PAIN SPECIALISTS OF SOUTHERN OREGON

Dear Sir or Madam,

Welcome to Pain Specialists of Southern Oregon. We are committed to providing you with state-of-the-art interventional pain management and clinical services. Thank you for choosing us for your care.
Joseph Savino, M.D., George Johnston, D.O., Brett Quave, M.D. and Daniel Kim, M.D are fellowship-trained in Pain Medicine. Dr. Savino and Dr. Quave are board-certified in Anesthesia, with a subspecialty certification in Pain Management. Dr. Johnston and Dr. Kim are board-certified in Physical Medicine & Rehabilitation, with a subspecialty certification in Pain Management. Their goal is to partner with the referring physician to optimize your care.

APPOINTMENTS
Enclosed you will find several forms. Please complete each form and return them to our office via mail or email (forms@mypaincare.org) **at least one week** prior to your scheduled appointment so that your provider is prepared for your visit. We have a link to a printable and fillable pdf version of these forms at https://painspecialists.com/new-patient-forms/. Please also bring any records, imaging on discs or CDs, and imaging reports pertaining to your condition. Please plan to arrive **at least 30 minutes** early so there is adequate time to ensure all your records are organized and completed for your visit with our team. We look forward to meeting you. Please do not hesitate to contact us with questions.

FINANCIAL POLICY
We participate with most major insurance companies. Co-payments and/or co-insurance payments are due at the time of service. For patients who do not have insurance and are unable to pay in full at the time of service, please contact our office prior to your appointment to discuss a financial payment plan. As a convenience to our patients we accept cash, checks and/or VISA/MasterCard/ Discover and American Express.

Someone from our office will contact you the day before your visit to complete the Celeri testing that our office requires to help manage your care plan. Our office will bill your insurance for the Celeri test, however, if your insurance applies that service towards your yearly deductible, then you may receive a bill.

OUR LOCATIONS:

- 825 Bennett Ave., Medford, Oregon, 97504 →

- 3555 Lear Way, Medford, Oregon, 97504 →

Please ensure you make note of the location of your appointment.

Pain Specialists of Southern Oregon
P (541) 779-5228 * F (541) 772-1533

PAIN SPECIALISTS OF SOUTHERN OREGON

DEMOGRAPHICS

Today's Date: _____

Patient Name: _____ Date of Birth: _____
Last First M.I

Soc Sec#: _____ - _____ - _____ Drivers Lic#: _____ Marital Status: _____

Language: English: _____ Other: _____ Race: _____ Ethnic Group: _____

Physical Address: _____ City: _____

State: _____ Zip Code: _____

Mailing Address: _____ City: _____

State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Ok to Leave a Detailed Message? Yes No Ok to send a Text Message? Yes No

Visit Related to: Work Comp: Yes No Motor Vehicle Accident: Yes No

Email Address: _____

Employer: _____ Employer Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Referring Provider: _____ Phone: _____

Primary Care Provider: _____ Phone: _____

Pharmacy Name: _____ City: _____ Phone: _____

PAIN SPECIALISTS OF SOUTHERN OREGON

RELEASE OF INFORMATION

I, _____, hereby authorize
Patient Name

Pain Specialists of Southern Oregon to release information about my:

Medical Information

Billing Information

Appointment Information

Other: _____

*Required by Pain Specialists of Southern Oregon:

*Referring Provider: _____
Name

*Primary Care Provider: _____
Name

If requested by:

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

Patient Signature: _____ Date: _____

Representative Signature	Relationship	Date

PAIN SPECIALISTS OF SOUTHERN OREGON

ADVANCED CARE

Do you have a health care proxy in the event you are unable to make your own medical decisions?

Designee's Name:_____Phone Number: _____

Do you have a living will? Yes No

Which statement best reflects your wishes on advanced care recommendations?

Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.

Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.

Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

Patient Signature:_____Date: _____

_____

Representative Signature Relationship Date

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PAIN QUESTIONNAIRE

Name: _____ DOB: _____ Appointment Date: _____

1. Indicate the area of pain that you would most like to address today (e.g. “neck”, or “low back”)

2. Which side does this primarily affect?
3. Does this pain radiate anywhere? Yes No
4. If yes, then where does it radiate to?
5. How long has this pain been present?
6. Is there any known event that caused this pain? Yes No

   If you answered “yes”, please describe here:

7. Do you hurt all the time? Yes No
8. Is there any one time of day that you reliably hurt more than others?

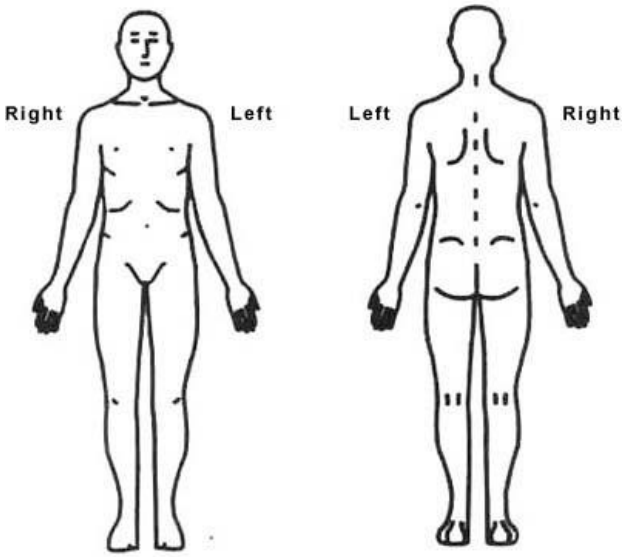
   If you answered “yes”, please indicate when:

9. Your pain occurs: Worse after activity Worse in the morning Worse during the day Worse during the night Worse at the end of the day Worse in the cold
10. Describe your pain: Aching Burning Cramp-like Dull Tingling Sharp Shooting Stabbing Other
11. What activities make your pain worse? (i.e. prolonged sitting, lying down, bending, lifting, twisting, walking, etc.):
12. What makes your pain feel better? (i.e. rest, changing positions, exercise, pain medication, heat, ice, sitting, lying down):

PAIN SPECIALISTS OF SOUTHERN OREGON

PAIN QUESTIONNAIRE

13. On the diagram, shade in the painful area that you indicated on the previous page.



14. **ASSOCIATED SYMPTOMS (CHECK ALL THAT APPLY)**

NUMBNESS

Left shoulder numbness	Right shoulder numbness
Left upper arm numbness	Right upper arm numbness
Left forearm numbness	Right forearm numbness
Left hand numbness	Right hand numbness
Left finger numbness	Right finger numbness
Left thigh numbness	Right thigh numbness
Left lower leg (below the knee) numbness	Right lower leg (below the knee) numbness
Left foot numbness	Right foot numbness

WEAKNESS

Left arm weakness	Right arm weakness
Left leg weakness	Right leg weakness

OTHER

Bladder incontinence	Bowel incontinence
Balance difficulties	Groin numbness

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PAIN QUESTIONNAIRE

15. What therapies have you used to treat these symptoms?

<u>TREATMENTS</u> (CHECK ALL THAT APPLY)

Activity modification	Chiropractic
Acupuncture	Physical therapy
Bracing	When did you last attend PT for this problem?
Heat	
Ice	

<u>MEDICATIONS</u> (CHECK ALL THAT APPLY)

Opioids		**NSAIDS/Tylenol**		**Muscle Relaxants**	
Tramadol	Methadone	Tylenol	Celebrex	Soma	Valium
Codeine	Morphine	Aspirin	Ibuprofen	Flexeril	
Nucynta	Buprenorphine	Naproxen	Relafen	Zanaflex	
Dilaudid	Hydrocodone	Volteren	Daypro	Robaxin	
Oxycodone	Oxymorphone	Indocin	Feldene	Skelaxin	

Antidepressants		**Other**	
Elavil (amitriptyline)	Paxil	Neurontin (gabapentin)	Lyrica (pregabalin)
Pamelor	Prozac	Tegretol	Topamax
Cymbalta (duloxetine)	Savella	Imitrex	Mexilitine
Efferxor (venlafaxine)	Zoloft	Xanax	Klonopin
		Ativan	Ambien

16. What procedure(s) have you had to treat the pain? **(CHECK ALL THAT APPLY)**

No Procedures	Epidural Steroid Injection(s)	Facet Joint Injections
Medial Branch Blocks Trial(s)	Facet Rhizotomy (Ablation)	Sacroiliac Joint Injection(s)
Spinal Cord Stimulator Trial(s)	Spinal Cord Stimulator (Permanent)	Trigger Point Injection(s)
Peripheral Nerve Injection(s)	Spinal Fusion Surgery	Decompression Surgery (laminectomy or discectomy)

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PAIN QUESTIONNAIRE

Medications (Please list all current medications or check the applicable box below)

I will bring a copy of my medication list (Please provide the list to the front desk receptionist)

I am on anticoagulant therapy

I am not currently taking any medications

Medication Name	Dosage	# of times dosage taken per day

Allergies (please list all known allergies or check applicable box below):

I will bring a copy of my allergy list (please provide the list to the front desk receptionist)

I have no known drug allergies

Medication	Please describe allergic reaction, severity & symptoms

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PAIN QUESTIONNAIRE

Past Medical History

Anemia	Emphysema
Arthritis	GI ulcer
Anxiety	Heart attack
Asthma	Hepatitis
Atrial fibrillation	HIV/AIDS
Bipolar disorder	Hypertension
Bleeding disorder	Kidney disease
Cancer	Liver disease
Breast cancer	Depression
Prostate Cancer	BPH
Bronchitis	Osteoporosis
CHF	Seizures
Clotting disorder	Shingles
COPD	Stroke
Diabetes	Thyroid disease
Coronary artery disease	Other:

Family History

Please mark if a Blood Family Member has ever had any of these conditions. If so, please indicate their relationship to you.

Disease	Relationship
Cancer	
Heart disease	
Diabetes	
Hypertension	
Stroke/TIA	
Alcohol abuse	
Drug abuse	
Depression	
Seizures	
Osteoarthritis	
Scoliosis	

Social History

Alcohol Use

None Occasionally Drinks/day

Drug Use

None Past Drug Use: Type

Current Drug Use: Type

Tobacco Use

Never smoked

Former smoker & Quit

Current & Cigarettes/day

Please list your surgical history:

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PAIN QUESTIONNAIRE
Review of Symptoms

Constitutional	Yes	**Respiratory**	Yes	**Musculoskeletal**	Yes
Activity change		Chest tightness		Joint pain	
Appetite change		Choking		Back pain	
Chills		Cough		Gait problem	
Abnormal sweating		Shortness of breath		Joint swelling	
		Stridor		Muscle pain	
HENT		Wheezing		Neck pain	
Congestion				Neck stiffness	
Dental problem		**Cardio**			
Drooling		Chest pain		**Skin**	
Ear discharge		Leg swelling		Color change	
Ear pain		Palpitation		Pallor	
Facial swelling				Rash	
Hearing loss		**GI**		Wound	
Mouth sores		Abdominal distension			
Nosebleeds		Abdominal pain		**Immuno**	
Postnasal drip		Anal bleeding		Environmental allergies	
Runny nose		Blood in stool		Food allergies	
Sinus pain		Constipation		Immunocompromised	
Sinus pressure		Diarrhea			
Sneezing		Nausea		**Neurological**	
Sore throat		Rectal pain		Dizziness	
Ringing ears		Vomiting		Facial asymmetry	
Trouble swallowing				Headaches	
Voice change		**Genitourinary**		Light-headedness	
		Difficulty urinating		Numbness	
Eyes		Pain with urination		Seizures	
Eye discharge		Involuntary urination at night		Speech difficulty	
Eye itching		Flank pain		Syncope	
Eye pain		Increased urinary frequency		Tremors	

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PAIN QUESTIONNAIRE

Eye redness		Genital sore		Weakness	
Photophobia		Blood in urine			
Visual disturbance		Penile discharge		**Hematologic**	
		Penile pain		Enlarged lymph nodes	
		Penile swelling		Bruise/bleed easily	
		Scrotal swelling			
		Testicular pain		**Psychiatric**	
		Urinary urgency		Agitation	
		Decreased urine output		Behavior problem	
				Confusion	
				Decreased concentration	
				Bad mood	
				Hallucinations	
				Hyperactive	
				Nervous/anxious	
				Self-injury	
				Sleep disturbance	
				Suicidal ideas	

PAIN SPECIALISTS OF SOUTHERN OREGON

NO SHOW/MISSED APPOINTMENT POLICY

Pain Specialists of Southern Oregon understand that sometimes you need to cancel or reschedule your appointment and that there are family obligations or emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-48-hour notice). You can cancel appointments by calling the following number: 541-779-5228

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call to you is made/attempted one (1-2) business days prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment with at least a 24-48 hours' notice: There is a waiting list to see our providers and whenever possible, we like to fill canceled spaces to shorten the waiting period for our patients.

2. If less than a 24-48 hour cancellation is given this will be documented as a "No-Show" appointment.

3. If you do not present to the office for your appointment, this will be documented as a "No-Show" appointment.

4. If you have a "No-Show/Missed" appointment, you may receive a no-show fee of $25.00.

5. Dismissal from the practice may be considered if habitual behavior is identified (i.e., more than 2 in a rolling calendar year).

I have read and understand Pain Specialists of Southern Oregon "No Show/Missed Appointment Policy" and understand my responsibility to plan appointments accordingly and notify our clinic appropriately if I have difficulty keeping my scheduled appointments.

_____ _____ _____

Patient Name Date of Birth Date

_____ _____

Patient Signature or Parent/Guardian if minor Relationship to Patient

_____ _____

Staff Signature Date

Thank you for your understanding and cooperation as we strive to best serve the needs of our patients.

PAIN SPECIALISTS OF SOUTHERN OREGON

FINANCIAL POLICY

Please be assured that everyone in this practice provides medical care in the highest quality possible to all our patients, in an atmosphere of caring, trust and mutual respect.

Your complete understanding of your financial responsibilities is essential; the following is our financial policy that all patients are required to read and sign prior to seeing a healthcare provider. Please let us know if you need any clarification on our payment policies.

Please present to the office with a form of payment to meet your financial obligations to your insurance provider and to your healthcare provider. We accept cash, debit card, check, MasterCard, Visa, Discover and American Express.

You are responsible for all copays, coinsurance, deductibles, and non-covered services. We are obliged to collect your copay at the time of service per your insurance company. Please understand that we cannot waive deductibles, coinsurances or copays that are required by your insurance. Patient portion of payment is due at time of service unless prior arrangements have been made with the business office.

We accept assignment with most major insurance companies and participating provider plans. However, please note:

1. Your insurance policy is a contract between you, your employer and the insurance company. Our relationship is with you, not your insurance carrier.
2. All charges are your responsibility whether your insurance company pays or not (to the extent of insurance contractual obligation).
3. Returned checks will be subject to any bank fees charged to our office, in addition to a service fee, and will be billed to you.
4. Unpaid balances are subject to collections process.

We understand that temporary financial problems may affect timely payment of your balance. Balances not paid within 90 days will be turned over to an outside collections agency, unless prior payment arrangements have been made with our business office. Patients turned over to a collection agency will also cease to be patients of Pain Specialists of Southern Oregon.

Due to the hardship imposed on the practice and other patients, scheduled appointments that are missed, cancelled and /or rescheduled with less than 24 hours' notice will result in a fee and may also result in discharge from the practice. The fee for missed appointments is determined based on the level of hardship it imposed on the practice. This fee will not be covered by your insurance and must be paid prior to you seeing the healthcare provider.

Prescriptions provided outside of an office visit due to missed, cancelled and/or rescheduled appointments are subject to a fee and payment will be required at the time prescription is provided.

I have read and understand Pain Specialists of Southern Oregon's "Financial Policy" as described above.

Patient Signature/Authorized Signature Date

Printed Name of Patient / Printed Name of Authorized Signer Relationship to patient if not patient

Authorization to Release and Assign Insurance Benefits: I authorize release of any information required to act on any insurance claim and permit photocopy or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to Pain Specialists of Southern Oregon the medical and/or surgical benefits I am entitled from my insurance company and/or Medicare. This authorization is in effect for all future claims until I choose to revoke it in writing.

Patient Signature/Authorized Signature Relationship to patient if not patient Date

I understand the following regarding my pain management while under care of a provider at PSSO:

BEHAVIOR STANDARDS:

- To ensure continuity of care and provide you with the best possible benefit from each visit, we do not allow patients to change providers unless adjustments are required by the clinic to balance operations in extreme circumstances (i.e., your provider is overbooked, your provider has left the practice, your provider is out ill, etc.).
- We will treat you with respect and courtesy and request that you treat us in the same way. There is no room in our relationship for disrespect or abusive communication in any form, including foul language, aggressive or threatening communications of any kind verbal or written. If we cannot maintain a polite and professional relationship, we will not continue that relationship resulting in dismissal from the practice.
- To maximize the benefits of pain management care, we require paperwork or electronic forms to be completed before regular visits.
- Appointment times are precious, and we require all our patients to complete paperwork prior to their appointment, to maintain their calendar and to ensure that they arrive at the appropriate location (Bennett or Lear Way) 15 minutes before their appointment. If you are late to your appointment or arrive with paperwork not completed, you may need to be rescheduled.
- We deliver integrated pain management and expect that all our patients will receive their care, interventions such as injections and if needed medication management exclusively from our practice. We do not co-manage patients with other pain management providers. We will, however, work collaboratively with your primary doctor and any other specialties (except pain management) that you receive treatment from as needed during your care with us.
- This agreement covers both Pain Specialists of Southern Oregon (PSSO) and our ambulatory surgery center, Crater Lake Surgery Center (CLSC).

By signing this agreement, I agree that I have read this agreement in full and will abide by the standards noted within it. I have been offered the opportunity to ask questions and my questions have been answered.

Patient Name: _____ Date of Birth: _____

Patient signature: _____ Date: _____