coughing up blood | Yes | No | Irritability | Yes | No |
| | | | Suicidal thoughts | Yes | No |
| | | | Bipolar | Yes | No |

| Cardiovascular | | | Hematological | | |
|---|---|---|---|---|---|
| Palpitations | Yes | No | Easy bruising | Yes | No |
| Swelling | Yes | No | Bleeding disorders | Yes | No |
| Syncope | Yes | No | Bleeding tendency | Yes | No |
| High Blood Pressure | Yes | No | Thyroid | Yes | No |
| Heart Disease | Yes | No | Lymphadenopathy | Yes | No |
| | | | Anemia | Yes | No |

| Gastrointestinal | | | Allergic/Immunological | | |
|---|---|---|---|---|---|
| Diarrhea | Yes | No | Seasonal allergies | Yes | No |
| Changes in bowel habits | Yes | No | Immune disorders | Yes | No |
| Abdominal pain | Yes | No | Food allergies | Yes | No |
| Change in appetite | Yes | No | Skin rashes/reactions | Yes | No |
| Constipation | Yes | No | Hives | Yes | No |
| Blood in stool | Yes | No | Allergies | Yes | No |
| Indigestion | Yes | No | | Yes | No |

**Signature: _____ DOB: _____ Date: _____**

**Paul E. Pinson, M.D.**
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Cleveland, TN 37312

**Please List All MEDICATION ALLERGIES:**

_____

_____

**List ALL Prescription Medications (Provide printout or copy of list, if you have one):**

| Medication | Strength | Dosage Instructions | How Long in Use |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Past Medical History: (Circle ALL that apply)**

| | | | | |
|---|---|---|---|---|
| Abdominal | Skin | Groin | Rectal | Digestive |
| Weight Loss | Hip/Leg | Cholesterol | Arthritis | Allergies |
| Acute Infections | Venereal Disease | Heredity Defects | Lyme Disease | Gallstones |
| Diabetes | Hypertension | Cancer | Meningitis | Heart |
| Lung | Liver | Kidney | Ear | Sleep |
| Lupus | Pancreas | Neck | Eyes | HIV/AIDS |
| Asthma | Back Pain | Foot Pain | Urinary | Bowels |
| Nausea | Hand | Shaking | Fainting | Memory Loss |
| Headaches | Migraines | MS | Convulsions | Spasms |
| Thyroid | Dizziness | Anxiety | Depression | Psychological |
| Fatigue | Stroke/TIA's | Seizures | Parkinson's | Fibromyalgia |
| Head Injury | Cerebral Palsy | Vertigo | Balance Problems | Attention Problems |
| Numbness | Swallowing | Anemia | Female Issues | |

**Signature: _____ DOB: _____ Date: _____**

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**Please List ALL surgeries and hospitalizations and provide dates:**

_____

_____

**SOCIAL HISTORY**

**# Of Brothers: _____ # Of Sisters: _____ # Of Children: _____**

**Circle: Mother is ALIVE / DECEASED Father is ALIVE / DECEASED**

**Patient Social History: Education Level: _____ Current Job: _____**

**Employer Name: _____ Employment Status (Circle): Full Time Part Time**

**Prior Work History: _____**

**Use of Alcohol (circle): NEVER RARELY MODERATE DAILY**

**Use of Tobacco (circle): NEVER FORMER Current packs per day: _____ Would you like to quit? Y / N**

**Use of Illicit drugs (circle): NEVER RARELY MODERATE DAILY**

**FAMILY HISTORY**

**If applicable, enter M (Mother); F (Father); S (Sibling); C (Child); PGF (Paternal GrandFather); MGF (Maternal GrandFather); PGM (Paternal GrandMother); MGM (Maternal GrandMother).**

| **Cardiovascular** | Parkinson' Disease | **Oncology** |
|---|---|---|
| CAD | Seizures | Cancer |
| Heart Disease | Stroke | Metabolic Disease |
| **Gastro** | **Psychiatric** | Headache |
| GERD | Depression | Muscle Weakness |
| **Neurology** | Drug Abuse | Myopathy |
| Dementia | Endocrine | Peripheral Neuropathy |
| Migraine | Diabetes | Tremor |

**Signature: _____ DOB: _____ Date: _____**

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Cleveland, TN 37312

# Pain Management Agreement

The purpose of this agreement is to create an understanding regarding controlled substances (a type of medication that is regulated by states and the Federal government) that may benefit your chronic pain symptoms. My goal is to treat you safely with these potent medications and also to prevent abuse of or addiction to these medications. Medications such as opioids (narcotic analgesics), benzodiazepines tranquilizers, barbiturate sedatives, and muscle relaxants, that may be useful in managing pain, can be problematic in several ways. These medications have "street value" and potential for abuse. Although these medications may be prescribed with the goal of improving your comfort and functionality, their medical use is also associated with the risk of serious adverse effects such as development of an addiction disorder or a relapse in a person with a prior addiction history. The extent of this risk is uncertain, but it is known to be higher in certain vulnerable patients. My goal is to have you take the lowest possible dose of medication that is reasonably effective in managing your pain and improving your function, and when possible, have it tapered and eventually discontinued, while at the same time monitoring and managing these potential risks.

Because these medications have the potential for abuse or diversion (i.e. sharing, trading or selling to ANYONE other than whose name is on the prescription), strict accountability is necessary for both medical safety and legal reasons. Therefore, the following policies are agreed to by you, the patient, to help me keep you safe and to provide you with good care.

1. You must get a prescription for all controlled substances from Pain and Spine Specialists or, during his or her absence, by the covering physician, unless specific written authorization is obtained for an exception. (Multiple sources can lead to unwanted medication interactions or poor coordination of treatment.)

2. You must obtain all controlled substances from the same pharmacy. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is _____ and their phone number is _____.

3. You must inform our office of any new medications or medical conditions and of any adverse effects you experience from any of the medications that you take.

4. You must give the prescribing physician permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability and coordinating your care.

5. You may not share, sell or otherwise permit others to have access to these medications. You must take all medications exactly as prescribed, unless you develop side effects. If you develop side effects, you must consult with your doctor or local emergency providers.

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Cleveland, TN 37312

6. You must not stop these medications abruptly or without consulting the prescribing physician, as an abstinence/withdrawal syndrome may develop.

7. You must agree that your urine may be tested for controlled substances before initiation of therapy, random urine samples and random pill counts. You must cooperate in such testing, and you must agree that the presence of unauthorized substances, illicit substances or absence of prescribed medications may prompt referral for assessment for addictive disorder and possible tapering and discontinuation of the controlled substances immediately or in the future.

8. You will not give your prescriptions or bottles of these medications to anyone else. These substances may be sought by other individuals with chemical dependency and should be closely safeguarded. You will take the highest degree of care with your medications and prescriptions. You will not leave them where others might see or otherwise have access to them.

9. **You must bring original containers of medication to each office visit.**

10. You must keep all controlled substances in a secure area. Since the medications may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.

11. You must exercise extreme caution when taking these medications and driving or operating heavy machinery. The use of these medications may induce drowsiness or change your mental abilities, thereby making it unsafe to drive or operate heavy machinery. The effects of these medications are particularly problematic during any dose changes. If you are the slightest bit impaired, you must refrain from these activities.

12. You must discuss the long-term use of controlled substances with your physician. Prolonged opioid use can be associated with serious health risks. You need to understand these risks.

13. You must agree that medications will not be replaced if they are lost, flushed down the toilet, destroyed, left on an airplane, etc. If your medication has been stolen and you complete a police report regarding the theft and present that report to the prescribing physician, an exception may be made at the discretion of your treating physician.

14. You must agree that early refills will not be given.

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15. You understand that prescriptions may be issued early only if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date.

16. You agree that, if the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.

17. You agree that failure to adhere to these policies may result in tapering and cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.

18. You agree that prescription renewals are contingent on keeping scheduled appointments. Do not phone for prescriptions after hours or on weekends. If you receive any controlled substances in an ER, you must report that incident to your prescriber, in writing, within 48 hours.

19. You recognize that any medical treatment is a trial, and that continued prescription is contingent on evidence of benefit and improved functionality.

20. You acknowledge that the risks and potential benefits of therapy with controlled substances have been explained to you and that you have had the opportunity to ask any questions that you may have. You understand and agree that failure to adhere to these policies will be considered noncompliance and may result in cessation of opioid prescribing by your physician and possible dismissal from this clinic.

I affirm that I have full right and power to sign and be bound by this Pain Management Agreement. I further affirm that I have been given the opportunity to ask any questions I may have and that I have read, understand, and accept all of its terms.

**Signature: _____ DOB: _____ Date: _____**

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# Non-Compliant Patient Policy

Our office policy allows us to terminate or discharge patients who are non-compliant to our office policies with or without notice.

Should you do any of the following, you could be terminated/discharged as a non-compliant patient:

- Repeatedly fail to show up for scheduled appointments (policy: 1 no show = 1 warning; 2 no show = discharge)
- Repeatedly reschedule appointments (Policy: 3 reschedules in one year, must reschedule with at least 24 hour notice)
- Failure to show up for procedures (Policy: 1 reschedule allowed with 24 hour notice)
- Failure to take prescribed medications as directed
- Failure to obtain imaging studies, laboratory test, or other diagnostic procedures
- Dropping out of physical therapy or refusing physical therapy
- When referred to a specialist, not making or keeping appointments
- Abusive behavior towards staff members
- Failure to comply to any/all parts of Pain Management Agreement
- Failure to show up for mandatory pill count

We are concerned about your health and non-compliance endangers your health. Your condition requires continued medical care and your well-being demands that you actively participate in your treatment plan. We need you to be engaged in this process, or we cannot, in good conscience, continue to have you as a patient.

By signing below, you understand our office policy and will follow your treatment plan as discussed with your provider. Should you be non-compliant, you understand you may be terminated/discharged as a patient and will need to go to your primary care doctor and establish care with another Pain Management Specialist.

**Signature: _____ DOB: _____ Date: _____**

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# Notice of Privacy Practices

**FOR YOUR PROTECTION**

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.

**YOUR RECORDS ARE PRIVATE**

We understand that information we collect about is personal. Keeping these records private is one of our most important responsibilities. Pain and Spine Specialists follows the HIPAA regulations which require many safeguards to protect your privacy. For this notice, we will use the term "records" to mean the paper or electronic records we maintain about you.

Your records may be used and disclosed by the employees at Pain and Spine Specialists who serve you, as well as persons or agencies who work for us and sign strict confidentiality contracts.

**WHO SEES AND SHARES MY RECORDS?**

In general, we may use and disclose your information for treatment, payment and healthcare operations. Specific examples include:

- Providing treatment for your medical problems, including ordering lab tests, making referrals to other healthcare providers, and consulting with other medical providers you have seen,
- To secure payment, for example, a billing clerk will electronically transmit billing information to your insurance company or 3rd party payer
- Certain business associates, who are under contract to maintain confidentiality, may see your information. For example, if you accidently overpay, and we send a refund check, our accountant may see this refund check.
- For other operations to operate and manage Pain and Spine Specialists: these include improving quality of care, training staff, managing costs, and conducting other business duties. For example, a quality assurance reviewer may audit your records to determine whether appropriate services were provided,
- To remind you of an appointment for services,

**COULD MY RECORDS BE RELEASED WITHOUT MY PERMISSION?**

There are limited situations when we are permitted or required to disclose your records, or parts of them, without your signed permission. These situations include:

- Reports to public health authorities to prevent or control disease or other public health activities,
- To protect victims of abuse, neglect, or domestic violence,
- For oversight including investigations, audits, accreditation and inspections, such as are conducted by the State Department of Health, or State Pharmacy Board, and federal agencies,
- When a court order, subpoena or other legal process compels us to release information,
- Reports to law enforcement agencies when reporting suspected crimes, when responding to an emergency or in other situations when we are required to cooperate,
- In connection with an emergency, or to reduce or prevent serious threat to public health and safety,
- to coroners, medical examiners and funeral directors,
- to victims of alleged violence or sex offenses,
- For workers' compensation programs,
- For specialized government functions including national security, protecting the president, operating government benefit programs, and caring for prisoners,
- In connection with "whistle blowing" by an employee of Pain and Spine Specialists.

All other uses not described above require that we obtain your signed permission as described below.

**WHAT IF MY RECORDS NEED TO GO SOMEWHERE ELSE?**

For any purpose not described above, we will release your information only with your explicit written authorization. Federal law requires that we notify you that all healthcare providers must obtain your permission to release your information for any of the following:

1. To release Psychotherapy Notes,

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Cleveland, TN 37312

2. For marketing purposes,
3. To sell information about you.

Please note that it is not and has never been this practice's policy to sell information about you or to use your information for marketing.

Your written permission, called an "authorization," tells us what, where, why and to whom the information must be sent. Your signed authorization is valid until the date you specify. You can revoke this authorization at any time by letting us know in writing.

**WHAT ARE MY RIGHTS REGARDING PRIVACY, ACCESS TO MY RECORDS, AND THE ACCURACY OF MY RECORDS?**

You have legal rights concerning your privacy, access to your records, and the accuracy of your records:

1. If you request, we will show you your records, or give you a copy.
2. If you think some of the information is wrong, you may ask that it be changed, or that new information be added.
3. If you request, we will mail all communications to a confidential address.
4. If you request, we will provide a list of any places where your records have been sent.
5. You may request that we make additional limits on how we use or disclose your information. We must honor requests to not bill a 3rd party payer if you pay the invoice in full. We will consider other requests but are not obliged to honor them.
6. You may receive a paper copy of this notice.

To exercise any of these rights, mail or email your request to:

HIPAA Privacy Officer
Pain and Spine Specialists
3917 Georgetown Road, NW
Cleveland, TN 37312

**OUR DUTIES**

We are required by law to abide by the terms of this notice. In the event of a breach, that is, an unintended release of your information contrary to these practices, we will notify you via first class mail. From time to time we may make changes to our policies, and if and when we do, your records will be protected by our new, changed policies. Our current notice will always be available on our website.

**QUESTIONS OR COMPLAINTS**

If you have any questions about this notice, or you think that we have not protected your records and you wish to complain about any privacy or records access matter, please contact:

Attn: HIPAA Privacy Officer
Pain and Spine Specialists
3917 Georgetown Road, NW
Cleveland, TN 37312
423-813-3830

We will never retaliate against you for filing a complaint. Further, if you are not satisfied with the results, you may also complain to the federal government:

Secretary of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201
www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

**Signature: _____ DOB: _____ Date: _____**

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# Office Policies and Consent to Treat and Bill

**Financial and Billing Policy**

- I authorize Paul E. Pinson, M.D. and his staff to bill and seek payment from my insurance company for services rendered to me.
- I understand that I am responsible for payment of co-pay, co-insurance, and/or deductible amounts at the time of service.
- I understand that I am responsible for the necessary referrals (if required) from my referring physician. If I do not obtain necessary referrals, I must either reschedule my appointment or pay for the services at the reduced benefit level as stated by my insurance plan.
- I understand that any balance due after insurance is my responsibility and that balance due to Paul E. Pinson, M.D. may be subject to a billing fee or having interest applied if my balance is not paid within 30 days.
- I understand my medical records might not be released until my balance is paid in full.
- I understand that there is a $40.00 fee for returned checks. Payment for returned checks must be made by credit card or money order. Cash is NOT accepted in this office. Returned checks that are not paid after 30 days may be referred to a collection agency and collected to the fullest extent allowed by Tennessee law.
- I understand that if my account is referred to a collection agency for nonpayment, I will be responsible for the total amount of my bill plus collection/attorney fees.

**Authorization to treat and bill for services:**

- I authorize Paul E. Pinson, M.D. and his staff to treat my medical condition(s) and to bill my insurance company for services rendered.
- I authorize Paul E. Pinson, M.D. and his staff to release my medical information to other physicians, my insurance company, or pharmacy if necessary to ensure that I receive quality medical care and to obtain payment for services and/or medications.
- I authorize Paul E. Pinson, M.D. and his staff to release and receive information regarding my prescription history in order to further treat my condition

**Receipt of HIPAA Notice of Privacy Practices**

- I acknowledge that I have been provided the practice's HIPAA Notice of Privacy Practices.

**Signature: _____ DOB: _____ Date: _____**

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## Relative Form

Name: _____ Date: _____

Due to the specialty of this practice, it is very important to notify us if **ANY** of your relatives are also under the care of Paul E. Pinson M.D. List your relatives under our care and your relationship to them.

- Relative: _____ Relationship: _____
- Relative: _____ Relationship: _____
- Relative: _____ Relationship: _____
- Relative: _____ Relationship: _____
- Relative: _____ Relationship: _____

Please understand that falsifying this information will terminate your contract with this office and result in dismissal.

## No-Show and Late Cancellation Fee

Patients who cancel an office visit with less than 24 hours notice or patients who do not come to a scheduled appointment may be subject to a $50.00 fee.

Patients who cancel a procedure appointment with less than 24 hours notice or patients who do not show for a scheduled procedure may be subject to a $75.00 fee.

**Signature: _____ DOB: _____ Date: _____**

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# Privacy Instructions

## Contacting You

We take your privacy very seriously. Please let us know how we may contact you to remind you about appointments, discuss lab test results, and other matters.

| | Specify your Phone Number | OK to Leave Detailed Message | Leave Message with our practice name and callback number only | Do Not Call |
|---|---|---|---|---|
| Home | (  )  - | ☐ | ☐ | ☐ |
| Work | (  )  - | ☐ | ☐ | ☐ |
| Cell | (  )  - | ☐ | ☐ | ☐ |
| Fax | (  )  - | ☐ | ☐ | ☐ |
| Other | (  )  - | ☐ | ☐ | ☐ |

Normally, Pain and Spine Specialists will NOT contact you via email. However, in the event of any breach of confidentiality or security, email will be the fastest way to advise you.
Email Address: _____

☐ I authorize Pain and Spine Specialists to notify me via email in the event of a data breach

## Others we may speak with

Please give us guidance regarding speaking with any family or friends when we call, or if they contact us regarding your care and/or payment for your care. It is OK for Pain and Spine Specialists to speak with:

| Name | Relationship | Phone | Date of Birth |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

I have received the HIPAA Notice of Privacy Practices and have provided the above instructions.

**Signature: _____ DOB: _____ Date: _____**

---

**For Office Use Only**

Pain and Spine Specialists made a good faith effort to obtain the above information.
□ Individual refused to sign
□ An emergency situation prevented us from obtaining this acknowledgement
□ Other _____

Staff Signature: _____ Date: _____

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# Patient Pregnancy Status

Patient Name: _____

Check all that apply:
[ ] I have had a hysterectomy and am unable to become pregnant.
[ ] I am post-menopausal and I am unable to become pregnant.
[ ] I am not able to get pregnant because: _____

[ ] I am of child bearing age and I am taking the following measures to prevent pregnancy
[ ] Contraception
[ ] Birth Control: (Medication Name): _____
[ ] Other: _____

I understand that it is not recommended that I become pregnant while taking opioid or narcotic medications. I understand that some medications are contra-indicated during pregnancy. For this reason, I **MUST** notify Paul E. Pinson, M.D. immediately should I have a positive pregnancy test, or realize I have become pregnant. I understand that even at the time of a missed period or positive pregnancy test, these medications may already be causing harm to my unborn child. I understand that I cannot hold Pain and Spine Specialists or Paul E. Pinson, M.D. responsible for any harm that may occur if I am pregnant or if I become pregnant. It is ultimately my responsibility to be certain Paul E. Pinson, M.D. is aware that I am pregnant. I have read and understand the following known risks to taking opioids while pregnant. I also understand that Pain and Spine Specialist, or Paul E. Pinson, M.D., is not able to know every possible risk of taking opioids/narcotics while pregnant.

Complication could include a miscarriage or fetal death, pre-term labor and delivery, incomplete lung development, incomplete development of the heart walls which may result in a septic defect, various congenital heart defects, low birth weight, neonatal abstinence syndrome, and other birth defects or pregnancy complications which may result in harm to you or your unborn child or cause a 'high risk' pregnancy rating and monitoring to occur. These may also result in hospitalizations for you and/or your child.

I have read and understand the above risks and agree to notify Paul E. Pinson, M.D. of any concern for pregnancy as well as any positive pregnancy test.

**Signature: _____ DOB: _____ Date: _____**

Pain and Spine Specialists
peace restored

**Paul E. Pinson, M.D.**
3917 Georgetown Road, NW
Cleveland, TN 37312

# OSA Risk Assessment

Signature: _____ DOB: _____ Date: _____

Have you ever been diagnosed with sleep apnea? _____
Are you currently being treated for sleep apnea? _____

If the answer to the above questions is **NO**, then fill out this assessment

| | Yes | No |
|---|---|---|
| Do you snore loudly? | | |
| Do you often feel tired, fatigued, or sleepy during the daytime? | | |
| Has anyone observed you stop breathing or choking/gasping during your sleep? | | |
| Do you have or are you being treated for high blood pressure? | | |
| Are you older than 50? | | |
| Is your neck size large? (For males: shirt collar 17 inches or more, for females: shirt collar 16 inches or more) | | |
| Are you male? | | |
| Is your Body Mass Index (BMI) more than 35 $kg/m^2$?<br>What is your height? _____ Weight? _____<br>**Office Use Only:** Calculated BMI:_____ | | |

**Office Use Only:** Total Yes: _____

**Signature: _____ DOB: _____ Date: _____**