www.georgiapainassociates.com

GPA, Canton
2000 Village Professional Drive,
Suite 200
Canton, GA 30114
678-661-4545

GPA, Braselton
5745 Old Winder Hwy, Suite C
Braselton, GA 30517
Phone: (770) 450-6350
Fax: (770) 967-0833

GPA, Tucker
2060 Northlake Pkwy.
Tucker, GA 30084
Phone: (678) 245-6235
Fax: (770) 710-0925

To Our New Patients:

Welcome and thank you for choosing Georgia Pain Associates. We appreciate the confidence and trust that you have placed in us and we look forward to meeting you in person. Our goal is to provide the highest quality care in a friendly, caring and efficient environment.

In an effort to make your visit a smooth and pleasant one, we have several patient information forms to be completed ***before*** your appointment. Please complete the forms and bring them with you to your initial visit. This information will be used in the preparation of your patient chart. If you arrive at your appointment with the forms ***not*** completed, your appointment will be rescheduled. You may download the forms from our website at **www.georgiapainassociates.com**.

If your insurance company requires a referral or authorization number for you to see a specialist, please contact your primary care physician for the necessary referral or authorization.

Your visit is payable at the time of service by cash, check, or credit card (Visa and MC). If you have an insurance plan that our office is contracted with, please provide the necessary insurance information to our front office ***before*** your first visit so that we can confirm your coverage benefits prior to your appointment.

Should you need to change the appointment time, simply call our office to reschedule. We ask the courtesy of a 24-hour notice for cancellations.

We look forward to seeing you at our office. Thank you for giving us the opportunity to serve you. Should you have any questions or concerns, please contact our office at 678-661-4545.

Thank you,

New Patient Coordinator

GEORGIA PAIN ASSOCIATES

Patient Demographic Form

PATIENT INFORMATION						
❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Last Name:	First Name:	Middle Name:	Marital status (circle one) Single / Mar / Div / Sep / Widow(er)		
	Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?				
Home phone no.: ( ) -	Cell phone no.: ( ) -	Birth date: / /	Age:	Sex: ❑ M ❑ F	Social Security #: - -	
Street Address:			Mailing Address if different:			
City:	State:	ZIP Code:	City:	State:	ZIP Code:	
Employer:			Work phone no.: ( ) -	Work fax no.: ( ) -		
Employer Address:			May we contact you at work? ❑ Yes ❑ No			

INSURANCE INFORMATION	
Company name	ID Number
Group Name	Phone Number

MEDICAL INFORMATION	
Primary Care Physician: Date of last physical	Phone
Address	Fax
Are you **ALLERGIC** to any medications? No Yes (please list):	
List All **CURRENT MEDICATIONS** here:	
Pharmacy Name and Phone:	

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone	Work phone
		( )	( )
		( )	( )
		( )	( )

By signing below, I affirm that all the above information is true and correct to the best of my knowledge.

Patient signature	Date

2000 Village Professional Dr, Suite 200
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GEORGIA PAIN ASSOCIATES

Patient Name:			
Referring Physician:			
Is your problem:	❑ Work related? ❑ Auto or Other Accident related? ❑ Neither	Do you have legal representation? ❑ Yes ❑ No	Are you being covered under Work Comp ❑ Yes ❑ No
Please briefly describe your **MAIN** problem / complaint:			
How long have you had this problem:			
Did your problem start suddenly or gradually with time?			
Please explain how problem began:			

MEDICATIONS: Please indicate all current **PAIN medications** with **dosages** and **frequency**:		
Please indicate all **previous PAIN medications** prescribed in the past with **maximum dosages** and **frequency** tried:		

ALLERGIES: List all medication you have taken that caused side effects/allergic reaction – **ALSO LIST WHAT HAPPENS WHEN TAKE THE MED**:			
Medication	**Reaction**	**Medication**	**Reaction**
Medication	**Reaction**	**Medication**	**Reaction**
Medication	**Reaction**	**Medication**	**Reaction**
Iodine/Betadine ❑ Yes ❑ No	X-ray Contrast ❑ Yes ❑ No	Latex ❑ Yes ❑ No	Other ❑ Yes ❑ No

Past Medical and Surgical History:

Medical: ❑ High Blood Pressure ❑ Diabetes ❑ Heart Disease ❑ Thyroid ❑ Cancer ❑ Stroke ❑ Psychiatric: _____

Surgeries: ❑ None ❑ Appendix ❑ Gallbladder ❑ Hysterectomy ❑ Back or Neck _____

Other Medical or Surgical History:

Social History

Occupation:	❑ Light Duty ❑ Full Duty	❑ Unemployed ❑ Retired	❑ Disability ❑ Permanent ❑ Temporary Reason:

Tobacco use	❑ Current ❑ Never ❑ Quit	Packs per day:	Age started: Age stopped:	**Drug Use**	❑ Current ❑ Never ❑ Quit	What type: ❑ Marijuana ❑ Cocaine ❑ Heroin ❑ Methamphetamine ❑ Other:	Age started: Age stopped:
Alcohol use	❑ Current ❑ Never ❑ Quit	How Much per day: What type:	Age started: Age stopped:	**Have you ever been treated for substance:**			
				Dependency	❑ Yes	❑ No	When:
				Abuse	❑ Yes	❑ No	
				Addiction	❑ Yes	❑ No	

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GEORGIA PAIN ASSOCIATES

Patient Name:								
Review of Systems: Do you have any of the following problems?								
	YES	**NO**		**YES**	**NO**		**YES**	**NO**
General Symptoms:			**Cardiac:**			**Respiratory:**		
Excessive or unexplained Fatigue			Congestive Heart Failure			Shortness of Breath		
Unexplained Weight Loss			High Blood Pressure			Frequent Cough		
Fever, Chills			Chest Pain			Wheezing		
Night Sweats			Palpitations or cardiac dysrhythmia			Lung Disease or Cancer		
Loss of Appetite			Atrial fibrillation			Tuberculosis		
Other:			Heart Attack			Coughing Blood		
			Pacemaker			Pneumonia		
Neurological/HEENT:			Anticoagulant therapy			Emphysema		
Bowel/Bladder Dysfunction			Syncope (fainting spells)			Asthma		
Headaches			Other Cardiovascular disease:			Other:		
Blurry or Double Vision								
Dizziness			**Musculoskeletal:**			**Gastrointestinal:**		
Passing Out (Syncope)			Swelling Feet/Legs			Incontinence		
Hearing Loss			Pain/Swelling Joints			Persistent Nausea or Vomiting		
Weakness			Back Pain			Esophageal reflux		
Difficulty speaking or moving			Rheumatoid Arthritis			Abdominal Pain		
Neuropathy (diabetic or other)			Osteoarthritis			Constipation or Diarrhea		
Problems Swallowing			Other:			Crohn's or Colitis		
Strokes						Ulcers		
Seizures			**Genitourinary**			Bloody Bowel Movements		
Other:			Incontinence			Liver Disease/Hepatitis		
			Prostate Disorder			Gall Bladder Disease		
Hematologic/Lymphatic:			Blood in Urine			Cancer		
Bruising			Difficulty or Pain on Urination			Other:		
Bleeding Problems			Kidney Disease					
Low Blood Count			Cancer			**Endocrine:**		
Swollen Glands / Nodes			Other:			Thyroid Disease/problems		
Blood Clots						Diabetes (Type I or II)		
Leukemia / Cancer			**GYN:**			Diabetic Neuropathy		
Other:			**Are you pregnant or is there any chance that you could be pregnant?**			Heat or cold intolerance		
						Other:		
Psychiatric:								
Depression or Anxiety			Abnormal Vaginal Bleeding			**Skin/Integumentary:**		
Bipolar			Pelvic tumors, masses, cancer			Rash		
Suicidal Thoughts / attempts			Endometriosis			Skin cancer		
Schizophrenia			Other:			Other skin disorders:		
Other:								

The preceding patient information has been reviewed and discussed with my patient.	
Signature of patient or person completing the form	Physician's signature

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GEORGIA PAIN ASSOCIATES

Consent for Use of Protected Health Information (PHI)

It is the policy of Georgia Pain Associates to take reasonable actions to protect the privacy of our patients. In order to protect privacy, the staff will not discuss protected health information nor acknowledge your patient status except as required by law with anyone other than the patient except as detailed in our Patient Agreement and Consent for Release unless otherwise noted below.

☐ _____ Initials — NO, I am requesting Georgia Pain Associates **not** to acknowledge that I am a patient or to release any protected health information to anyone other than my referring and/or primary care physician and myself.

OR

☐ _____ Initials — YES, I am authorizing Georgia Pain Associates to acknowledge my patient status and/or discuss my protected health information with the following family members and/or friends.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name: _____ DOB: _____

Patient/Guardian Signature: _____ Date: _____

~~~~~~

Revocation of Personal Information Release

At this time I no longer wish for my PHI to be discussed with anyone other than myself. By this statement I wish to revoke the above authorization with any of the above named individuals.

Patient Signature: _____Date:_____
~~~~~~

GEORGIA PAIN ASSOCIATES

Doctor / Patient / Georgia Pain Associates Agreement

This agreement is between_____ (Patient), Georgia Pain Associates (The Center), and _____ (Doctor). We at Georgia Pain Associates understand that your pain is a significant hindrance to the quality of life you desire. In order to help you achieve your goals, we may recommend different medicines, selective diagnostic and therapeutic procedures, physical and occupational therapy, therapeutic massage, and psychological counseling, as needed. **Narcotic Medication for pain may not be prescribed at the first visit. This type of medication is solely given based on the medical findings and treatment plan of our doctor and is NOT based on previously prescribed medications.** Although narcotics have a long history of safety, there are possible side effects. Therefore, we must weigh the risks versus benefits before prescribing these medications. If we decide to use these medicines, the following conditions must be met:

- I understand that a reduction in the intensity of my pain and an improvement in my quality of life are the goals of this program.
- If deemed necessary, we may require a consult from a pain psychologist.
- Additional Therapy may be recommended for which you are required to participate.
- I realize that all narcotic medications have potential side effects. In addition to analgesia, narcotics may produce dependency, addiction, respiratory depression, drowsiness, and changes in mood, anxiety, and mental clouding. I will report any such side effects to the physician immediately. Narcotics may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. I agree that I will not attempt to perform any such activity until my ability to perform the activity has been evaluated.
- You must maintain the dosing schedule prescribed by the doctors from this clinic. You may not increase the dose on your own. You must come in and discuss any changes before they are made. If you take your medication in any way other than prescribed, it may not be refilled.
- I will not seek or accept prescriptions for pain medication from any other doctor, clinic, hospital or other source besides this office, unless approved.
- If you receive narcotics from any other clinic, doctor, dentist or hospital, you are required to notify this clinic by telephone within one working day of filling the prescriptions.
- You must have your narcotic prescriptions filled at only one pharmacy and must have the pharmacy name and number on file at this office. You must fill your prescriptions in the State of Georgia. Narcotics cannot be called in for any reason. Narcotic prescriptions can only be given to the patient. You may not sell, share or trade your prescriptions.
- Narcotic Prescriptions may not be replaced if lost, stolen, flushed, burned, or are otherwise missing for any other reason, even with a police report.
- You must submit to a urine Drug Screen at every office visit. These will be sent off to an independent lab for confirmation.
- You may be required to undergo ***random*** urine drug screen testing and random pill counts. If so, you will be contacted by telephone. **It is your responsibility to provide a telephone number where you can be contacted during regular business hours 8-5 M-F. If you cannot answer your telephone personally, you are responsible for an answering machine or other method of receiving the telephone message that day. If you fail to come in for a drug screen or pill count on the day you are called, you may not receive narcotic prescriptions from this clinic in the future.**
- In the event of a need to discontinue taking my medications, I will consult with the Doctor and strictly follow his instructions for the safe tapering off my medication. Failure to do so may result in severe withdrawal effects and possibly even death. I understand that even with the tapering process there may be some discomfort or withdrawal effects.
- You must not take any illegal drugs or any medications prescribed to someone other than you. You must avoid drinking alcohol if you are taking a narcotic medication for pain control. I understand that I must contact my physician before taking sedatives, antihistamines, or benzodiazepines. Some examples include but are not limited to: Soma, Xanax (alprazolam), Ativan (lorazepam), and Benadryl.
- By signing this agreement you give this office permission to request information and share information about your narcotic prescription history with other pharmacies, medical offices or law enforcement agencies.
- I understand that all female patients should notify the physician if they are pregnant or possibly at risk to become pregnant. I understand that children born while the mother is on opiate therapy would likely be physically dependent at birth.
- Should this office feel that I might be doing harm to another or myself, I agree to waive any applicable privilege or right to privacy or confidentiality with respect to the prescribing of my pain medication and/or mental state.
- If I am or ever have been on probation, or arrested for a narcotic-related offense, I understand that I **must disclose** this information **immediately**.

This agreement is entered into on the _____ (Day) day of _____ (Month), _____ (Year)

My signature below acknowledges my understanding and agreement with the above stated terms.

Patient Name	Patient Signature
Doctor Signature	Witness Signature

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GEORGIA PAIN ASSOCIATES

Policies and Disclosures

Patient Privacy Practices

By signing this form I am stating I have received a copy of the "Patient Privacy Practices" from Georgia Pain Associates, which describes how medical information about you may be used or disclosed and how you can obtain access to information.

1. **Payment Methods-** Payment is due at time of service. If you do not have your payment we will have to reschedule your appointment. We accept Cash, MasterCard, and Visa. We will file a claim with your insurance company after your co-payment has been paid for all office visits and procedures. Although it is our policy to verify your benefits, please understand that you are responsible for any services not covered by your insurance. Some payment plans are available.

2. **Missed Appointments or "No-show" Appointments**- We ask that you call if you cannot make your scheduled appointment. If you do not call at least 24 hours in advance the following fees will be assessed to your account. These fees are not billable to insurance and are due before your next visit: $25.00 for missed appointment and $100.00 for a missed procedure.

   If you fail to no show for 2 appointments we reserve the right to refuse scheduling or rescheduling of any appointments for you to be seen again. A no-show is defined as not showing for an appointment or canceling an appointment less than 24 hours before the scheduled time.

3. **Consent for treatment:** I hereby give consent to Georgia Pain Associates and their respective staff and providers to perform medical procedures and testing, which are appropriate for my condition, symptoms, illnesses or injuries.

4. **Medical Records Requests**: Medical records requests may be submitted in writing and are subject to a fee. We must have a Medical Records consent signed by the patient and sent from the requesting Physician's office

Patient Name: _____Date of Birth: _____

Signature: _____Date:_____

Notice of Patient Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Georgia Pain Associates is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Georgia Pain Associates uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide. For example, Georgia Pain Associates may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you. Georgia Pain Associates may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, and for emergencies. We may provide de-identified information for research studies. We also provide information when required by law. In any other situation, Georgia Pain Associates's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time. Georgia Pain Associates may change its policy at any time. When changes are made, a new Notice of Patient Information Practices will be posted in a common area of our clinic. You may also request an updated copy at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reason other than treatment, payment, or other related administrative purposes. You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. Georgia Pain Associates will consider all such requests on a case-by-case basis, but the company is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Georgia Pain Associates may have violated your privacy rights, or if you disagree with any decisions that we have made regarding access or disclosure of your personal health information, please contact our HIPAA Compliance Office at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Georgia Pain Associates health information practices, or if you have a complaint, please contact us below:

HIPAA Compliance Office
2000 Village Professional Drive
Canton, GA 30114
678-661-4545

EVERY PATIENT MUST RECEIVE A COPY OF THIS FORM

STUDY ID# _____ HOSPITAL # _____

DO NOT WRITE ABOVE THIS LINE

Brief Pain Inventory (Short Form)

Date: _____/_____ /_____ Time: _____

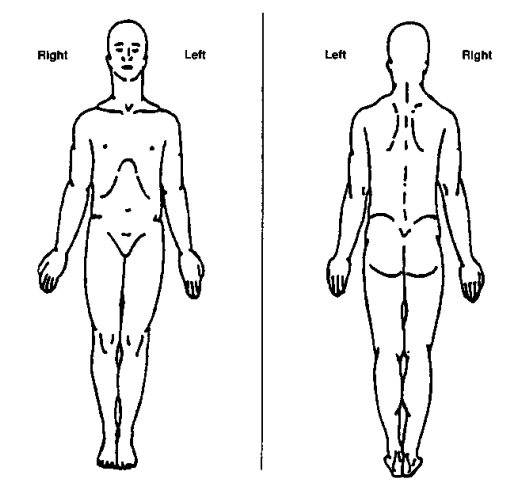
Name: _____ _____ _____

Last First Middlle Initial

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these every-day kinds of pain today?

1. Yes 2. No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3. Please rate your pain by circling the one number that best describes your pain at its worst in the last 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

4. Please rate your pain by circling the one nuimber that best describes your pain at its least in the last 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

5. Please rate your pain by circling the one number that best describes your pain on the average.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

6. Please rate your pain by circling the one number that tells how much pain you have right now.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

7. What treatments or medications are you receiving for your pain?

8. In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
No Relief										Complete Relief

9. Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General Activity

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

B. Mood

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

C. Walking Ability

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

D. Normal Work (includes both work outside the home and housework)

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

E. Relations with other people

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

F. Sleep

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

G. Enjoyment of life

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

SOAPP® Version 1.0 - SF

Name: _____ Date: _____

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you have mood swings?	0 1 2 3 4
2. How often do you smoke a cigarette within an hour after you wake up?	0 1 2 3 4
3. How often have you taken medication other than the way that it was prescribed?	0 1 2 3 4
4. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0 1 2 3 4
5. How often, in your lifetime, have you had legal problems or been arrested?	0 1 2 3 4

Please include any additional information you wish about the above answers. Thank you.

Annual Questionnaire

Once a year, all our patients are asked to complete this form because drug use and alcohol use can affect your health as well as medications you may take. Please help us provide you with the best medical care by answering the questions below.

Are you currently in recovery for alcohol or substance use? ☐ Yes ☐ No

Alcohol: One drink = 

12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

		None	1 or more
MEN < 65:	How many times in the past year have you had 5 or more drinks in a day?	○	○
WOMEN (& MEN > 65):	How many times in the past year have you had 4 or more drinks in a day?	○	○

Drugs: Recreational drugs include cannabis (marijuana, pot), cocaine, stimulants (Ritalin, Concerta, Adderall), methamphetamine (speed, crystal), inhalants (paint thinner, aerosol, glue), sedatives (Valium, Xanax, Rohypnol), hallucinogens (LSD, mushrooms, ecstasy), street opioids (heroin). Prescription opioids include fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin],methadone, buprenorphine.

	None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?	○	○