SOUTHWEST PAIN MANAGEMENT
Relief begins here.

Dr. Robert Groysman, MD

Bob DeLillo, CRNA, NSPM-C, ARNP, CNPM, AFAAPM

PATIENT INFORMATION FORM

PRINT PLEASE

TWO PAGE FORM COMPLETE AND SIGN BACK OF THIS FORM

REGISTERED BY: _____

PATIENT NAME: LAST	FIRST	MIDDLE	DATE OF BIRTH	DRIVERS LICENSE #	SOCIAL SECURITY NUMBER

RESIDENCE ADDRESS: NUMBER STREET	CITY	STATE	ZIP CODE	Gender

MAILING ADDRESS: PO NUMBER IF APPLICABLE	CITY	STATE	ZIP CODE	

HOME PHONE NUMBER	CELL PHONE NUMBER	EMAIL ADDRESS	

EMERGENCY CONTACT NOT LIVING WITH YOU	RELATIONSHIP	PHONE NUMBER	SECONDARY PHONE NUMBER

PATIENTS EMPLOYMENT

YOUR CURRENT EMPLOYER NAME: (BUSINESS NAME)	DIRECT WORK PHONE NUMBER

EMPLOYER PHYSICAL ADDRESS:	DIRECT EMAIL ADDRESS

	CURRENT POSITION (TITLE)	DEPARTMENT	

SPOUSE, DOMESTIC PARTNER OR GUARANTORS EMPLOYMENT

LAST	FIRST	MIDDLE	DATE OF BIRTH	DRIVERS LICENSE #	SOCIAL SECURITY NUMBER

CURRENT EMPLOYER NAME: (BUSINESS NAME)	DIRECT WORK PHONE NUMBER

EMPLOYER PHYSICAL ADDRESS:	DIRECT EMAIL ADDRESS

	CURRENT POSITION (TITLE)	DEPARTMENT	

YOUR PERSONAL PHYSICIAN INFORMATION

REFERRING DOCTOR NAME	STREET ADDRESS	CITY	ZIP CODE	REFERRING DOCTOR PHONE NUMBER

FAMILY DOCTOR NAME	STREET ADDRESS	CITY	ZIP CODE	FAMILY DOCTOR PHONE NUMBER

HEALTH PLAN INFORMATION-

WC Patients Please list private insurance under secondary

PRIMARY INSURANCE COMPANY	INSURANCE PHONE NUMBER	GROUP NUMBER	IDENTIFICATION NUMBER

SUBSCRIBERS NAME	RELATIONSHIP TO SUBSCRIBER	SOCIAL SECURITY NUMBER

SECONDARY INSURANCE	INSURANCE PHONE NUMBER	GROUP NUMBER	IDENTIFICATION NUMBER

SUBSCRIBERS NAME	RELATIONSHIP TO SUBSCRIBER	SOCIAL SECURITY NUMBER

SIGN & COMPLETE THE INFORMATION ON THE BACK OF THIS FORM IN ITS ENTIRITY

WORKERS' COMPENSATION INFORMATION

TO COMPLY WITH CALIFORNIA WORKERS' COMPENSATION REGULATIONS PERTAINING TO WORK RELATED INURIES. MPMC MUST HAVE DETAILED INFORMATION TO ENSURE THAT YOUR MEDICAL CARE IS AUTHORIZED AND SUBMITTED PROMPTLY FOR CLAIMS PROCESSING IF YOUR MEDICAL CARE IS COVERED BY WORKERS' COMPENSATION INSURANCE. WORKERS' COMPENSATION PATIENTS ARE REQUIRED COMPLETE ALL OF THE INFORMATION IN THIS SECTION IN ITS ENTIRITY. IF YOU ARE NOT AWARE OR SURE

OF THIS REQUIRED INFORMATION PLEASE CONTACT THE EMPLOYER, WHERE YOU WORKED, WHEN YOU WERE INJURED. THAT EMPLOYER HAS AN OBLIGATION TO PROVIDE YOU WITH THIS NECESSARY CLAIMS MANAGEMENT INFORMATION.

IS YOUR MEDICAL CARE AT MPMC ATRIBUTED TO A WORK RELATED INJURY? ☐ YES ☐ NO

DATE OF INJURY MM/DD/YYYY	ADJUSTERS NAME	ADJUSTERS PHONE NUMBER	WORKERS' COMPENSATION CLAIM NUMBER

NAME OF WORKERS' COMPENSATION INSURANCE	ADDRESS OF W/C INSURANCE	CITY	STATE	ZIP CODE

NAME OF EMPLOYER AT TIME OF INJURY	LOCAL MAILING ADDRESS	CITY	STATE	ZIP CODE

DO YOU HAVE AN ATTORNEY REPRESENTING YOU? ☐ YES ☐ NO

WHAT IS YOUR WORKERS COMPENSATION APPEALS BOARD (WACB) NUMBER: _____

NAME OF ATTORNEY AND LAW FIRM	LAST	FIRST	PHONE NUMBER

ADDRESS OF ATTORNEY:	NUMBER & STREET	CITY	STATE	ZIP CODE

I _____ authorize my Southwest Pain Management (SPM) physician and any other physician or therapist who provides care or services to me as well as my attorney and pharmacy to exchange information relating to my medical condition(s)/services provided. If I am hospitalized during the course of my care with SPM. I authorize the hospital to release information to SPM regarding any treatment provided to me.

If my treatment is covered by an acceptable insurance, I hereby authorize my benefits to be paid directly to SPM. I understand that I am financially responsible for all deductibles, co-payments, products and services not covered by my insurance company

I authorize SPM to release, to my insurance company, contracted reviewing agency and/or state or governmental agency, any information necessary on the processing of my medical claim, including information relating to medical condition(s).

All information disclosed within these sessions meets applicable standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and will not be released without my written permission except as identified above and disclosure is required by law. I have been provided with a copy of this "Notice of Privacy Practice" and have been informed a copy of the complete notice is available for review in the Lobby at SPM. I may also request a copy of the notice.

Disclosure or PHI may be required by law in the following circumstances: when there is reasonable suspicion of child or elder abuse, when there is reasonable suspicion that the patient presents a danger of violence to others or themselves. Disclosure may also be required pursuant to a legal proceeding.

This authorization shall extend for the duration of my treatment at SPM unless otherwise specified in writing by me or my responsible representative(s).

_____ (Initial) I have received a copy of SPM rights and responsibilities.

Please place an X in the box that applies and sign authorization form.

☐ **Patient** ☐ **Parent** ☐ **Guardian of Minor** ☐ **Guardian or conservator of an incompetent patient**

☐ **Beneficiary or personal representative of deceased patient**

Date: _____ **Signature:** _____

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PATIENT MEDICAL HISTORY FORM

CURRENT MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what?
Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	Dose (include strength & number of pills per day)	How long have you been taking this?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

PAST MEDICAL HISTORY

Do you now or have you ever had:

❑ Diabetes
❑ High blood pressure
❑ High cholesterol
❑ Hypothyroidism
❑ Goiter
❑ Cancer (type) _____
❑ Leukemia
❑ Psoriasis
❑ Angina
❑ Heart problems
❑ Heart murmur
❑ Pneumonia
❑ Pulmonary embolism
❑ Asthma
❑ Emphysema
❑ Stroke
❑ Epilepsy (seizures)
❑ Cataracts
❑ Kidney disease
❑ Kidney stones
❑ Crohn's disease
❑ Colitis
❑ Anemia
❑ Jaundice
❑ Hepatitis
❑ Stomach or peptic ulcer
❑ Rheumatic fever
❑ Tuberculosis
❑ HIV/AIDS

Other medical conditions (please list):

_____

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SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD
- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

Women Only:
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

OTHER PROBLEMS:

WOMENS REPRODUCTIVE HISTORY:

Age of first period:
Pregnancies:
Miscarriages:
Abortions:
Have you reached menopause? Y / N At what age?

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NARCOTICS CONTRACT

Dr. Groysman and his staff understand that your pain is a significant hinderance to the quality of life you desire. In order to help you achieve your goals we may utilize oral narcotics or other medication supplements with treatment. Narcotics have a long history of safety when used in the proper manner. Addiction to narcotics may occur with continuous use over several weeks; therefore, we must weigh the risks versus the benefits of using these medications. Dr. Groysman will discuss these risks with you when they are prescribed and your pharmacist will also give you more information. It is important to take all medications as prescribed by Dr. Groysman. Taking more medication than prescribed can result in serious and life-threatening complications including but not limited to: **respiratory failure, cardiac arrhythmia, possible overdose and death**. ***As of September 11th, 2011, in the state of Texas "Doctor Shopping" is a felony and will be reported immediately.***

Listed below are the terms and conditions you are required to adhere to in order to be under the care of Integrative Pain and Spine (SPM). If any of these rules ae violated, Dr. Groysman reserves the right to dismiss you from his care.

- I agree to take my medication as prescribed. If my pain level increases such that I need to increase my dosage, I will call SPM and discuss this with a nurse or Dr. Groysman before taking any action. _____ **(Initial)**
- I allow any providers, Dr. Groysman or staff members under the direction of the provider to perform random pill counts on any medications prescribed by SPM. _____ **(Initial)**
- I will not request or accept pain medication from any other provider or facility unless in an emergency situation (ie: trauma or injury resulting in a hospital visit/admission). _____ **(Initial)**
- I will fill my prescriptions only at the pharmacy on file with SPM. _____ **(Initial)**
- I am aware that lost or stolen prescriptions will not be replaced without a police report. _____ **(Initial)**
- I am aware that it is my responsibility to keep track of when my prescriptions will run out. I understand that prescription refills can take up to **48 hours** to process and I will plan accordingly. _____ **(Initial)**
- I understand that if I run out of my medication early, it may not be refilled by SPM. I understand that even if SPM chooses to refill my medication, my pharmacy may not. _____ **(Initial)**
- I consent to random drug testing to be performed by SPM. I understand that any detection of illicit substances may result in immediate dismissal from care. _____ **(Initial)**
- I understand that any illegal or drug seeking activities will be immediately reported to the authorities. _____ **(Initial)**
- I understand that in accordance with the law, I will be unable to receive my medication without an in-office visit with Dr. Groysman. I understand that in accordance with the law, no narcotics can be filled across Texas state lines. _____ **(Initial)**
- I understand that I will no longer receive narcotics if one of the following occurs:
    1. Dr. Groysman feels that narcotics are not relieving my pain adequately. _____ **(Initial)**
    2. I develop side effects that ae concerning to Dr. Groysman. _____ **(Initial)**
    3. I give away, sell or abuse the narcotics prescribed. _____ **(Initial)**
    4. The Texas Department of Public Safety database indicates I have obtained narcotics from another provider or facility. _____ **(Initial)**

- I understand that my pain management care may also include non-narcotic treatment. I am aware that if I refuse or do not follow through with the recommended treatment plan including non-narcotic options, that my narcotic treatment may be terminated. _____ **(Initial)**
- If I feel I have become dependent on narcotics or begin taking more than prescribed, I will notify SPM immediately and seek rehabilitation treatment. _____ **(Initial)**

THIS CONTRACT WILL REMAIN IN EFFECT FOR THE DURATION OF MY CARE WITH SOUTHWEST PAIN MANAGEMENT.

Date **Signature** **Printed Name**

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.

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Name: _____ Date of Birth: _____ Today's Date: _____

Reason for Today's Visit (Mark ALL that apply)

- ☐Medication Refill
- ☐Procedure Follow Up
- ☐Neck Pain
- ☐Low Back Pain
- ☐Mid Back Pain
- ☐Facial Pain
- ☐Leg Pain
- ☐Shoulder Pain
- ☐Arm Pain
- ☐Image Review
- ☐Other:_____

Are your pain medications helping? ☐Yes ☐No

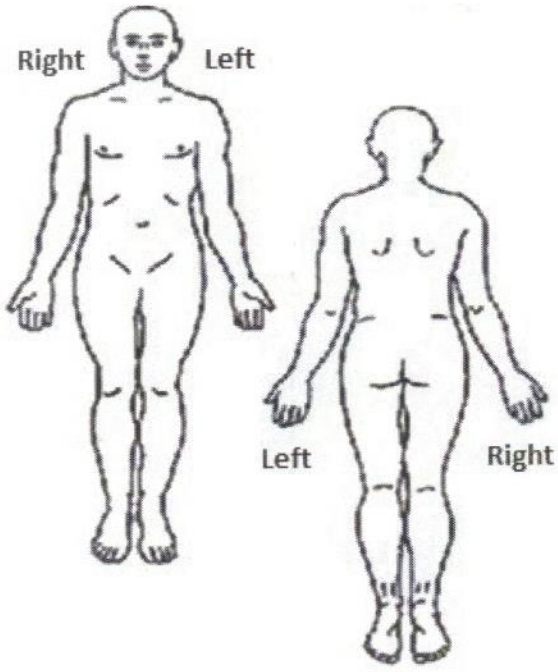
Improved Pain Relief: _____% (0-100%)

Functional Improvement: _____% (0-100%)

Have you stopped taking any of your medications?

Are you taking any blood thinners?

Indicate where your pain is located:



What is your pain level NOW(1-10): _____

1. Use the following letters to describe your pain.

Ache = A
Burning = B
Cramping = C
Dull = D
Numbness = N
Pins/Needles = P
Stabbing = S
Throbbing = T
Muscle spasm = M

2. Draw arrows where the pain radiates.

Patient Signature:_____ Date:_____

Vitals:

BP: Pulse: Oxygen:

Height: Weight: Temp:

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PATIENT RESPONSIBILITIES

At Southwest Pain Management, we believe patients and families are partners in ensuring that the best possible care is provided in a healthful, safe environment. We count on you to participate in your care in the following ways:

1. When requested by SPM staff, present your insurance card(s) and present picture identification. At each appointment your co-payments and balances due must be paid. SPM accepts cash, money orders, travelers' checks, Visa, MasterCard, Discover, bank cards and checks. SPM has sanctions associated with returned checks and non-payment of accounts.
2. Know what your health plan benefits are so we can appropriately provide medical care to you and refer you, when necessary, to an outside medical provider; such as, laboratory, pharmacy, x-ray, etc. Talk with your insurance company to determine if SPM is a contracted or network provider.
3. You are required to have a Primary Care Physician (PCP) and provide SPM with your PCP's current Name, Address and Phone number.
4. Don't be late for your appointment. Be at this office at least fifteen (15) minutes prior to your scheduled appointment time to check in, provide your medical information and complete the patient interval questionnaire. If you are late you may be rescheduled.
5. Provide the physician with the most accurate and complete information regarding present complaints, past illnesses, hospitalizations, medications, allergies and unexpected changes in your condition.
6. Follow the plan of care, if agreed upon, or express concerns with compliance.
7. If you are prescribed medications, you MUST maintain compliance with laboratory studies as well as all conditions of the narcotic contract or you WILL be discharged.
8. You and your family are responsible for following the pre-operative and post discharge plan of care. You are responsible for the outcomes if you do not follow the plan of care. Ask questions when you do not understand what you are told or what you are expected to do.
9. Provide an adult to transport you home from after a procedure, and remain with you for 24 hours, if required by the physician.
10. At each appointment, and prior to your treatment or examination, you are responsible for completing a patient interval questionnaire which includes a complete listing of all your medications including over-the-counter products and dietary supplements as well as any allergies or sensitivities.
11. Sign all forms pertinent to medical treatment, authorization, billing agreement and release of medical information.
12. Your medications must be taken as prescribed. Medication refills are made during your visit. Be sure to review all your medication needs with your attending medical provider during your appointment.
13. Inform SPM about any living will, medical power of attorney, or other directive that could affect your care
14. Be respectful of all the health care providers and staff as well as other patients. You and your family are responsible for following the practice's rules and regulations concerning patient care and conduct.

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Financial Policies

At Southwest Pain Management, we have implemented to following financial policies to ensure you understand the financial expectations we have of our patients.

PAYMENT:
We are in network with most health plans. When requested by SPM staff, present your insurance card(s) and present picture identification. Your benefits and eligibility will be verified before your appointments. Once your out of pocket estimate for your visit is determined, payment is expected at the time of your appointment for services rendered. If you do not present your insurance information prior to your visit, you will be expected to pay for your visit in full.

At each appointment, your estimated out-of-pocket portion including deductible and co-payments will be collected. All outstanding balances due must also be paid in full before each visit. Our office accepts cash, checks or credit cards (MasterCard, Visa, Discover and American Express. Health savings accounts (HSA). Health reimbursement accounts (HRA) and flexible spending accounts (FSA) may also be used to pay for your appointments.

A CREDIT CARD MUST BE KEPT ON FILE.

CANCELLATION OF APPOINTMENTS:
We have set aside time for you and as a specialized practice, there is no double booking. A credit card on file is required upon scheduling your Initial Appointment and an updated credit card is kept on file for the term of your treatment with the Practice. A 48-hour notice of cancellation is required for all office visits and procedures. All cancellations must be made by telephone by calling our office at 214-560-2000.

A fee of $50 will be charged for late cancellations of office visits and a fee of $150 will be charged for late cancellations of procedures.

_____ _____
Patient Name Date of Birth

_____ _____
Card Holder Name Phone Number

_____ _____
Credit Card Number Expiration Date

_____ _____
SEC Billing Address

I acknowledge the polices as stated above and authorize Southwest Pain Management to charge my credit card above for all fees associated with these policies.

_____ _____
Signature Date

HIPAA NOTICE OF PRIVACY PRACTICES
As required by the Privacy Regulations Promulgated Pursuant to the
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

We may use or disclose your protected health information in the following situations without your authorization: as Required by Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with our Office Manager in person or by phone at 214-560-2000.

Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

We welcome your comments:
Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.