Pain Relief Partners
Working With You to Lower Your Pain
www.loweryourpain.com

Date_____

PATIENT NAME: _____DATE OF BIRTH: _____AGE: _____

PHONE NUMBER: _____EMAIL: _____

STREET ADDRESS:_____

PRIMARY CARE PROVIDER: _____NAME OF CLINIC: _____

EMERGENCY CONTACT: _____ EMERGENCY CONTACTS PHONE NUMBER: _____

1. Where do you have symptoms? _____

2. Rate the intensity of your symptoms today. (0=Symptoms, 10=Debilitating) _____

3. What do the symptoms feel like?

Dull Sharp Burning Throbbing Pins and Needles Aching Numbness Tingling

Stabbing Shooting Constant Intermittent Rarely Present No Pain Other: _____

4. What caused your pain, and how long have you been in pain?

_____

5. Have you had treatment to this area before? _____

6. Does your pain travel? _____7. Where does it travel? _____

8. How do your symptoms affect your movement? _____

9. What aggravates your symptoms?

Sitting Standing Sneezing Walking Using stairs Lifting/Carrying Pushing Pulling Moving your head

Getting In/Out of Bed/Chair/Car Specific movement: _____

10. What makes your symptoms better? _____

11. Caffeine: □ No □ Yes What kind? _____

Alcohol – beer, wine, liquor □ No □ Yes Recreational/Street drugs □ No □ Yes Tobacco □ No □ Yes

12. Please list current medications:

_____

_____

13. Are you allergic to any medication? _____

14. Surgical history: _____

15. Other health history/diagnosis:

_____

_____

HOW DID YOU HEAR ABOUT US? THE COLUMBIAN, THE OREGONIAN, TV COMMERCIAL, FACEBOOK AD, WEB SEARCH, POSTER/FLYER, RADIO, MAGAZINE, Referral, Other>

_____

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HIPAA RELEASE

The practice:

(a) Is required by federal law to maintain the privacy of your Protected Health Information and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy with respect to your Protected Health Information.

(b) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your Protected Health Information than that which is provided for under federal law.

(c) Is required to abide by the terms of the Privacy Notice.

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your Protected Health Information that is maintains.

(e) Will distribute any revised Privacy Notice to you prior to implementation. (f) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This notice is effective as of 07/26/2004.

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of this notice, and my understanding and my agreement to its terms.

_____

PATIENT

_____

DATE

FOR PRACTICE USE ONLY

Practice Documentation of Good Faith Effort to Obtain Acknowledgement.
Patient's acknowledgement of this notice could not be obtained because:

_____ Patient refused to sign
_____ Communication barrier prohibited obtaining acknowledgement
_____ Emergency circumstances
_____ Other
Details: _____

_____

Signature of Practice

_____

Date

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Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.P.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Pain Relief Partners to release my records and any information to the following individuals.

1. _____ Relation to Patient: _____

2. _____ Relation to Patient: _____

3. _____ Relation to Patient: _____

4. _____ Relation to Patient: _____

5. _____ Relation to Patient: _____

Patient Name: _____ Date: _____

Patient Signature: _____

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ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Assignment of Insurance Benefits – Appointment as Legal Authorized Representative

I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to the Provider and The Force Law Firm PC and their affiliated law firms (hereinafter, "My Authorized Representatives") and I appoint them as my authorized representative with the power to:

- ✓ File medical claims with the health plan
- ✓ File appeals and grievances with the health plan
- ✓ Institute any necessary litigation and/or complaints against my health plan ***naming me as plaintiff in such lawsuits and actions if necessary*** (or me as guardian of the patient if the patient is a minor)
- ✓ Discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan

I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. I authorize communication with the Provider and his authorized representatives by email and my email address is _____@_____. I understand I can revoke this authorization in writing at any time.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

Patient Signature _____ Date _____