PMS- PATIENT FINANCIAL INFORMATION FORM

Patient Name:____ **Date**:_____-_____-_____

Address:____

City/State/Zip:____ **Drvr Lic#: State:** ______#:___________

E-mail address: ____

Home-Cell Phone:____________________________________ **Work Phone**:_______________________

Social Security No.:____________________________ **Date of Birth:**___________________________

Employer & Address:____

No. Years Employed:____________________________ **Marital Status:** Mar Div Sgl Sep Wid

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SPOUSE INFORMATION: N/A

Name:____ **Date of Birth:**_____________________

Address if different than above:____

____

E-mail address: ____

Employer:____

Cell / Work Phone:____________________________________ Social Security No.:____________________

Emergency Contact other than spouse:____
(Name, address, tel#:)

____

Do not write below this line.

IN-OFFICE USE ONLY:

Current medications list: ____

____

PCP?: ____

Who is last pain medications prescribing physician?: ____

Notice of Oral Fluid testing given? Y N
Notice to bring medication bottles and containers to each visit given?: Y N
Notice that only Cash, Credit Card or Debit Card accepted for payment given?: Y N
Initial of Office agent contacting patient: ____________________________________

INSURANCE INFORMATION: ***Please have insurance card ready for copying.***

Primary Insurance Co.:____

Address:____

Insured
Name:____

Insurance No.:______________________________ Group No.:____________

Date of Birth of policy holder:____________ Effective Date:____________

Deductible Amt: ________ Met?: Yes No Precertification Needed?: Yes No

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Secondary Insurance Co.:____

Address:____

Insured Name:____

Insurance No.:______________________________ Group No.:____________

Date of Birth of policy holder:____________ Effective Date:____________

Deductible Amt: ________ Met?: Yes No Precertification Needed?: Yes No

Do not write below this line.

IN-OFFICE USE ONLY:

Primary Insurance Co. benefits paid:____

____

Secondary Insurance Co. benefits paid:____

____

Remarks:

____

____

____

____

PAIN MANAGEMENT SERVICES
John A. Campa III, MD, PC
1701 MOON ST. NE ▪ SUITE 100 ▪ ALBUQUERQUE, NM 87112 **TEL (505) 508-1543 / FAX (505) 554-2118**
http://paindiagnosis.net help@paindiagnosis.net

Patient Information & Medical History

Name:____Date:___________________

Address:______________________City:___________________State:_______Zip:_________

Phone: (cell) ___________________(home)______________________(work)______________

E-mail:______________________________ DOB:_____________ Age:_______ Sex: F M

Occupation: Retired __________________________ Last 4 numbers of your SSN: _________

How did you hear about us?: Magazine Newspaper Sign Friend:_______________________
TV Internet Dr.____

Medicare, Medicaid Status:
Are you covered by or receiving Medicare benefits? Yes No
Are you covered by or receiving Medicaid benefits? Yes No

Current legal status of your case or problem:

Does your case involve an OPEN legal claim or matter related to Workers Comp or work related injury? Yes No

Does your case involve an OPEN legal claim or matter related to a Motor Vehicle Accident? Yes No

Does your case involve an OPEN legal claim or matter related to a Personal Injury Claim: Yes No

Have you contacted or retained an attorney to assist you with your claim or lawsuit?
Yes No

Attorney Name-Address-Tel:____

Disability Status:
Have you been denied disability benefits ? Yes No

Are you receiving Private Disability Insurance benefits (loans, credit-card, etc.)?:
Yes No Application pending

Are you receiving SSA-SSDI (Title II) disability benefits?: Yes No Application pending

Are you receiving SSA-SSI (Title XVI) benefits?: Yes No Application pending

Are you receiving VA benefits for a military service connected disability?:
Yes No Application pending

Describe the military service connected disability:_________________________________

Patient Information & Medical History
- continued.

Current Pain Problem - What is your main problem and What part of your body does your problem affect most ?:

____

____

It has been present for how long?: ____

How did your problem begin or start?: ______________________________________

____

Was a nerve/EMG test done? Y - N Did it show neuropathy? Y - N

Describe your pain - Circle all that apply - Is your pain?:

constant off & on sharp aching squeezing tight burning tingling numb

shooting electric-like cold

worse-night worse-with-weight-bearing pins-needles throbbing pressure

Other words:

____

What is your average Pain Score?:

If zero is no pain & ten (10) is the worst pain you can imagine, from 0 to 10, What is your average pain score?:

____

Medical History (circle yes or no, and explain yes answers)

Are you?: Right Handed Left Handed Both

How tall are you?: ______________________________

Yes No Do you have control of your bowels & bladder?
If not, what is the cause?____

Yes No Are you allergic to Local Anesthetics like Lidocaine or Xylocaine or metals or egg whites?

Yes No What medications are you allergic to?

Yes No Do you have a history of severe, life-threatening allergic/anaphylactic reactions or other multiple severe allergies? What are they:
____

Yes No Have you had a serious reaction to moisturizing creams or other hyaluronic acid products?

Patient Information & Medical History
- continued.

Yes No Have you had lab work that included: CBC-Complete Blood Count, PT, PTT ?
If so, when were the last tests done ? ________________________________

Yes No Do you have a serious preexisting disease such as diabetes, congestive heart failure, uncontrolled coronary artery disease, Rheumatoid arthritis, lupus, Hepatitis-C, HIV-AIDS or any other or have you undergone transplant surgery?

Yes No Do you have a history of large, raised or thick scars or keloid scars?

Yes No Are you under the care of a physician?
Name of last Pain Management doctor:________________________________

Yes No Are you pregnant or breastfeeding?

Yes No Could you be pregnant? Your last period was when?:____________________

Yes No Are you on Birth Control? What kind?: ________________________________

Yes No Tobacco use: None cigarettes cigars chewing pipe snuff
Packs per day: 1/2 1 2 3 / For how long?: ____________Yrs
Were you a smoker ?: No Yes How long you smoked?:__________

Yes No Alcohol use: None beer liquor wine / Daily Weekly Socially
For how long?: ____________________ Yrs

Yes No Are you a recovering alcoholic?: No Yes
If Yes, Last drink when?:__________________

Yes No Substance Abuse/Recreational drug use now & in the past: None
List:
____

Please circle diseases or medical problems below that you have or have had:

Diabetes Shingles-PHN Neuropathy HBP-High Blood Pressure RA-Rheumatoid Arthritis
Migraine SLE-Lupus Scleroderma Hepatitis-C HIV-AIDS Transplant surgery
Heart Disease Stroke-TIAs Epilepsy-Seizures MS-Multiple Sclerosis Myasthenia Gravis
Low-High Thyroid Vitamin Deficiency-B12 Anemia Sickle Cell Lyme Disease
Bleeding-Clotting-Problem DVT PE-Pulmonary Embolism

Cancer-Type: ____

Fractures:

____

Please list surgeries:

____
____
____

Patient Information & Medical History
- continued.

Other unlisted problems?:

____
____
____

Please circle or list medications & doses you are taking:

Hydrocodone/APAP   Oxycodone   Hydromorphone   Dilaudid   Morphine   Tramadol

Methadone   Duragesic   Fentanyl   Insulin   Metformin   Gabapentin   Lyrica   Cymbalta

Vit. D   B12   Folic Acid   Coumadin-Warfarin   Heparin   Lovenox

*****Are you taking any Drugs that suppress your immune system ? Y - N

FAMILY HISTORY:

Please circle diseases or medical problems below that members of your FAMILY have:

Diabetes   Shingles-PHN   Neuropathy   HBP-High Blood Pressure   RA-Rheumatoid Arthritis   Migraine   SLE-Lupus   Scleroderma   Hepatitis-C   HIV-AIDS   Transplant surgery
Heart Disease   Stroke-TIAs   Epilepsy-Seizures   MS-Multiple Sclerosis   Myasthenia Gravis   Low-High Thyroid   Vitamin Deficiency-B12   Anemia   Sickle Cell   Lyme Disease
Bleeding-Clotting-Problem   DVT   PE-Pulmonary Embolism

Cancer-Type: ____
____
____

Comments:

I ATTEST THE ABOVE INFORMATION TO BE TRUE, KNOWING MY PHYSICIAN RELIES ON THIS INFORMATION TO PROVIDE SAFE AND EFFECTIVE TREATMENT RECOMMENDATIONS.

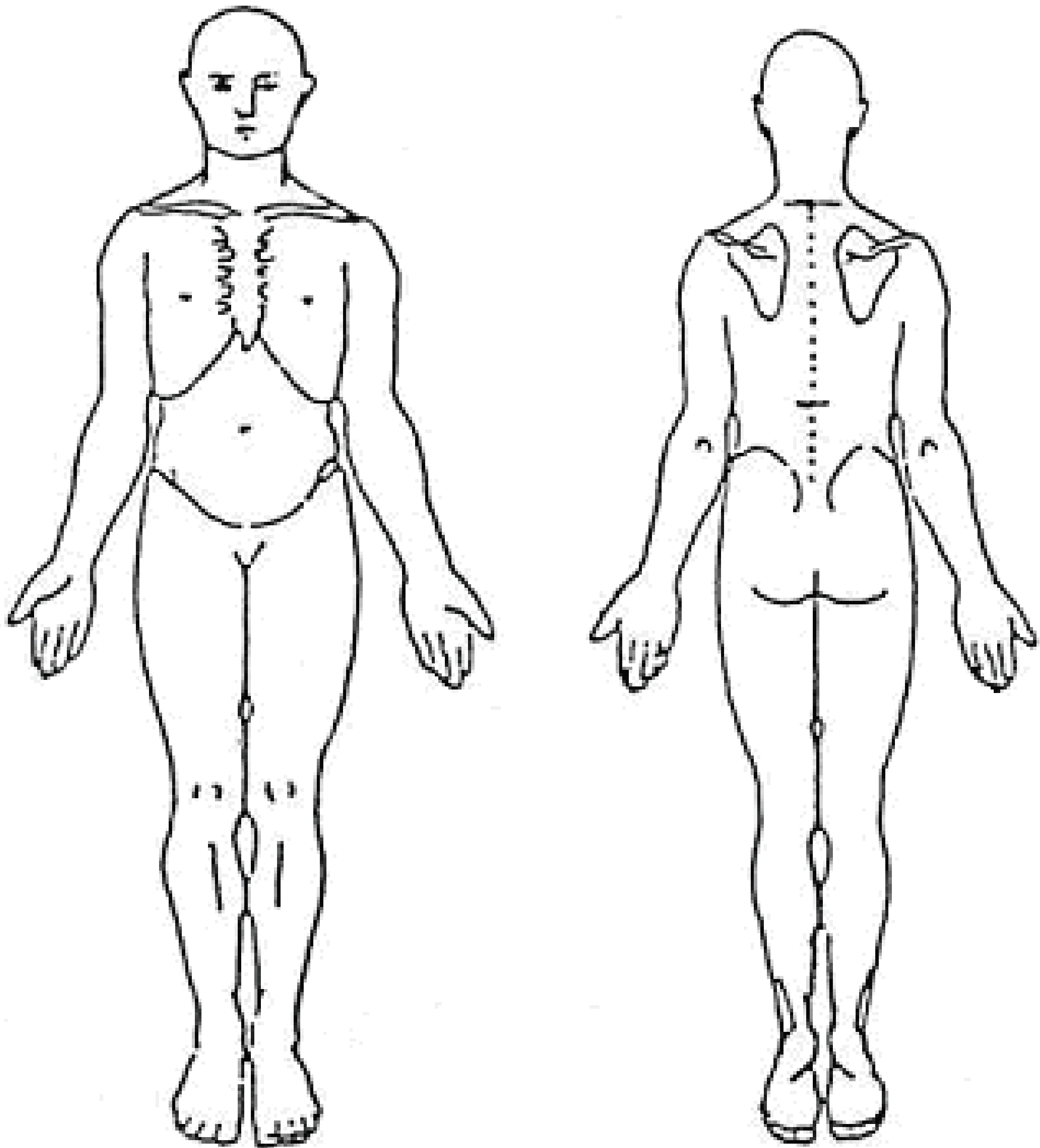
Patient Signature ____

Date: ____

SYMPTOM BODY FIGURE – FOR SHOWING SYMPTOMS OR PAIN

Patient: ______________________________ Date: ________________

- Place a "X's" your symptom or pain is constant and "Y's" where it shoots to.
- Place "O's" where the symptom or pain is most severe.
- Write any comments in the white space around the figures you believe would be helpful to the doctor, such as areas of numbness, tingling or weakness.



KEY: 'X' = CONSTANT 'Y' = RADIATES 'O' = MOST SEVERE

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INDIVIDUAL PATIENT DISCLOSURE AUTHORIZATION OF INFORMATION FORM

I. AUTHORIZATION TO DISCLOSE AND OBTAIN PROTECTED HEALTH INFORMATION

A. Reason (event) for obtaining / disclosing requested protected health information: Continuity of Medical Care

B. I authorize John A. Campa III, MD to disclose my protected health medical information to:

- **Strike through an item below to decline authorization:**
- Any referring or consulting: physician, attorney, Case Management Nurse
- Hospital, Medical Facility, Pharmacy, Pharmacist providing medications

C. I authorize John A. Campa III, MD to obtain medical information from:

- **Strike through an item below to decline authorization:**
- Any referring or consulting: physician, attorney, Case Management Nurse
- Hospital, Medical Facility, Pharmacy, Pharmacist providing medications

D. I understand this authorization provides that:

- I have the right to access my protected health information to be used or disclosed.
- I may revoke this authorization at any time by contacting your Privacy Officer in writing at: John A. Campa III, MD, c/o Privacy Officer, 1701 Moon St. NE, Suite 100, Albuquerque, NM 87112.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA privacy rules.
- This practice will not condition treatment on my providing authorization for the requested use or disclosure.

____ ____________________

PATIENT'S / GUARDIAN SIGNATURE & RELATIONSHIP TO PATIENT DATE

____

WITNESS

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MEDICATIONS & PHARMACY INFORMATION

1. If you are coming to our office for the first time, you must bring with you all CURRENT pain medication prescription bottles that you are taking.

Comments: ____

2. List the pharmacies and locations where you fill your prescriptions:

____
____
____

MEDICAL RECORDS INFORMATION

If you are coming to our office for the first time, please provide the following medical records information:

1. Last Pain Management doctor's name & address:

____
____
____
____

2. The address & name of the hospital or outpatient center if you were in the hospital or center in the last 2 years for a Pain Management reason or surgery:

____
____
____

3. When & Where you had your X-rays, MRI or CT-scans for your pain problem:

____
____
____
____

4. When & Where you had your last blood work done:

____
____
____
____

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PATIENT:_________________________________ **ADDRESS:**____

CAREGIVER: ______________________________ **ADDRESS:**____

INFORMED CONSENT:

- FOR PATIENT OR CAREGIVER

- Dr. Campa will be prescribing Controlled Substance Medications to assist you in the management of your pain.
- These medications can help you.
- They can also hurt or result in death when not taken with the proper guidance and precautions.
- Some of the main dangers that may result from their use are:
    - ❖ If you take controlled substances with alcohol or other medicines, you could get sick or die.
    - ❖ You can become sleepy.
    - ❖ You could become unable to drive a motor vehicle or use machinery.
    - ❖ You could have trouble breathing.
    - ❖ You could develop constipation or have trouble urinating.
    - ❖ You could become allergic to controlled substances.
    - ❖ Controlled substances can cause side effects like confusion, nausea and vomiting.
    - ❖ Controlled substances can harm your unborn baby or pass from your breast milk to the baby.
    - ❖ You could develop a physical need for controlled substances. This is called: **DEPENDANCE**
    - ❖ You could become sick, if you suddenly stop controlled substances. This is called: **WITHDRAWAL**
    - ❖ You could develop a strong CRAVING and abuse controlled substances. This is called: **ADDICTION**
- You will bear any costs incurred when you undergo blood, urine or oral fluids testing. The cash price per test for these services will range from: $100 - $200 (Oral Fluids Testing).
- Dr. Campa will answer any questions you may have regarding the use of these medications.
- Please do so before signing below.

I ATTEST I have read and understand this Informed Consent, as detailed above. Dr. Campa has answered any questions I may have had regarding the use of Controlled Substances and the risks associated with that use, and I freely assume those risks.

SIGNATURES:

Patient: ____________________________________ **Caregiver(s):** ____________________________________

Date: ____________________________________

PATIENT – PHYSICIAN MEDICATION CONTROLLED SUBSTANCE AGREEMENT AND INFORMED CONSENT

VERY IMPORTANT – READ CAREFULLY BEFORE YOU SIGN!

Patient & Physician Agreement – Patient or Caregiver to enter initials for each item:

1.) ____ The patient/caregiver(s) agree(s) that all prescription renewals must be anticipated in a timely manner, that is within **3 (three) days before** prescription expiration or exhaustion in order to obtain a renewal, if deemed medically appropriate by the physician. Less than a three day notice will likely result in a three to ten day delay in responding to the request, depending on physician availability, and patient may experience withdrawal symptoms.

2.) ____ The patient/caregiver(s) is responsible for informing the physician of the renewal within the time period above, either in person at follow-up or by telephone - **(866) 284 – 6970 - press '7'** - during regular business hours (8:30 a.m. – 4:00 p.m., MST). After hours, weekend and holiday requests will NOT be considered. Controlled substances (including Ultram, Ultracet, Tramadol, Soma, Soma Compound, Carisoprodol) prescriptions may only be picked up in person (must be over 18 yo.) or by the patient's representative (must be over 18 yo.), with proper picture identification (e.g., valid driver's license). It is the patient's responsibility to make arrangements and prepay a common carrier (e.g., Fed Ex/UPS) for those prescriptions that are to be sent by courier to the designated pharmacy.

3.) ____ The patient/caregiver(s) agree(s) to bring the MOST RECENT prescription container for EACH controlled substance (including Ultram, Ultracet, Tramadol, Soma, Soma Compound, Carisoprodol) that requires renewal. The containers MUST correspond to the last prescription recorded in the medical record with the labels intact and legible so that appropriate control information may be documented by the physician in the medical record. Specifically, the prescription registration number and pharmacy telephone number will be noted and verified. The patient/caregiver(s) agree(s) to trade with only ONE pharmacy regarding controlled substances (including Ultram, Ultracet, Tramadol, Soma, Soma Compound, Carisoprodol) so as to facilitate this AGREEMENT. Where necessary, the patient must provide a readily verifiable reason for use of another pharmacy.

4.) ____ The patient/caregiver(s) agree(s) to safe keep these controlled substances in a secure manner, so as to prevent access to children and unauthorized persons. In the event of a theft or loss of a controlled substance (including Ultram, Ultracet, Tramadol, Soma, Soma Compound, Carisoprodol) medication or prescription, the local police <u>must</u> be notified and a copy of the OFFICIAL police report be brought to the this office which MUST include the Officer's printed name, badge/ID number and telephone number of the police department making the report. Only then will the physician consider the request for a prescription renewal.

5.) ____ At the discretion of the physician, DNA Pharmacogenomics (to test your liver's ability to metabolize narcotics, one time test) periodic patient NM State Board of Pharmacy (prior and current) PMP - Prescription Monitoring Program medication profiles and/or random oral, blood and urine toxicology drug screens for controlled substances or drugs of abuse as well as narcotic blood levels of the patient/caregiver(s) may be ordered to verify compliance with this AGREEMENT. You will bear any costs incurred when you undergo blood, urine or oral fluids testing. The cash price <u>per test</u> for these services may range from: $100 - $200 (Oral Fluids Testing)

6.) ____ Should the patient receive controlled substances (including Ultram, Ultracet, Tramadol, Soma, Soma Compound, Carisoprodol), such as NARCOTICS and SEDATIVES, from other providers, this office MUST be informed by the patient/caregiver(s) WITHIN 72 HOURS of having filled the prescription. The following information will be given to the office: the provider's name and telephone number and the reason for the prescription.

7.) ____ Should the patient/caregiver(s) not adhere to or otherwise violate this AGREEMENT or furnish false information, then the patient may be discharged from the physician's care with two weeks notice being given immediately, in writing, sent to the patient's/caregiver(s)'s last address of record. Alternative remedies and/or consequences will be at the discretion of the physician.

8.) ____ Should the undersigned physician believe that I may have developed a medication use problem, I agree to undergo an evaluation by a clinical expert specialized in the diagnosis of drug addiction or substance abuse disorders; otherwise, I understand that I will be dismissed from care.

9.) ____ Pursuant to New Mexico Senate Bill 215 and NM Medical Board Title 16, Chapter 10, Part 14 - Rule regarding Management of Pain with Controlled Substances, and in order to comply with the above regulations and guidelines and to further the safe use and prescription of controlled substances for patients that require pain management, the patient/caregiver(s) recognizes that the current office procedure will require the following:
- The frequency of routine medication follow-up for the renewal of prescriptions for controlled substances will depend on a particular patient's individual case specifics, as well as the following:

- the type of controlled substance prescribed
- the <u>DEA Federal Class level</u> of the controlled substance prescribed
- the number of controlled substances prescribed
- the total quantity of medication prescribed
- any particular concerns the physician may have regarding the patient's use and safe-keeping of their medication

- With the above in mind, the patient/caregiver(s) understands that medication follow-ups for refills may be required at monthly intervals, varying from: 1, 2, 3, 4 or 6 months, routinely at <u>2 months</u> if patient is in <u>good standing</u> with the this practice.

- If significant medication use and/or safe-keeping issues occur, then a patient may be seen as often as every 1-2 weeks, until the problem is resolved.

- Routine drug testing, either in the form of urine or oral fluids toxicology may be performed at each visit. The patient will be responsible for any cost incurred. The cash price <u>per test</u> for these services may range from: $100 - $200 (Oral Fluids Testing).

- The New Mexico Prescription Monitoring Program that tracks a patient's prescriptions filled for controlled substances across the state, including the pharmacy used and the prescribing doctor, will be queried on a regular basis. Any irregularities found that cannot be adequately explained, may result in the patient being dismissed from care.

10.) ____ MEDICAL NOTES AND EXCUSED ABSENCES FROM WORK OR SCHOOL:
I understand that should I be absent from work or school due to my pain condition, to obtain a medical excuse, I will need to come to the office and be seen that day. The medical note to cover my absence will only cover a period from the day I was seen by the doctor, and any time the doctor recommended after that date. Medical notes for work or school absences will NOT be given for any dates that the doctor did not authorize.

11.) ____ By my signature below, I ATTEST that I/caregiver am not in violation of or have not violated any other healthcare provider Controlled Substances or Medication Use Agreement, now or in the past. Failure to disclose this information may result in dismissal from care.

I ATTEST I have read, understand and Agree to abide by the Patient-Physician Medication Controlled Substance Agreement, as detailed above.

SIGNATURES:

Patient: ____ Caregiver(s): ____

Date: ____

Witness: ____ **Prescribing Physician: John A. Campa III, MD**

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TO ALL PATIENTS & CAREGIVERS –

DEDICATED PRESCRIPTION REFILL LINE NOTICE

As the practice has become very busy, and due to our limited staff resources, we do not take prescription refill requests over the phone. With receipt of this letter, you are hereby advised that requests for Prescription Refills **MUST** be called in to our:

Dedicated Voice Mail for Medication Refills

Phone# to call: (866) 284 – 6970 - Then press '7'.

This will apply to ALL Prescription Requests. If you forget and call in to the office, your request will not be taken by our staff and you will be reminded to call the above number. Remember, as before, your request must be received no later than three (3) working days **PRIOR** to the date you need your prescription – Unless you are undergoing a narcotic taper process by the doctor.

We appreciate your cooperation and regret any inconvenience this may cause.

Clinical Staff for - John A. Campa III, MD

This procedure will be in effect for you, upon receipt of this notice.

Patient and/or Caregiver, Sign below:

Notice Received by: ____

Date: ________________________________

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NOTICE OF $50 MISSED APPOINTMENT NO-SHOW, NO CALL FEE

Read carefully, initial and sign below.

1. With my signature below, I acknowledge that I will be responsible for paying in full, a fee of $50.00 (Fifty dollars), should I not show up to an appointment, and not call the office, (505) 508-1543, to inform the staff or leave a message, that I would be unable to make the appointment, with either Dr. Campa or Dr. Larison. ______ **Initials**

2. I understand that no further medical care or prescriptions will be provided to me, effective the date of the missed appointment, until the above amount is paid. ______ **Initials**

3. I understand that after the third missed appointment, no-call, no-show occurrence, I will be dismissed from the practice, and no further medical care or prescriptions will be provided to me, effective the date of the missed appointment. ______ **Initials**

4. I have read and agree to the above. My signature and printed name appear below. ______ **Initials**

______________________________ ______________________________

Patient signature **Date signed**

____

Patient Printed Name

10-26-2015

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PAIN MANAGEMENT COMPLIANCE PROCEDURE FOR THIS PRACTICE, AS PER:

- **New Mexico Senate Bill 215**
- **NM Medical Board Title 16, Chapter 10, Part 14 - Rule regarding Management of Pain with Controlled Substances**

In order to comply with the above regulations and guidelines and to further the safe use and prescription of controlled substances for our patients that require pain management, the current office procedure will require the following:

- The frequency of routine medication follow-up for the renewal of prescriptions for controlled substances will depend on a particular patient's individual case specifics, as well as the following:

- the type of controlled substance prescribed
- the **DEA Federal Class level** of the controlled substance prescribed
- the number of controlled substances prescribed.
- the total quantity of medication prescribed
- any particular concerns the physician may have regarding the patient's use and safe-keeping of their medication

- With the above in mind, medication follow-up visits for refills may be required at monthly intervals, varying from: 1, 2, 3, 4 or 6 months.

- If significant medication use and/or safe-keeping issues supervene, then a patient may be seen as often as every 1-2 weeks, until the problem is resolved.

- Routine drug testing, either in the form of urine or oral fluids toxicology may be performed randomly while you are a patient of this practice. The patient will be responsible for any cost incurred.

- The **New Mexico Prescription Monitoring Program** that tracks a patient's prescriptions filled for controlled substances, the pharmacy used and the prescribing doctor, will be queried on a regular basis. Any irregularities found that cannot be adequately explained, may result in a patient being dismissed from the practice.

- A **Physician-Patient Controlled Substances Agreement** must be signed by the patient.

Signature of Patient: ____________________

Date Signed: ____________________