3815 E. Bell Road, Suite 1500
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(602) 494-5015 • (602) 445-9369 Fax
www.pvpain.com

Paradise Valley Pain Specialists

Paul Wang, D.O.
Fellowship-trained in Pain Management
Board-certified in Physical Medicine & Rehabilitation

Pain Assessment Questionnaire

DATE: _____

NAME: _____
Last First Middle

Male Female (circle)

AGE: _____ DOB: _____

MARITAL STATUS: Single Married Significant Other's Name: _____

REFERRING PHYSICIAN: _____
Name Number Fax

PRIMARY CARE PROVIDER: _____
Name Number Fax

CARDIOLOGIST: _____ ❑ None
Name Number Fax

SPINAL SURGEON: _____ ❑ None
Name Number Fax

NEPHROLOGIST: _____ ❑ None
Name Number Fax

Check one: ❑ Psychiatrist ❑ Neurologist ❑ Oncologist ❑ Rheumatologist ❑ Orthopedic Surgeon

_____
Name Number Fax

OTHER PHYSICIANS you have seen specifically for this pain problem: _____

_____

You have been referred to Paradise Valley Pain Specialists. Our goal is to help you improve your level of function and reduce your level of pain. We specialize in both the evaluation and management of many types of pain disorders.

In order to develop an effective plan of treatment, we need to obtain detailed information about you and your health. Please take time to complete the following questionnaire. In addition, we will ask to copy your insurance card(s) and state issued identification when finished with this form.

Thank you,
Paradise Valley Pain Specialists

Patient Name: DOB:

Pain Description

When did your pain begin? _____

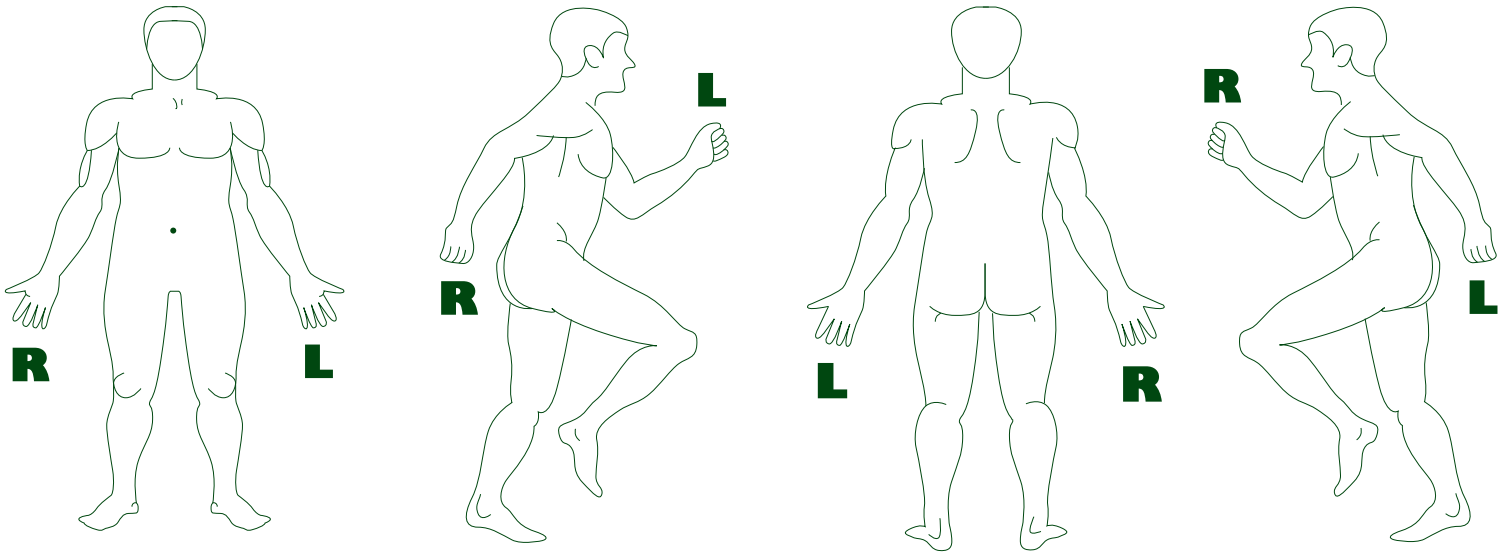
Where is your pain?_____

_____

Please check the words that best describe your pain.

❑ Aching ❑ Dull ❑ Constant ❑ Numbing ❑ Coldness ❑ Burning
❑ Sharp ❑ Stinging ❑ Stabbing ❑ Tingling ❑ Cramping ❑ Radiating

Please shade the locations of your pain in the diagrams below.



Pain Description

Please indicate if any of the following increases, decreases, or causes no change to your pain.

Stimulus/ Treatment	Increase Pain	Decrease Pain	No Change	Stimulus/ Treatment	Increase Pain	Decrease Pain	No Change
Heat	❑	❑	❑	Standing	❑	❑	❑
Cold	❑	❑	❑	Sneezing/Coughing	❑	❑	❑
Weather Changes	❑	❑	❑	Physical Therapy	❑	❑	❑
Lying Down	❑	❑	❑	Massage Therapy	❑	❑	❑
Sleep	❑	❑	❑	Urination	❑	❑	❑
Physical Activity	❑	❑	❑	Bowel Movement	❑	❑	❑
Sexual Intercourse	❑	❑	❑	Tension	❑	❑	❑
Sitting	❑	❑	❑	Fatigue	❑	❑	❑

My pain is the result of an: ❑ accident ❑ illness ❑ I do not know what caused my pain

Please describe illness or accident: _____

_____

If accident, is there litigation involved? ❑ Yes ❑ No Please explain: _____

_____

Attorney Name: _____ Phone: _____ Fax: _____

Do you have an open workman's comp claim? ❑ Yes ❑ No

Pain Scales

(0 = No pain 10= Worst pain)

Please rate your present pain level.

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Please rate your worst pain level.

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Please rate your average pain level.

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Functional Scales

(0 = Not able 10 = Very able)

Please rate your ability to cope with pain.

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Please rate your ability to perform activities of daily living such as hygiene, household chores, transportation, etc.

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Please rate your ability to function and interact well with family and friends.

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Please rate your ability to work in your usual occupation.

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Pain Treatment History

Please indicate which diagnostic procedures you have had and the approximate date/location where the test was performed.

Diagnostic Procedure	Body Part/Area	Date	Location
Bone Scan/SPECT			
MRI Scan			
CT Scan			
Myelogram			
X-Ray			
EMG/Nerve Conduction Study			
Urine Drug Screen			
Lab Work			

Please indicate the amount of relief and date of the following treatments if applicable.

Treatment	No Relief	Moderate Relief	Excellent Relief	Date
Surgery	❑	❑	❑	_____
Traction	❑	❑	❑	_____
Spine Injection	❑	❑	❑	_____
Physical Therapy	❑	❑	❑	_____
Chiropractic Care	❑	❑	❑	_____
Acupuncture	❑	❑	❑	_____
TENS Unit	❑	❑	❑	_____

Do your pain medications provide relief? ❑ Yes ❑ No ❑ I do not take pain medications

If yes, how much relief do you receive?

❑ 10% ❑ 20% ❑ 30% ❑ 40% ❑ 50% ❑ 60% ❑ 70% ❑ 80% ❑ 90% ❑ 100%

Which pain medications have you tried?: _____

_____

Do your pain medications improve your function? ❑ Yes ❑ No ❑ I do not take pain medications

If yes, how much improvement in function do you receive?

❑ 10% ❑ 20% ❑ 30% ❑ 40% ❑ 50% ❑ 60% ❑ 70% ❑ 80% ❑ 90% ❑ 100%

Please indicate any side effects caused by your pain medications.

❑ Nausea ❑ Vomiting ❑ Rash ❑ Constipation ❑ Upset Stomach ❑ Sedation

❑ Dizziness ❑ Acid Reflux ❑ Itching ❑ No side effects ❑ Other: _____

Sleep Behavior

Do you have difficulty falling asleep? ❑ Yes ❑ No

Do you have difficulty remaining asleep? ❑ Yes ❑ No

Are you ever awakened by your pain? ❑ Yes ❑ No

How many hours do you sleep, on average, per night?

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ More than 10

Medical History

In order to develop your individualized plan of treatment, gathering detailed information about your past medical history, past psychological history, family, and social history are very important. Please answer the following questions openly and specifically. Please use back of form if more space is needed.

Weight: _____ Height: _____

Please check any major illnesses that may apply.

❑ High blood pressure ❑ Vascular problems ❑ Epilepsy ❑ Osteoarthritis (regular/common arthritis)

❑ Diabetes ❑ Heart disease ❑ Tuberculosis ❑ Hepatitis

❑ Lupus ❑ Asthma ❑ Stroke ❑ Rheumatoid arthritis

❑ Shingles ❑ HIV/AIDS ❑ Emphysema ❑ Kidney problems

❑ Thyroid Problems ❑ Cancer ❑ Other: _____

_____

Surgical History

Please list prior surgeries or procedures below.

Date	Surgery/Procedure	Physician

Family Medical History

Please list any family members (such as mother, father, brother, etc) that may have or are currently suffering from any medical or psychiatric conditions such as: diabetes, hypertension, heart disease, cancer, stroke, chronic pain, depression, bipolar disorder, etc.

Condition: _____ Specific family member _____

Condition: _____ Specific family member _____

Condition: _____ Specific family member _____

Allergy History

If you are allergic to any medications, please list the medication name and reaction you had below.

Medication	Reaction

Medications

Please list all medications that are currently prescribed to you.

Name	Strength	Directions	Prescribing Doctor

Please check the appropriate box if you currently take any of the following medications.

❑ Yes ❑ No Coumadin

❑ Yes ❑ No Plavix

❑ Yes ❑ No Lovenox

❑ Other blood thinners:_____

Education & Family Life

Please list your highest education level completed: _____

Marital status: ❑ Single and never married ❑ Married ❑ Divorced ❑ Widowed

❑ I have (#)_____ children. Ages: _____ Significant other's name: _____

Employment

Occupation: _____ Employment status: _____

What are your current work restrictions, if any? _____

If you are unemployed, employed part-time, or have work restrictions, is this due to your present pain condition? ❑Yes ❑ No

If employed, how many hours do you work each week?

❑ Less than 10 ❑ 11-20 ❑ 20-30 ❑ 30-40 ❑ More than 40

Habits

Do you smoke? ❑Yes, currently ❑Yes, in the past ❑ No, never

If yes, how many packs do you smoke per day? ❑ 0-1/2 ❑ 1/2-1 ❑ 1-2 ❑ More than 2

How long have you smoked? Years: _____ Months: _____

Do you use alcohol? ❑Yes ❑ No If yes, how many drinks do you consume?

I consume _____ drinks every day. I consume _____ drinks every week. I consume _____ drinks every month.

Have you ever used misused, abused, or been addicted to prescription medications?

❑Yes, currently ❑Yes, in the past ❑ No, never

Have you ever used illegal drugs (cocaine, intravenous drugs, etc)?

❑Yes, currently ❑Yes, in the past ❑ No, never

Have you ever been treated for addiction? ❑Yes ❑ No Have you ever been treated for alcoholism? ❑Yes ❑ No

Have you ever had psychiatric, psychological, or social work treatments/evaluations for any diagnosis/problem, including your current pain? ❑Yes ❑ No

If yes, for what diagnosis or problem were you treated?_____

When were you treated? _____ Therapist's name: _____

Have you considered suicide? ❑Yes ❑ No Date: _____

Have you ever planned suicide? ❑Yes ❑ No Date: _____

Have you ever attempted suicide? ❑Yes ❑ No Date: _____

Review of Systems

Are you currently experiencing any of the following?

General		Neuro		Eyes		Respiratory	
Yes	No	Yes	No	Yes	No	Yes	No
❑	❑ Chills	❑	❑ Headaches	❑	❑ Visual changes	❑	❑ Shortness of breath
❑	❑ Night sweats	❑	❑ Dizziness			❑	❑ Persistent cough
❑	❑ Fever	❑	❑ Weakness (specify) _____			❑	❑ Difficulty breathing

Cardiovascular		Gastrointestinal		Skin		Genitourinary	
Yes	No	Yes	No	Yes	No	Yes	No
❑	❑ Chest pains	❑	❑ Nausea	❑	❑ Sores	❑	❑ Urinary retention
❑	❑ Abnormal heart beat	❑	❑ Vomiting	❑	❑ Rashes	❑	❑ Urinary incontinence
		❑	❑ Diarrhea			❑	❑ Urinary discharge
		❑	❑ Bowel incontinence				
		❑	❑ Constipation				

Patient Information

Name: _____ ❑ M ❑ F
Last First Middle

Address: _____
City State Zip

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ Email: _____

Age: _____ DOB: _____ SS#: _____

Marital Status: Single Married Divorced Widowed Domestic Partner Student: Full-time Part-Time

Current Employer: _____ Occupation: _____

Emergency Contact: _____
(not living with you) Name Phone Relation

Referring Physician: _____ Primary Physician: _____

Primary Insurance Information

HMO PPO EPO POS OPEN ACCESS CoPay $ _____

_____
Name of Insurance Company Phone Number

_____
Policy Holder Name (for Workers' Comp List Employer & Employer Address)

_____
Policy Holder Social Security Number Policy Holder Date of Birth

_____
Member ID# (or Workers' Comp Claim #) Group # Date of Injury (Workers' Comp ONLY)

Secondary Insurance Information

HMO PPO EPO POS OPEN ACCESS CoPay $ _____

_____
Name of Insurance Company Phone Number

_____
Policy Holder Name

_____
Policy Holder Social Security Number Policy Holder Date of Birth

_____
Member ID# Group #

Permission to Treat Patient

I hereby authorize medical care by Paradise Valley Pain Specialists for the person named above as "patient" on this document. I also give Paradise Valley Pain Specialists permission to file claims with my insurance company and to receive payment for my medical care and /or procedures. **I also understand that I am financially responsible for all charges not covered by my insurance for services rendered on my behalf or my benefits.**

Patient Signature Date

Guardian Signature Date

Witness Signature Date

Assignment of Insurance Benefits

I hereby authorize payment directly to Paradise Valley Pain Specialists of all insurance benefits related to my care. I authorize Paradise Valley Pain Specialists to release any information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions. **I also understand that I may be responsible for any co-payment or co-insurance due at the time of any and all office visit(s) and/or procedures.**

Patient Signature Date

Guardian Signature Date

Witness Signature Date

Medicare Authorization

I request that payment of my Medicare benefits be made to Paradise Valley Pain Specialists on my behalf for any services furnished by Paradise Valley Pain Specialists or under their direction. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the charge determination of the Medicare carrier.

Patient Signature Date

Guardian Signature Date

Witness Signature Date

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Patient Signature or Personal Representative Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority

Responsibility for Insurance

Due to all various HMO and PPO insurance plans now in effect in the market place, it has become a very complicated process to become familiar with each plan.

All the various companies and plans have their individual requirements regarding payment, patient's co- payment, and pre-certification requirements for various procedures.

We therefore request that all patients provide all information needed from their insurance company and assume responsibility for giving this information to our office and any other health facility involved in their particular treatment or illness including hospital treatment. Also to notify their insurance company of any changes in their care or treatment so that proper handling and payment will be made by their insurance company.

Although you may receive a precept or authorization number from your insurance company, please remember that this does not guarantee that your insurance company will pay for our procedure. It is your responsibility to call your insurance benefits department to see if you have any pre-existing or routine testing clauses in your contract which would prevent your insurance company from paying the bill.

We have always filed and will continue to file claims for patients, but the patient must share equal responsibility for obtaining and giving the doctor or insurance company the necessary information needed to get their claims processed and paid within a reasonable time period.

While we realize that patients are not always given all the information required by their insurance company or agent, but it is still the patient's responsibility to call and obtain this information before receiving treatment and before filing claims for treatment. We can not emphasize enough how important this is, for you the patient to receive the proper benefits you are entitled to under your insurance plan or contract.

We are therefore requesting your cooperation so that we may better serve you and give you the proper health care you deserve without having to spend an exorbitant amount of time dealing with the pros and cons of your insurance company. You should have and know all the information required by your individual plans of insurance to avoid any confusion on your behalf of what is being provided for you.

Thank you for your cooperation.

Patient (Or Legal Guardian) Signature Date

Financial Policy

Because of our commitment to provide you with the highest standard of medical care, we want you to be aware of our policies concerning payment of your medical expenses.

At the initial visit and all visits, the patient is responsible for co-payment/co-insurance amount, plus any deductible. **If our office cannot verify insurance benefits, payment is due in full when you check- out from your appointment.**

If your insurance carrier sends payment directly to you, then payment in full is due at each visit. Should an overpayment occur on the deductible or percentage amounts charged, we will apply a credit to your account. A refund is available upon request.

If you are waiting for coverage to become effective or have no insurance, payment in full will be expected the day you are seen. **We accept cash or check. We do not accept credit cards.** If you would like to be billed for your co-pay or deductible, there will be a $25 administrative fee. Due to pending insurance contract status or a decision not to contract with your insurance company, out-of-network charges may apply. If you do not have any out-of-network benefits, payment is due in full at each visit. It is your responsibility to call your insurance company and obtain this information before receiving treatment and before filing claims for treatment.

We require that an adult (parent or legal guardian) accompany a minor patient unless prior written authorization is given to our office. The adult accompanying the minor patient is required to pay in accordance with our policies. We do not accept third party assignments nor do we recognize or enforce the terms of divorce decrees.

There is a **$50.00 service fee on all returned checks in addition to the amount of the check.** NSF (non-sufficient funds) checks must be redeemed with certified funds (cashier's check, credit card, money order, certified check or cash) at or before the next office visit.

Please notify us with at least 24 hours notice if you must cancel your appointment so that we may let another patient have your appointment time. **If you do not provide at least 24 hours notice, there will be a "no-show" charge for an office visit of $95 and a "no-show" charge for a procedure, including an injection of $375**.

It is your responsibility to know your coverage and benefits and if we are a preferred or assigned provider of your plan. Please be aware that some or all services provided for you may not be covered by your specific plan. In the event that your plan does not cover all services, you will be billed for the services that are not covered.

If your insurance has not paid your account in full within 120 days, you will be billed the balance. A late charge of $25 will be assessed each month if you do not pay the entire balance within 30 days of the billing date. Bills that are not paid within 90 days of the first billing will be transferred to an outside collection agency unless other arrangements have been made. We will make every effort to work with you so please contact our office manager if there a need for a payment plan or there are problems prior to 90 days. If you are unable to keep your account current, we will not be able to provide additional medical services to you unless prepayment is made for services.

In the event that payment is not made on this account and it is placed with a licensed collection agency, you agree to pay the fees of the collection agency equal to a maximum of 58% of our outstanding balance at the time the account is placed with the collection agency; interest of 10% per year will be accrued on the principal balance. Should legal action be necessary to collect the account, you agree to pay attorney fees and court costs incurred for collection.

I have read and understood the foregoing Financial Policy and agree to abide by the terms of the policy.

By signing below, I have read and understand the Financial Policy and agree to abide by the terms of the policy.

Print Name	Signature	Date
Witness Name	Witness Signature	Date

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Non-Covered Services Agreement

Paradise Valley Pain Specialists (hereafter referred to as PVPS) participates with health care plans as a convenience for its patients. PVPS cannot control what insurance plans will and will not cover.

There are certain services that are not covered by your insurance, and should you request any of these services you need to know that there may be an associated fee.

Copy of Medical Records

$0 when PVPS requests services for you from an outside source, or when another physician requests records, copies are faxed or mailed at no charge.
$0 insurance company, for the purpose of determining payment for a service rendered by your PVPS provider, records are copied or faxed at no charge.
Charges for copies for yourself are as follows: $25 for file retrieval
No extra charge for the first 5 pages copied
In addition, $1 per page after the 5th page up to the 9th page copied
$10 for 10 pages, up to 19 pages copied
$20 for 20 pages up to 49 pages copied
$30 for 50 pages and greater copied
** Upon receipt of prepayment, signed medical record release, and self-addressed stamped envelope, we will mail these records to you or you can call the office to schedule a pick-up time. Please allow 7 -10 days for processing your request upon receipt of your prepayment.*

Faxing Medical Records

If you request your own records for your own personal use, PVPS will fax up to 10 pages of medical records to a secure number provided by you. By providing and signing for PVPS to fax your records you agree to hold harmless and release PVPS from all HIPAA responsibilities should there be any errors during the fax transmission.

Forms: *PVPS does not supply any of these forms*

$40 per page for A.P.S. (attending physician statement) and a standard charge for the office visit subject to your individual insurance benefits
$45 per page for F.M.L.A, D.O.T., and a standard charge for the office visit - subject to your individual insurance benefits.

Prescriptions

- If you request a prescription to be mailed to you, you may provide PVPS with self-addressed stamped envelopes, otherwise you will incur the Collect on Delivery (C.O.D.) expense.
- $15 medication refill request not accompanied by an office visit, when the visit is due or overdue (regardless of the reasons)

**Note: Due to the amount of labor required, PVPS no longer deals with mail order prescription companies.*

Office Visits:

$50 for a same day visit, when the provider has no openings and is booked
$50 for an office visit beyond the usual business hours

By signing below, I have read and understand the Non-Covered Services agreement, agree to abide by the terms of the agreement, and will also prepay the associated fees for the services listed above.

Print Name	Signature	Date
Witness Name	Witness Signature	Date

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PVPS Patient Agreement

1. I recognize that my chronic pain represents a complex problem, which may benefit from physical therapy, psychotherapy, behavioral medicine strategies, and additional diagnostic studies. I also recognize that my active participation in the management of my pain is extremely important. I agree to actively participate in all aspects of the recommended treatment to maximize functioning and improve coping with my condition.
2. I agree to schedule and keep follow-up appointments with my physician at Paradise Valley Pain Specialists, primary care physician, and consulting providers at recommended intervals. I understand that failure to keep appointments may lead to discontinuation of treatment.
3. I am responsible for keeping track of the amount of medication left and to plan ahead for arranging the refill of my prescriptions in a timely manner so I will not run out of medications.*
4. I agree to submit to urine and blood screens to detect the use of non-prescribed medications (including "street" drugs) at any time.
5. If I am prescribed an opioid medication, I agree to monthly office visits. In addition, the first time I receive an opioid prescription from PVPS, I agree to sign the "Informed Consent and Controlled Substance Agreement" form, trilateral agreement, or quadrilateral agreement. I will also provide a urine sample and/or blood sample for testing. This agreement is not effective until I receive a copy signed by all parties involved.
6. If I am requesting that PVPS take over the writing of prescription for opiates from another physician or initiate opiate therapy, I understand and agree that this will not be done for at least 2 office visits from the time of your request. Determining whether you are a candidate for opiate therapy can take up to 2 – 3 months.

6b. Labwork, imaging studies, consults, and waiting for signed documents take time. I understand that if I cannot wait this long, I will need to ask my primary care physician or referring physician for a referral to a different pain physician. If I am unable to reach my PCP or referring physician, I agree to go to the nearest emergency room or call 911.

7. If I violate any of the above conditions, my obtaining prescriptions and/or treatment at PVPS may be terminated.
8. If the violation involves any illegal activity such as altering a prescription, I understand that the incident may be reported by Paradise Valley Pain Specialists to other physicians caring for me, local medical facilities, pharmacies and other authorities such a the local police department, Drug Enforcement Agency, etc. as deemed appropriate for the situation.
9. I allow my medical records to be released to my PCP and any other physicians who may be involved in the the management of my pain. I understand and agree that I need to have a primary care physician.
10. I understand and agree that medical records and dictations will be stored on the portal at Abrazo Health Care since we are on staff there and the majority of his procedures are performed at Paradise Valley Hospital. I will contact the medical records department at Paradise Valley Hospital at (602) 923-5614 should I have any questions about how they are stored.
11. I understand that PVPS does not do their own billing, but utilizes Physician Management Solutions. I will direct billing questions to (480) 298-2620.

***MEDICATION REFILL INFORMATION:**

A. **Advance notice of <u>3 business days</u> is required for refills of prescriptions.**
B. Requests for scheduled refills must be telephoned to (602-494-5015). Refills will not be made after 4 pm, on holidays, or on weekends.
C. All controlled substances cannot be telephoned in to a pharmacy.
D. Pharmacy Name: _____ Phone: _____

Address: _____ Zip Code: _____

BY SIGNING BELOW I INDICATE THAT I UNDERSTAND AND AGREE TO ALL THE TERMS OF THE ABOVE AGREEMENT. I HAVE RECEIVED A COPY OF THIS FOR MY OWN RECORDS.

Patient (or Guardian) Signature Date Witness Signature Date