PATIENT INFORMATION

NAME: _____ SR./ JR / II/ III
FIRST MIDDLE LAST

MAILING ADDRESS:_____ CITY_____STATE_____ ZIP_____

MALE: ____ FEMALE: _____ DATE OF BIRTH_____EMPLOYED: YES_____ NO_____

EMPLOYER'S NAME & ADDRESS: _____

OCCUPATION: _____

PHONE HOME: _____CELL _____WORK_____

SOCIAL SECURITY #_____SINGLE__ MARRIED__ SEPARATED__ DIVORCED__ WIDOW(ER)__

Patient Call Back Survey: Yes or No / Call: Home, Cell or Other: _____
Are you a member of Senior Circle? YES____ NO_____ or Healthy Woman? YES_____ NO_____

BILLING INFORMATION

PERSON RESPONSIBLE FOR PAYMENT—IF NOT THE PATIENT (*SKIP TO INSURANCE IF PATIENT IS RESPONSIBLE PARTY*)

CIRCLE ONE: PATIENT PARENT SPOUSE OTHER_____

NAME: _____ DATE OF BIRTH: _____SS# _____

ADDRESS IF DIFFERENT FROM ABOVE: _____

PHONE: _____CELL: _____ WORK: _____

INSURANCE INFORMATION

1. PRIMARY INSURANCE: _____
INSURANCE COMPANY NAME AND ADDRESS

_____
POLICY HOLDER'S NAME DATE OF BIRTH SOCIAL SECURITY #

_____
POLICY ID NUMBER GROUP NUMBER PATIENT'S RELATIONSHIP TO POLICY HOLDER

2. SECONDARY INSURANCE:_____
INSURANCE COMPANY NAME AND ADDRESS

_____
POLICY HOLDER'S NAME DATE OF BIRTH SOCIAL SECURITY #

_____
POLICY ID NUMBER GROUP NUMBER PATIENT'S RELATIONSHIP TO POLICY HOLDER

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: _____

ADDRESS:_____PHONE:_____ CELL :_____

WAS THIS AN ACCIDENT? Y / N AUTO: _____ WORKER'S COMP: _____ OTHER: _____

REFERRING PHYSICIAN:_____

FINANCIAL POLICY

We strongly feel all patients deserve the very best medical care that we can provide. Everyone benefits when financial arrangements are agreed upon. We have prepared this material to acquaint you with our policy.
Our professional services are rendered to you, not the insurance company. Payment for treatment is your responsibility.

FINANCIAL AGREEMENTS
PLEASE INITIAL IF APPLIES TO PATIENT

_____ ***I HAVE NO INSURANCE COVERAGE*** I understand that I am responsible for payment of services rendered to myself or dependents at the time of service.

INSURANCE AUTHORIZATION AND ASSIGNMENT
PLEASE INITIAL ALL THREE

_____ I hereby authorize the ***RELEASE OF ANY INFORMATION NECESSARY*** to process insurance claims and request payment of benefits to be made for services rendered to my dependents or myself.

_____ I understand I am responsible ***AT THE TIME OF SERVICE*** for paying any required co-payment and/or deductible.

_____ Check with your insurance company to verify your eligibility; ***WE BILL AS AN OFFICE VISIT.*** Some insurance may require a referral from your primary care physician. .

MEDICARE/MEDIGAP
PLEASE INITIAL IF APPLIES TO PATIENT

FOR MEDICARE PATIENTS ONLY _____
MEDICARE NUMBER

_____ I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Finance Administration or it's intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

MEDIGAP (Authorization Statement) _____
POLICY NUMBER

_____ I authorize any holder of medical or other information about me to be released to process this Medigap claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to myself or to the party who accepts assignment.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY OF THIS OFFICE AND AGREE TO ABIDE BY THE SAID POLICY.

***** OTHER'S ALLOWED ACCESS TO MY MEDICAL RECORDS:** _____

SIGNATURE:
PATIENT/PARENT/GUARDIAN: _____ **Date** _____

I will be paying by: _____Check _____Cash _____MasterCard/Visa/Discover/American Express

There will be a $30.00 charge on all returned checks.

GULF COAST OCCUPATIONAL, SPORTS, and Pain Medicine
Dr. Ron R. Lee

Pain Management
PERSONAL HEALTH HISTORY

Name: _____
Date of Birth: _____

Cardiovascular
___Chest pain/discomfort
___Palpitations
___Shortness of Breath
___Hypertension
___Heart disease/defect

Musculoskeletal
___Back pain/strain
___Neck pain/strain
___Knee pain/strain
___Other joint pain/strain
_____

Neurological
___Headaches
___Seizures
___Fainting
___Dizziness
___Memory loss

Psychiatric
___Anxiety
___Depression
___Sleep problems
___Emotional Disturbances

Genitourinary
___Painful/bloody urination
___Leaking urine
___Nighttime urination
___Discharge: Penis or Vaginal
___Unusual vaginal bleeding
___Concern with sexual functions

Gastrointestinal
___Heartburn/reflux
___Blood or change in in bowel movement
___Nausea/vomiting/ diarrhea
___Pain in abdomen
___Special Dietary Regimen

Ears/Nose/Throat/Mouth
___Difficulty hearing/ Ringing in ears
___Hay fever/allergies/ Congestion
___Trouble swallowing
___Ear infection
___Nosebleeds

Endo
___Cold/heat intolerance
___Increase thirst/appetite
___Diabetes

Respiratory
___Cough/wheezing
___Coughing up blood

Blood/Lymphatic
___Unexplained lumps
___Easy bruising/ bleeding
___ Other blood disorder/ disease

Please list all medication, Over the counter and Prescription, which you are <u>currently</u> taking:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

I attest the above information to be true to the best of my knowledge:

_____ _____
Applicants signature Date

GULF COAST OCCUPATIONAL, SPORTS, and Pain Medicine
Dr. Ron R. Lee

Pain Management
MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____
Date Pain Symptoms Began: _____
Was this an accident? ❑ Yes ❑ No If so, when? _____
Chief Complaint: _____
_____

ALLERGIES (DRUG, LATEX, ECT.): _____

Have you ever been in a motor vehicle accident? ❑ **Yes** ❑ **No** If yes, explain: _____
_____

Have you even been turned down for military service, life insurance, or employment for health reasons? ❑ **Yes** ❑ **No** If yes, explain: _____
_____

Have you ever lost any time from work do to illness or injury during the past 5 years?
❑ **Yes** ❑ **No** If yes, explain: _____

Have you ever had any work or activity restrictions due to you health? ❑ **Yes** ❑ **No** If yes, explain:_
_____

Please list all **SURGERIES** and dates: _____
_____

Have you ever had an epidural or nerve block? If so, when and where: _____
_____

Have you ever had an MRI, CT, or X-rays taken? If so, explain: _____
_____

Do you currently have any of the following:
Metal in the body: ❑ **Yes** ❑ **No** If yes, explain: _____
Stints in the Heart, Lungs, or Kidneys: ❑ **Yes** ❑ **No** If yes, explain: _____
_____
History of CANCER: ❑ **Yes** ❑ **No** If yes, explain: _____
Claustrophobic (fear of small spaces): ❑ **Yes** ❑ **No**
Pacemaker: ❑ **Yes** ❑ **No**
Are you currently taking Blood Thinners? If so please list: _____

Gulf Coast Occupational, Sports and Pain Medicine
1615 North Alston Street
Foley, AL 36535

Medications	SIG	Date	Date	Date	Date

ALLERGIES:

Gulf Coast Occupational, Sports, and Pain Medicine
1615 North Alston Street
Foley, AL 36535
Office Phone (251)923-2050 Office Fax (251)923-2051

CONSENT TO RELEASE PERSONAL INFORMATION

I _____ hereby authorize Gulf Coast Occupational, Sports, and Pain Medicine to release any and all information regarding my doctor visits including but not limited to: appointments date and time, medications that may be prescribed, and any referral appointments made for further evaluation. By signing this form, I also release Gulf Coast Occupational, Sports, and Pain Medicine, and its staff, of any damages due to the misuse of information by the consented party.

Name	Relationship to patient
_____	_____
_____	_____
_____	_____

_____ _____
SIGNATURE OF PATIENT **DATE**

_____ _____
WITNESS **DATE**

PAIN MANAGEMENT AGREEMENT:

I UNDERSTAND AND AGREE TO THE FOLLOWING:
That this pain management agreement relates to my use of any and all medication(s) (i.e. Opioids, also called "narcotics, painkillers" and other prescription medications, etc.) for chronic pain prescribed my physician. I understand that there are federal and state laws, regulations, and policies regarding the use and prescribing of controlled substance(s). **Therefore, medication(s) will only be provided as long as I follow the rules specific in this Agreement.**

My physician may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines and /or conditions may cause discontinuation of medication(s) and /or my discharge from care and treatment. Discharge may be immediate for any criminal behavior. (Patient to initial each section below):

_____My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the **medications(s) may be discontinued**.
_____I will **disclose** to my physician **all medications(s)** that I take at any time, prescribed by any physician.
_____I will **bring all medication(s)** prescribed by my pain management physician to each and every visit. All medications are subject to pill count.
_____I will use the medication(s) **exactly as directed by my physician**.
_____I agree **not to** share, sell or otherwise permit others, including my family and friends, to have access to these medications.
_____I will **not assist in the misuse/diversion of my medications; nor will I give or sell them to anyone else.**
_____All medication(s) must be obtained at **one pharmacy, where possible**. Should the need arise to change pharmacies, my physician must be informed. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my physician to release my medical records to my pharmacist as needed.
_____I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medications(s) are exactly like money. **If either are lost or stolen, they may NOT BE REPLACED.**
_____**Refill(s) will not be ordered before the scheduled refill date**. However, early refill(s) are allowed when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.
_____I will receive medication(s) **only from ONE physician** unless it is for an emergency or the medication(s) that is being prescribed by another physician is approved by my physician. Information that I have been receiving mediations(s) prescribed by other doctors that has not been approved by my physician may lead to discontinuation of medication(s) and treatment.

_____If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medications(s), **then my physician may try alternative medication(s) or may taper me off all medication(s).** I will not hold my physician liable for problems caused by the discontinuance of medication(s).

_____**I agree to submit to urine and/or blood screens** to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), treatment for chronic pain may be terminated. Also, a consult with or referral to an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an addictionologist or a physician who specializes in detoxification and rehabilitation and /or cognitive behavioral therapy/psychotherapy.

_____I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. 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 pain management program** recommended by my physician to achieve increased function and improved quality of life.

_____I agree that I **shall inform any doctor** who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.

_____I hereby give my physician **permission to** discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).

_____I must take the medication(s) as instructed by my physician**. Any unauthorized increase** in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.

_____I must **keep all follow-up appointments** as recommended by my physician or my treatment may be discontinued.

I certify and agree to the following: (Patient to initial each section below)

_____**I am not currently using illegal drugs or abusing prescription medication(s)** and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substances that might impair my judgment.

_____I have **never been involved** in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc).

_____**No guarantee or assurance has been made** as to the result that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life.

_____I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain. **I fully understand the explanations regarding the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.**

_____

Patient Signature

_____

_____

Name and contact information for pharmacy

_____

Physician Signature (or Appropriately Authorized Assistant)

Gulf Coast Occupational Sports & Pain Medicine

Patient Name: **DOB:**

PAST MEDICAL HISTORY	YES NO (Circle One)
ADHD	YES NO
ALLERGIES	YES NO
ANEMIA/BLOOD DISORDER	YES NO
ANEURYSM	YES NO
ANXIETY DISORDER	YES NO
ARTHRITIS	YES NO
ASTHMA	YES NO
ATHEROSCLEROSIS	YES NO
BACK / NECK PROBLEMS	YES NO
BLOOD CLOTS	YES NO
BOWEL PROBLEMS	YES NO
BREAST PROBLEMS	YES NO
BRONCHITIS	YES NO
CANCER: SPECIFY	YES NO
CARDIAC ARRHYTHMIA	YES NO
CAROTID BLOCKAGE	YES NO
CONCUSSION OR SPINAL TRAUMA	YES NO
CORONARY ARTERY DISEASE	YES NO
DEMENTIA	YES NO
DEPRESSION (INCLUDING POST	YES NO
PARTUM)	YES NO
DIABETES	YES NO
DIALYSIS	YES NO
DIZZINESS	YES NO
EAR PROBLEMS	YES NO
EXCESSIVE PERSPIRATION	YES NO
EYE PROBLEMS	YES NO
FEMALE PROBLEMS / INFECTIONS	YES NO
FIBROMYALGIA	YES NO
GASTROINTESTINAL BLEEDING	YES NO
GOUT	YES NO
HEAD TRAUMA OR INJURY	YES NO
HEADACHES	YES NO
HEART DISEASE	YES NO
HEARTBURN / REFLUX	YES NO
HEPATITIS / LIVER DISEASE	YES NO
HERNIATED DISC	YES NO
HERPES	YES NO
HIGH CHOLESTEROL	YES NO
HIV / AIDS	YES NO
HYPERTENSION	YES NO
KIDNEY DISEASE	YES NO
LUNG DISORDER	YES NO
MIGRAINES	YES NO
NERVE DISEASE	YES NO
OBESITY	YES NO

	YES NO (Circle One)
OSTEOPOROSIS	YES NO
PARATHYROID DISEASE	YES NO
PERIPHERAL VASCULAR DISEASE	YES NO
PLEURISY	YES NO
PNEUMONIA	YES NO
PROSTATE	YES NO
PULMONARY DISEASE	YES NO
PULMONARY EMBOLISM	YES NO
RADIATION / CHEMOTHERAPY	YES NO
RETINOPATHY	YES NO
RHEUMATIC FEVER	YES NO
SEIZURES	YES NO
SKIN PROBLEMS	YES NO
SLEEP DISORDER	YES NO
STROKE	YES NO
THYROID DISEASE	YES NO
TUBERCULOSIS	YES NO
ULCERS	YES NO
URINARY/BLADDER/KIDNEY PROBLEMS	YES NO
USE OF BLOOD THINNERS	YES NO
USE OF NSAIDS	YES NO
VARICOSITIES	YES NO
VASCULAR DISEASE	YES NO
HAVE YOU BEEN HOSPITALIZED OR SEEN IN THE ER IN THE PAST YEAR?	YES NO

Gulf Coast Occupational Sports and Pain Medicine

Social and Health Summary

Patient Name:_____ **Date of Birth:**_____

	Please write or circle your answer. Answer all questions that apply. Those that do not apply please respond with N/A.
Smoking Status:	Never Former Daily Occasionally Unknown
Smoking- How much?	
Smoking- Date stopped?	
Have smoked since what age	
Alcohol intake	None Occasionally Moderate Heavy
Illicit (illegal) drugs	Yes No
If so What? How Often?	
Chewing Tobacco?	
Advanced Directive	
Caffeine Intake If so What?	None Occasionally Moderate Heavy
Exercise Level	None Occasionally Moderate Heavy

PLEASE INDICATE ***(WITH THE NOTED ABBREVIATION)***, IF ANY OF THE FOLLOWING APPLY TO THE LISTED IMMEDICATE FAMILY MEMBERS.

Father= ***F*** Mother= **M** Brother= **B** Sister= **SS** Son= **S** Daughter= **D**

Paternal Grandfather= **PGF** *(Dad's Parents)* Maternal Grandfather= **MGG** *(Mom's Parents)*

Paternal Grandmother= **PGM** Maternal Grandmother= **MGM**

Example:

DIABETES	*M*	*SS*	*PGM*		

Aids					
Alcoholism					
Alzheimer's Disease					
Anxiety					
Asthma					
ADD					
Benign Prostatic Hypertrophy					
Cerebrovascular Accident					
Cholelithiasis					
Colon Cancer					
COPD					
Coronary Artery Disease					
Depression					
Diabetes, Type 2					
Drug Abuse					
Hepatitis C					
HIV					
Hyperlipidemia					
Hypertension					
Hypothyroidism					
Lung Cancer					
Migraines					
Myocardial Infarction					
Obesity					
Osteoporosis					
Prostate Cancer					
Renal Stones					
Rheumatoid Arthritis					
Seizure Disorder					
Testicular Cancer					
DECEASED					

Medication Refill Policy

This is to inform you of the policy for processing medication refill request. Your cooperation with this policy allows our office to provide you with the highest quality clinical care and service.

- If your prescription bottle indicates that you have refills left, you do not need to contact our office. Please contact your pharmacy and they will refill it for you. If there are no refills remaining at your pharmacy, you may ask your pharmacist to contact our office for a refill authorization.
- You may contact our office for a refill request. Please note it may take 24 to 48 business hours to process your request. This is why we ask that you contact our office 3 days before your medication is due to run out. If you use a mail order pharmacy, please contact our office 14 days before your medication is due to run out.
- Please have the following information readily available at the time of the request:
    - The name and spelling of the medication
    - The dosage and directions of your medication
    - The name and location of the pharmacy of your choosing
- In order to provide the highest clinical service to you, we will review your medical record to determine if a follow-up visit or medication adjustment is needed before refilling your medication.
- Some medications require a prior authorization. Depending on your insurance, this process may involve several steps by both your pharmacy and provider. Our office and your pharmacy are familiar with the process and will handle the prior authorization as quickly as possible. Please check with your pharmacy for updates on your request.
- If you have any questions regarding your medication, please discuss these during your appointment. If for any reason you feel your medication needs to be adjusted or changed please contact our office immediately.
- It is important to keep your scheduled appointment to ensure you receive timely refills. Repeated no shows or cancellations will result in a denial of refills.
- Medication refills will only be addressed during regular office hours. Please notify our office on the next business day if you find yourself out of medication after hours.
- Refills on medication can only be authorized on medications prescribed by physicians in our office. We will not refill medications prescribed by other physicians.

Patient Name Printed_____

Patient Signature_____

Date_____

Patient Consent for E-Prescribing (Electronic Prescribing)

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

Printed Name_____

Signature_____

Date_____

Patient Portal Consent Form

Gulf Coast Occupational, Sports, and Pain Medicine

1615 North Alston St. Foley, AL 36535

Purpose of this Form

Gulf Coast Occupational, Sports, and Pain Medicine offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or passphrase to login to the portal site. Because the connection channel between your computer and the Website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the Web site and your computer.

Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it.

Only you can make sure these two factors are present. **We need you to make sure we have your correct email address and that we are informed if it ever changes.** You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us.

If you pick up secure messages from a web site, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should promptly go to the web site and change it.

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures Regarding the Patient Portal that appears at login. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein and including the policies and procedures as set forth in the login screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. All of my questions have been answered and I understand and concur with the information provided in the answers.

E-mail address _____

Patient Name Printed _____

Patient Signature _____ Date _____

Witness Signature _____ Date _____