



# Alabama Anesthesiology & Pain

OF NORTHEAST ALABAMA

## New Patient Form

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

Gender:  Male  Female Race: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Current Address: \_\_\_\_\_

Phone Numbers:

Home: \_\_\_\_\_  Cell: \_\_\_\_\_  Other: \_\_\_\_\_

Email Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact Relationship: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

### Primary Insurance

Insurance Name: \_\_\_\_\_ ID/Policy Number: \_\_\_\_\_ Group: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Policy Holder DOB: \_\_\_\_\_

### Secondary Insurance

Insurance Name: \_\_\_\_\_ ID/Policy Number: \_\_\_\_\_ Group: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Policy Holder DOB: \_\_\_\_\_

### Medical History

Have you previously had any type of surgery?  No  Yes

If so, please list the procedure and the year it was performed:

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Do you have any hardware in your body?  No  Yes

If so, please list here: \_\_\_\_\_

**Medical History Continued**

Please list any recent imaging related to your chronic pain:

Facility: \_\_\_\_\_ Type of Imaging: \_\_\_\_\_

Facility: \_\_\_\_\_ Type of Imaging: \_\_\_\_\_

Please list any medical problems you currently have, or have had in the past:

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Heart Disease                 | <input type="checkbox"/> COPD               | <input type="checkbox"/> Gout                   | <input type="checkbox"/> Stomach Ulcers        |
| <input type="checkbox"/> Heart Attack                  | <input type="checkbox"/> Asthma             | <input type="checkbox"/> Seizure Disorder       | <input type="checkbox"/> High Cholesterol      |
| <input type="checkbox"/> Congestive Heart Failure      | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Chronic Kidney Disease | <input type="checkbox"/> Chronic Constipation  |
| <input type="checkbox"/> High Blood Pressure           | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Kidney Stones          | <input type="checkbox"/> Migraines             |
| <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Cancer             | <input type="checkbox"/> Depression/ Anxiety    | <input type="checkbox"/> Anemia                |
| <input type="checkbox"/> Stroke/ Neurovascular Disease | <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Hypothyroidism         | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Sleep Apnea                   | <input type="checkbox"/> MRSA               | <input type="checkbox"/> Heartburn (GERD)       | <input type="checkbox"/> Fibromyalgia          |

Do you drink alcohol?  No  Yes, how much/ how often? \_\_\_\_\_

What is your current smoking status?  Never  Former, how much/how often? \_\_\_\_\_  
 Current, how much/ how often? \_\_\_\_\_

Please list any significant medical issues within your immediate family:

	Relationship to you
<input type="checkbox"/> Drugs/ Alcohol Abuse	_____
<input type="checkbox"/> Depression/ Mental Illness	_____
<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Other (please specify)	_____

Current Medication:

Name	Strength	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: Medication Reaction

_____	_____	_____
_____	_____	_____
_____	_____	_____

## **A word About Opioid Medications and the Treatment of Chronic Pain**

### ***Is AAAPC Pain Management Right for Me?***

***Please read and sign this document before continuing the packet.***

Your visit with the doctor at AAAPC is a consultation for him to determine the best approach to the treatment of your chronic pain. He makes determination of your treatment using all information available related to your history, examination, current physical condition, and by his evaluation of any tests or imaging (xray, MRI, etc) available. Those suffering chronic pain should not expect complete elimination of pain from treatment. A more achievable goal for most is the improvement in daily functioning and in quality of life. We will use every means available to try to help you reach and maintain that goal.

In times past, opioid medications were the primary treatment for chronic pain and used as first-choice medication and often used as the only form of treatment. A referral to pain management used to mean that your doctor felt that it was time for you to start an opioid medication for chronic pain such as hydrocodone, oxycodone, or morphine, just to name a few. We have learned over the last two decades that this approach was largely ineffective and dangerous for treating chronic pain and resulted in a great deal of harm to patients. It also contributed to the current opioid crisis making opioid overdose one of the leading causes of death nationwide.

Though we prescribe opioid medications to certain patients, it is not an appropriate choice for all patients. In fact, if we determine that non-opioid pain medicines, physical therapy, procedures for pain and surgical or orthopedics consultations have not been appropriately tried first, we will choose these approaches before considering the use of opioids in treatment.

If you have been prescribed opioids from another doctor for your chronic pain, this does not mean that we agree that it is the appropriate medication for you. Most often, there are numerous treatments that your doctor has not offered that need to be done first before ever adding an opioid medication. In general, opioids are now considered last-resort for the treatment of chronic pain. Opioids are severely discouraged and can be harmful in certain chronic pain conditions such as fibromyalgia and chronic headaches. Both conditions can be worsened when attempting to treat them with opioids.

If you believe that you may have a problem with opioids or think that you are addicted to them, be sure and discuss this with the doctor. This is a common problem, and we treat opioid dependency here. In fact, there are treatment options for opioid dependency, such as Suboxone, that are very effective for chronic pain.

If you do not agree with the treatment plan provided by the doctor, be sure to discuss your concerns with him during your consultation. If he chooses not to put you on the medication that you desire after discussing it with him and you believe that it is the only medication right for you, then you may follow-up at another practice for your treatment. You will not be refunded any payment that you made for your initial consultation if you disagree with the treatment plan.

I have read and understand the information above about the use of opioids for pain at AAAPC.

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

# AAAPC OF NORTH EAST ALABAMA

## Patient Agreement to Pain Treatment with Opioid Medication

**I recognize that the following are reasons why opioids may be immediately modified or discontinued.**

**Reasons include, but are not limited to, the following:**

- Multiple no shows, cancellations, or late appointments
- Failure to keep up with current account balances
- Abusive or disrespectful behavior towards staff
- Hostile or threatening behavior in order to obtain narcotics
- Evidence of buying or selling medications
- Drug or alcohol related arrest
- Appearing intoxicated at clinic visits
- Taking old opioid prescriptions
- Overdose resulting in hospitalization
- Overtaking medication
- Altering or forging prescriptions
- Obtaining narcotics from multiple prescribers
- Non-compliance with other forms of treatment. (i.e procedures, non-opioids, therapy, etc)
- Hoarding (stockpiling medication)
- Accepting a prescription for cough syrup with hydrocodone or codeine without calling and informing our clinic
- Requesting early medication refills due to overtaking
- Lost or stolen prescriptions
- Telephone reports that a patient is selling prescriptions
- Taking a family member or friends medications
- Showing up negative for prescribed medications on a urine drug screen
- Attempted alteration of a urine sample
- Illicit drugs in urine (cocaine, methamphetamines, heroin, etc.)
- Failing to show up for a pill count or drug screen within the allotted time frame
- Refusal to take drug screen in allotted time frame
- Failing to bring all medications to a pill count and drug screen
- Being inappropriate on pill counts

Patient Name: \_\_\_\_\_ DATE: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ DATE: \_\_\_\_\_

**AAAPC OF NORTH EAST ALABAMA**  
**Patient Agreement to Pain Treatment with Opioid Medication**

**Pain Treatment Program Statement**

We here at AAAPC of NEA are making a commitment to work with you in your efforts to get better. To help you in this work, we agree that:

We will help you schedule regular appointments for medicine refills. If we have to cancel or change your appointment for any reason, we will make sure you have enough medication to last until your next appointment.

We will make sure that this treatment is as safe as possible. We will check regularly to make sure you are not having bad side effects.

We will keep track of your prescriptions and test for drug use regularly to help you feel like you are being monitored well.

We will help connect you with other forms of treatment to help you with your condition. We will help set treatment goals and monitor your progress in achieving those goals.

We will work with any other doctors or providers you are seeing so that they can treat you safely and effectively.

We will work with your medical insurance providers to make sure you do not go without medicine because of paperwork or other things they may ask for.

If you become addicted to these medications, we will help you get treatment and get off of the medications that are causing you problems safely, without getting sick.

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Patient Name

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Patient Signature

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Date

**AAAPC OF NORTH EAST ALABAMA  
Notice of Privacy and Your Rights**

The following is a statement of your rights to your protected health information:

You have the right to inspect, obtain 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 in use in a civil, criminal, or administrative action or proceeding; and protected health information that is subjected to a law that prohibits access to said 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 purpose 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 requests must state the specific restrictions requested and to whom you want the restrictions to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes that it is in your best interest to permit use and disclosure of your protected health information, then it will not be restricted. You then have the right to use another healthcare professional/ provider.

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

You have the right to have your physician 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 these changes. You have the right to object or withdraw as provided in this notice.

You may complain to us or 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 their protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

Your signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

\_\_\_\_\_

Patient Name

\_\_\_\_\_

Signature

\_\_\_\_\_

Date