READ ME - VERY IMPORTANT APPOINTMENT NOTICE

The **Patient Questionnaire** included in this packet is absolutely essential to the efficient use of your appointment time.

Depending on the complexity of your problem and past medical and surgical history, estimated time to complete the packet is 30-60 minutes.

At your first appointment, **1 ½ hours** is provided for the doctor to review the completed Questionnaire and then discuss your problem with you in detail. A comprehensive, in-depth physical exam will then be performed – in order to provide you with the best diagnosis and treatment recommendations possible.

Because of this, the Patient Questionnaire **MUST** be completed and returned to our office **BEFORE** an appointment is scheduled.

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

---

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#:)

____

Provide Insurance Information on next page.

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

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:

____

____

____

____

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 and psychological 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 and psychological 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. Drugs of Abuse – Mental Illness – Communicable Diseases Authorization:

- **Strike through an item below to decline authorization:**
- I hereby authorize John A. Campa III, MD and its duly authorized agents and employees to disclose or obtain protected health information, including the patient's identity, pertaining to any medical care and treatment, including records involving communicable or venereal disease, psychiatric, drug abuse and/or alcoholism.
- The information authorized for disclosure may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to disease such as hepatitis, syphilis, gonorrhea and human immunodeficiency virus (HIV), also known as acquired immune deficiency syndrome (AIDS).

E. I authorize the disclosure of any medical information necessary to process this claim.

F. **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.
- I will receive a copy of this completed and signed authorization form.

____ ____________________

PATIENT'S / GUARDIAN SIGNATURE & RELATIONSHIP TO PATIENT DATE

____

WITNESS

AUTHORIZATION – ASSIGNMENT OF MEDICAL BENEFITS

I. ASSIGNMENT OF MEDICAL BENEFITS

I hereby assign, transfer and set over to: John A. Campa III, MD, all of my rights, title and interest to my medical **reimbursement** benefits for services rendered under my insurance policy.

II. ROUTINE COLLECTIONS WAIVER – WHEN THE INSURANCE CHECK IS SENT TO THE PATIENT

In the event the **payment** for my medical reimbursement benefits for services rendered under my insurance policy is sent directly to me and/or deposited to a bank account under my control, or to an account to which I have access to, or to an account of a family member, I hereby **waive** my right to the normal collection procedures, notices and letters used in medical collections and agree that such payment that I have received, as stated above, will become immediately due and payable to: John A. Campa III, MD, **within 10 days** of receipt of same.

I agree to contact and notify the practice of John A. Campa III, MD **within this same 10 day** period to arrange delivery of the payment received to his office.

I understand that should I fail to comply with the above, I may be additionally liable and responsible for any of the following required to collect the above payment:

- Attorney's fees
- Court costs
- Subpoena costs
- Reasonable interest due on the outstanding payment

____ ____________________

PATIENT'S / GUARDIAN SIGNATURE & RELATIONSHIP TO PATIENT DATE

____

WITNESS

PATIENT – PHYSICIAN MEDICAL CARE AND DIAGNOSTIC TESTING AGREEMENT

VERY IMPORTANT – READ CAREFULLY BEFORE YOU SIGN!

PATIENT/ADDRESS: ____

CAREGIVER(S)/ ADDRESS(ES): ____

1.) ____The patient/caregiver(s) agree(s) (herein referred to as "patient") that in order to continue medical care with this center, including the provision of medications and Controlled Substances, and to more precisely determine the cause of their symptoms and any appropriate, definitive treatment that may be indicated, the following must be adhered to:

a.) ____ The Diagnostic Testing outlined at each visit, must be completed within 6 weeks of having been ordered. This includes:

- X-rays
- MRI scans
- CT scans
- Myelograms
- Bone Scans
- Discograms
- Root Blocks
- EMG
- Nerve Conduction Testing
- Evoke Potentials Testing

b.) ____ Patient must notify this office if an unforeseen event has occurred and will interfere with the timely completion of the testing.

2.) ____ Should the patient not adhere to or otherwise violate this AGREEMENT, furnish false information or **NOT COMPLETE THE DIAGNOSTIC TESTING**, 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 last address of record. Alternative consequences will be at the discretion of the physician.

3.) ____ By my signature below, I ATTEST that I have read and will abide by the above Agreement. I understand the failure to do so, may result in discharge from the physician's care, as outlined in #2.

SIGNATURES:

Patient: ______________________________ Caregiver(s): ______________________________

Date: ______________________________ Physician: John A. Campa III, MD

Witness: ______________________________

ver. 02052011

JOHN A. CAMPA III, MD - CLINICAL NEUROSCIENCES

1701 MOON ST. NE ▪ SUITE 100 ▪ ALBUQUERQUE, NM 87112 **TEL (505) 508-1543 / FAX (505) 554-2118**

http://paindiagnosis.net help@paindiagnosis.net

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 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 7 (seven) days of prescription expiration or exhaustion in order to obtain a renewal, if deemed medically appropriate by the physician. Less than a seven 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, **(505) 508-1543**, 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 y.o.) or by the patient's representative (must be over 18 y.o.), 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 must 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, 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 per test 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 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.

- 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.) ____ 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): ____________________________________

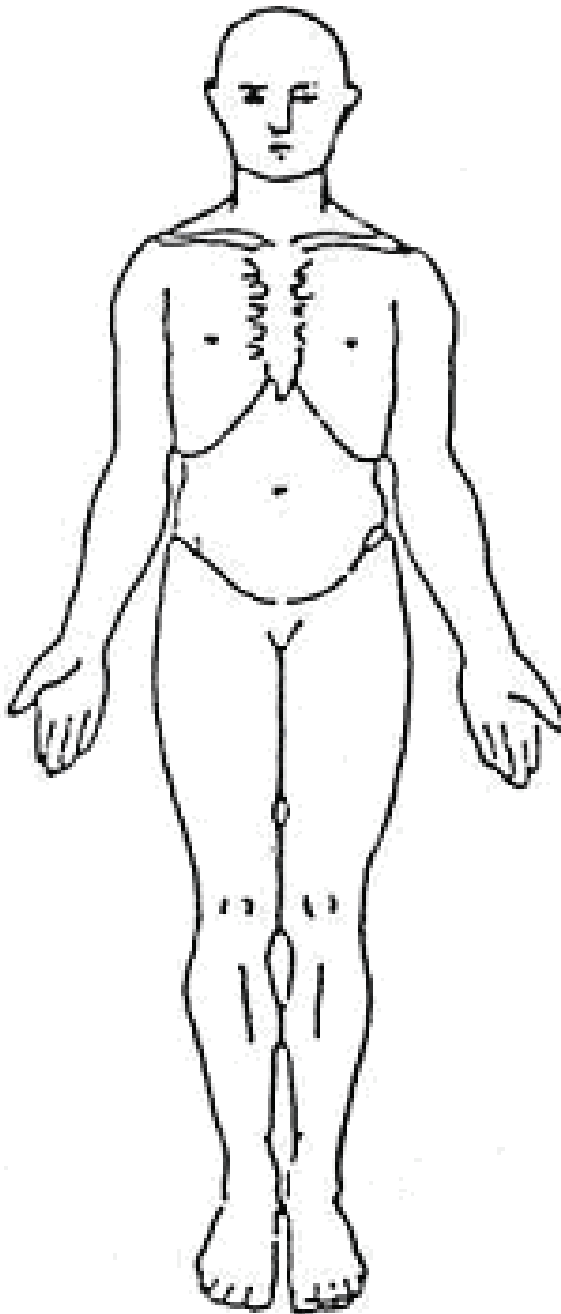
Date: ____

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

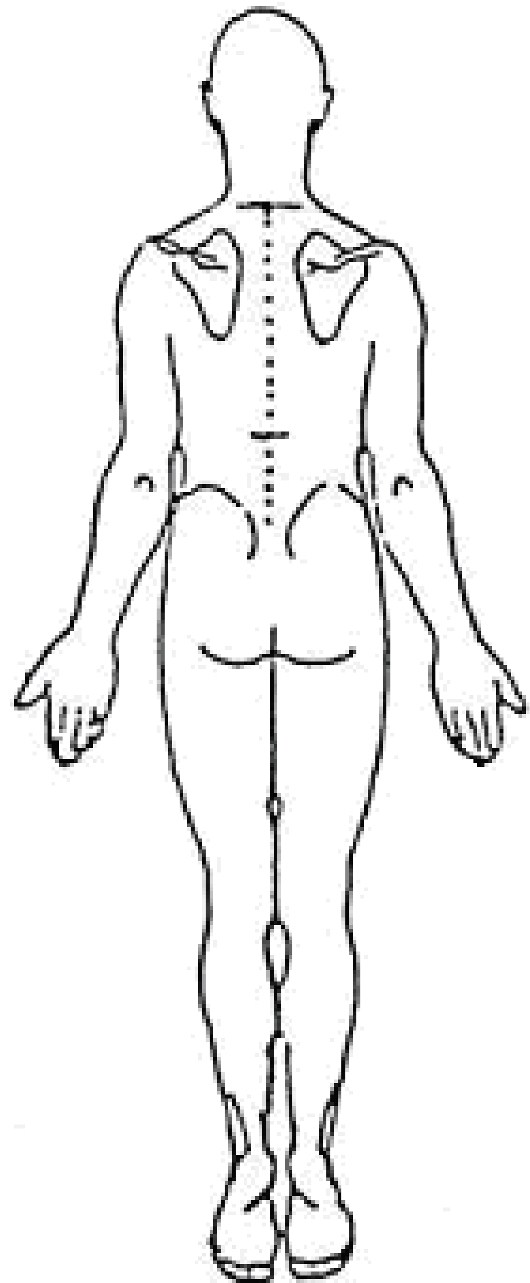
Symptom Body Figure – For Showing Symptoms or Pain

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.



Front



Back

Key: 'X' = Constant 'Y' = Radiates 'O' = Most Severe

Initial Consultation - Patient Questionnaire

NOTICE: Be brief and complete those blanks and questions that apply to you. The information you provide will allow you and the doctor to gain the most from your appointment time. It will be held in strict confidence and is subject to the same limitations of disclosure as other confidential and sensitive patient medical records.

Remember: You, the patient, are ultimately responsible for your good health, welfare and recovery. Our staff and physicians will make every effort to assist you to this end. The first step towards recovery starts with an accurate assessment of your current medical, pain or neurological problem in the context of your past medical, social and family history. Of course, any preexisting health problems or previous injuries that you have had may have a direct impact on your recovery. Therefore, the accuracy and completeness of the information you have provided is crucial to the overall understanding of your particular problem and how it may affect your life as a person. In this way, we will be better able to help you.

Date of Visit:______-______- _____ **Patient Name:**____

Date of Birth: ____________________________________ **SSN:**____________________________________

Who referred you or how did you find out about our center?:_______________________________________

prior-patient friend attorney personal-physician yellow-pages newspaper ad magazine/journal ad Internet

If prior patient, friend or other, give name:____

Who is your Primary physician?:____
(name & address or tel. no.)

Name and relationship of persons accompanying you in the exam room?:__________________________________

____

Your medical expenses are being paid by?: Self-Pay Worker's-Comp. Your Private Insurance

Motor Vehicle Accident Insurance Other Party's Insurance Carrier

Other:____

Occupation: *(If <u>retired or disabled</u>, list main type or types of work you did during your life.)*

Your job title & length of Employment: ____

Employer name, address:____

<u>Claim/Suit Status</u> **– Does your case involve an *OPEN* legal claim or matter related to Workers Comp, a Motor Vehicle Accident, Personal Injury Claim:** Y - N / If so, reply to the following:

Have you contacted or retained an attorney to assist you with your claim or lawsuit? Y - N

Attorney Name-Address-Tel:____

*If applicable, complete **ATTACHMENT - GEN** and any of the following **ATTACHMENTS** <u>relevant</u> to your problem:

If your problem is related to an **On the job Injury ,** Complete **ATTACHMENT - OTJ.**

If your problem is related to a **Motor Vehicle Accident,** Complete **ATTACHMENT - MVA.**

If your problem is related to a **Personal Injury Claim or Law Suit,** Complete **ATTACHMENT - PI.**

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Initial Consultation - Patient Questionnaire

Disability Status:

Have you been denied disability benefits ? Y - N

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

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

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

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

Describe the military service connected disability:____

SUBJECTIVE: Circle

Age:___________ yrs **Height:**___________ **You are:** Right-hand Left-hand Both **Sex:** M F

What is your main problem and What part of your body does your problem affect most ?: (be as specific as possible)

____

____

____

____

____

____

It has been present for how long?:

____

____

____

How did your problem begin or start?:

____

____

____

____

____

____

____

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Describe any similar problem or injury in the past not already mentioned above & give dates:

____

____

Does your problem cause trouble falling asleep?: Yes No

Does your problem awaken you from sleep?: Yes No

Over the past year has your weight been: stable up down ***How much lost or gained?:**_________________

If you lost or gained 10 pounds or more, Why?: Diet Over-eating Don't know (explain below if necessary)

____

During your menstrual period is your problem: NA worse better No-change

Do you have control of your bowels?: Yes No **How long has this been a problem?:**_______________

Do you have control of your bladder?: Yes No **How long has this been a problem?:** _______________

Do you have a problem with erection or arousal during sex related to your problem?: Y - N NA

How long has this been present?:____

Describe the location of any numbness or tingling <u>related</u> to your problem: None NA

____

How long has this been present?:____

Describe the location of any weakness that is <u>related</u> to your problem: None

____

How long has this been present?:____

Overall your condition is: Improving Unchanged Worsening **Due to:** Increased pain Increased weakness Fatigue

SYMPTOM and PAIN DESCRIPTORS: Circle or write in your own words. **NA**

Your symptom or pain is best described as: burning aching throbbing sharp dull tearing shooting tight grabbing pulling

____

Is your symptom or pain?: Constant or Comes & goes ______________________________

Where is it constant?:____

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Score your symptom or pain on a scale from 0 to 10, if 0 is no pain and 10 is the worst you can imagine, circle a number for each category:

Lowest score: 0 1 2 3 4 5 6 7 8 9 10

Average score: 1 2 3 4 5 6 7 8 9 10

Highest score: 1 2 3 4 5 6 7 8 9 10

Circle the following which aggravate your symptom or pain: Nothing

Prolonged: sitting standing stooping bending lying walking climbing cold-weather touching

stress driving/riding in car lifting vacuuming carrying pulling

Other/Certain Position?: ____________________

What helps you the most?: Nothing self-determination physical-therapy TENS pain-medication

sleep-medication nerve-blocks psychology-staff rest heat cold massage

Certain position?: Lying down ____________________

SOCIAL HISTORY:

Education - Include types of degrees and area of concentration, e.g., PhD-Physics:

Highest level of schooling: _______ grade H.S. GED College ____________________

Military Service?: Yes No How long?: ____________ Country: USA ____________

Military branch: Army Marine Corps Navy Air Force National Guard Coast Guard

Your highest rank or grade?: ____________________

Combat?: No Yes **Where/when?**____________________

City born in: ABQ ____________ **City raised in:** same ____________

Recent travel beyond 300 mi.?: Where/When?: No ____________________

Flu, cold or tick bite recently?: No Yes **When & Where?:**____________________

Recent Immunizations-Vaccines: /When?: No / Flu Tetanus Pneumonia ____________

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?**:_________ **Last time you smoked?**:____________

Alcohol use: None beer liquor wine / Daily Weekly Socially **For how long?:** ____________ Yrs

If you drink socially, describe What you drink, How often and How much?: ____________________

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

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Substance/Recreational drug use now & in the past: None / List: ____________________________________

____

What dangerous Chemicals, Poisons, Toxins or Radiation have you been exposed to?: None

____

____

How long?: ____

Date your last <u>normal</u> menstrual period began?: NA ____

Birth control type?: None pill tubal condom hysterectomy vasectomy sponge foams

Other:____

Could you be pregnant?: No Yes Maybe ____

Total number of: NA Pregnancies _______ Births _______ Miscarriages _______ Abortions _____

PAST AND CURRENT TREATMENT MODALITIES INVENTORY: NA

Has physical or massage therapy helped?: Not-had Yes No ____

Has traction helped?: Not-had Yes No ____

Has a TENS unit helped?: Not-had Yes No ____

Has biofeedback and relaxation training helped?: Not-had Yes No ______________________________________

Has hypnotherapy helped?: Not-had Yes No ____

Has acupuncture or chiropractic adjustment helped?: Not-had Yes No ______________________________

If you have had a psychological evaluation regarding your current problem, give date & results: Not-had

____

INTERVENTIONAL INVENTORY: NA

Circle any of the following you have had and give dates?: None

trigger-point-injections epidural-steroids facet-blocks stellate-ganglion-blocks cryoablation

lumbar-sympathetic-blocks phentolamine-block caudal-blocks dorsal-column-stimulator morphine pump

lumbar-sympathectomy celiac-plexus-block neurectomy radio-frequency-denervation

Did they help?: Briefly No ____

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ANTICOAGULATION / BLOOD THINNERS / BLEEDING TENDENCY / DEVICE INVENTORY: NA

Are you on blood thinning medication?: No Yes Coumadin Warfarin aspirin ___________________________

Do you have a Bleeding Disorder, Tendency or Increased Risk For Bleeding?: No Yes Describe

____

Do you have a cardiac pacemaker?: No Yes

Do you have any other electrically powered devices in your body?: No Yes Describe

____

Do you have any metal or metallic devices in your body?: No Yes Describe

____

ALLERGY STATUS: circle medication allergy or sensitivity to certain medications: None

Stadol Nubain Levo-Dromoran Duragesic Codeine Morphine Demerol Dilaudid Hydrocodone

Methadone Tylox Penicillin Sulfa Tetracycline Iodine X-ray-dyes Tape Aspirin Darvon Tramadol Ultram

Others:____

Are you sensitive to or have you had a bad reaction to local anesthetics?: No *****

CURRENT MEDICATIONS: None

List all CURRENT medications (Include doses for pain medications). Include over-the-counter medicines, Tylenol, aspirin, etc.

____ Tylenol____

____ Aspirin____

____ Advil_____

____

____

____

____

____

____

____

____

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PAST MEDICAL HISTORY: Circle and give dates or describe any of the following medical conditions you have had diagnosed by a physician. Indicate any related hospitalizations and related dates.

Loss of consciousness/Concussions: No ______________________________

Injury to head-neck-back: No ______________________________

Headaches: No Migraine Muscle-tension ______________________________

Seizures-epilepsy-convulsions: No______________________________

Stroke or brain hemorrhage: No______________________________

Brain tumors & Arteriovenous malformation: No______________________________

Myasthenia gravis Multiple-sclerosis Muscular-dystrophy No______________________________

High-blood-pressure sugar-Diabetes No ______________________________

RSD-Reflex-sympathetic-dystrophy: No______________________________

Heart problems: No heart attack mitral-valve-prolapse angina heart-failure atrial-fibrillation abnormal-rhythm

____

Emphysema Bronchial-asthma Pneumonia Liver-failure Hepatitis Cirrhosis

____

Kidney failure stones Bladder-infections Endometriosis Prostatitis Epididymitis Orchitis

____

Gastritis GERD Esophagitis Hiatal-hernia Ulcers Colitis Crohn's Diverticulitis

____

Arthritis: Osteo Gout Rheumatoid

____

Lyme Disease Systemic-lupus Discoid-lupus Scleroderma Polymyositis Arteritis (NOT ARTHRITIS)

____

Syphilis Tuberculosis Aids-HIV Sarcoid Amyotrophic-lateral-sclerosis (ALS)

____

Depression Mental-retardation Suicide-attempts Manic-depressive Chronic nerves Bipolar ADD
+ pain related

____

Dementia Parkinson's or Huntington's disease Alzheimer’s

____

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Anemia Sickle cell Parathyroid Thyroid-condition: high low goiter

Blood-clotting-problems Phlebitis DVT Pulmonary-embolism

Blood-transfusion dates: No

Cancer, type, & date diagnosed:

*Give dates: Chemotherapy (What chemicals given?) Radiation-therapy (What body areas?)

SURGICAL HISTORY: Circle and give dates. None

Spine-Lumbar (low back) Spine-Cervical (neck) Spine-Thoracic (mid-back)

prostate appendectomy gallbladder total-hysterectomy tubal vasectomy cardiac-bypass tonsillectomy

laparoscopy dorsal-column-stimulator pain pump colostomy carotid surgery breast surgery-augment. Carpal tunnel

Other:

FAMILY MEDICAL HISTORY: Circle and indicate the person, their relation to you, and whether they are on your mother's or father's side of the family, who has had any of the following medical conditions diagnosed by a physician.

Unknown - Adopted

Headaches: Migraine Tension

Seizures-epilepsy-convulsions:

Stroke or Brain hemorrhage:

Brain tumors & Arteriovenous malformation:

Myasthenia gravis Multiple-sclerosis Muscular-dystrophy

High-blood-pressure sugar-Diabetes:

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RSD-Reflex-sympathetic-dystrophy: ____________________

Heart problems: heart attack mitral valve prolapse angina heart-failure atrial-fibrillation abnormal rhythm

____

Arthritis: Osteo Gout Rheumatoid Endometriosis Kidney failure

____

Lyme Disease Lupus Scleroderma Polymyositis Arteritis (NOT ARTHRITIS)

____

Syphilis Tuberculosis Sarcoid Aids-HIV Amyotrophic-lateral-sclerosis (ALS)

____

Depression Mental-retardation Suicide-attempts Manic-Depressive Chronic nerves Bipolar ADD

____

Alcohol abuse Drug abuse Ulcers Cirrhosis ____________________

____

Parkinson's disease Huntington's disease Alzheimer's disease Dementia

____

Anemia Sickle cell Thyroid condition: high low goiter

____

Blood-clotting-problems Phlebitis DVT Pulmonary-embolism

____

Cancer & type: ____________________

IF THE PATIENT IS A MINOR - PLEASE ANSWER THE FOLLOWING:
Length of the pregnancy?: Term-9 mos. / ____________________
Complicated labor?: Y - N / ____________________
Delivery?: Vaginal Forceps C-section / ____________________
Did patient suffer any birth related trauma-fetal distress? Y - N / ____________________
Did the patient reach child growth and development milestones as expected?: Y - N

____
Age of first menstrual period?: _____ yrs. Periods are every: _____ days Periods last: _____ days / ____________
Is the patient a: Twin / Triplet / etc. ? Y - N

Comments &/or other Medical history & Hospitalizations not covered above:

____

Signature & relation of persons completing questionnaire:

Patient: ____________________

Other/relation: ____________________

E-mail address to contact patient/Guardian by: ____________________

Reviewed & Confirmed: DRC / ____________________

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ATTACHMENTS – COMPLETION HELP

If applicable, complete **ATTACHMENT - GEN** and any of the following **ATTACHMENTS** relevant to your problem:

- If your problem is related to an **On the job Injury ,** Complete **ATTACHMENT - OTJ.**

- If your problem is related to a **Motor Vehicle Accident,** Complete **ATTACHMENT - MVA.**

- If your problem is related to a **Personal Injury Claim or Law Suit,** Complete **ATTACHMENT - PI.**

ATTACHMENT **GEN**

GENERAL CLAIM / LAWSUIT LEGAL-MEDICAL INVENTORY: (page 1 of 2)

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

Have you been involved in prior work related claims or law suits?: No Yes

Give dates of injuries & Attorneys representing you at that time: NA

____

____

____

____

***Indicate the status of these claims or lawsuits as: settled appeal pending dropped**

Have you been involved in prior motor-vehicle accident related claims or law suits?: No Yes

Give dates of injuries & Attorneys representing you at that time: NA

____

____

____

***Indicate the status of these claims or lawsuits as: settled appeal pending dropped**

Have you been involved in prior personal-injury related claims or law suits?: No Yes

Give dates of injuries & Attorneys representing you at that time: NA

____

____

____

____

***Indicate the status of these claims or lawsuits as: settled appeal pending dropped**

Have you been involved in prior medical malpractice claims or law suits?: No Yes

Give dates of injuries & Attorneys representing you at that time: NA

____

____

____

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ATTACHMENT GEN

GENERAL CLAIM / LAWSUIT LEGAL-MEDICAL INVENTORY: (page 2 of 2)

List the names of all parties you have filed lawsuits or claims against or are planning to sue or file claim against as related to your current injury: None

____

____

____

____

List the last three jobs you have held & how long you were employed: NA

Job	Length of employment
1.	
2.	
3.	

Are you still working?: NA Yes No full-duty light-duty retired laid-off fired ______________

You have not worked since when?: NA ______________

Can you return to light duty?: Yes No Why not?:______________

____

If you are unable to work at your usual occupation because of your injury, what other types of work can you do by way of your education, training and experience?:

____

____

____

Date you returned to work?: NA ______________

Remarks:

____

____

____

____

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ATTACHMENT OTJ

ON THE JOB INJURY CLAIM / LAWSUIT LEGAL-MEDICAL INVENTORY: (page 1 of 1)

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

If Work-Occupational related Injury related, answer the following:

Date of Injury: _____-_____-_____

Other dates: ____

Length of Employment at the time of the injury:____

Has employer's worker's compensation insurance carrier recognized your injury as work related injury?
Yes No

Are you receiving worker's compensation benefits?: Yes No

Name of party you have a claim/suit against:____

The location where the injury occurred: ____

Date Incident/Injury report was completed: same day _____________________________________

After the injury occurred, were you able to walk about?: Yes No

<u>At the scene</u> of the injury, what parts of your body were experiencing pain or did not function properly?:
None

____

Did you go the emergency room/company physician or nurse the day of the injury?: Yes No

Name of doctor/nurse/hospital emergency room:____

Were you admitted?: Yes No **For how long?:**____

Were x-rays or other tests done?: Yes No

If you were sent home, what were you told your diagnosis was?:_______________________________

____

Contact person / Insurance Adjuster & telephone#:_______________________________________

____

Witnesses to the injury?: None / **Names:**____

***If available, bring a copy of the accident report and any photographs you may have of the accident or your injuries.**

Remarks:

____

____

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ATTACHMENT **MVA**

MOTOR VEHICLE ACCIDENT RELATED LEGAL-MEDICAL INVENTORY: (page 1 of 2)

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

If Motor Vehicle Accident related, answer the following:

Date of the MVA:_____-_____-_____

Location of accident scene:____

Approximate time of day: Morning Noon Afternoon Night ______________________________

Weather conditions at time of accident:____

Road conditions at time of accident:____

Were you driving?: Yes No **Were you at a full stop or moving?:** full stop moving

How fast was your vehicle traveling?: _______ mph **What was the posted speed limit?:** ____________

What were you driving in?: Year ________ Model___________________________________

What type of vehicle hit you?:____

Approximately how fast was the other vehicle traveling?: ____________________________ mph

What part of your vehicle was hit?: rear-end ____

What part of the other vehicle hit yours?:____

Did you have time to brace yourself just prior to impact?: Yes No

Were you wearing a seat/lap belt?: Yes No **Were you wearing a shoulder belt/restraint?:** Yes No

Did your air-bag inflate?: NA No Yes **Did your seats break?:** No Yes

Were you wearing protective head gear?: No Yes ___________________________________

Were you thrown from the vehicle?: No Yes _______________________________________

Did your head, neck or trunk of your body "whiplash" during the accident?: Yes No

Was the whiplash motion: Forward-Backward or Side-to-Side?: ___________________________

Were you facing forward or turned to one side at the time of impact?: Forward Turned Right. Left

Did you strike anything inside your vehicle, explain?:______________________________________

____

Did you lose consciousness at the scene of the accident?: Yes No **For how long?:**____________

After the accident were you able get out of your vehicle & walk about?: Yes No

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ATTACHMENT **MVA**

MOTOR VEHICLE ACCIDENT RELATED LEGAL-MEDICAL INVENTORY: (page 2 of 2)

At the scene of the injury, what parts of your body were experiencing pain or did not function properly?:
None

____

Did you go the emergency room/company physician or nurse the day of the injury?: Yes No

Name of doctor/nurse/hospital emergency room:________________________________

Were you admitted?: Yes No **For how long?:**________________________________

Were x-rays or other tests done?: Yes No

If you were sent home, what were you told your diagnosis was?:________________________

____

Contact person / Insurance Adjuster & telephone#:______________________________

____

Witnesses to the accident/injury?: None / **Names:**______________________________

***If available, bring a copy of the accident report and any photographs you may have of the accident or your injuries.**

Remarks:

____

____

____

____

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ATTACHMENT PI

PERSONAL INJURY CLAIM / LAWSUIT LEGAL-MEDICAL INVENTORY: (page 1 of 1)

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

If Personal Injury related, answer the following:

Date of Injury: _____-_____-_____

Name of party you have a claim/suit against:____

The location where the injury occurred: (store address & number, residence, etc.)

____

Date Incident/Injury report was completed: same day ____

After the injury occurred, were you able to walk about?: Yes No

At the scene of the injury, what parts of your body were experiencing pain or did not function properly?:
None

____

Did you go the emergency room/company physician or nurse the day of the injury?: Yes No

Name of doctor/nurse/hospital emergency room:____

Were you admitted?: Yes No **For how long?:**____

Were x-rays or other tests done?: Yes No

If you were sent home, what were you told your diagnosis was?:_____________________________________

____

Has the other party's insurance carrier recognized responsibility for your claim?: Yes No

Contact person / Insurance Adjuster & telephone#:____

____

Witnesses to the injury?: None / **Names:**____

***If available, bring a copy of the accident report and any photographs you may have of the accident or your injuries.**

Remarks:

____

____

____

____

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PAIN DIAGNOSIS – JOHN A. CAMPA III, MD
1701 MOON ST. NE ▪ SUITE 100 ▪ ALBUQUERQUE, NM 87112 TEL (505) 508-1543 / FAX (505) 554-2118
http://paindiagnosis.net help@paindiagnosis.net

HIPAA: Notice of Privacy Practices Patient Acknowledgement

Patient Name:____

Date of Birth: __________________________

I understand that, under the Health Insurance Portability and Accountability (HIPAA) Act of 1996, I have certain rights to privacy in regards to my protected health information (PHI).

I have received, read and understood The Notice of Privacy Practices and acknowledge that the practice of John A. Campa III, MD reserves the right to change the terms of its Notice of Privacy Practices.

I understand the practice of John A. Campa III, MD will provide a current Notice of Privacy Practices on request.

____
Signature

____
Relationship

____
Date

1701 MOON ST. NE ▪ SUITE 100 ▪ ALBUQUERQUE, NM 87112 TEL (505) 508-1543 / FAX (505) 554-2118
http://paindiagnosis.net help@paindiagnosis.net

HIPAA: Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

We understand that information about you and your health is very personal and therefore, we will strive to protect your privacy as required by law. We will only use and disclose your personal health information as allowed by applicable law.

We are committed to providing state-of-the-art health care services through the practice of patient care, education, and research. Therefore, as described below, your health information will be used to provide you care and may be used to educate health care professionals and for research. We train our staff and workforce to be sensitive about privacy and to respect the confidentiality of your personal health information. We are required by law to maintain the privacy of our patients' personal health information and to provide you with notice of our legal duties and privacy practices with respect to your personal health information. We are required to abide by the terms of this Notice of Privacy Practices so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice of Privacy Practices effective for all personal health information maintained by us. You may receive a copy of any revised notice by mailing a request to: John A. Campa III, MD, 1701 Moon St. NE, Suite 100, Albuquerque, NM 87112-3900.

The terms of this Notice of Privacy Practices apply to an entities owned and operated by and/or affiliated with the practice of John A. Campa III, MD
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USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

The following categories detail the various ways in which we may use or disclose your personal health information. For each category of uses or disclosures, we will give you illustrative examples. It should be noted that while not every use or disclosure will be listed, each of the ways we are permitted to use or disclose information will fall into one of the following categories.

Your Authorization. Except as outlined below, we will not use or disclose your personal health information for any purpose unless you have signed a form authorizing the use or disclosure. This form will describe what information will be disclosed, to whom, for what purpose, and when. You have the right to revoke that authorization in writing, except to the extent we have already relied upon it.

Uses and Disclosures for Treatment. We will make uses and disclosures of your personal health information as necessary for your treatment. For instance, doctors, nurses, and other professionals involved

in your care will use information in your medical record to plan a course of treatment for you that may include procedures, medications, tests, etc. We may also disclose your personal health information to institutions and individuals outside the practice of John A. Campa III, MD that are or will be providing treatment to you.

Uses and Disclosures for Payment. We will make uses and disclosures of your personal health information as necessary for payment purposes. For instance, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you or we may use your information to prepare a bill to send to you or to the person responsible for your payment.

Uses and Disclosures for Health Care Operations. We will use and disclose your personal health information as necessary, and as permitted by law, for health care operations. This is necessary to run the practice of John A. Campa III, MD and to ensure that our patients receive high quality care and that our health care professionals receive superior training. For example, we may use your personal health information in order to conduct an evaluation of the treatment and services we provide, or to review the performance of our staff.

And, for education and training purposes, your health information may also be disclosed to doctors, nurses, technicians, medical students, residents, fellows and others.

Persons Involved In Your Care. Unless you object, we may in our professional judgment disclose to a member of your family, a close friend, or any other person you identify, your personal health information to facilitate that person's involvement in caring for you or in payment for that care. We may use or disclose personal health information to assist in notifying a family member, personal representative or any other person that is responsible for your care of your location and general condition. We may also disclose limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Appointments and Services. We may use your personal health information to remind you about appointments or to follow up on your visit.

Health Products and Services. We may from time to time use your personal health information to communicate with you about treatment alternatives and other health-related benefits and services that may be of interest to you.

Research. We may use and disclose your personal health information as permitted by law for research, subject to your explicit authorization, and/or oversight by the practice of John A. Campa III, MD. In all cases where your specific authorization has not been obtained, your privacy will be protected by confidentiality requirements.

For example, we may approve the use of your health information with only limited identifying information to conduct outcomes research to see if a particular procedure is effective.

Business Associates. Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, legal services, etc. At times it may be necessary for us to provide certain portions of your personal health information to one or more of these outside persons or organizations who assist us with our payment/billing activities and health care operations. In such cases, we require these business associates to appropriately safeguard the privacy of your information.

Other Uses and Disclosures. We are permitted or required by law to make certain other uses and disclosures of your personal health information without your consent or authorization. Subject to conditions specified by law:

- We may release your personal health information for any purpose required by law;
- We may release your personal health information for public health activities, such as required reporting of disease, injury, and birth and death, and for required public health investigations;
- We may release your personal health information to certain governmental agencies if we suspect child abuse or neglect; we may also release your personal health information to certain governmental agencies if we believe you to be a victim of abuse, neglect, or domestic violence;
- We may release your personal health information to entities regulated by the Food and Drug
- Administration if necessary to report adverse events, product defects, or to participate in product recalls;
- We may release your personal health information to your employer when we have provided health care to you at the request of your employer for purposes related to occupational health and safety; in most cases you will receive notice that information is disclosed to your employer;
- We may release your personal health information if required by law to a government oversight agency conducting audits, investigations, inspections and related oversight functions;
- We may use or disclose your personal health information in emergency circumstances, such as to prevent a serious and imminent threat to a person or the public;
- We may release your personal health information if required to do so by a court or administrative order, subpoena or discovery request; in most cases you will have notice of such release;
- We may release your personal health information to law enforcement officials to identify or locate suspects, fugitives or witnesses, or victims of crime, or for other allowable law enforcement purposes;
- We may release your personal health information to coroners, medical examiners, and/or funeral directors;
- We may release your personal health information if necessary to arrange an organ or tissue donation from you or a transplant for you;
- We may release your personal health information if you are a member of the military for activities set

out by certain military command authorities as required by armed forces services; we may also release your personal health information if necessary for national security, intelligence, or protective services activities; and

- We may release your personal health information if necessary for purposes related to your workers' compensation benefits.

Confidentiality of Alcohol and Drug Abuse Patient Records, HIV-Related Information, and Mental Health Records.

The confidentiality of alcohol and drug abuse patient records, HIV-related information, and mental health records maintained by us is specifically protected by state and/or Federal law and regulations. Generally, we may not disclose such information unless you consent in writing, the disclosure is allowed by a court order, or in limited and regulated other circumstances.

RIGHTS THAT YOU HAVE

Access to Your Personal Health Information. Generally, you have the right to access, inspect, and/or copy personal health information that we maintain about you. Unless you are currently a patient in our hospital or during a scheduled appointment with a clinician, requests for access must be made in writing and be signed by you or your representative. We will charge you for a copy of your medical records in accordance with a schedule of fees established by applicable state law. You may obtain an access request form from the doctor's office.

Amendments to Your Personal Health Information. You have the right to request that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your representative, and must state the reasons for the amendment/correction request. If an amendment or correction you request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. Please note that even if we accept your request, we may not delete any information already documented in your medical record. You may obtain an amendment request form from the doctor's office.

Accounting for Disclosures of Your Personal Health Information. You have the right to receive an accounting of certain disclosures made by us of your personal health information except for disclosures made for purposes of treatment, payment, and healthcare operations or for certain other limited exceptions. This accounting will include only those disclosures made in the six years prior to the date on which the accounting is requested but, in no event will include disclosures made prior to January 01, 2008. Requests must be made in writing and signed by you or your representative. Accounting request forms are available from the doctor's office. The first accounting in any 12-month period is free; you will be charged a fee of $20 for each subsequent accounting you request within a 12-month period.

Restrictions on Use and Disclosure of Your Personal Health Information. You have the right to request restrictions on certain of our uses and disclosures of your personal health information for treatment, payment, or health care operations. For example, you may request that we do not share your health information with a certain family member. A restriction request form can be obtained from the doctor's office. We are not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate and we retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event we have terminated an agreed upon restriction, we will notify you of such termination.

Confidential Communications. You have the right to request communications regarding your personal health information from us by alternative means or at alternative locations and we will accommodate reasonable requests by you. You must request such confidential communication in writing.

Paper Copy of Notice. As a patient you retain the right to obtain a paper copy of this Notice of Privacy Practices, even if you have requested such copy by e-mail or other electronic means. Our Notice may also be obtained on our website at http://paindiagnosis.net.

ADDITIONAL INFORMATION

Complaints. If you believe your privacy rights have been violated, you may file a complaint in writing with the doctor's office. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. All complaints must be made in writing and in no way will affect the quality of care you receive from us.

For further information. If you have questions or need further assistance regarding this Notice of Privacy Practices, you may contact us in writing at: John A. Campa III, MD, 1701 Moon St. NE, Suite 100, Albuquerque, New Mexico 87112-3900, or by telephone at (505) 508-1543, or by e-mail at help@paindiagnosis.net.

Effective Date. This Notice of Privacy Practices is effective January 01, 2008.