ANCORA
pain recovery

Last Name:_____MI:_____First: _____

Date of Birth:_____Social Security #:_____ ☐ Male ☐ Female

Address:_____City/State/Zip: _____

Home Phone:_____Cell Phone: _____

May we leave a voice message? ☐ Yes ☐ No Email Address: _____

Preferred Method of Contact:_____Marital Status: _____

Employer:_____Occupation: _____

Primary Care Physician:_____PCP Phone: _____

Are you currently being represented by an attorney for a MVA or work related accident? ☐ Yes ☐ No

Spouse's Information *If not married, then emergency contact information

Last Name:_____MI:_____First: _____

Contact Info: _____

Insurance Information

Primary Carrier:_____Policy #: _____

Policy Holder's Name:_____Date of Birth: _____

Secondary Carrier:_____Policy #: _____

Policy Holder's Name:_____Date of Birth: _____

How did you hear about our practice? _____

Do we currently treat any of your family members?_____Yes _____No If so, their name(s)?

Name:_____Relationship: _____

Please list the name and number of the one and only pharmacy you will use to fill your prescriptions:

Do you speak English fluently? ☐ Yes ☐ No

If no, what is your primary language? _____

Patient Name:_____ DOB: _____

Previous Medical Providers

So that we may better evaluate your medical condition, we must have a complete record of your past medical history. Please list all of the medical providers you have seen for your pain so that we may request your records. We ask that this list be as complete as possible so that we may provide a proper treatment plan.

Doctor:_____ Address: _____

Phone #:_____ Fax (REQUIRED):_____

Doctor:_____ Address: _____

Phone #:_____ Fax (REQUIRED):_____

Consent to Release Confidential Information to Family Members/Friends

I,_____, give the physicians and office staff of Ancora Pain Recovery permission to discuss my medical condition and/or account information with the following individual:

Name:_____ Relationship: _____

**This consent is in force indefinitely unless revoked in writing by the patient.

Patient Signature:_____ Date: _____

Narcotic Agreement

By signing below I am acknowledging that I understand I will NOT be prescribed narcotics on my initial new patient visit with Ancora Pain Recovery. I understand that the initial consultation is an opportunity for me to meet the physician, share my history and symptoms, and discuss a detailed care plan.

Patient Signature:_____ Date: _____

Translation Services

Please acknowledge you will notify our office at least 72 business hours in advance if you require translation services at any of your upcoming appointments with Ancora Pain Recovery. If we do not receive notification we will assume you do not require translation services or you will have an interpreter with you.

Patient Signature:_____ Date: _____

Por favor notifique a nuestra oficina por lo menos 72 horas antes de su próxima cita con Ancora Pain Recovery si necesita servicios de traducción. Si no recibimos notificación, vamos a suponer que usted no necesita servicios de traducción o usted traerá su proprio traductor.

Firma del paciente:_____ Date: _____

Missed or No Show Appointments

If you cannot make a scheduled appointment we ask that you call at least 24 hours in advance to avoid the following fees: $35.00 for a missed appointment, $100.00 for a missed procedure, $50.00 for a missed therapy appointment. These charges will be added to your account and must be paid in full prior to your next visit.
If you fail to keep two appointments we reserve the right to refuse scheduling or rescheduling of any future appointments.

Patient Signature:_____ Date: _____

Notice of Privacy Practices (HIPAA)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have been informed by Ancora Pain Recovery of their Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information (available in office in print form or on the practice website at www.AncoraPain.com). I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions.

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

Patient Signature:_____ Date: _____

Financial Policies & Disclosures

I hereby give consent to Ancora Pain Recovery and their respective staff to perform medical procedures, which are appropriate for my condition, symptoms, illness(es) or injury(ies). I hereby assign to Ancora Pain Recovery the benefits of any and all insurance policies, including Health Insurance and Personal Injury Protection (PIP) to which I may be entitled. I hereby direct any and all insurance companies to make direct payment to Ancora Pain Recovery for all services, items and/or supplies furnished to me. I request that all payments to Ancora Pain Recovery be sent directly to the billing address. I hereby authorize the release of any medical or psychological information necessary to submit, document or process insurance claims on my behalf.

I understand payment is due at the time of service. Ancora Pain Recovery will file a claim with my insurance company after my co-payment has been paid for all office visits and procedures. I understand that I am responsible for any services not covered by my insurance.

I understand that occasionally lab sample analysis is performed by a reference laboratory other than, or in addition to, Ancora Pain Recovery. I understand I am responsible for any bills from that laboratory.

In consideration of courtesy and patience extended to me by Ancora Pain Recovery, I hereby agree that the statute of limitations with respect to any claim for charges for services by Ancora Pain Recovery shall not begin to run until there is a denial by me, in writing and sent by certified mail with return receipt requests, of any balance claimed to be due and owing Ancora Pain Recovery.

There is a charge of $25.00 for any returned check, plus the amount of the check. Checks will no longer be accepted if a check presented for payment is returned for non-sufficient funds.

Some of our locations at Ancora Pain Recovery may occupy the same building as an ambulatory surgery center, however, these are completely separate businesses. Procedures performed in a surgery center may generate additional bills such as:

- Physician (doctor who performed procedure)
- Facility (surgery center)
- Anesthesia (anesthesiologist's services, if required)

Patient Signature:_____ Date: _____

Patient Name:_____DOB: _____

Briefly describe the events that caused your pain and the date it began: _____

_____

_____

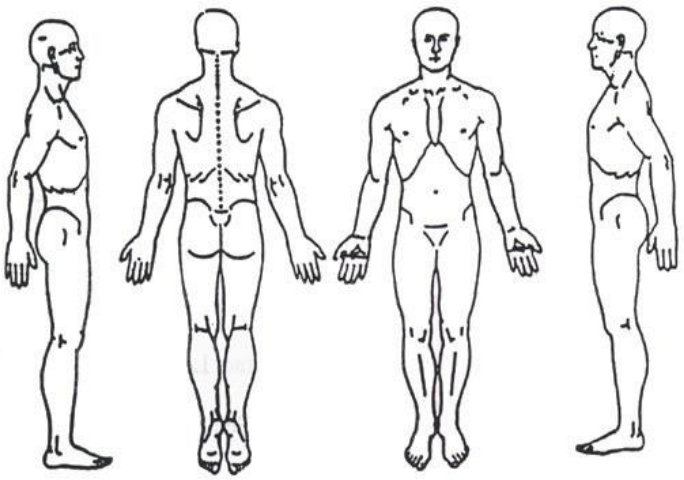
List all medications, dosages you are currently taking and what they are for: _____

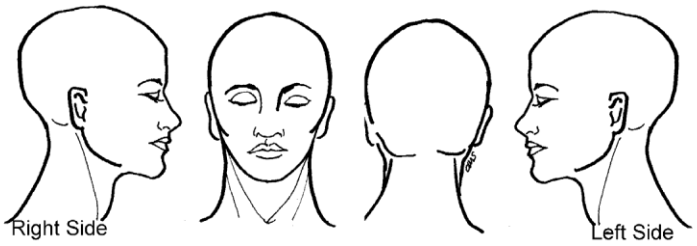
_____

_____

_____

Shade in the areas where you feel pain:





What is your most painful area? _____

Check all locations of your pain:

☐ Head	☐ Neck	☐ Left Shoulder	☐ Right Shoulder	☐ Left Arm/Hand
☐ Right Arm/Hand	☐ Upper Back	☐ Lower Back	☐ Left Leg	☐ Right Leg
☐ Left Foot	☐ Right Foot			

How did your pain start?

☐ Gradually	☐ Suddenly	☐ Work Injury	☐ Non-work Injury	☐ Auto Accident

How long have you had pain?_____Hours _____Days _____Weeks _____Months _____Years

Describe your pain:	☐ Sharp	☐ Aching	☐ Stabbing	☐ Burning
☐ Shooting	☐ Throbbing	☐ Numbness	☐ Dull	☐ Electrical
☐ Tingling	☐ Night Time	☐ Headaches	☐ Pins/Needles	☐ Spasms/Tightening

Patient Name:_____DOB: _____

When you move, do you have sharp, electrical shocking pain radiating into an extremity? _____

If yes, how far down does it radiate?

☐ Left Arm ☐ Right Arm ☐ Left Fingers ☐ Right Fingers ☐ Left Leg

☐ Right Leg ☐ Left Foot ☐ Right Foot ☐ Left Toes ☐ Right Toes

Do you have weakness in any limb? _____

If yes, how far down does it radiate?

☐ Left Arm ☐ Right Arm ☐ Left Fingers ☐ Right Fingers ☐ Left Leg

☐ Right Leg ☐ Left Foot ☐ Right Foot ☐ Left Toes ☐ Right Toes

Do you have numbness or tingling in any limb? _____

If yes, how far down does it radiate?

☐ Left Arm ☐ Right Arm ☐ Left Fingers ☐ Right Fingers ☐ Left Leg

☐ Right Leg ☐ Left Foot ☐ Right Foot ☐ Left Toes ☐ Right Toes

Your pain is aggravated by:

☐ Nothing ☐ Sneezing ☐ Coughing ☐ Starting Stool ☐ Bending

☐ Lying ☐ Sitting ☐ Standing ☐ Walking ☐ Excercising

☐ Twisting ☐ Cold ☐ Bright Light ☐ Medication ☐ Everything

Your pain is relieved by:

☐ Nothing ☐ Lying ☐ Resting ☐ Sitting ☐ Bending

☐ Heat/Ice ☐ Massage ☐ Bracing ☐ Physical Therapy ☐ Dark Room

☐ Medication ☐ Standing ☐ Walking

Severity of your pain is:

☐ None ☐ Very Weak ☐ Weak ☐ Moderate ☐ Strong

☐ Intense ☐ Severe ☐ Excruciating ☐ Intolerable

Your average pain score in the past month, 0 - 10, ten being the worst? _____

Course of pain is:

☐ Increasing ☐ Decreasing ☐ Recurring ☐ Without Change

Patient Name:_____DOB: _____

Treatments you've tried:

☐ Medication ☐ Physical Therapy ☐ Massage Therapy ☐ Facet Injection ☐ Nerve Block

☐ Psychotherapy ☐ Chiropractic ☐ Epidural ☐ Spinal Cord Stimulator ☐ SI Joint Inj.

☐ RFTA, Nerve Ablation ☐ Surgery w/devices ☐ Surgery w/outdevices

On an average day, how many hours are you up, moving about or active?_____Hours

On an average night, how many TOTAL hours do you sleep?_____Hours

Is your sleep broken at night?_____ Do you feel rested in the morning? _____

Any bowel or bladder leakage when sitting? _____

New or bothersome side effects include:

☐ Bladder Leakage ☐ Dizziness ☐ Drowsiness ☐ Lack of Concentration ☐ Itching

☐ Recent Falls ☐ Constipation ☐ Moodiness ☐ Dropping Things ☐ Other: _____

Social History

Marital status? _____ Are you or could you be pregnant? _____ Do you live alone? _____

Do you have children?_____If yes, what are their ages? _____

Have you previously used illegal drugs:?_____If yes, what? _____

Are you currently using illegal drugs?_____If yes, what? _____

Do you drink alcohol?_____If so, how much/often? _____

Do you consume caffeinated drinks?_____If yes, how many per day? _____

Are you a smoker?_____If yes, how long?_____Packs per day? _____

Are you currently employed?_____If yes, what is your current occupation? _____

If not, what was your most recent occupation and how long ago? _____

Are you not working due to your pain?_____Are you receiving compensation for a disability? _____

Are you involved in litigation (lawsuit)?_____If so, who is your attorney? _____

Are you currently a student?_____Highest level of education completed? _____

Please list family members who have physical and/or mental disabilities and describe: _____

_____

_____

Patient Name:_____DOB: _____

If you have any of the following, please check the box.

History of:

- ☐ Arthritis
- ☐ Bleeding or Clotting
- ☐ Cancer
- ☐ Chest Pain
- ☐ Diabetes Mellitus
- ☐ Gastric Ulcer
- ☐ Headaches
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Neurological Disease
- ☐ Respiratory Disease
- ☐ Seizure Disorder
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis

Allergies:

- ☐ No Known Allergies
- ☐ Aspirin
- ☐ Acetaminophen
- ☐ Antibiotics _____ (Name of Antibiotic)
- ☐ Iodine
- ☐ Latex
- ☐ Morphine Derivative
- ☐ NSAIDs
- ☐ Penicillin
- ☐ Nuts
- ☐ Sulfa Drugs
- ☐ Seafood

Family History:

- ☐ Alcohol Abuse
- ☐ Drug Abuse
- ☐ Cancer
- ☐ Diabetes Mellitus
- ☐ Heart Disease

Surgeries/Hospitalizations

Date:_____Reason:_____Location: _____

Date:_____Reason:_____Location: _____

Date:_____Reason:_____Location: _____

Imaging Studies

Date:_____Reason:_____Location: _____

Date:_____Reason:_____Location: _____

Date:_____Reason:_____Location: _____

Patient Name:_____ DOB: _____

Please indicate if you have any of the following:

General Symptoms:

- ☐ Pain
- ☐ Medication Change
- ☐ Weight Loss
- ☐ Significant Weight Change
- ☐ Weight Gain
- ☐ Chills
- ☐ Fever
- ☐ Night Sweats

Skin Symptoms:

- ☐ Clamminess
- ☐ Excessive Sweating
- ☐ Hair Loss
- ☐ Pale Skin (Pallor)
- ☐ Rash
- ☐ Skin Color Changes

HEENT Symptoms:

- ☐ Headache
- ☐ Visual Disturbances
- ☐ Decreased Hearing
- ☐ Ear Ringing (Tinnitus)
- ☐ Off Balance (Vertigo)
- ☐ Nasal Congestion

Respiratory Symptoms:

- ☐ Cough
- ☐ Difficulty Breathing
- ☐ Shortness of Breath (Dyspnea)

Gastrointestinal Symptoms:

- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea/Vomiting

Breast Symptoms:

- ☐ Breast Pain

Cardiovascular Symptoms:

- ☐ Chest Pain
- ☐ Fainting/Black Outs
- ☐ Edema (Swelling)
- ☐ Hypertension
- ☐ Orthopnea
- ☐ Leg Pain/Swelling
- ☐ Shortness of Breath

Male Genitourinary Symptoms:

- ☐ Change in Urinary Stream
- ☐ Groin Pain
- ☐ Incontinence
- ☐ Testicular Pain
- ☐ Impotence

Female Genitourinary Symptoms:

- ☐ Change in Urinary Stream
- ☐ Incontinence
- ☐ Menstrual Pain

Endocrine Symptoms:

- ☐ Appetite Changes
- ☐ Excessive Thirst
- ☐ Excessive Urination
- ☐ Hair Changes
- ☐ Sexual Dysfunction

Musculoskeletal Symptoms:

- ☐ Back Pain
- ☐ Decreased Range of Motion
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Muscle Atrophy/Wasting

Musculoskeletal Symptoms Cont.:

- ☐ Muscle Cramps
- ☐ Muscle Weakness
- ☐ Muscle Pain (Myalgia)
- ☐ Swelling of Extremities

Neurological Symptoms:

- ☐ Auras-Migraine (Changes Prior)
- ☐ Decreased Memory
- ☐ Dizziness
- ☐ Fainting
- ☐ Falls
- ☐ Stool Incontinence
- ☐ Urinary Incontinence
- ☐ Numbness
- ☐ Seizures
- ☐ Vertigo/Spinning
- ☐ Weakness in Extremities

Psychiatric Symptoms:

- ☐ Change in Sleep
- ☐ Depression
- ☐ Easily Irritated
- ☐ Suicidal Thoughts
- ☐ Hypersomnia - Excessive Sleep
- ☐ Insomnia
- ☐ Inability to Concentrate
- ☐ Mood Changes
- ☐ Panic Attacks
- ☐ Suicidal Planning

Hematology Symptoms:

- ☐ Anemia
- ☐ Easy Bruising

Northeast Georgia Anesthesia Services DBA Ancora Pain Recovery
Records Release Authorization Form

Patient Name:_____Date of Birth:_____/_____/_____SSN: _____

Address:_____Phone: _____

I request that my protected health information (PHI) from_____be disclosed to:

Recipient Name: Ancora Pain Recovery Fax:_____(preferred) or via mail to:

Street:_____City/State/Zip: _____

I authorize the following PHI to be released from my medical record(s): emergency room record, laboratory reports, radiology reports, pathology reports, immunization records, abstract/summary (including discharge summary, history & physical, operative reports, consultations, and test results), and itemized billing records.

Other: _____

I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse. State and Federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

Alcohol, Drug, or Substance Abuse Records	☐ Yes	☐ No	Dates:_____
HIV Testing and Results	☐ Yes	☐ No	Dates: _____
Mental Health	☐ Yes	☐ No	Dates: _____
Psychotherapy Records	☐ Yes	☐ No	Dates:_____

☐ Covering the period of healthcare from: Specific Date(s):_____to_____OR

☐ All past, present and future encounters/visits

Purpose for requesting information: ☐ Legal ☐ Insurance ☐ Personal Continuation of Care

☐ Other (please specify):_____

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information
- Management Department at the following address: 1620 Prince Ave, Athens, GA 30606. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. If I fail to specify an expiration date/event/condition, this authorization will expire 1 year from the date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules.
- Marketing: Financial remuneration has been received by a third party for marketing purposes. (Only required if applicable to the organization.)
- Sale of PHI: Remuneration is received for disclosure of my health information. (Only required if applicable to the organization)

_____ _____
Patient or Authorized Representative Signature Date

_____ _____
Print Name Relationship to Patient (if applicable)

Ancora Pain Recovery

Compliance with Care Agreement

We at Ancora Pain Recovery understand that your pain is a significant hindrance to the quality of life you desire. In order to help you achieve your goals, we may recommend different medicines, selective diagnostic and therapeutic nerve blocks, physical and occupational therapy, therapeutic massage and psychological counseling, as needed. Narcotic medication for pain will NOT be prescribed on your first visit. This type of medication is given solely based on the medical findings and treatment plan of an Ancora Pain Recovery physician and not doctors you may have visited previously. Although narcotics have a long history of safety, there are possible side effects. Therefore we must weigh the risks versus benefits before prescribing these medications. If we decide to use these medicines, the following conditions must be met:

Please read each item carefully then initial in the spaces indicated, acknowledging your understanding of each item.

_____ 1. If deemed necessary, we will require a consult from a psychologist.

_____ 2. Additional therapy may be recommended for which you are required to participate.

_____ 3. You must maintain the medication dosing schedule prescribed by the doctors from this clinic. You may not increase the dose on your own. You must come in and discuss any changes before they are made. If you take your medication in any way other than prescribed, it will not be refilled.

_____ 4. You must notify this office before you receive/take narcotics from any other clinic, doctor, or hospital.

_____ 5. You must have your narcotic prescriptions filled at only one pharmacy and must have the pharmacy name and number on file at this office. Narcotics cannot be called in for any reason.

_____ 6. Narcotic prescriptions can only be given to the patient. They cannot be mailed or picked up by someone else.

_____ 7. Narcotic prescriptions may not be replaced if lost or stolen or for any other reason, even with a police report.

_____ 8. If a medicine is not working for you and you would like it changed, please call to make an appointment for a medication change evaluation and bring in the unused portion of medication. Unused narcotics must be destroyed in our office.

_____9. You will be required to undergo random urine drug screen testing and random pill counts. When selected you will be contacted by telephone. It is your responsibility to provide and maintain a telephone number where you can be contacted during regular business hours 8 am - 5 pm, Monday - Friday. If unable to answer personally, you are responsible for having a voice mail or other method of receiving the telephoned message that day. If you fail to come in for a drug screen or pill count on the day you are called you will be discharged from the clinic.

_____ 10. You are required to inform our office of your out-of-town travel, prior to your departure. You will call the office and inform a staff person of your name and the dates of your travel. If you are called for a random pill count or urine drug screen and fail to show saying you were out of town, but do NOT have the trip noted in your chart, your provider reserves the right to discontinue your medication.

_____ 11. You must not take any illegal drugs or medications prescribed to someone other than you. You must not give any medications prescribed to you, to another person. You must avoid drinking alcohol if you are taking a narcotic medication for pain control. **We will not prescribe you narcotics if you are taking benzodiazepines from any doctor.** Contact your physician before taking sedatives, antihistamines or Benzodiazepines. Some examples include but are not limited to: Soma, Xanax, Ativan or Benadryl.

_____ 12. By signing this agreement you give this office permission to request information about your narcotic prescriptions from other medical offices or pharmacies.

Compliance with Care Agreement, continued

_____ 13. By signing this agreement you give us permission to share your narcotic prescription history with other pharmacies, physician offices, or law enforcement agencies.

_____ 14. Weekly visits may be required to monitor your condition when narcotics are initially prescribed or after a change in medications. If the above conditions are broken, we reserve the right to dismiss you from our care.

_____ 15. Side effects. You understand that controlled substances may cause a variety of side effects including, but not limited to: nausea, vomiting, constipation, dry mouth, difficulty with urination, urinary retention, confusion, weight changes, suppressed immune system, altered hormone levels (thyroid, sexual hormones), itching, allergic reactions, fluid and blood chemistry imbalances, and altered sexual function. There is also a risk of becoming physically dependent or addicted. Therefore, you understand if that taken improperly controlled substances may cause excess sedation, depressed breathing and even death, especially if combined with alcohol, Benzodiazepines (Xanax, Valium, Ativan etc.) or other mood or consciousness-altering substances. You understand that you may not drive a motor vehicle or other heavy machinery while taking narcotics, and you will comply with all state and federal laws regarding such activities while using these medications.

_____ 16. You understand that your medications should be kept up and out of the way or locked up from children or irresponsible adults.

_____ 17. You understand that it is unlawful to receive similar controlled substance medications (narcotics, Benzodiazepines, etc.) from this practice as well as another provider, within the same time period. Failure to disclose this information may result is being dismissed from our care.

Patient Name:_____DOB: _____

Patient Signature:_____Date: _____

Physician's Signature: _____