KEARNEY
PAIN TREATMENT CENTER

Patient Name: _____

Patient Fee Agreement

I understand that all professional services rendered are charged to and are the responsibility of the patient. Although Kearney Pain Treatment Center, LLC / Heartland Pain Clinics, LLC will complete insurance forms to expedite insurance carrier's payments, I understand that I am responsible for all fees incurred, including all charges not covered by the insurance carrier for any reason. If my insurance carrier requires by contract a "co-pay" payment to be made by the patient, I will pay that co-pay payment on the day that service is provided.

I understand that it is my responsibility to complete payment in full for services provided on the day charges are incurred. If, for any reason, my account becomes delinquent for 60 days or more, I authorize and understand that my contact information will be turned over to a collection agency and that I am financially responsible for my outstanding balance and any fees that may be associated with the collection process.

Signature of Patient or Guarantor: _____ Date: _____

Insurance Authorization and Assignment

I hereby authorize Kearney Pain Treatment Center, LLC / Heartland Pain Clinics, LLC to furnish information to my insurance carrier(s) concerning my medical condition and treatments. I hereby assign to Kearney Pain Treatment Center, LLC / Heartland Pain Clinics, LLC all payments for medical services rendered to me or my dependent. I understand that I am responsible for all charges for services rendered that are not covered by insurance and I will pay such charges according to the Patient Fee Agreement.

Signature of Patient or Guarantor: _____ Date: _____

Medical Records Release

I hereby authorize Kearney Pain Treatment Center, LLC / Heartland Pain Clinics, LLC to release any information that may assist in my medical or dental care. This may include medical records such as pathology reports, culture reports, progress notes, x-ray and operative reports. I also give permission for Kearney Pain Treatment Center, LLC / Heartland Pain Clinics, LLC to discuss my treatment with a physician or dentist in the event that it may be deemed necessary to provide me with medical and dental care. This release also includes release of information to physical or occupational therapy and communication with my therapist. Personal records requests will incur fees.

Signature of Patient or Guarantor: _____ Date: _____

HEARTLAND PAIN CLINICS, LLC.
CONSENT TO LEAVE MESSAGES

How can we reach you?
Phone Message/Fax Consent

Heartland Pain Clinics, LLC. at times, we may need to contact you about test results, appointments, referrals or billing/insurance information. By filing out the information below, we will be better able to serve you. In an effort to protect your privacy and follow federal guidelines, we have developed on leaving medical care messages. Unless we have written permission to do so:

- We will NOT leave messages with anyone except the patient or legal guardian
- We will NOT leave messages on voicemail or answering machines
- We will NOT send faxes

Please read below and carefully consider who, if anyone, you want to have access to your medical/account information.

I, _____ give my permission for **Heartland Pain Clinics, LLC.** to leave phone messages and/or fax messages regarding my medical care/account information. I fully understand that this consent will remain valid until revoked in writing by me.

Patient Name: _____

Date of Birth: _____

Would you prefer to receive <u>normal</u> tests results?

❑ Fax Fax Number: _____

❑ US Mail Address: _____

May we leave a phone message to inform you that test results are available and to contact our office for those results?

❑ Yes ❑ No Home Phone: _____

❑ Yes ❑ No Work Phone: _____

❑ Yes ❑ No Cell Phone: _____

Who else may we share your test results with on your behalf?

Spouse/Partner: ❑ Yes ❑ No If yes, Name: _____

Son/Daughter: ❑ Yes ❑ No If yes, Name: _____

Other: ❑ Yes ❑ No If yes, Name: _____

Special Instructions, if any: _____

Signature: _____ Date: _____

HEARTLAND PAIN CLINICS

PATIENT/PROVIDER ASSESSMENT

Today's Date

Name

First | Last | MI | Phone #

O Male O Female

Gender (Select One) | Height | Weight | Birthdate | Age

Primary Insurance | Patient ID / Member ID

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

Mark Circle if Answer is Yes

O Are you pregnant?	O Do you have a pain or insulin pump?
O Do you have a pacemaker or defibrillator?	O Do you have any electrical or metal implants or sensors of any kind?

SECTION 1 — **Regarding your health**

O Do you have high cholesterol?	O Do you often feel fatigued?
O Do you have hypertension *(high blood pressure)* ?	O Do your hands and feet get cold easily?
O Do you have diabetes?	O Have you ever experienced vision loss?

[1A] Have you ever been diagnosed with any of the following cardiovascular disease or symptoms?

O Do you experience abdominal pain?	O Do you experience disturbance in your speech?
O Peripheral Vascular Disease (PVD - Circulation disorders in blood vessels)?	O Beurger's disease (Inflammation or clotting in blood vessels in hands or feet)?
O Atherosclerosis of the Aorta?	O Gangrene?
O Ateriovenous Fistula?	O Transient Cerebral Ischemia (TIA, mini-stroke)?
O Diabetes I with circulatory disorders?	O Diabetes II with circulatory disorders?
O Raynaud's Syndrome *(discoloration of fingers and/or toes whenexposed to changes in temperature (cold or hot) or emotional event)* ?	O Do you haveChronic ulcer(s)? Stage II, III or IV?
O Cerebrovascular Disease (CVA, Stroke)?	O Embolism of the upper limb/limbs (Artery obstruction in the arms)?

[1B] Have you ever been diagnosed with any of the following cardiovascular conditions or symptoms?

O Diabetes I with neurological symptoms?	O Diabetes II with neurological symptoms?
O Do you ever have pain in your arms and/or legs?	O Do you ever notice a distburbance in the sensation of your skin (Tingling or numbness)?
O Edema (swelling in arms and or legs)?	
O Dizzy and or light headed when you stand up?	O Peripheral Neuropathy (a result of damage to your peripheral nerves, often causes weakness, numbness and pain, usually in your hands and feet. It can also affect other areas of your body)?
O Reflex Dystrophy (Chronic Pain in Limbs after injury, stroke or heart attack)?	
O Reflex Sympathetic Dystrophy (marked by burning pain, swelling, and motor and sensory disturbances especially of an extremity after an injury)?	O Degenerative Disease (as arteriosclerosis, diabetes mellitus, or osteoarthritis) characterized by progressive degenerative changes in tissue)?
O Rapid Heart Rate (Tachycardia)?	O Idiopathic Peripheral Neuropathy? When the cause can't be determined, it's called idiopathic neuropathy. Includes numbness, tingling and pain in legs and or feet.
O Hypotension (very low blood pressure)?	
O Hyperhidrosis (Excessive sweating)?	

SECTION 2 — **Regarding your personal and family health history.**

O Do you smoke or have you ever smoked?	O Has anyone in your immediate family (blood relatives) been diagnosed with cardiovascular disease (CVD), or have had a heart attack?
O Has anyone in your immediate family (blood relatives) passed away from Sudden Cardiac Death Syndrome (SCD)?	O Do you have a history of CVA or TIA (Stroke or mini stroke)?

NOTICE OF HIPAA AND PRIVACY PRACTICES: This office protects your privacy as well as optimize your quality of care through access to your healthcare data. as part of your privacy, we will never share your information with a third party for marketing purposes. However, HIPAA guidelines allow sharing of general information for statistical reasons, such as a government health department or official third party. Your information may be used within this office or practice or with other healthcare professionals for training and educational purposes pursuant to HIPAA guidelines.

Patient Signature | Physician Signature

HEARTLAND PAIN CLINICS
COMPASSIONATE.RESTORATIVE MEDICINE

J PAUL MEYER, M.D.

603 N. DIERS AVE., SUITE 2 | GRAND ISLAND, NE 68803 | P: (308) 398-1147 | F: (308) 398-1149
2908 W. 39TH STREET, SUITE D | KEARNEY, NE 68845 | P: (308) 455-8023 | F: (308) 455-8024

New Patient Information: (Please Print)

Patient's Legal Name: Last: _____ First: _____ MI: _____

Male / Female Birth Date: _____ Age: _____ SSN#: _____

Address: _____

Phone #: _____ Cell #: _____ Work Phone: _____

Email Address: _____

Name of Spouse or Legal Guardian: _____ Phone: _____

Who referred you to our office? _____

Who is your Primary Care or Family Physician? _____

Employment Information

Patient's Employer: _____ Phone #: _____ Ext: _____

If the patient is a minor, please list both parents and employers:

Mother_____ Employer_____Phone_____ Ext_____

Father_____Employer_____Phone_____Ext_____

Emergency Contact Information

Nearest relative or friend not living with you: _____

Phone: _____ Alternate Phone_____

Relationship to Patient: _____

Insurance Information (we will need a copy of your cards to file a claim)

Primary Insurance Carrier_____

Name of Policyholder_____ Relationship to Patient_____

Policyholder's Date of Birth_____ Policyholder's SSN_____

Policyholder's Employer_____ Phone_____

Secondary Insurance Carrier_____

Name of Policyholder_____ Relationship to Patient_____

Policyholder's Date of Birth_____ Policyholder's SSN_____

Policyholder's Employer_____ Phone_____

Third Party Billing

Is your injury work related? Y N If yes, Date of Injury: _____

Insurance Co._____ Adjuster/Case Mgr._____ Phone_____

Is your injury due to an accident? Y N If yes: MVA / OTHER Have you obtained an accident report? _____

Are you currently involved in any litigation? Y N If yes, with whom? _____

Attorney: _____ Phone _____

I hereby authorize my insurance benefits to be paid directly to the facility and the physician. I understand that I am financially responsible for Non-covered services. I authorize the physician to release my information in the processing of any insurance claim.

Signature_____ Date

Name_____ Age_____ Date_____

Referring Physician_____ Primary Care Physician_____

Chief Complaint_____

Date Pain Began_____ Describe onset or event _____

Please describe your pain:

Use the pictures below to mark the areas on your body where you feel the described sensations. Use the appropriate symbols. Mark the areas of radiation by using arrows and include all affected areas.

NUMBNESS:

_____
_____
_____

PINS AND NEEDLES:

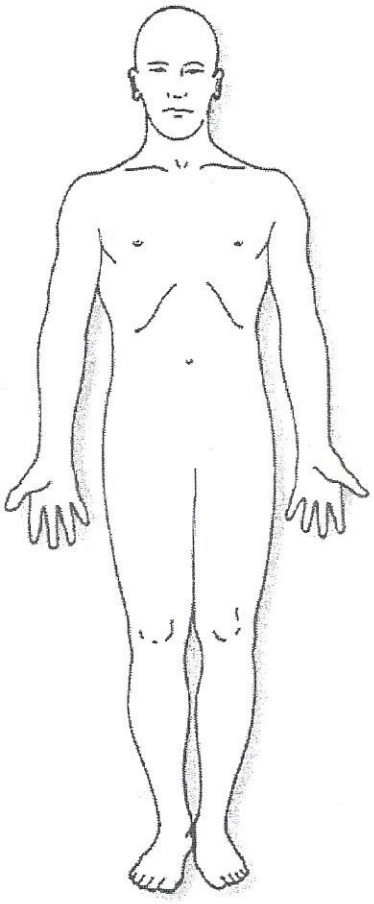
OOOOO
OOOOO
OOOOO

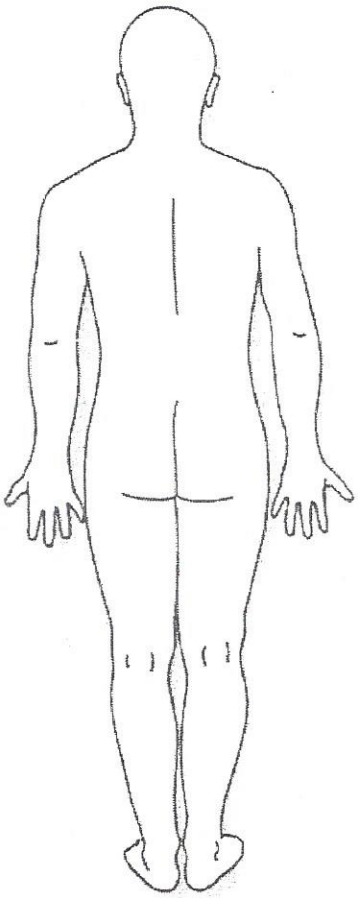
BURNING:

XXXXX
XXXXX
XXXXX

STABBING:

///////
///////
///////





Location of pain

Burning	Y N	_____
Aching	Y N	_____
Throbbing	Y N	_____
Sharp	Y N	_____
Dull	Y N	_____
Shooting	Y N	_____
Stabbing	Y N	_____
Swelling	Y N	_____

Location of pain

Tingling/ Pins and Needles	Y N	_____
Coldness	Y N	_____
Numbness	Y N	_____
Skin Discoloration	Y N	_____
Muscle Spasm	Y N	_____
Muscle Tightness	Y N	_____
Bowel/Bladder Problems	Y N	_____

Other_____

Using Pain Scale of 0-10, Rate your pain. **0=No pain 10=worst pain ever**

At its Worst:	0	1	2	3	4	5	6	7	8	9	10
At its least:	0	1	2	3	4	5	6	7	8	9	10
At its usual:	0	1	2	3	4	5	6	7	8	9	10
Today:	0	1	2	3	4	5	6	7	8	9	10

How do the following affect your pain? **B=makes better** **W=makes worse** **N=no effect**

Relaxation	B	W	N	Standing	B	W	N
Heat	B	W	N	Walking	B	W	N
Cold	B	W	N	Lying Down	B	W	N
Alcoholic Drinks	B	W	N	Exercise	B	W	N
Medication	B	W	N	Sexual Activity	B	W	N
Sitting	B	W	N	Coughing/Sneezing	B	W	N

Have you been hospitalized for your pain? Yes No
If Yes, please give the date, facility and physician who cared for you: _____

_____

What time of the day is your pain at its worst? _____
On average, how many hours do you sleep? _____
How has your appetite changed with your pain? increased_____ decreased_____ no change_____

If you have low back and leg pain, indicate percentage: back_____% leg_____%

Previous Treatments:

Injections or Blocks	Y	N	If yes, please give the date, facility and physician name:

_____

If yes, please list date and treatment facility name:

Physical Therapy	Y	N	_____
Chiropractor	Y	N	_____
Acupuncture	Y	N	_____
Hypnosis	Y	N	_____
TENS Unit	Y	N	_____
Mental Health	Y	N	_____

Testing:

If yes, please list date and treatment facility name:

Lumbar MRI/CT	Y	N	_____
Cervical MRI/CT	Y	N	_____
Thoracic MRI/CT	Y	N	_____
Myelogram	Y	N	_____
EMG	Y	N	_____
Discogram	Y	N	_____
Bone Scan	Y	N	_____

Medical History (Do you have or have you ever had the following?)

Arthritis	Y	N	Anticoagulant Therapy	Y	N
Glaucoma	Y	N	Lung Disease	Y	N
Cataracts	Y	N	COPD/Emphysema	Y	N
Back Trouble	Y	N	Jaundice	Y	N
Blood Disease	Y	N	Paralysis	Y	N
Stroke	Y	N	Thyroid Disease	Y	N
HIV/AIDS	Y	N	Psychiatric Disorder	Y	N
Depression	Y	N	Abnormal EKG	Y	N
Cancer	Y	N	Anxiety	Y	N
Epilepsy/Seizures	Y	N	Muscle Weakness	Y	N
High Cholesterol	Y	N	High Blood Pressure	Y	N
Heart Attack	Y	N	Fracture of Facial Bones	Y	N
Heart Murmur	Y	N	Kidney Disease	Y	N
Hepatitis	Y	N	Stomach Disorder	Y	N
Mononucleosis	Y	N	Asthma	Y	N
Fracture	Y	N	Muscular Disorder	Y	N
Diabetes	Y	N	Bone Disease	Y	N
Blood Transfusion	Y	N	Infection	Y	N

Past Surgical History:

Any hospitalizations in the past year other than for above surgery? Y N If yes please give details:

List all PAIN medications:

Medication	Dose	Frequency	Prescribing Physician

List all other medications, including over the counter medications, vitamins and herbal supplements:

Medication	Dose	Frequency

Do you take any blood thinning medications such as Plavix, Coumadin, Warfarin, Aggrenox, Heparin or Aspirin?

Y N **If yes, please list:** _____

Prescribed by: _____

Medication Allergies: _____

Medical Problems that run in your family: _____

Social History:

Do you object to a blood transfusion? Y N
Drink alcohol? never occasionally frequently daily
Use street drugs or have a history of addiction or abuse? Y N
Use tobacco? Y N If yes, packs per day: _____ smokeless tobacco? Y N
Are you now or is there a possibility of you being pregnant? Y N Maybe NA
Number of Children_____
Marital Status Married____ Single____ Divorced____ Widowed____ Separated____
Occupation:_____

Are you currently working? Y N If not, last day worked: _____

Do you currently have:

Fever	Y	N	Wheezing	Y	N
Coughing	Y	N	Muscle Aches	Y	N
Hearing Loss	Y	N	Heartburn	Y	N
Sore Throat	Y	N	Sinus Problems	Y	N
Chest Pain	Y	N	Vomiting	Y	N
Headaches	Y	N	Paralysis	Y	N
Urinary Pain	Y	N	Blood in Urine	Y	N
Excessive Dry Skin	Y	N	Numbness	Y	N
Diarrhea/Constipation	Y	N	Skin Rash	Y	N
Joint Pain Swelling	Y	N	Fatigue	Y	N
Irregular Heartbeat	Y	N			