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PAIN CLINIC

General Information:

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex:_____ SSN: _____

Home Address: _____

Mailing Address (If Different than Above): _____

Email Address: _____

Home Phone Number:_____ Cell Phone Number: _____

Is it OK to leave a message? ☐ 1= Yes ☐ 2 =No

Language: _____ Race: _____ Ethnicity: _____

Marital Status (Please Circle One of the Following): Single Married Relationship Widowed

Spouse/Partner:_____ Contact Number: _____

In Case of Emergency:

Name:_____ Relationship:_____

Home Phone Number: _____ Cell Phone/Other Number: _____

Is it OK to leave a message? Yes____ No_____

Is the Emergency Contact aware of your addiction? Yes____ No_____
☐ 2 = No

Do you have a valid form of government issued id?
☐ 1 = Yes ☐ 2 = No

How did you hear about us? ( ) Google ( ) Website ( ) Signage ( ) Billboard

Or who can we thank for sending you to us _____

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Insurance Information:

Primary Insurance: _____

Policy Number:_____Group Number: _____

Secondary Insurance: _____

Policy Number:_____Group Number: _____

How did you hear about the clinic?

☐ 1 = Spouse/partner ☐ 2 = Friend ☐ 3 = Healthcare Provider 4 = Flyer

☐ 5 = Parent/guardian ☐ 6 = Hotline 7 = Treatment Locator ☐ 8 = Other: _____

What is your preferred name and pronouns? (e.g., he/him/his, she/her/hers, they/their/theirs): _____

Are you currently pregnant?

☐ 1 = Yes
☐ 2 = No
☐ 3 = Don't Know
☐ 4 =Other_____

Transportation

How would you get to the program if you needed to get here?
☐ 1 = I would drive
☐ 2 = I would use public transportation
☐ 3 = I would use a ride share/taxi
☐ 4 = I would walk
☐ 5 = I would get a ride from a family/friend
☐ 6 = I would use medical transportation
☐ 7 = I would need a PT1
☐ 8 = Other _____
☐ 9 = Unable to travel to clinic. Explain: _____

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Housing

Have you spent one or more weeks on the street or in a shelter in the last three months?

☐ 1=Yes ☐ 2=No

What type of place are you living in now?

☐ 1 = In a house or apartment I own or rent
☐ 3 = In a house or apartment owned or rented by family or friends
☐ 4 = Hotel
☐ 5 = Alcohol or substance use treatment program
☐ 6 = Shelter
☐ 7 = Street or car
☐ 8 = Sober Home
☐ 9 = Other: _____
☐ 10 = Prefer not to say

Who do you live with at this time?

☐ 1 = I live alone.
☐ 2 = I live with my partner/significant other.
☐ 3 = I live with family members.
☐ 4 = I live with friends/acquaintances.
☐ 5 = Other: _____

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Substance Use History

	Age of Initiation	*Date of Most Recent Use*	*Frequency*	*Route of administration*	*Amounts Used*	*Currently Using?*
Opioid *__Heroin* *__Fentanyl* *__Oxycodone product* *__Buprenorphine* *__Methadone* *__Other opioid*						
Benzodiazepine						
Alcohol						
Cocaine (including crack cocaine)						
Amphetamines (including methamphetamine)						
Tobacco/nicotine *Vaping*						
Cannabis						
Other (e.g., Kratom, K2, synthetic cannabinoid, PCP)						

Have you ever shared injection or other substance use supplies? ☐ 1= Yes ☐ 2 = No

Have you ever belonged to a syringe service program? ☐ 1= Yes ☐ 2 = No

Do you have access to clean/new injection supplies? ☐ 1= Yes ☐ 2 = No

Do you have naloxone? ☐ 1= Yes ☐ 2 = No

Are you willing to carry naloxone? ☐ 1= Yes ☐ 2 = No

Have you ever overdosed? ☐ 1= Yes ☐ 2 = No

Number of lifetime overdoses: _____

Was naloxone administered? ☐ 1= Yes ☐ 2 = No

Have you ever been hospitalized due to an overdose? ☐ 1= Yes ☐ 2 = No

Recovery History

What was the longest period of time that you have been in recovery?

_____

When was this? _____

What were you doing at that time for your recovery?

_____

Addiction Treatment History

Have you ever engaged in treatment for a substance use disorder? ☐ 1= Yes ☐ 2 = No

If yes, how many times to each type?

_____ Detoxification Program
_____ Methadone Maintenance
_____ Buprenorphine Maintenance
_____ Naltrexone (oral or injectable)
_____ Injectable Buprenorphine (Sublocade® or Brixadi®)
_____ Residential (e.g., Halfway House)
_____ Section to Treatment
_____ Intensive Outpatient Program
_____ MOUD while incarcerated

Do you attend peer support meetings? (Check all that apply)

☐ 1 = AA
☐ 2 = NA
☐ 3 = Smart Recovery
☐ 4 = Other: _____
☐ 5 = None

How many meetings do you attend each week?
☐ 1 = 1-2 week
☐ 2 = 3-4 week
☐ 3 = 5-6 week
☐ 4 = None
☐ 5 = Other: _____

Do you have a sponsor? ☐ 1= Yes ☐ 2 = No

Do you have any history of a process addiction?
☐ 1 = Gambling
☐ 2 = Sex
☐ 3 = Shopping
☐ 4 = Eating disorder (overeating, bulimia, anorexia)
☐ 5 = Other: _____
☐ 6 = No

Comments: _____

Treatment History

Have you ever engaged in a Methadone Maintenance program? ☐ 1 = Yes ☐ 2 = No

Where and when did you engage in Methadone Maintenance?

_____

How long were you on Methadone Maintenance? _____

What was your dose? _____

Did you ever earn take-homes? ☐ **1 = Yes** ☐ **2 = No**

If you are no longer on methadone treatment, why did you stop?

_____

If currently engaged in methadone treatment, who is the primary contact person?

_____

Are you willing to sign a consent for release of information so that we can communicate with your opioid treatment program about your treatment plan?
☐ 1 = Yes ☐ 2 = No

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Buprenorphine History

Have you ever been prescribed buprenorphine before?
☐ 1 = Yes ☐ 2 = No
If yes:

Where and when you prescribed buprenorphine? _____

What was your dose? _____

Did you ever receive an extended-release buprenorphine injection? If yes, please provide details:

_____

Why did you stop taking buprenorphine? _____

Naltrexone History

Have you ever been prescribed naltrexone before?
☐ 1= Yes ☐ 2 = No

If yes:

Where and prescribed naltrexone: _____

Did you ever receive an extended-release naltrexone injection? If yes, please provide details:

_____

Why did you stop naltrexone treatment? _____

Mental Health History

Are you currently seeing a psychiatrist, psychologist, or counselor for a mental health condition?
☐ 1 = Yes ☐ 2 = No

Where do you see your psychiatrist, psychologist, or counselor? _____

What is their name? _____

How often do you see them? _____

Are you currently taking any medication for this/these conditions(s)?
☐ 1 = Yes ☐ 2 = No

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If yes, what medications are you taking? _____

Are you willing to sign a consent for release of information so that we can communicate with your psychiatrist, psychologist, or counselor about your treatment plan?
☐ 1 = Yes ☐ 2 = No

Have you ever been hospitalized for a mental health condition?
☐ 1 = Yes ☐ 2 = No

Have you ever attempted to end your life or to hurt yourself?
☐ 1 = Yes ☐ 2 = No

How many times did you try to end your life or to hurt yourself? _____

Do you currently have thoughts about hurting yourself or ending your life?
☐ 1 = Yes ☐ 2 = No *(If no, skip to homicide question)*

If yes:
Do you currently have a plan for how you would hurt yourself or end your life?
☐ *1 = Yes* ☐ *2 = No*

Do you have the means to carry out your plan?
☐ *1 = Yes* ☐ *2 = No*

Have you ever attempted or thought about homicide (killing someone else)?
☐ *1 = Yes* ☐ *2 = No (If no, skip to health status)*

If yes:
Are you presently thinking about killing someone?
☐ *1 = Yes* ☐ *2 = No*

Do you have the means to carry this out?
☐ *1 = Yes* ☐ *2 = No*

If patient screens positive to any of the above italicized questions, staff member conducting the screener must implement institutional protocols regarding acute suicidal ideation or homicidal ideation.

Health Status

Have you ever been diagnosed with any of the following medical conditions? Mark all that apply.

☐ 1 = Head Trauma/Brain Injury (specify type): _____
☐ 2 = HIV ➔ If yes, are you currently in care? ☐ 1 = Yes ☐ 2 = No

☐ 3 = Hepatitis C ➔ If yes, have you been treated? ☐ 1 = Yes ☐ 2 = No
☐ 4 = Severe Liver or Kidney Disease ➔ If yes, are you currently in care? ☐ 1= Yes ☐ 2 = No
☐ 5 = Chronic Pain Syndrome (specify type): _____
☐ 6 = Other (specify type): _____
☐ 7 = None

Health Care Provider Information

Where do you access most of your healthcare?
☐ 1 = Emergency department
☐ 2 = Primary care clinic
☐ 3 = Walk-in clinic (e.g., Minute Clinic, urgent care setting)
☐ 4 = Shelter-based clinic or street outreach team
☐ 5 = Community program (e.g., Engagement center for persons experiencing homelessness)
☐ 6 = Criminal-legal setting (e.g., jail or prison)
☐ 7 = Other (specify type): _____
☐ 8 = None

Do you have a primary care provider? ☐ 1 = Yes ☐ 2 = No
If yes, can you tell us their name and where they are located?

_____

Social History

Are you currently employed? ☐ 1 = Yes ☐ 2 = No

If yes, what do you do for work? _____

What is a typical work schedule (in terms of days and hours working per week)?

_____

Have you ever spent any time in jail/prison? ☐ 1 = Yes ☐ 2 = No

If yes, what is the longest period of time you spent in jail/prison? _____

When was your most recent incarceration? _____

Are you on probation or parole? ☐ 1 = Yes ☐ 2 = No

Do you have any outstanding legal issues? ☐ 1 = Yes ☐ 2 = No

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Social Support

Do you have any support persons in your life? ☐ 1 = Yes ☐ 2 = No

If yes, who would you say are you support persons?

☐ 1 = Significant other/partner
☐ 2 = Parent
☐ 3 = Friend/acquaintance
☐ 4 = Employer/supervisor
☐ 5 = Other: _____

If you are in a relationship, do you feel safe (emotionally, physically, and mentally) with your partner?
☐ 1 = Yes ☐ 2 = No

Does your support person(s) know about your substance use disorder? ☐ 1 = Yes ☐ 2 = No

Do any other family members have a history of substance use disorder?
☐ 1 = Yes ☐ 2 = No

Treatment Goals

Can you tell me what your goals are for treatment?

_____

_____

_____

_____

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PAIN CLINIC

WHERE YOUR FAMILY BECOMES OURS

Medical History:

Surgery:	Date:

Broken Bones:

Hospitalizations:

Date:	Hospital	Reason for Hospitalization:

P: (575) 303-2929 530 N Telshor Blvd. Ste A., Las Cruces, NM 88011 Care@eliteprimarynm.com

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WHERE YOUR FAMILY BECOMES OURS

Family History:

Mother: Living Deceased Age/Cause of Death: _____

Medical History: _____

Father: Living Deceased Age/Cause of Death: _____

Medical History: _____

Number of Siblings: _____ Number of Children: _____

Do you have any family in the local area? Yes No

P: (575) 303-2929 530 N Telshor Blvd. Ste A., Las Cruces, NM 88011 Care@eliteprimarynm.com

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WHERE YOUR FAMILY BECOMES OURS

Patient Authorization for the Release of Medical Records

Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

I hereby authorize **Elite Primary Care,** to request the medical records from

_____

Records requested are as follows:

___Lab Reports, X-Rays, EKG Reports

___History and Physical, Echocardiograms

___Nuclear/Regular Stress Tests

___ Holter Monitors

___Cath/ PTCA/ Stent Reports

___All Records

___Other: _____

_____

I specifically release of information relating to:

___Substance abuse (including alcohol/drug abuse)

___STD related information (HIV and AIDS related testing)

___Mental health (including psychotherapy notes)

_____
Signature of patient and Legal Guardian

I understand that I have the right to revoke this authorization at anytime. I also understand that I must do so in writing and present my written revocation to Elite Primary Care at the above address. I understand that the revocation will not apply to my insurance company when insurers contest a claim under my policy.

_____ _____ _____
Signature of patient and Legal Guardian **Date** **Relationship to Patient**

P: (575) 303-2929 **530 N Telshor Blvd. Ste A., Las Cruces, NM 88011** **Care@eliteprimarynm.com**

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WHERE YOUR FAMILY BECOMES OURS

Release of Medical Information

I, _____ hereby give authority to_____,
Patient's Name Name and Relationship

to have access to the indicated medical information below, effective _____.
Date

___**Procedures**

___**Medications**

___**Appointment times and cancellations**

___**Patient history**

___**All medical information may be released**

I understand that I may request to cancel this release of information in writing for whatever reason, at anytime and that information about me or anything pertaining to me will not be released to anyone but the person mention above. I also understand that Elite Primary Care cannot be held liable for any misuse of information obtained by the person mentioned above.

_____ _____ _____
Signature of patient and Legal Guardian **Date** **Relationship to Patient**

_____ _____
Witness Printed Name and Signature Date

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CONTROLLED SUBSTANCE TREATMENT AGREEMENT

Patient: _____ **Date:** _____

The purpose of this contract is to define the expectations between the prescriber:
Dr. _____ and the patient regarding the use of narcotic medications.

I understand that I have a chronic pain syndrome requiring the use of narcotics for the control of the pain. In addition, I understand that the use of chronic narcotic medication carries the risk of addiction as well as side effects from the medication. I understand that narcotics may impair my ability to operate a motor vehicle or heavy equipment.

In order to reduce the chances of abuse of the medication, certain parameters regarding the prescription are agreed to:

1. **I will not use the medicines at doses higher than prescribed.**
2. **I will not ask for or receive narcotic prescriptions from other medical providers, except as authorized by my physician.**
3. **I will not ask for early prescription refills except under the most adverse conditions.**
4. **No replacements will be provided for lost medications or prescriptions.**
5. **If an early refill is granted for reasons of travel, etc., the next refill will be delayed by an amount of time equal to the number of days early the refill is given.**
6. **I understand that my physician will need to see me for regularly scheduled visits to follow up on my chronic pain issues. It is my responsibility to schedule the appointments so that I do not run out of medication.**
7. **I will request medication refills at least 3 business days ahead of the time I will run out.**
8. **I agree to release information from all pharmacies where I obtain medications. I will choose one pharmacy to fill my pain medications and I will notify my physician if I change pharmacies.**
9. **I will consent to random drug testing.**
10. **No refills will be made at night, on holidays or weekends. I will no request refills from on-call physician.**

I have been informed that I may not take other drugs such as tranquilizers, sedatives, or antihistamines without first consulting with my physician. I understand that I should not mix my medications with alcohol. The combination use of the above drugs may produce profound sedation, respiratory depression, and in worst cases, death.

Failure to abide by these parameters will be grounds for termination of the prescription of narcotics by
Dr. _____ and may result in **termination** from this practice.

Medication: _____ Dosage: _____ Monthly Quantity: _____
Pharmacy: _____ Telephone #: _____

I have read, understand and agree to follow the rules of this agreement. I authorize a copy of this agreement to be released to my pharmacist.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

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HIPAA Compliance Patient Consent Form

Our notice of privacy practices (on the back) provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

Your rights:

- Get a copy of your health and claims records
- Ask us to correct health and claims records
- Request confidential communications
- Ask us to limit what we use or share
- Get a list of those with whom we've shared information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you feel your rights are violated

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

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PAIN CLINIC

WHERE YOUR FAMILY BECOMES OURS

Patient Financial Responsibility

As a courtesy to our patients, we have enrolled in numerous managed care insurance programs. We are pleased to be able to provide this service to you, and we will make every effort to verify coverage and bill your insurance company correctly. However, it is not possible for us to keep track of all the individual requirements of each plan.

It is the responsibility of each patient to know the details of his or her insurance plan in addition to any lapses in insurance coverage. Any charges that occur as a result of insurance plan restrictions or lapses in coverage are ultimately the patient's responsibility. Unfortunately, if you do not inform us of special requirements required by your plan and we order medically necessary services, such as lab work, hospitalization, or supplies that are not covered by your plan; we may bill you directly for those charges. If current insurance coverage cannot be verified prior to each appointment, payment will be due at the time of service.

The office bills only for services performed by our providers. Laboratories are separate entities and will bill you or your insurance company for services that are performed. If you have any questions about your laboratory bill please contact them or your insurance company directly

Providing the highest quality of medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance plan guidelines, whenever possible. With your cooperation you should be able to receive all of the insurance benefits you are entitled to, and we will be able to focus our efforts on striving to provide you with excellent medical care. Elite Primary Care offers a 50% discount for uninsured patients and this is payment is required at the time service is rendered.

We may charge an upfront $35.00 administrative fee for completing forms such as disability or insurance and medical records requests. Please be aware that these services may require up to seven to ten days to complete.

If an account is not paid in full within 90 days, a 25% collection-processing fee will be added to the outstanding balance and will be turned over to a collection company for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

Checks returned for any reason will be assessed a $35.00 service fee in addition to the amount of the check. NSF checks must be redeemed with certified funds and checks will no longer be permitted as payment.

We attempt to contact every patient to remind them of their appointment; however, it is the responsibility of the patient to arrive for their appointment on time. Elite Primary Care also reserves the right to charge a no-show fee for patients who miss appointments without calling to cancel within 24 hours of the appointment. The current no-show fee is $25.00 and is subject to change without notice.

I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by myself.

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PAIN CLINIC

WHERE YOUR FAMILY BECOMES OURS

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operation
- The practice reserves the right to change the privacy policy as allowed by law
- The patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease
- The practice may condition receipt of treatment upon execution of this consent

BY SIGNING BELOW, I ACKNOWLEDGE I HAVE RECEIVED A COPY, READ, AND UNDERSTAND THE FOLLOWING POLICIES. I ACCEPT THE RIGHTS AND RESPONSIBILITIES OUTLINED WITHIN THEM:

- Patient Rights Regarding Medical Records
- HIPPA Policy and Responsibilities
- Patient Financial Responsibility including collections, no-show policy

This consent was signed by: _____

Please PRINT Name

Signature: _____ Date: _____

Witness: _____ Date: _____