



Rama Letchuman, M.D. Kathleen Majors, M.D.  
Matthew Mosura, M.D. Ross B. Nelson III, M.D.  

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Board Certified in Pain Management

Welcome New Patient,

We at Pain Care Consultants welcome you to our clinic. This letter is to confirm that we have received a referral for you to see us. In order for us to schedule your appointment, you will need to complete and return this New Patient Packet. A signed records release will need to be returned to our office in order for us to receive your records that are needed for your visit (included in your packet). This information is important in helping our physicians to better understand your medical background.

Please remember to bring your insurance card and driver's license with you to be copied at the time of your visit. If you are currently taking medications please bring **all** of your pill bottles with you to your appointment. It is also your responsibility to verify your insurance coverage for your office visit. Also, be prepared to pay your co-pay at the time of service.

Due to the high volume of calls that come into the office, please leave a message. If I am away from my desk or on the other line I will get back with you as soon as I can. **Leave your name, date of birth, referring doctor, your phone number with area code, and what the call is pertaining to.**

**WE MUST HAVE THIS PAPERWORK COMPLETED IN ORDER TO SCHEDULE YOUR APPOINTMENT. PLEASE MAIL OR E-MAIL PACKET BACK WHEN COMPLETED.**

Thank you for giving us the opportunity in being involved in your care!

**Karen Micinski**  
**New Patient Coordinator**  
**318-629-5522**  
**kmicinski@msil.md**

1500 Line Ave. Suite 202 • Shreveport, LA 71101  
318/629-5505 (Phone) • 318/629-5506 (Fax)  
[www.paincarela.com](http://www.paincarela.com)



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## General Information

Your initial visit at Pain Care Consultants will be with one of our Board Certified pain management physicians. After visiting with the physician, you will receive a comprehensive treatment plan. We use a multidisciplinary approach to treat pain, so your plan may include diagnostic/therapeutic procedures, physical therapy, psychological evaluation/treatment, medication management, lab tests, and/or radiological examinations. For your convenience, we offer a majority of these treatments at many of our office locations.

### DIAGNOSTIC/THERAPEUTIC PROCEDURES

Depending on your situation, your physician may prescribe an injection that may be used for diagnosis and/or treatment. The details of the injection will be explained by your medical provider and through educational materials.

### PHYSICAL THERAPY

Through exercise, massage, and stretching, physical therapy can increase your strength, improve the movement of your joints, decrease your pain, and improve your function.

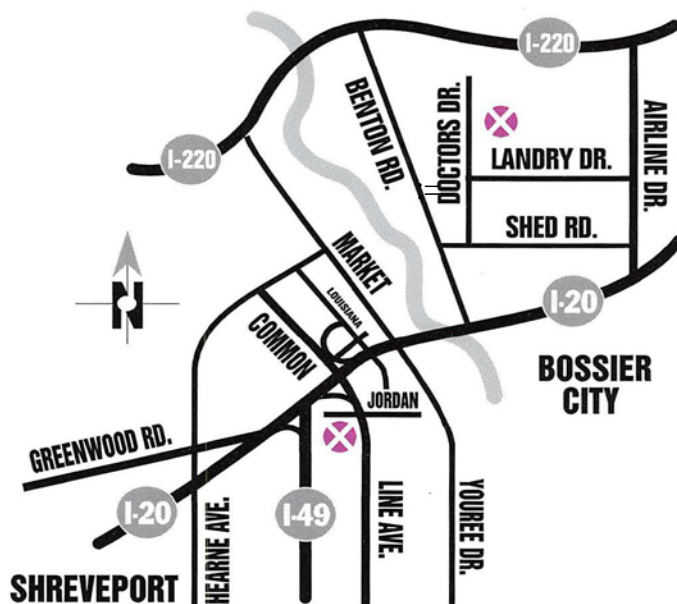
### PSYCHOLOGICAL EVALUATION/TREATMENT

Behavioral Health therapists working with patients that suffer with chronic pain are not trying to decide whether a patient's pain is real or imaginary. We understand that we cannot visualize pain and that it is real to the person that suffers with it every day. Pain can affect multiple parts of your life, including your ability to participate in your hobbies or job, interact with your family members, or even perform simple household chores. This can lead to significant frustration and possibly even depression. Behavioral Health therapists can help with these problems by using psychology-based treatment approaches that can reverse some of these effects of pain. Our goal is to help you regain the life you had before you started experiencing pain.

### MEDICATION MANAGEMENT

All medications have the potential for side effects and may require multiple adjustments to find the best dosage that reduces your pain while minimizing side effects. These adjustments will typically take place during your office visits.

## Directions



### 1500 Line Avenue Location:

**1-20 Eastbound**- From 1-20, take Line Ave. exit. Merge right onto Line Ave. Pain Care Consultants is at the corner of Line and Jordan. 1500 Line Ave. Turn right on Jordan then left on Elizabeth St. Take a left into parking lot. Patient drop off is at the glass doors under the breezeway. Check in is on the 2nd floor in suite 202. Overflow parking is across Elizabeth St. in parking lot.

**1-20 Westbound**- Take Common St. exit. Veer right in circle, turn right onto Louisiana, right on Fairfield, and left onto Line Ave. Go under 1-20 and uphill to 1500 Line Ave.. Pain Care Consultants is at the corner of Line Ave. and Jordan St. Turn right on Jordan then left on Elizabeth St. Take a left into parking lot. Patient drop off is at the glass doors under the breezeway. Check in is on the 2nd floor in suite 202. Overflow parking is across Elizabeth St. in parking lot.

### 2005 Landry Drive Location:

**1-20 Eastbound**- From 1-20, take Airline Drive Exit. Turn left on Airline Drive under 1-20 heading North for approximately 1 mile to Airline Drive and Shed Road through the intersection and turn onto the first street on the left which is Landry Drive.

**1-20 Westbound**- From 1-20, take Airline Drive Exit. Turn right and go approximately 1 mile to Airline Drive and Shed Road through the intersection and turn onto the first street on the left which is Landry Drive.

**1-220**- Take Airline Drive Exit. Drive South on Airline Drive for approximately 3 miles. Go over railroad tracks and turn onto the first street on the right which is Landry Drive.

1500 Line Ave. Suite 202 • Shreveport, LA 71101  
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## OFFICE POLICIES

### **Emergencies**

If you feel you have a life-threatening emergency, dial 911 or go to your nearest emergency facility.

### **Calls to the Office**

If you have any questions or concerns, please feel free to contact our office. Someone will return your call as soon as possible, usually within 24 hours. Many times we return calls at the end of the day. If the matter is an emergency and cannot wait until the end of the day for a response, please let us know when you call.

### **Financial Policy**

Please read our financial policy that is enclosed with your New Patient Forms. For more information, you can contact our office at 318-629-5505.

### **Insurance**

- We will bill your insurance company for services rendered. You are responsible for any amount that your insurance company does not pay, or co-pay if you are in an HMO or PPO. Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. You are responsible for the full amount if your insurance fails to pay promptly.
- Not all of our physicians are members of HMO and PPO plans. Please be sure to ask in advance if the doctor you are about to see belongs to your particular insurance plans. If your insurance company sends you payment for services, you are responsible for forwarding it to our office.
- We are participating providers for Medicare. We will file your Medicare and secondary insurance. If you do not have a secondary insurance carrier, we must bill you for the 20% of the Medicare allowable. You will be billed for any procedure not covered by Medicare.

### **Usual and Customary Rates**

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

### **Cancellation of Appointments**

We understand that circumstances can occur that make it necessary for you to cancel or reschedule an appointment. Please contact us at least 24 ahead of time, if you need to cancel or reschedule your appointment. Our policy is to charge for missed appointments at the rate of a normal office visit. Regardless if you have private insurance or Workers' Compensation, you will be responsible for this charge at the time of your next visit.

## **Prescriptions**

Refills for prescriptions will require an office visit. Be sure to bring a list of your medications to all office visits.

- **Medications WILL NOT be renewed over the phone from your pharmacy**
- **There will be NO PHONE-IN REFILLS**
- **You MUST PICK UP a prescription in the office**
- **Patients MUST OBTAIN ALL PRESCRIPTIONS before leaving the office**
- **We DO NOT DEAL WITH MAIL-IN PHARMACIES – If you MUST USE A MAIL-IN PHARMACY for NON-CONTROLLED MEDICATIONS, you MUST DEAL WITH THEM YOURSELF.**
- **You MUST obtain opioid (pain) medication locally**
- **We are not responsible if the actions of the pharmacy result in your running out of medication.**

## **Medical Records**

Copies of records or requests for transfer of records to other physicians must be done in writing. Please contact our medical records department at (318) 629-5505 or fax requests to (318) 629-5506. As a courtesy to our patients, we do not charge CURRENT patients or physician offices for medical records requests.

Any other entity requesting medical records will be subject to costs as the following rate: \$1 per page for the first 25 pages, \$.50 for pages 26-500 and \$.25 per page thereafter and a handling charge of \$7.50. These reasonable cost limitations were set forth by the Louisiana Revised Statutes 40:1299.96. This charge is payable in advance when the forms are submitted to us for completion.

Please allow five (5) working days to complete requests.

## **Medical Forms**

There will be a \$25 charge per form and this charge is payable when the forms are submitted to us for completion. For FMLA and disabilities forms, these are completed on a case by case basis.

At least seven working days are necessary to complete paperwork. Medical forms CANNOT be completed on the days you are seen by one of our physicians.

# Musculoskeletal Institute of Louisiana

Orthopedic Specialists of Louisiana • Pain Care Consultants • Electrodiagnostic Medicine

## FINANCIAL POLICY and CONTRACT WITH PATIENT

Thank you for choosing us as your health care provider. We are committed to providing our patients with the best treatment possible. We hope that you understand that our credit and collection policies are a necessary part of assuring the financial resources needed to maintain this vital health care facility for our patients and community.

Our charges for your care are considered to be the usual and customary charges in line with what other specialists in this geographical area charge their patients. You are responsible for payment of your bill in full, regardless of your insurance company's determination of usual and customary charges for this area. The only exceptions for this are if you are covered by Medicare or you are covered by a PPO or HMO for which we are a provider of services.

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### STATEMENT OF RESPONSIBILITY

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By signing below, I hereby enter into a contract with MUSCULOSKELETAL INSTITUTE OF LOUISIANA, LLC, for the furnishing of medical and/or surgical procedures for illness or injury. I understand that I am contractually responsible for the total bill incurred as a result of treatment received. Although I may have insurance coverage, I understand that this is an agreement between me and my insurance carrier to pay certain amounts for my medical care. The obligation to pay my doctor bill is an obligation by me to my doctor. I am totally responsible for payment of my doctor bill in full. This is regardless of the status of any pending insurance claim or the insurance company's determination of usual and customary rates or amount of assignment. I accept full responsibility for payment of the account, and depending upon the circumstances, I may be expected to pay in full at time of service. I hereby acknowledge that I should coordinate personally with my health insurance carrier. I hereby grant MUSCULOSKELETAL INSTITUTE OF LOUISIANA, LLC, its agents and attorneys the right to disclose my confidential health care information for purposes of collection of my bill through contact with any third party or through a lawsuit.

In the event that I am covered by a managed care PPO or HMO for which my doctor is a provider of services, I understand that the clinic will accept the allowable charges and will write off any amount that is disallowed by insurance. **I accept responsibility for payment of my co-pay and/or deductible at time of service, any allowable amount not paid by insurance, and/or treatment my policy does not cover.** I understand that you do accept assignment on Medicare and I will not owe any disallows that are written off of my account. **However, I understand that I am responsible for my deductible, co-pay and any charges not covered by Medicare.**

If I am here as the result of a liability claim, I understand that my doctor cannot wait for settlement of my claim in order to be paid and that payment is due at the time services are rendered. My attorney and/or insurance carrier will be provided with an itemized statement for my reimbursement.

If I am here as the result of an on the job injury and my workman's compensation claim is denied, I understand that I am personally responsible for payment of the bill in full.

In the event that credit is extended to me, I understand that any bill rendered by MUSCULOSKELETAL INSTITUTE OF LOUISIANA, LLC is due and payable upon receipt of statement. If payment in full creates a financial hardship, the clinic will consider an extended payment plan arrangement. I also understand that I may pay my bill in full at any time by cash, check, or any major credit card. **There is a fee (currently \$25) for any checks returned by the bank.** In the event of default in the payment of any amount due and this account is turned over to an agency or attorney for collection or legal action, **I hereby agree to be held liable for my outstanding balance plus attorney fees of 25% of my balance over 30 days in arrears. I also understand that I will be held liable for all court costs and judicial interest.** I, the undersigned, have read and understand this contract, and hereby agree to the terms herein.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
PATIENT/RESPONSIBLE PARTY

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### ASSIGNMENT OF BENEFITS/AUTHORITY TO RELEASE INFORMATION

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I have this date, assigned to MUSCULOSKELETAL INSTITUTE OF LOUISIANA, LLC the benefits due me under my existing policy or policies of insurance. I understand, in so far as they are necessary to cover such expenses, that the above assignment of insurance is accepted by MUSCULOSKELETAL INSTITUTE OF LOUISIANA, LLC as a convenience to me. Said company is hereby given my consent to file claims on said policy and to do such other actions as it deems necessary in connection therewith so as to promptly obtain payment to the company, direct, and without payment to me.

I authorize the release of all medical records to the referring and family physicians, to my insurance carrier, and/or my attorney at law. I allow fax transmittal of my records, if necessary.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
PATIENT

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PARENT/GUARDIAN

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RELATIONSHIP TO PATIENT

# Musculoskeletal Institute of Louisiana

Orthopedic Specialists of Louisiana • Pain Care Consultants • Electrodiagnostic Medicine

## AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize Musculoskeletal Institute of Louisiana to use or disclose the following protected health information (PHI) from the medical records of the patient listed below:

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_

- I will pick up copies of my records  Mail copies of my records to the individual noted below  
 Fax my records to: \_\_\_\_\_  Provide my records in electronic form

| Information is to be disclosed by | And is to be provided to: |
|-----------------------------------|---------------------------|
| Name:                             | Name:                     |
| Address:                          | Address:                  |
| Phone:                            | Phone:                    |
| Fax:                              | Fax:                      |

**Purpose of request:**  Patient's Request  Dispute  Legal  Referral  Other: \_\_\_\_\_

**Information to be disclosed from my health record: (check appropriate box(es))**

- Only the period of events from \_\_\_\_\_ to \_\_\_\_\_  
 Recent Progress Notes  Pathology/ Lab Reports  X-Ray Reports/Films  
 Billing Records  Operative Report  Entire Health Record \*(Excludes Psychotherapy Notes)  
 Other: \_\_\_\_\_

**If you would like any of the following sensitive information disclosed, check the applicable box(es) below:**

- Alcohol/Drug Abuse Treatment Referral  HIV/AIDS-related Treatment  
 Mental Health (*Other than Psychotherapy Notes*)  
 Psychotherapy Notes (If Checking this box, no other boxes may be checked. A separate Authorization to Release/Request for an individual's Health Information must be completed to obtain additional records.)

**I understand (Please Initial):**

- \_\_\_\_ I understand that this authorization will expire two years from my last date of service visit. A photocopy of this form will be considered as valid as the original
- \_\_\_\_ I have the right to revoke this Authorization in writing at any time to Musculoskeletal Institute of Louisiana and the revocation will not apply to information already retained, used, or disclosed in response to this Authorization.
- \_\_\_\_ **In order to release sensitive information regarding Alcohol/Drug Abuse Treatment/Referral, HIV/AIDS-Related Treatment, Mental Health (other than psychotherapy notes), I must check the appropriate box or boxes. In order to authorize the use or disclosure of Psychotherapy Notes I must only check this specific box on this form. Authorizations for the use or disclosure of other health record information may not be made in conjunction with authorizations pertaining to Psychotherapy Notes. If this box is checked with other boxes, another authorization will be required to authorize the use or disclosure of Psychotherapy Notes Only.**
- \_\_\_\_ My health care and payment for my health care will not be affected if I do not sign this form.
- \_\_\_\_ The information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

**By signing below, I acknowledge that I have read and understand this Authorization (a copy of the signed form will be given to you)**

\_\_\_\_\_  
Signature of Patient, Parent or Legal Representative                      Relationship to Patient                      Date



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## CHRONIC NARCOTIC TREATMENT AGREEMENT

### WARNING

***Narcotics are dangerous drugs.***

***They can cause very serious side effects and complications including addiction, disability, and death.***

#### I UNDERSTAND AND AGREE TO THE FOLLOWING

That this chronic narcotic treatment agreement relates to my use of any and all medication(s) for chronic pain prescribed by 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 so long as I follow the rules specified 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:**

I, \_\_\_\_\_ (print name), agree to the following:

- I understand that the use of narcotic analgesics (pain medicine) for treatment of pain other than cancer pain is controversial and not routine. Other alternatives have either been tried or offered and are unacceptable to me.
- I will not obtain any other narcotics or other controlled substances from other physicians or dentists including narcotic cough medications, tranquilizers, sleeping pills or sedatives **without prior approval of my pain doctor**. I understand that my surgeon/dentist will not be writing outpatient prescriptions, but rather my pain doctor will be writing my pain prescriptions after surgery, and I need to inform my pain doctor so that my medications can be adjusted after surgery.
- **I WILL NOT OBTAIN OR SEEK NARCOTICS FROM ANYONE OTHER THAN PAIN CARE CONSULTANTS (DRS. NELSON, MAJORS, MOSURA OR LETCHUMAN)). I WILL NOT INCREASE, DECREASE, STOP OR ALTER MY DOSE OF NARCOTICS WITHOUT PRIOR APPROVAL OF PAIN CARE CONSULTANTS. I UNDERSTAND THAT INCREASING MY DOSE OF NARCOTIC UNAUTHORIZED OR OBTAINING NARCOTIC PRESCRIPTIONS OUTSIDE OF THIS OFFICE WILL RESULT IN DISCHARGE FROM THIS PAIN PROGRAM.**
- I agree to have Drs. Nelson, Majors, Mosura and Letchuman obtain my pharmacy records, psychiatric records and medical records.
- I understand that I must notify Drs. Nelson, Majors, Mosura and Letchuman of any criminal indictment or arrest. I give permission for Drs. Nelson, Majors, Mosura and Letchuman to obtain information and records regarding criminal indictments, arrests and convictions. I understand that withholding information of past or current criminal charges or convictions will result in discharge from pain management.
- All prescriptions for narcotic medications will be in written form and given to me in the office during follow-up visits. No such medications will be called in by phone.
- I must get my medications from one of the two pharmacies that I have listed and I must notify you if I change pharmacies at any time.

Pharmacy Name: \_\_\_\_\_ Phone \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Phone \_\_\_\_\_

- **AS PER STATE REGULATIONS, I UNDERSTAND THAT I MUST KEEP MY FOLLOW-UP OFFICE APPOINTMENTS, MINIMUM OF EVERY 3 MONTHS. IT IS MY RESPONSIBILITY TO KEEP MY OFFICE VISIT APPOINTMENTS. MY DOCTOR MAY REQUEST MORE FREQUENT VISITS AND I AGREE TO BE SEEN AS SCHEDULED.**
- I will submit to drug testing on a random basis. If unprescribed drugs are found in my blood, saliva or urine, or excessive levels of prescribed drugs are found, or if prescribed drugs are not found in expected amounts, all medications will be discontinued as per my doctor's instructions and I will have to find another physician to treat my pain.
- I agree to undergo psychological and/or psychiatric evaluation, including psychometric testing. This will be used to determine my suitability for chronic narcotic, invasive, or other treatment for my pain.
- I understand that operating any type of automobile, other vehicle, machinery, or any potentially hazardous device may be dangerous while taking narcotics. Therefore I will exercise extreme caution when undertaking such tasks. I will not perform any potentially hazardous task while taking narcotics. Because narcotics can decrease mental function, I will not make any important decisions or commitments without consulting responsible and trusted advisors while taking narcotics.
- I understand that it is illegal for me to transport narcotics in any container other than my original prescription bottle. I will keep my narcotics locked up in a safe to prevent loss or theft. I will remove only the amount of medicine for my immediate use to prevent loss of the entire stock. If my medication is lost or stolen, I will contact Pain Care Consultants as soon as possible. **I UNDERSTAND THAT LOST OR STOLEN MEDICATIONS OR PRESCRIPTIONS WILL NOT BE REPLACED.**
- I will not give away any of my medication, loan my medication or sell my medication. I understand that doing any of the above is illegal and a violation of federal and state drug laws and also a violation of our office narcotic treatment agreement and will result in immediate discharge from the pain management program.
- I agree to actively participate in physical therapy, counseling. **or any other forms of treatment** as recommended by my physician.
- **IF MY PAIN IS NOT WELL CONTROLLED WITH NARCOTICS, I UNDERSTAND THAT THE NARCOTICS WILL BE DISCONTINUED AS PER MY DOCTOR'S INSTRUCTIONS.**
- **I UNDERSTAND THAT STOPPING A LONG-ACTING NARCOTIC MEDICATION SUDDENLY CAN RESULT IN WITHDRAWAL, HEART ATTACK, STROKE, SEIZURE, PERMANENT DAMAGE, DISABILITY OR DEATH.**
- I understand I am not to use **Alcohol, Marijuana**, or any other **Illegal Street Drugs** while taking narcotic medication. If I do it may result in coma or death.
- I must always have a working phone number on file so we can reach you, if my number changes for any reason I must notify the office immediately.
- I understand if anyone from the office calls me and wants me to come in I must be able to report to the clinic within 24 hours to bring medications for evaluation and for labs.

I hereby certify that I have read this form or have had it read to me, that I understand all of it, and that I have had a chance to have all of my questions answered to my satisfaction. By voluntarily signing this form, I agree and accept the responsibilities associated with this type of therapy. I also understand that failure to comply with the above regulations may result in the immediate discontinuation of the controlled substances that have been prescribed, as well as possible discharge from the program. I understand that this Agreement contains the entire agreement of the parties and supersedes and replaces all prior agreements between the parties and such other agreements shall be null and void and of no further force or effect. I also understand that this document is self renewable, on a yearly basis. I agree that should I decide to terminate this agreement, I will do so in writing. This agreement will go into effect when pain medications are prescribed by this program or its affiliates.

Patient: \_\_\_\_\_(Signature) Physician: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

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New Patient Intake Form

**Patient Information**

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
 Street Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_ Gender:  Male  Female  
 Marital Status:  Married  Single  Divorced  Widowed Email: \_\_\_\_\_  
 Preferred Phone: \_\_\_\_\_  Home  Mobile  Work  
 Secondary Phone: \_\_\_\_\_  Home  Mobile  Work  
 Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Primary Insurance Plan**

Payer (e.g. BC/BS): \_\_\_\_\_ Plan: \_\_\_\_\_  
 Policy/I.D. Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
 Policy Holder Name: \_\_\_\_\_ Policy Holder Gender:  Male  Female  
 Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**Secondary Insurance Plan (if any)**

Payer (e.g. BC/BS): \_\_\_\_\_ Plan: \_\_\_\_\_  
 Policy/I.D. Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
 Policy Holder Name: \_\_\_\_\_ Policy Holder Gender:  Male  Female  
 Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**Workers Compensation Claim Information**

Complete this section only if your visit today is related to a Workers Compensation claim  
 Employer: \_\_\_\_\_ Date of initial injury: \_\_\_\_\_  
 Workers Comp Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Workers Comp Carrier: \_\_\_\_\_ Claim Number: \_\_\_\_\_  
 Adjuster Name: \_\_\_\_\_ Phone number: \_\_\_\_\_

**Law Firm (if applicable)**

Complete this section only if your visit today is related to a personal injury legal claim  
 Law Firm: \_\_\_\_\_ Lawyer Name: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Paralegal/Representative: \_\_\_\_\_  
 Fax Number: \_\_\_\_\_ Date of initial injury: \_\_\_\_\_  
 Is this a ongoing lawsuit:?  Yes  No

**Referral**

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_  
 How did you hear about us?  Family Member  Friend  Yellow Pages  Other: \_\_\_\_\_  
 Have you or any member of your immediate family been treated by our physicians before?  Yes  No  
 Name of Physician: \_\_\_\_\_ Name of Family Member: \_\_\_\_\_

**Preferred Pharmacy**

Pharmacy Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Street Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_



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**Authorization to Release Information Concerning Your Care**

We at **Musculoskeletal Institute of Louisiana** take your medical confidentiality very seriously. We will not and cannot release information without your written authorization.

This authorization allows our staff members to speak only with an individual(s) you designate in the event you are not available to receive phone calls or you have an adult member that helps coordinate your medical care. You should not designate your doctor.

As part of our Patient Privacy Policy, we will not leave any health information with any other person unless you specifically authorize below.

I do not authorize anyone to receive information regarding my medical care.

Per my request, release the following information on myself: (Check each that apply)

- Appointments       Account/Bill       Lab/Test Results       Medical Care/Treatment

Person: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone number(s): \_\_\_\_\_

Person: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone number(s): \_\_\_\_\_

Person: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone number(s): \_\_\_\_\_

**This will not include copies of your medical records. If you wish someone else to pick up a copy of your medical records, please fill out our Authorization to Use or Disclose Protected Health Information Form**

**Medical History and Consent for Treatment**

I certify that the information I have supplied is accurate, complete and true.

I authorize **Pain Care Consultants** and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

I give my consent for **Pain Care Consultants** to retrieve and review my medication history. I understand that this will become part of my medical record.

I acknowledge that I have had the opportunity to review **Musculoskeletal Institute of Louisiana** Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I authorize **Pain Care Consultants** to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize **Pain Care Consultants** to release any information required in obtaining procedure authorization or the processing of any insurance claims.

I understand that **Pain Care Consultants** will not release my Protected Health Information to any other party (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at its facility and on its website.

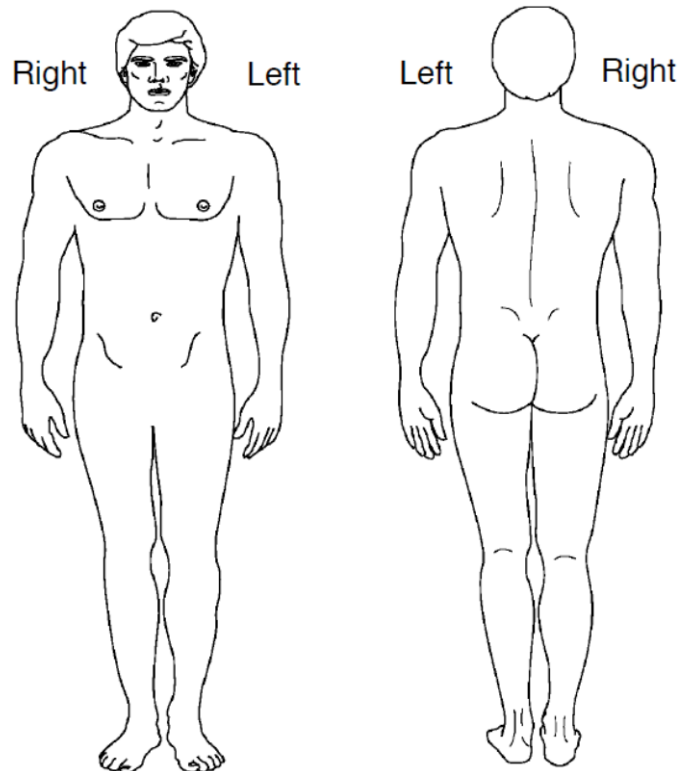
Print Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Location of Pain**

Use this diagram to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms:

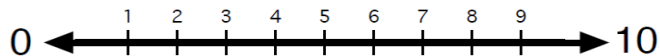
- “N” = numbness
- “S” = stabbing
- “B” = burning
- “P” = pins and needles
- “A” = aching



Where is your worst area of pain located? \_\_\_\_\_

Does this pain radiate? If so, where? \_\_\_\_\_

Please list any additional areas of pain: \_\_\_\_\_



**Rate Your Pain (0 = None and 10 = Worst pain imaginable)**

- \_\_\_\_\_ What number on the pain scale (0-10) best describes your **right now**?
- \_\_\_\_\_ What number on the pain scale (0-10) best describes your **worst pain**?
- \_\_\_\_\_ What number on the pain scale (0-10) best describes your **least pain**?
- \_\_\_\_\_ What number on the pain scale (0-10) best describes your **average pain over the last month**?

**In the last 24 hours rate how your pain has interfered with you (0= Does not interfere and 10= Completely interferes):**

- \_\_\_\_\_ General Activity
- \_\_\_\_\_ Mood
- \_\_\_\_\_ Walking Ability
- \_\_\_\_\_ Normal Work
- \_\_\_\_\_ Relationships with people
- \_\_\_\_\_ Sleep
- \_\_\_\_\_ Enjoyment of life

**Onset of Symptoms**

Approximately when did this pain begin? Date: \_\_\_\_\_

**What caused your current pain episode?**

- Accident at work       Following surgery       Pain “just began”       Accident at home       Cancer
- Motor Vehicle Accident       Other: \_\_\_\_\_

**How did your current pain episode begin?**  Gradually       Suddenly

**Since your pain began, how has it changed?**  Decreased       Increased       Stayed the same

**Describe the event that caused your pain** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Pain Description**

**How often does your pain occur?**  Continuously  1-2 times a day  1-2 times a month  Almost all the time  
 Several times a week  Less than once a month  Several times a day  Less than 3-4 times /month

**When is your pain at its worst?**  Mornings  During the day  Evenings  Middle of the night  
 Progressively worsens throughout the day  No changes – it's inconsistent or always the same

**What word best describes the frequency of your pain?**  Constant  Intermittent

**Check all of the following that describe your pain:**

- Aching  Band-like  Burning / Hot  Cramping  Deep  Dull  
 Muscle Spasm, Tightness  Numb  Piercing  Pressure  Shooting  Shock-like  
 Stabbing / Sharp  Squeezing  Throbbing  Tiring / Exhausting  Tingling / Pins and Needles

**Are you having trouble sleeping?**  Yes  No **Average number of hours of sleep per night:** \_\_\_\_\_ hours

**Difficulty falling asleep**  Yes  No **Difficulty staying asleep**  Yes  No

**If you have NECK and/or ARM pain:**

**Is the pain in your arm(s)** **Please divide your pain:**  
 Worse than your neck **Neck pain** \_\_\_\_\_%  
 Same as your neck **Arm pain** \_\_\_\_\_%  
 Less than your neck **The total should be 100%**

**If you have BACK and/or LEG pain:**

**Is the pain in your leg(s)** **Please divide your pain:**  
 Worse than your back **Back pain** \_\_\_\_\_%  
 Same as your back **Leg pain** \_\_\_\_\_%  
 Less than your back **The total should be 100%**

**How long can you sit?** \_\_\_\_\_ minutes. **How long can you stand?** \_\_\_\_\_ minutes

**How long can you drive/ride in car?** \_\_\_\_\_ minutes.

**How far can you walk?** \_\_\_\_\_ minutes or \_\_\_\_\_ miles

**What Makes Your Pain Better, Worse or No Change (Check All That Apply)**

|                     | Better | No Change | Worse |                   | Better | No Change | Worse |
|---------------------|--------|-----------|-------|-------------------|--------|-----------|-------|
| Bending/Stooping    |        |           |       | Coughing/Sneezing |        |           |       |
| Driving             |        |           |       | Relaxation        |        |           |       |
| Sitting             |        |           |       | Heat              |        |           |       |
| Standing            |        |           |       | Cold              |        |           |       |
| Lying Flat          |        |           |       | Lifting           |        |           |       |
| Lying Sideways      |        |           |       | Stress/Anxiety    |        |           |       |
| Twisting            |        |           |       | Sleep             |        |           |       |
| Walking             |        |           |       | Physical Activity |        |           |       |
| Walking UP Stairs   |        |           |       | Cold Weather      |        |           |       |
| Walking DOWN Stairs |        |           |       | Damp Weather      |        |           |       |
| Work Duties         |        |           |       | Pain Medications  |        |           |       |
| Sexual Activity     |        |           |       | Other _____       |        |           |       |

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Pain Treatment History**

**HOW DO THE FOLLOWING TREATMENTS IMPACT YOUR PAIN? \*\*\* IF YOU HAVEN'T TRIED IT, LEAVE THE ROW BLANK \*\*\***

| Treatment  | No Relief | Temp Relief | Excellent Relief | DATE(S)?<br>(ok to approximate) |
|--|-----------|-------------|------------------|---------------------------------|
| Acupuncture  |           |             |                  |                                 |
| Biofeedback  |           |             |                  |                                 |
| Chiropractic   |           |             |                  |                                 |
| Epidural Steroid Injection <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar                 |           |             |                  |                                 |
| Exercise Program   |           |             |                  |                                 |
| Facet Joint Injection/Medial Branch Blocks <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar |           |             |                  |                                 |
| Heat (Heating Pad; Hot Bath)   |           |             |                  |                                 |
| Hypnosis   |           |             |                  |                                 |
| Ice Packs  |           |             |                  |                                 |
| Joint Injections:  |           |             |                  |                                 |
| Massage  |           |             |                  |                                 |
| Meditation   |           |             |                  |                                 |
| Nerve Blocks:  |           |             |                  |                                 |
| Physical Therapy   |           |             |                  |                                 |
| Psychological Therapy  |           |             |                  |                                 |
| Radiofrequency Ablation:   |           |             |                  |                                 |
| Relaxation Therapy   |           |             |                  |                                 |
| Spinal Cord Stimulator: <input type="checkbox"/> Trial <input type="checkbox"/> Permanent Implant  |           |             |                  |                                 |
| Stretching   |           |             |                  |                                 |
| TENS Unit  |           |             |                  |                                 |
| Traction   |           |             |                  |                                 |
| Trigger Point Injection(s)   |           |             |                  |                                 |

I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS

Please describe any further details regarding previous pain treatments: \_\_\_\_\_  
 \_\_\_\_\_

**Diagnostic Tests and Imaging**

Mark all of the following tests you have had that are related to your current pain complaints:

- MRI of the \_\_\_\_\_ Date: \_\_\_\_\_ Facility: \_\_\_\_\_
- X-ray of the \_\_\_\_\_ Date: \_\_\_\_\_ Facility: \_\_\_\_\_
- CT scan of the \_\_\_\_\_ Date: \_\_\_\_\_ Facility: \_\_\_\_\_
- EMG/NCV study of the \_\_\_\_\_ Date: \_\_\_\_\_ Facility: \_\_\_\_\_
- Other diagnostic testing: \_\_\_\_\_

I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS.

**Physicians You Have Seen For Your Pain**

| Physician | Date | Treatment |
|-----------|------|-----------|
|           |      |           |
|           |      |           |
|           |      |           |
|           |      |           |
|           |      |           |
|           |      |           |
|           |      |           |
|           |      |           |
|           |      |           |
|           |      |           |

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Past Medical History**

|   | Yes | No | Notes |
|---|-----|----|-------|
| Aids  |     |    |       |
| Alzheimer Disease                                 |     |    |       |
| Anxiety   |     |    |       |
| Amputation  |     |    |       |
| Arterial Insufficiency                            |     |    |       |
| Asthma  |     |    |       |
| Bladder or Kidney Infection                       |     |    |       |
| Blood Disorders                                   |     |    |       |
| Brain Tumor                                       |     |    |       |
| Cancer (List Specific Type)                       |     |    |       |
| Colon Trouble                                     |     |    |       |
| COPD  |     |    |       |
| Depression  |     |    |       |
| Diabetes  |     |    |       |
| Fibromyalgia                                      |     |    |       |
| Gastroesophageal Reflux Disease (GERD)            |     |    |       |
| Glaucoma  |     |    |       |
| Gout  |     |    |       |
| Gynecology Problems (Specify)                     |     |    |       |
| Headache (Other than migraine)                    |     |    |       |
| Heart Disease                                     |     |    |       |
| Hiatal Hernia                                     |     |    |       |
| High Blood Pressure                               |     |    |       |
| History of Blood Transfusion                      |     |    |       |
| Kidney Disease                                    |     |    |       |
| Liver Disease                                     |     |    |       |
| Migraine Headache                                 |     |    |       |
| Mental Disorder (not depression or schizophrenia) |     |    |       |
| Neuropathy  |     |    |       |
| Osteoarthritis                                    |     |    |       |
| Osteoporosis                                      |     |    |       |
| Polio   |     |    |       |
| Positive HIV Test                                 |     |    |       |
| Prostate Trouble                                  |     |    |       |
| PTSD  |     |    |       |
| Rheumatic Fever                                   |     |    |       |
| Rheumatoid Arthritis                              |     |    |       |
| Schizophrenia                                     |     |    |       |
| Seizure (Epilepsy)                                |     |    |       |
| Shingles  |     |    |       |
| Sinus Trouble                                     |     |    |       |
| Stomach Ulcers                                    |     |    |       |
| Stroke  |     |    |       |
| Thyroid Problem                                   |     |    |       |
| Whiplash (Neck Injury)                            |     |    |       |

**Other medical history please list:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Past Surgical History**

Please indicate any surgical procedures you have had done in the past, including the date.

| Surgery | Date |
|---------|------|
|         |      |
|         |      |
|         |      |
|         |      |
|         |      |
|         |      |
|         |      |
|         |      |
|         |      |
|         |      |

I HAVE NEVER HAD ANY SURGICAL PROCEDURES.

**Anesthesia History**

Have you ever had any adverse reactions to anesthesia?  Yes  No

If yes, which type of anesthesia did you have problems with? (Please check all that apply)

- Local anesthesia     Epidural     General Anesthesia     IV Sedation

Has a family member ever had any adverse reactions to anesthesia?  Yes  No

If yes, which type of anesthesia did you have problems with? (Please check all that apply)

- Local anesthesia     Epidural     General Anesthesia     IV Sedation

**Current Medications**

Please indicate which (if any) of the following blood-thinners you are taking:

- Aggrenox     Coumadin / Warfarin     Effient     Lovenox     Plavix     Pletal     Pradaxa  
 Prasugrel     Ticlid     Other \_\_\_\_\_

Please list *all* medications you are currently taking. Attach an additional sheet, if required.

| Medication Name | Dose | Frequency | Medication Name | Dose | Frequency |
|-----------------|------|-----------|-----------------|------|-----------|
|                 |      |           |                 |      |           |
|                 |      |           |                 |      |           |
|                 |      |           |                 |      |           |
|                 |      |           |                 |      |           |
|                 |      |           |                 |      |           |
|                 |      |           |                 |      |           |
|                 |      |           |                 |      |           |
|                 |      |           |                 |      |           |
|                 |      |           |                 |      |           |

**Allergies**

Do you have any known drug allergies?  Yes  No

If Yes, please select below the medications you are allergic to.

- Penicillin     Tetracycline     Sulfa     Morphine     Erythromycin     Codeine  
 Radiographic Dyes     Other \_\_\_\_\_

What type of response did you have? \_\_\_\_\_

Topical Allergies:  Iodine/Betadine     Latex     Tape    Are you allergic to shellfish?  Yes  No

**Social History**

**Are you capable of becoming pregnant?**  Yes  No **If so, are you currently pregnant?**  Yes  No

**Who do you live with?**  Alone  Spouse  Parents  Roommate  Other: \_\_\_\_\_

**Highest level of education:**  Grammar school  High School  College  Post-graduate

**Tobacco Use:**  Has Never Used Tobacco  Current Tobacco User - Packs Per Day \_\_\_\_\_ I have smoked for \_\_\_\_\_ years.  
 Former Tobacco User - How many years did you smoke \_\_\_\_\_

**Alcohol Use:**  Never Drinks Alcohol  Current Alcoholism  History of Alcoholism  Drinks Alcohol Socially  
 Daily Limited Use - How many drinks per day? \_\_\_\_\_

**Have you ever gotten a DWI (DUI)?**  Yes  No **If Yes date(s), explain** \_\_\_\_\_

**Illegal Drug Use:**  Denies Any Illegal Drug Use  Currently Using Illegal Drugs (Which: \_\_\_\_\_)  
 Currently Uses Marijuana  Currently Using Someone Else's Prescription Medications  
 Formerly Used Illegal Drugs (not currently using) (Which: \_\_\_\_\_)

**Have you ever abused prescription medications?**  Yes  No (Which: \_\_\_\_\_)

**Are there any substance abuse issues in your household?**  Yes  No

**Have you ever been arrested?**  Yes  No **If Yes date(s), explain** \_\_\_\_\_

\_\_\_\_\_

**Do you cry often?**  Yes  No **Do you feel depressed?**  Yes  No

**Have you ever attempted suicide?**  Yes  No **If Yes date(s), explain** \_\_\_\_\_

\_\_\_\_\_

**Do you currently have thoughts of suicide?**  Yes  No

**Family History**

Mark all appropriate diagnoses as they pertain to your immediate family (mother, father, sister, brother, children) only.

Alcoholism  Arthritis  Cancer-Type \_\_\_\_\_  Colitis  
 Diabetes  Drug Abuse  Heart Disease  High Blood Pressure  High Cholesterol  
 Kidney Problems  Migraine Headache  Rheumatoid Arthritis  Schizophrenia  Seizures  
 Stroke  Other medical problems: \_\_\_\_\_

I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY.  I AM ADOPTED (No Medical History Available).

**Review of Symptoms**

**Mark the following symptoms that you currently suffer from. Note: Diagnosed conditions/Diseases should be noted under Past Medical History, above.**

**Constitutional:**  Abnormal Bleeding  Chills  Difficulty Sleeping  Easy Bruising  Excessive Sweating  
 Excessive Thirst  Fatigue  Fever  Insomnia  Low Sex Drive  
 Night Sweats  Swollen / Tender Lymph Nodes  Unexplained Weight Gain  
 Unexplained Weight Loss

**Skin:**  Blisters  Changes in Moles  Discoloration  Rashes  Sores

**Head/Ears/Eyes, Nose/Throat:**  Dental Problems  Earaches  Hearing Problems  Nosebleeds  
 Recurrent Sore Throats  Ringing in the Ears  Sinus Problems  Visual Changes

**Cardiovascular:**  Bleeding Disorder  Chest Pain  Deep Vein Thrombosis  Fainting  High Blood Pressure  
 Irregular Heartbeat  Lightheadedness  Shortness of Breath During Sleep  Swelling in the Feet

**Respiratory:**  Cough  Wheezing  Pulmonary Embolism  Short of Breath on Exertion  Short of Breath at Rest

**Gastrointestinal:**  Abdominal Cramps  Acid Reflux  Constipation  Coffee Ground Appearance in Vomit  
 Dark & Tarry Stools  Diarrhea  Hernia  Vomiting

**Musculoskeletal:**  Back Pain  Joint Pain  Joint Stiffness  Joint Swelling  Muscle Spasms  Neck Pain

**Genitourinary/Nephrology:**  Blood in Urine  Painful Urination  Decreased Urine Flow/Frequency/Volume  Flank Pain

**Neurological:**  Tremors  Dizziness  Headaches  Numbness/Tingling  Seizures  Instability When Walking

**Psychiatric:**  Depressed Mood  Feeling Anxious  Stress Problems  Suicidal Thoughts  Suicidal Planning