

# Charlottesville Interventional Pain Management

## Patient Demographics

Patient Name: \_\_\_\_\_

Address: Street / City / State / Zip

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patient's Social Security Number: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Subscriber Social Security Number: \_\_\_\_\_

Who to contact in case of emergency: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_



**CHARLOTTESVILLE  
INTERVENTIONAL  
PAIN MANAGEMENT**

2050 Abbey Road, Suite A | Charlottesville, VA 22911  
Telephone: (434) 295-3600 | Fax: (434) 220-0121

With my consent, Charlottesville Interventional Pain Management may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and Health Operations (TPO). Please refer to Charlottesville Interventional Pain Managements Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Charlottesville Interventional Pain Management reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Charlottesville Interventional Pain Managements Privacy Officer at 2050 Abbey Road, Suite A, Charlottesville, Virginia 22911.

With my consent, Charlottesville Interventional Pain Management may call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist Charlottesville Interventional Pain Management in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, x-rays and MRIs among others.

With my consent, Charlottesville Interventional Pain Management may mail to my home or other designated locations any items that assist Charlottesville Interventional Pain Management in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Confidential".

I have the right to request that Charlottesville Interventional Pain Management restricts how it uses or discloses my PHI to carry out TPO. However, Charlottesville Interventional Pain Management is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Charlottesville Interventional Pain Managements use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Charlottesville Interventional Pain Management may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient/Legal Guardian

**PRIVACY PRACTICES ACKNOWLEDGEMENT**

I have reviewed the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Charlottesville Interventional Pain Management: Patient Questionnaire

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Where is your pain? \_\_\_\_\_

How did your pain start? \_\_\_\_\_

How long have you had your pain? \_\_\_\_\_

Describe the Quality of your pain (ache, burning, stabbing, shooting, throbbing, knife like, pins and needles, etc.) \_\_\_\_\_

Times of the day that pain is worse. \_\_\_\_\_

Activities or positions that make pain worse. \_\_\_\_\_

Any weakness? (List where) \_\_\_\_\_

Any numbness or sensory loss? (List where) \_\_\_\_\_

List any medications, therapy, surgery or other treatments tried *for your pain*.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Severity of pain: On a scale from 0 - 10 (0: being no pain and 10: being the worst pain imaginable), how would you rate your pain today. Please circle the number and word that best describes your pain.

0    1    2    3    4    5    6    7    8    9    10

No Pain ----- Mild Pain ----- Moderate Pain ----- Severe Pain ----- Excruciating Pain

**IMPORTANT! You must inform your doctor if you answer yes to either of the following questions**

Are you taking any blood thinning or anticoagulant medications (Coumadin, Plavix, Pradaxa, Arixtra)? (List) \_\_\_\_\_

Are you Allergic to X-Ray Dyes (Omnipaque) or Iodine? \_\_\_\_\_

Are you or could you be pregnant? \_\_\_\_\_

**Past Medical History:** List any medical conditions you have (i.e. High blood pressure, diabetes etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medications:** Please list all medicines you take: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies:** \_\_\_\_\_  
\_\_\_\_\_

**Past Surgical History:** Please list all surgeries you have had.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Social History:**

Marital Status: \_\_\_\_\_ Number of children: \_\_\_\_\_ Occupation: \_\_\_\_\_

Is this a work related injury? \_\_\_\_\_ Date of injury: \_\_\_\_\_ Presently Working? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ Packs per day? \_\_\_\_\_ Do you drink alcohol? \_\_\_\_\_ Amount? \_\_\_\_\_ Have you ever had an alcohol or chemical dependency problem? \_\_\_\_\_

**Check all that apply:**

**Constitution:**  Change in appetite or weight  Fever or chills

**Ears:**  Hearing loss  Ear pain

**Cardiovascular:**  Chest pain  Palpitations  Lower extremity swelling

Fainting or passing out

**Respiratory:**  Cough  Shortness of breath  Wheezing

**Gastrointestinal:**  Diarrhea  Constipation  Blood in stools  Abdominal pain  Vomiting

Heartburn

**Genitourinary:**  Urinary frequency  Blood in urine  Incontinence  Pain in urination

**Musculoskeletal:**  Joint pain  Joint swelling

**Skin:**  Rash  Skin lesions

**Neurological:**  Headaches  Confusion  Trouble speaking  Trouble walking

**Psychiatric:**  Anxiety  Depression

**Hematologic/Lymphatic:**  Easy bruising  Easy bleeding  Swollen glands

Allergic/Immunologic:  Itching  Sneezing  Watery eyes  Recurrent infections

Endocrine:  Excessive thirst  Excessive urination  Sweating  Cold/heat intolerance

**Family History:** Please list any serious illness any of your blood relatives have had.

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**Notice to our patients:**

Many insurance companies insist that pre-authorization or approval for your medical visit or medical procedures be acquired in order that they will cover these expenses Charlottesville Interventional Pain Management (CIPM) attempts to be sure that such authorization has taken place, however we do not guarantee this. We recommend that you call your primary care physician's office or your insurance carrier *today* to check on this if you have any questions.

I understand that I have presented to Charlottesville Interventional Pain Management for medical services. I understand that my medical insurance company may require a referral from my primary care physician and/or pre-authorization in order for this visit and medical procedure(s) to be covered. It is my responsibility to check with my primary care physician and/or insurance company that official notification and referral/pre-authorization has been made with my insurance company. I understand that if the necessary referral or pre-authorization has not been made, I am fully responsible for the payment of the fees from this office.

We request that you make efforts to arrive at Charlottesville Interventional Pain Management at the requested time. Please contact us as soon as possible if it becomes necessary to cancel or re-schedule a medical appointment. I will be responsible for a \$57 office visit fee for missed appointments or appointment cancellations made less than 24 hours before my scheduled appointment time.

**Consent for Designated Blood Borne Pathogens and Medical Care, Release of Information**

Virginia Law requires health care providers to notify you that Hepatitis B and C or HIV Virus testing on a sample of your blood may be done if a health care worker is exposed to your blood or body fluids. As a health care provider under Virginia Acts of Assembly Section 32.1-45.1, whenever any health care worker associated with or working for Charlottesville Interventional Pain Management is directly exposed to body fluids of a patient which may transmit HIV or Hepatitis B and C, Charlottesville Interventional Pain Management will proceed to test that patient through his or her physician and the health care worker(s) who was exposed. When a person is tested, we will test for HIV: AIDs virus, Hepatitis B and C for the safety of all concerned. Also: I voluntarily consent to the medical care at Charlottesville Interventional Pain Management which may include examinations, tests, photographs and treatments by doctors and staff. No promises have been made to me as to the results of treatment or examinations. I hereby authorize the release of any medical information required to process my insurance claim. I also authorize my insurance payments to be directly to the physician.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

*(Please Do Not Write Below This Line)*

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**Physicians Section:**

The above medical history and questionnaire has been reviewed for the evaluation and management of this patient.

Physician's Signature \_\_\_\_\_

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_