Cordova Pain Specialists
1540 Appling Care Lane
Cordova, TN 38016

Medical Release Form

Phone: 901-444-3950 Fax: 901-444-3866

Patient Name: _____ Date of Birth: _____

Daytime Phone: _____ Evening Phone: _____

Release to: _____

Release From: _____

**Information to be released: ___copy of complete health record ___radiographs

___labs, testing and diagnostic reports ___MRI/CT scan reports ___Progress notes

I request and authorize Cordova Pain Specialists to release/receive the information specified below to/from the organization agency or individual named on this request.

I understand that the information in my health record may include information relating to sexually transmitted diseases, AIDS, HIV, Alzheimer Disease, behavioral or mental health conditions and treatment for alcohol or drug abuse(if any). My records may also include copies of records from other facilities that have been used in my care.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke the authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.
I understand that this authorization will expire in 12 months or on the following date, event or condition provided by the patient:

_____

I understand that once the above information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal privacy law and regulations. I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I can refuse to sign the authorization. My refusal to sign this authorization will not affect my ability to obtain treatment, payment, or enroll in a health care plan.

_____

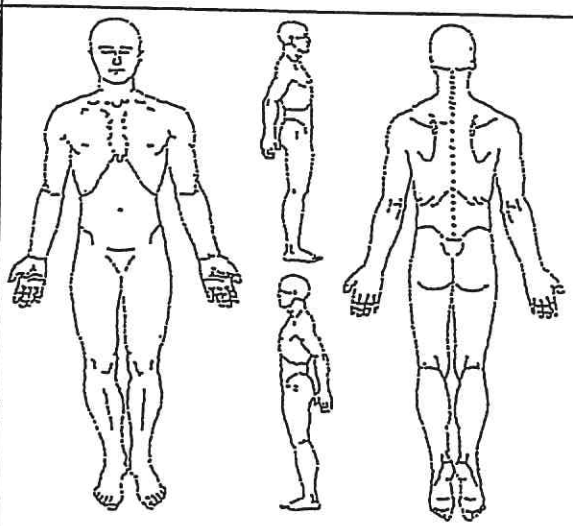
Signature Date

_____

Signature of person authorized to sign for patient Date

Cordova Pain Specialists

New Patient Medical History Form

Patient Name	Name of Primary Physician
Date of Birth	
Gender/Age	Office Phone/ Location of Physician
Date	
Pain History Background	
What is your main pain complaint	*Please shade the areas where you are having pain*
How long has the pain been present? Months_____ Years_____	*For the scales below circle a number using 0 to indicate none up to 10 to indicate most extreme/severe*
What words best describe how the pain feels? Sharp Burning Shooting Deep Stabbing Throbbing Aching Pressure Dull Tingling Numbness	Indicate your current pain 0 1 2 3 4 5 6 7 8 9 10
How often is your pain present? Constant Frequent (several times per hour) Sporadic(several times per day) Occasional(several times per week) Rare(several times per month)	Rate pain interference with general activity 0 1 2 3 4 5 6 7 8 9 10
Have you had previous pain Management Injections? (these include: epidural injection, Facet joint blocks, Radiofrequency procedure, Nerve blocks, Trigger Point Injections) YES NO	

Procedure	Physician	Date	Location	Helpful Yes or No

Do you have or have you had a SPINAL CORD STIMULATOR trialed or implanted? Yes No

Do you have or have you had a PAIN MEDICINE PUMP? Yes No

Have you ever been treated by a PAIN MANAGEMENT physician or CLINIC? Yes No

Name of Clinic/Physician	Location of Clinic	Dates of Treatment

Have you ever been treated by the following? Chiropractor Physical Therapist

MEDICAL HISTORY		
Do you have a bleeding disorder?	YES	NO
Do you take persciption blood thinners such as Plavix,coumadin, etc	YES	NO
Are you currently taking any antibiotics?	YES	NO
Do you have a pace maker?	YES	NO
Have you ever had mental health treatment?	YES	NO
Are you allergic to iodone, shellfish, IV contrast dye,latex or steriods?	YES	NO

Have you ever been diagnosed with any of the following conditions? (please circle any conditions below)

17	Depression	Emphysema	Rheumatoid arthritis
Stomach ulcer	Anxiety	COPD	Osteroarthritis
GI bleed	Insomnia	Cancer	Peripheral neuropathy
Heartburn/reflux	Seizures	Stroke	Multiple sclerosis (MS)
Diabetes	Fibromylagia	Asthma	Irritable bowel
Liver disease	Migraines	Hypothyroid	HIV/AIDS
Kidney disease	Psychiatric conditions	Hyperthyroid	Vascular disease
Bleeding disorder	Alcoholism	High blood pressure	Broken bones
Sleep apnea	Heart attach	Hepatitis	
Other conditions not listed above?			

Review of Conditions (please circle any conditions below)

Weight loss	Chest pain/pressure	Diarrhea	Heat/ Cold intolerance
Weight gain	Rapid heartbeat	Nausea/vomiting	Changes in appetite
Trouble sleeping	Poor circulation	Blood in stool	Coughing up blood
Fever	Swelling in legs/feet	Abdominal pain	Home oxygen use
Fatigue	Irregular heart rate	rashes	Depression
Joint pain	Headache	itching	Double vision
Joint stiffness	Recent Falls	Frequent urination	Eye pain
Muscle spasm/cramp	Poor memory	Kidney stones	Constipation
Muscle weakness	Fainting	Chronic cough	Dizziness
Snoring	Seizures	Wheezing	Ringing in ears
Hearing loss	Blurred vision	Shortness of breath	Nose bleeds

Patient Registration

First name_____MI._____ Last Name_____

Address:_____

City_____State_____Zip_____

Home #_____Mobile #_____

Mobile Service Carrier: _____

E-mail Address: _____

SS#_____Marital status Married Single Widow Divorced

Emergency Contact_____Phone

Spouse Information

Name_____Phone#_____

Referral Source

Physician Name_____Phone #_____Advertisement_____

Referring Patient_____Internet_____

Cordova Pain Specialists

Patient Name_____ DOB_____
Home #_____ Work_____
Pharmacy_____ Pharmacy #_____

Medication Name	*Dosage*	*Frequency*	*Perscribing Dr.*	*Date Reviewed*

Common Sense Rules for Using Controlled Medications

1. Follow your doctor's recommendations
2. Do not take more pills than prescribed per day
3. Do not share medications with family or friends
4. Do not take medications from family or friends
5. Do not sell medications
6. Do not take medications in any manner other than prescribed. Do not chew or inject your medication
7. Keep all medications out of reach of children
8. Do not leave your prescriptions or controlled medications lying around unprotected for others to steal and abuse them
9. Do no operate a motor vehicle if you feel mentally impaired using controlled medications. You are responsible for exhibiting good judgment in your daily affairs, including your use of controlled medications
10. Alcohol use should be curtailed when using controlled medications

Continued Use of Controlled Medication is based on your physician's/provider's judgment and a determination of whether the benefits to you of using controlled medications outweigh the risks of using them.

Your physician or provider may discontinue treating you at his or her discretion. Your physician or provider may require a consultation with an addiction specialist. You may be required to have more frequent visits. Failure to keep scheduled appointments may result in dismissal from clinic or discontinuation of controlled medications.

We believe in treating your pain and we recognize the value of controlled medications in this process. When used properly, controlled medications can help restore comfort, function, and quality of life. However, as stated above, controlled medications may also have serious side effects and are highly controlled because of their potential for misuse and abuse. It is important to work with your physician and communicate openly and honestly with him or her about your pain control needs. By doing so, medications can be used safely and successfully.

By your signature below, you are acknowledging that you have read and reviewed these matters with your physician and that you have sufficient information to make a decision to use the controlled medications prescribed.

You should **NOT** sign this form if you do not believe you have enough information to make an informed decision about your use of controlled medications and how they fit in to your pain management treatment plan.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Witness: _____ Date: _____

PATIENT AGREEMENT: Controlled Substance Treatment

PATIENT NAME: _____

CORDOVA PAIN SPECIALISTS

I understand that this agreement between myself; _____and Cordova Pain Specialists is intended to clarify the manner in which chronic (long-term) controlled substance will be used to manage my chronic pain. Chronic controlled substance therapy for patients who do not suffer from cancer pain is a controversial issue.

I understand that there are side effects to this therapy; these include, but are not limited to, allergic reactions, depression, sedation, decreased mental ability, itching, difficulty in urinating, nausea and vomiting, loss of energy, decreased balance and falling, constipation, decreased sexual desire and function, potential for overdose and death. Care should be taken when operating machinery or driving a car while taking these medication. When controlled substance are used long-term, some particular concerns include the development of physical dependence and addiction I understand these risks and have had my questions answered by my provider.

I understand that Cordova Pain Specialists provider will prescribe controlled substances only if the following rules are adhered to:

- All controlled substance prescriptions must be obtained from Cordova Pain Specialists. If a NEW condition develops, such as **trauma or surgery**, then the physician caring for that problem may prescribe narcotics for the increase in pain that may be expected. I will notify Cordova Pain Specialists within 48 hours of my receiving a narcotic or any other controlled substance from any other physician or other licensed provider. **For females only:**
  If I become pregnant while taking this medicine, I will immediately inform my obstetrician and obtain counseling on risks to the baby.

- I will submit urine and/or blood on request for testing at any time without prior notification to detect the use of non-prescribed drugs and medications and confirm the use of prescribed ones. On the first occasion **of cocaine, heroin or other illegal drug** in your drug screen, **you will never receive** narcotic medication from Cordova Pain Treatment Clinic again. I will submit to

pill counts without notice as per provider's request. I will pay any portion of the cost associated with urine and blood testing that is not covered by my insurance.

- Prescription refills will not be given prior to the planned refill dated determined by the dose and quantity prescribed. I will accept generic medications.
- Accidental destruction, loss/stolen of medications or prescriptions will not be a reason to refill medications or rewrite prescriptions early. A Police report will not be a reason to rewrite prescriptions. I will safeguard my controlled substance medication from use by family members, children and or other unauthorized person.
- You may be referred to an appropriate specialist to evaluate your physical condition.
- You may be asked to have an evaluation by either a psychiatrist or psychologist to help manage your medication needs.
- If your provider determines that you are not a good candidate to continue with the medications, you may be referred to a detoxification program.
- These medications may be discontinued or adjusted at your provider's discretion.
- I understand that it is my provider's policy that all appointments must be kept or cancelled at least 24 hours in advance. I understand that the original bottle of each prescribed controlled substance medication must be brought to every visit.

I understand that I am responsible for meeting the terms of this agreement and that failure to do so will/may result in my discharge as a patient of Cordova Pain Specialists. Grounds for dismissal form Cordova Pain Specialists include, but are not limited to: Evidence of recreational drug use, of drug diversion, of altering scripts (this may result in criminal prosecution). Of obtaining controlled substance prescriptions from other doctors without notifying this office in 48 hours, abusive language toward staff, development of progressive tolerance, use of alcohol or intoxicant, engagement in criminal activities.

Patient's Signature

Witness' Signature

Date

Date

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last 2 *weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

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

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

A2663B 10-04-2005

CORDOVA PAIN SPECIALISTS

I hereby instruct and direct _____
Insurance Company/ Attorney to release my benefits to and mailed directly to:

CORDOVA PAIN SPECIALISTS
1540 APPLING CARE LANE SUITE 105
CORDOVA, TN 38016

If my current policy prohibits direct payment to the provider, then I hereby instruct and direct you to release benefits payable to me and mail it as follows:

CORDOVA PAIN SPECIALISTS
1540 APPLING CARE LANE RD SUITE 105
CORDOVA, TN 38016

The expense benefits payable will be applied towards the total charges for professional services rendered. This is a direct assignment of my rights and benefits under the policy. This payment will not exceed my indebtedness to the above mention assignee. I have agreed to pay, in a current manner, any balance of said professional charges over and above this insurance payment.

A photo copy of this assignment shall be considered as effective and valid as the original.

I authorize the release of any information pertinent to my case to necessary insurance companies, adjusters, or attorneys involved in this case.

_____

DATE Signature of policy holder and/or claimant

If signing for a minor, please list the minors name: _____

CORDOVA PAIN SPECIALIST

Section A: The Patient

Name:_____

Address:_____

Telephone:_____ E-mail:_____

Section B: Acknowledgement of Receipt of Privacy Practices Notice

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature:_____ Date:_____

If personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name:_____

Relationship to Individual:_____

Section C: Signature

Signature:_____ Date:_____

Who may we speak with regarding your medical care?_____

_____

Relationship?_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

VS Diagnostics

Version 4.26.16

Pre-Evaluation Questionnaire

First Name	Last Name	MI	Today's Date

Insurance Company	Patient ID / Member ID

Gender (Select One) Male Female	Height	Weight	Birthday	Age

Are you pregnant? YES / NO ***Do you have a defibrilator? YES / NO***

Do you have a pain or insulin pump, or any electrical or metal implants or sensors of any kind? YES/ NO

Please answer the following questions to the best of your ability.

Section 1 *Regarding your personal and family health history.*

	YES		YES
Do you smoke or have you smoked?		Has anyone in your immediate family (blood relatives) been diagnosed with cardiovascular disease (CVD)?	
Do you have diabetes?			
Do you have high cholesterol?		Has anyone in your immediate family (blood relatives) passed away from Sudden Cardiac Death Syndrome (SCD)?	
Do you have a history of CVA or TIA?			

Section 2 *Regarding your health.*

[2A] Have you ever been diagnosed with any of the following cardiovascular diseases or symptoms?

	YES		YES
Do you have hypertension *(high blood pressure)* ?		Embolism of the upper limb/limbs (Artery obstruction in the arms)?	
Peripheral Vascular Disease *(PVD - Circulation disorders in blood vessels)* ?		Beurger's disease (Inflammation in blood vessels in limbs)?	
Raynaud's Syndrome *(Poor circulation in blood vessels in limbs)* ?			

[2B] Have you ever been diagnosed with any of the following cardiovascular conditions or symptoms?

	YES		YES
Diabetes I with neurological symptoms?		Diabetes II with neurological symptoms?	
Do you ever have pain in your arms or legs?		Do you ever experience a rapid heart rate *(Tachycardia)* ?	
Edema (swelling) in your arms/legs?		Do you ever notice a tingling/numbness feeling in your fingers or limbs?	
Peripheral Neuropathy?		Do you ever stand up and get dizzy and/or light headed?	
Do you have hypotension *(very low blood pressure)* ?		Do you experience hyperhidrosis *(Excessive sweating)* ?	
Degenerative Disease?		Reflex Dystrophy?	
Idiopathic Peripheral Neuropathy?		Reflex Sympathetic Dystrophy?	

VS Diagnostics, Inc follows HIPPA confidentiality laws and would never share any patient information.

Patient Signature	Physician Signature