NAME:_____DATE OF BIRTH:_____

PATIENT INFORMATION

GENDER:_____M_____F ADDRESS:_____

CITY:_____STATE:_____ZIP: _____

HOME PHONE:_____CELL PHONE:_____WORK PHONE: _____

ETHNICITY: ☐HISPANIC OR LATINO ☐NOT HISPANIC OR LATIN RACE: ☐AMERICAN INDIAN OR ALASKA NATIVE

☐ASIAN ☐NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐WHITE ☐BLACK OR AFRICAN AMERICA

EMAIL:_____MARITAL STATUS:_____MARRIED_____WIDOWED_____SINGLE

REFERRING PHYSICIAN:_____EMERGENCY CONTACT/PHONE #: _____

RESPONSIBLE PARTY INFORMATION

NAME:_____DATE OF BIRTH:_____

ADDRESS:_____

PHONE:_____SSN:_____RELATIONSHIP :_____

EMPLOYER:_____EMPLOYER PHONE:_____

NEW PATIENT INTAKE

Location of your pain & when did it start: _____

If your pain is a result of a personal injury (car accident , slip and fall, etc), is there an active case? Yes No

Is your pain constant or intermittent? _____ Where does your pain radiate?_____

On a scale of 0 to 10, how bad is your pain today? (0=no pain and 10= severe pain) : _____

Quality of your pain (circle all that apply): Numbness / Pins & Needles / Burning / Aching / Stabbing / Shooting

What **aggravates** your pain? (Circle all that apply): Sitting / Bending / Walking / Lying down / Leaning forward or back / Stairs

What **treatments** have you tried? (Circle all that apply)

MD/DO Directed Home Exercises / PT / Chiro / Injections / Anti-Inflammatories / Injections / Narcotics / Surgery

Did any of the above treatments help? If so, which ones? _____

PAST MEDICAL HISTORY

Please indicate if you have suffered any of the following medical conditions. Also, state the year when these occurred.

_____Arthritis	_____Diabetes	_____Liver Disease	_____Depression
_____Heart Disease / Attack	_____Cancer	_____Hepatitis	_____Anxiety
_____Stroke	_____Neurological Disease	_____Lupus / Rheumatoid	_____Schizophrenia
_____High Blood Pressure	_____Asthma / COPD	_____Seizures / Convulsions	_____Bipolar
_____Clotting Disorders	_____Acid Reflux / Ulcers	_____AIDS or HIV	
_____Blood Thinners	_____Kidney Disease	_____Headaches /Migraines	

Other:_____

NAME:_____ DATE OF BIRTH:_____

CURRENT PRESCRIBED MEDICATIONS

Please write current prescribed medications in the table below or provide list of medications to staff

ALLERGIES

Please list any allergies, including medications

_____

_____

_____

PAST SURGICAL HISTORY

Please list previous surgeries

_____

_____

_____

FAMILY HISTORY

Please list any disease, illness, or ailments in your IMMEDIATE FAMILY.

_____

_____

_____

SOCIAL HISTORY

Do you smoke? Yes / No

Do you drink alcohol? Yes / No

NAME:_____ DATE OF BIRTH:_____

REVIEW OF SYMPTOMS

In the past few months, have you had any of the following symptoms or difficulties (circle all that apply)? If you have any difficulty that bears further explanation, please indicate so and explain at the bottom of this page.

- **Neurologic** Neck pain Low back pain Other Pain
- **6 point ROS** Fever Chills Night sweats Unexplained weight loss
- **Allergy/Immunology** Swollen lymph glands
- **Ophthalmologic** Loss of vision Double vision Eye pain Eye discharge.
- **ENT** Hoarseness Hearing loss Ear pain Trouble swallowing
- **Respiratory** Respiratory depression Difficulty breathing Cough
  Wheezing Reports of excessive snoring Reports of apnea while asleep
- **Endocrine** Excessive sweating Heat intolerance Cold intolerance Fatigue
- **Cardiovascular** Chest pain New leg swelling Palpitations Heart murmur
- **Gastrointestinal** Nausea Vomiting Diarrhea Constipation Blood in stool Abdominal pain
- **Hematology** Easy bruising Prolonged bleeding
- **Skin** Hives Itching Rash
- **Psychiatric** Depression Anxiety Alcohol addiction Illegal drug abuse
  Prescription drug abuse Recent substance abuse treatment Craving medications
  Difficulty controlling medication use Suicidal thoughts Homicidal thoughts
  Family or work problems related to medication use

NAME:_____ DATE OF BIRTH:_____

HIPAA Acknowledgement and Consent Form

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have received a copy of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.

I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address(s) below to obtain a current copy of the Notices of Privacy Practices. I consent to receiving text messages about my appointments.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment, or health care organizations.

I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it's bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Patient's Printed Name	Date of Birth
Signature of Patient	Date
Legal Representative	Relationship to Patient

Clinic Policies

Initials_____Payment is due at the time services are rendered. I understand that if I have insurance that I am the responsible party, and that having insurance does not guarantee payment of the services rendered to me. I authorize submission of my claim to the insurance company listed above**.**

Initials_____If you are unable to make an appointment please call within 24 hours prior to your appointment time to reschedule. If you fail to notify our office prior to missing your scheduled appointment you will be charged a NO SHOW fee of $15 for an office visit and $25 for a procedure. Frequent NO SHOWS may result in a release from the practice**.**

Initials_____Permission for treatment: I hereby authorize physician and assistants for the care of the patient named on this record to administer treatment as may be deemed necessary including examinations of treatments that may be ordered to be performed by the clinical personnel. I acknowledge that no guarantees have been made to me to the result of examinations or treatments to be performed.

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.

_____ _____

Signature Date

***Please list the names of any persons you wish to release your personal medical records/medical information to:

Name: **Relationship:**

Name: **Relationship**

Name: **Relationship:** .

NAME:_____ DATE OF BIRTH:_____

Controlled Substance Agreement

We are committed to doing all we can to treat your chronic pain condition. In some cases controlled substances are used as a therapeutic option in the management of chronic pain and related anxiety and depression which is strictly regulated by both stated and federal agencies. This agreement is a tool to protect both you and the physician by establishing guideline, within the laws, for proper controlled substance use. The words "we" and "our" refer to the facility and the words "I", "you", "your", "me", or "my" refer to you, the patient.

1. I understand that chronic opioid therapy has been associated with not only addiction and abuse but also multiple medical problems including the suppression of endocrine function resulting in low hormonal levels in men and women which may affect mood, stamina, sexual desire, and physical and sexual performance.
2. For female patients, if I plan to become pregnant or believe that I have become pregnant while taking this medication, I am aware that, should I carry the baby to delivery while taking these medications, the baby will be physically dependent upon opioids. I will immediately call my obstetrician and this office to inform them of my pregnancy. I am also aware that opioids may cause a birth defect even though it is extremely rare.
3. I have been informed that long term and/or high doses of pain medications may also cause increased levels of pain known as opioid induced hyperalgesia (pain medicine causing more pain) where simple touch will be predicted as pain and pain gradually increases in intensity and also the location with hurting all over the body. I understand that opioid induced hyperalgesia is a normal expected result of using these medicines for a long period of time. This is only treated with addition of non-steroidal anti-inflammatory drugs such as Advil, Ibuprofen, etc. or by reducing or stopping opioids. I understand that I should not operate any heavy machinery while under the influence of narcotics.
4. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine uses is markedly decreased, stopped, or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening.
5. I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain, however it has been seen and may occur to me. If it occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment, reduce the dose, or stop it.
6. I: All controlled substances must come from the physician whose signature appears below or during his/her absence, by the covering physician unless specific authorization is obtained for an exception.
7. I understand that I must tell the physician whose signature appears below or during his/her absence the covering physician, all drugs that I am taking, have purchased, or have obtained, even over-the-counter medications. Failure to do so may result in drug interactions or overdoses that could result in harm to me, including death.
8. I may not seek prescriptions or controlled substances from any other physician, healthcare provider, or dentist. I understand it is unlawful to be prescribed the same controlled medication by more than one physician at a time without each physician's knowledge.
9. I also understand that it is unlawful to obtain or to attempt to obtain a prescription for a controlled substance by knowingly misrepresenting facts to a physician or his/her staff or knowingly withholding facts from a physician or his/her staff (including failure to inform the physician or his/her staff of all controlled substances that I have been prescribed).
10. All controlled substances must be obtained at the same pharmacy when possible. Should the need arise to change pharmacies, our office must be informed.
11. You may not share, sell, or otherwise permit others, including your spouse or family members, to have access to any controlled substances that you have been prescribed.
12. Early refills will not be given; all patients will be seen every 30 days to receive refills on medications. Renewals are based upon keeping scheduled appointments ONLY during working hours. Please DO NOT make excessive phone calls for prescriptions on early refills and do not phone for refills after hours or on weekends. Summit Spine & Joint Centers, LLC have hours of operation between 8:30 am and 5:00 pm on Monday through Friday. Medication refill requests made via telephone have 24 BUSINESS HOURS to be returned.

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NAME:_____ DATE OF BIRTH:_____

13. Unannounced pill counts (random or planned) urine or serum adherence monitoring may be requested from you and your cooperation is required. Presence of unauthorized substances in urine or serum toxicology screens may result in your discharge from the facility and its physicians and staff.
14. I will not consume excessive amounts of alcohol in conjunction with controlled substances. I will not use, purchase, or otherwise obtain any other legal drugs except as specifically authorized by the physician whose signature appears below or during his/her absence by the covering physician, as set forth in Section 2 above. I will not use, purchase, or otherwise obtain any illegal drugs, including marijuana, cocaine, etc. I understand that driving while under the influence of any substance, including a prescribed controlled substance or any combination of substances (e.g. alcohol and prescription drugs), which impairs my driving ability may result in DUI charges.
15. Medications or written prescriptions may not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen, it will not be replaced unless explicit proof is provided with direct evidence from authorities. A report narrating what you told the authorities is not enough.
16. In the event you are arrested or incarcerated related to legal or illegal drugs (including alcohol) refills on controlled substances will not be given.
17. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribed by this physician and other physicians at the facility and that law enforcement officials may be contacted
18. I also understand that the prescribing physician has permission to discuss all diagnostic and treatment details, including medications, with dispensing pharmacists, other professionals who provide your healthcare, or appropriate drug and law enforcement agencies for the purposes of maintaining accountability.
19. I am aware that it is a felony in Georgia for a patient to fail to disclose to his physician that he has received a controlled substance of a similar therapeutic use from another practitioner.
20. I affirm that I have full right and power to sign and to be bound by this agreement, that I have read it and understood and accept all of its terms.

My signature below acknowledges that I have read and received the Controlled Substance Agreement and the policies concerning prescription of dependence producing drugs.

Patient's Full Name	Date
Patient's Signature	Date
Supervising Provider Signature	Date
Witness	Date

Amit Patel, M.D.
Steven T. Nguyen, M.D.
Srinand Mandyam, M.D.
Gabriel Marrero, M.D.
Thomas Cheriyan, M.D.
Adam Gover, M.D.
Trusharth Patel, M.D.
Gaurav Rajput, D.O.
Amit M Patel, M.D.
An Do, M.D.

Jose Mathew, D.O.
Celine Mathew, D.O.
Gerald Chai, D.O.
Douglas Freiberger, M.D.
Scott Linacre, P.A.
Dalandra Belcher, N.P.
Deborah Wilkens, N.P.
Mekinnah Currie, N.P.
Billy Wikoff, N.P.
Ngoc Tran, P.A.

Faxed Medical Records Request

Date:_____ Fax:_____

Provider:_____ Attention:_____

Phone: _____

Please fax records ASAP

Patient Name:_____ DOB:_____

At your earliest convenience, please fax over the following information:

- All treatment records including the 1st office note
- Procedure notes (if applicable)
- Imaging reports in paper format (X-rays, MRIs, CT scans)
- Most recent lab work / urine drug screen results (the last three if applicable)
  Medication record
- Dismissal / Discharge letter (if applicable)
- Mental health / substance Abuse
- Other (specify):

_____

Please fax the information to 770-962-3643.

Patient Signature:_____Date: _____

By signing above, I authorize the named health care provider to release the information or records to Georgia Pain and Wellness Center via facsimile or by mail and I understand that this authorization will expire one year from the date of the signature above

If you have any questions, please call us at 770-962-3642