



Welcome to Advanced Pain Medicine Associates. Your appointment is scheduled for:

Date: \_\_\_\_\_ Time: \_\_\_\_\_

In this packet, you will find all of the patient forms required by Advanced Pain Medicine Associates. Please **complete at home and bring with you to your appointment.** (We will have to reschedule your appointment if you have not filled out these forms completely by the time of your appointment.) Any missed, rescheduled or cancelled appointment less than 24 hour notice will be charged \$30.00

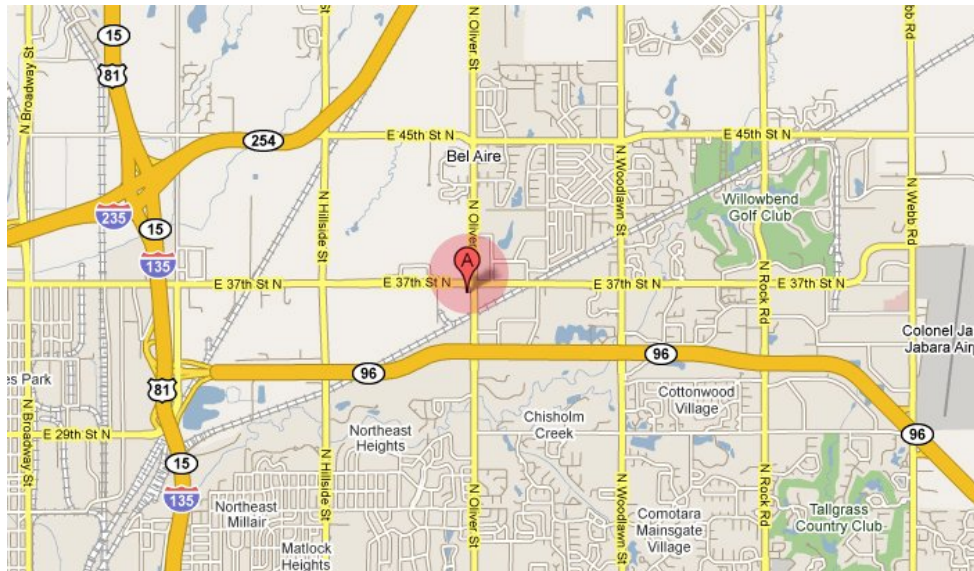
You **must** bring the following items with you to your appointment:

1. All insurance information (including worker's comp info).
2. Your authorization if you have an HMO insurance plan.
3. Any X-Ray's, MRI's, or CT Scan reports and films.
4. All medication that you are currently taking.
5. Any other information that you think relevant.

**Please arrive 30 minutes prior to your appointment.**

Our address is:

3715 N. Oliver  
Wichita, Kansas 67220  
Our phone #: (316) 942-4519  
Fax: (316) 942-4655



**From I-35 North/South** (Kansas City/Oklahoma City) (Turnpike) – Exit off I-35 at **exit 53** toward KS-96/WICHITA (Turnpike Toll). Merge onto KS-96 W toward HUTCHINSON. Take the OLIVER exit. Turn **RIGHT** onto N OLIVER ST. Proceed ¼ mile to facility on left. Advanced Pain Medicine Associates is located at the corner of Oliver and 37<sup>th</sup> street.

**From 135 South** (South Wichita) – Merge onto KS-96 E via **EXIT 10A**. Take the OLIVER exit. Turn **LEFT** onto N OLIVER ST. Proceed ¼ mile to facility on left. Advanced Pain Medicine Associates is located at the corner of Oliver and 37<sup>th</sup> street.

**From 135 North** (Hutchinson) – Merge onto KS-96 E via **EXIT 10**. Take the OLIVER exit. Turn **LEFT** onto N OLIVER ST. Proceed ¼ mile to facility on left. Advanced Pain Medicine Associates is located at the corner of Oliver and 37<sup>th</sup> street.

**From 235 South** – Merge onto I-135 S/US-81 S/KS-15 S/KS-96 E via **EXIT 16A**. **Continue .8 Miles** and Merge onto KS-96 E via **EXIT 10**. Take the OLIVER exit. Turn **LEFT** onto N OLIVER ST. Proceed ¼ mile to facility on left. Advanced Pain Medicine Associates is located at the corner of Oliver and 37<sup>th</sup> street.

ADVANCED PAIN MEDICINE ASSOCIATES

\*\*Providing Hope for Pain Sufferers\*\*

3715 N. Oliver, Wichita, KS 67220 Tel. 316.942.4519 Fax 316.942.4655

JON C. PARKS M.D. GEORGE. G. FLUTER M.D. JARED T. SCOTT M.D.

Rita Simpson P.A. Lien Graham P.A. Rhonda Janzen ARNP

AUTHORIZATION TO RELEASE / DISCLOSE HEALTH INFORMATION

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Social Sec#: \_\_\_\_\_

- 1. I authorize the use or release/disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the release/disclosure to:

Provider Name: \_\_\_\_\_

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

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

- 3. This information may be disclosed or released to the following individual or organization:

4. For the purpose of: \_\_\_\_\_

- 5. The type and amount of this information is to be used or released/disclosed as follows:

◇ Entire Record

◇ Accounting / Billing Information

◇ Physical Therapy

◇ Diagnostic / Imaging Reports: \_\_\_\_\_

◇ Lab Reports: \_\_\_\_\_

◇ Other { Specify}: \_\_\_\_\_

- 6. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome {AIDS} or human immunodeficiency virus {HIV}. It may also include information about behavioral or mental health services and/or treatment for alcohol and drug abuse. Initial: \_\_\_\_\_
7. I understand that treatment is not conditional upon the execution of this authorization. I understand that if the person or entity receiving this information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.
8. I understand that fees may be charged for preparing and sending copies of records.
9. APMA is not responsible for completeness, legibility or omittance caused by the copying of any medical records from another institution.
10. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the HIPAA compliance officer at APMA. I understand revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire 1 year from the date of signature.

Signature of Patient or Legal Representative \_\_\_\_\_

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

If Signed by Legal Representative, Relation to Patient \_\_\_\_\_

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

{42 C.F.R.Part2: Prohibition of Redislosure: The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient}.

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NEW PATIENT EVALUATION

Today's Date \_\_\_\_\_

Patient's Full Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  Married  Single \_\_\_\_\_

Home# \_\_\_\_\_ Work# \_\_\_\_\_ Cell# \_\_\_\_\_

Address \_\_\_\_\_ City/St. \_\_\_\_\_ Zip \_\_\_\_\_

Who referred you to our practice? \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone# \_\_\_\_\_

Allergies/Reactions \_\_\_\_\_

Current Medications:

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

Previous Surgeries:	Type	Date	Surgeon
---------------------	------	------	---------

- |          |       |       |       |
|----------|-------|-------|-------|
| 1. _____ | _____ | _____ | _____ |
| 2. _____ | _____ | _____ | _____ |
| 3. _____ | _____ | _____ | _____ |
| 4. _____ | _____ | _____ | _____ |
| 5. _____ | _____ | _____ | _____ |

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

MEDICAL HISTORY

			<u>You/Family</u>	<u>Who</u>	<u>When</u>
Heart Attack	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Chest Pain	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart Murmur	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart Palpitations	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Irregular Heart Beat	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Congestive Heart Failure	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Shortness of Breath	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
High Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Low Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Headache	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Stroke	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Fainting	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Scarlet Fever	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Rheumatic Fever	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Lupus Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
HIV/AIDS	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hepatitis/Jaundice	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Asthma/Emphysema	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Bronchitis	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Chronic Cough	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Lung Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Tuberculosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Pleurisy	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Pneumonia	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Thyroid Disease/Trouble	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Epilepsy/Seizures/Convulsions	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Kidney Disease/Dialysis	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cancer/Type _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Leukemia	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cirrhosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Swollen/Painful Joints	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Phlebitis/Blood Clots	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Ulcer	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Psychiatric History	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Are you:  Right handed  Left handed

Domestic Situation:

With whom do you currently reside with? \_\_\_\_\_

Are there any substance abuse issues in the household?  No  Yes

If yes to the above, explain \_\_\_\_\_

Are you currently able to take care of yourself?  No  Yes

If no, please give the name and phone of your care giver \_\_\_\_\_ # \_\_\_\_\_



Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Please list any tests and studies done in relation to your chronic pain.

Test/Studies	Month/Year done	Results

• Indicate which of the following describes your usual current quality of pain.

- Sharp
- Dull
- Aching
- Shooting
- Burning

• Indicate your usual level of pain

- Mild
- Uncomfortable
- Distressing
- Very Severe
- Unbearable

• How often are you confined to bed because of your pain?

- Never
- About once a week
- Daily, or more often
- Less than once a week
- Several times per week

• What makes your pain worse?

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Nothing          | <input type="checkbox"/> Sitting      |
| <input type="checkbox"/> Walking          | <input type="checkbox"/> Cold and Ice |
| <input type="checkbox"/> Bending/Twisting | <input type="checkbox"/> Medication   |
| <input type="checkbox"/> Lying down       | <input type="checkbox"/> Heat         |
| <input type="checkbox"/> Standing         | <input type="checkbox"/> Exercise     |

• Does the pain stop when you quit the above activities?

- Always
- Sometimes
- Never

• What makes your pain better?

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Nothing          | <input type="checkbox"/> Sitting      |
| <input type="checkbox"/> Walking          | <input type="checkbox"/> Cold and Ice |
| <input type="checkbox"/> Bending/Twisting | <input type="checkbox"/> Medication   |
| <input type="checkbox"/> Lying down       | <input type="checkbox"/> Heat         |
| <input type="checkbox"/> Standing         | <input type="checkbox"/> Exercise     |

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

• Is your pain;

- Constant
  - Intermittent
- 

• Is your pain;

- Worse in the morning after getting up
  - Worse in the evening after being up all day
  - Worse at night when trying to sleep
  - No pattern to the pain
- 

• Do you experience pain;

- Everyday
  - 1 to 2 days per week
  - 3 to 4 days per week
  - 5 to 6 days per week
  - Sometimes a week may go by with no pain
- 

• What other things have you tried for your pain?

- Physical/Occupational Therapy
  - TENS unit
  - Biofeedback
  - Anti-inflammatory pills
  - Acupuncture
  - Narcotic pills
  - Chiropractic care
- 

• Do you ever experience any weakness?

- No       Yes      If "Yes", please explain \_\_\_\_\_
- 

• Have you had in the past or do you currently have any loss of control of your bowel or bladder function?

- No       Yes      If "Yes", please explain \_\_\_\_\_
- 

• Do you have any areas of numbness?

- No       Yes      If "Yes", please explain \_\_\_\_\_
-

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

- Rate your level of pain. “0” is equal to no pain and “10” is equal to the worst pain you have ever experienced.

No Pain- 0 1 2 3 4 5 6 7 8 9 10 Worst Pain-

- Using the symbols below, indicate on the diagram where you have pain.

XXXX = Shooting/Stabbing pain

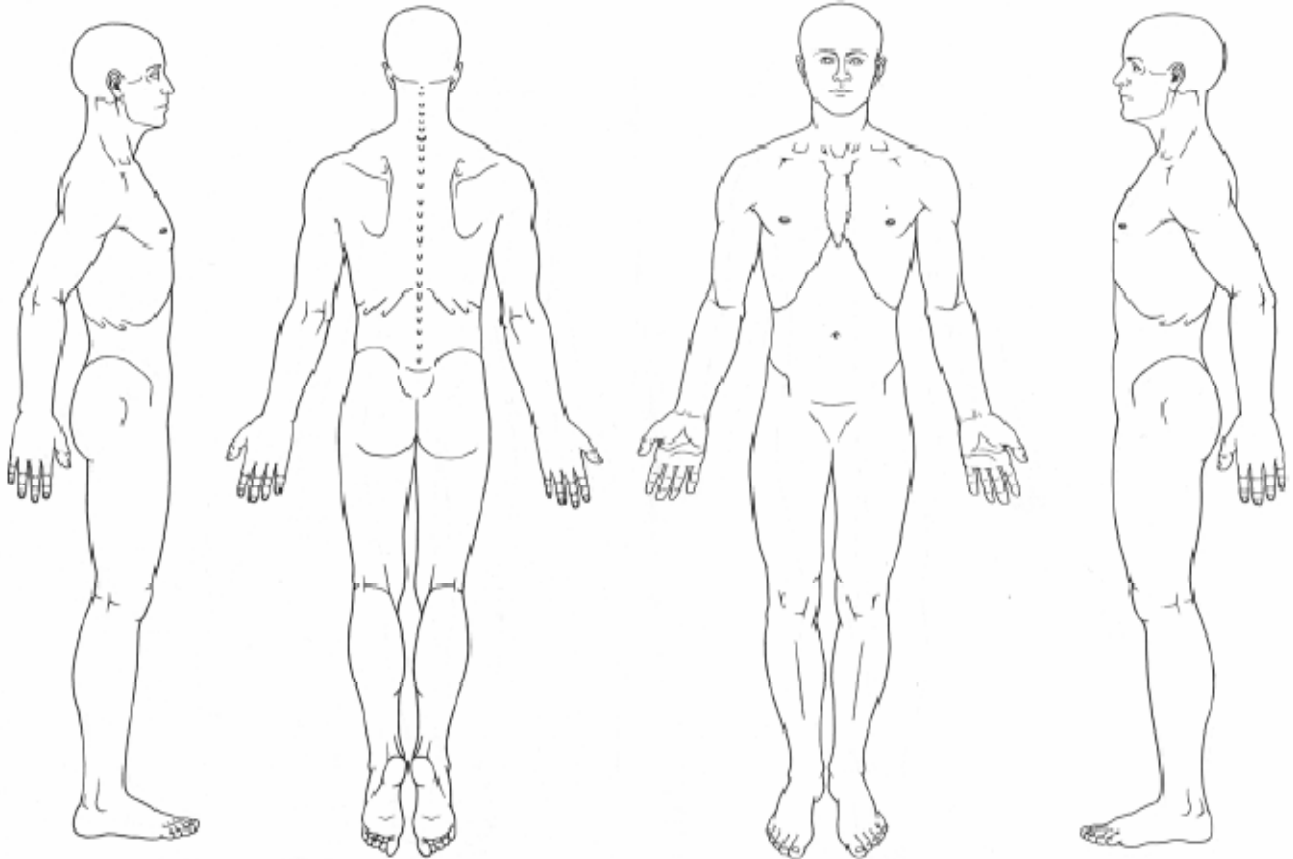
///// = Numbness

+++++ = Burning Pain

\*\*\*\*\* = Achy Pain

0000 = Pins & Needles

#### = Other Pain



**ADVANCED PAIN MEDICINE ASSOCIATES  
3715 N. OLIVER  
WICHITA, KS 67220**

**PATIENT FINANCIAL POLICY**

Advanced Pain Medicine Associates is committed to providing you with the best possible care and will be happy to discuss questions regarding our policies, fees or your responsibilities at any time. A clear understanding of the "Patient Financial Policy" is important for the entire scope of your care.

All patients must complete our "Patient Information Form" before seeing a provider. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance, phone changes etc....)

**INSURANCE:** As a courtesy we will file your insurance claims. We will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, co-payments, non-covered charges and "usual and customary" charges. We will supply factual information as necessary.

**REGARDING HMO'S, PPO'S AND MANAGED CARE PROGRAMS:** It is your responsibility to obtain referral forms required by your particular insurance company. We will do our best to remind you when a referral is due, but ultimately you are required to keep track of the referrals on hand. If you present to the office without a current referral you will be asked to sign an advanced beneficiary form and you will be responsible for the bill or reschedule the appointment.

**COPAYS:** You are expected to pay your copay prior to seeing your provider. If you are unable to pay, you will be required to reschedule your appointment.

**REGARDING PATIENTS WITH NO INSURANCE:** We will not set up payment arrangements, therefore if you do not have coverage you will be required to pay for your service prior to seeing the provider.

**REGARDING MEDICARE:** Our providers are all participating with Medicare. We will file all claims with your Medicare and your supplemental insurance, if applicable. If you do not have a supplemental insurance you will be responsible for the co-insurance and/or deductible amount following the processing of your claim.

**REGARDING MEDICAID:** Our providers do not participate in any form of Kansas Medicaid or Medikan program. You are considered a cash pay patient and the payment is required on the date of service.

**FORM COMPLETION:** A charge of \$20.00 is due before the forms will be completed. (Disability, FMLA, Physician statements, etc.)

**WORKERS COMPENSATION/AUTO LIABILITY:** Our office requires authorization prior to the initial visit. We will do our best to obtain the authorization prior to the visit. You are also required to provide us with Health Insurance coverage in case your workers' comp or auto denies the service. If you do not have health insurance you may be asked to pay for the service in advance. Any claims paid after we have received your payment will be refunded promptly.

**COPAYS/DEDUCTIBLES/GUARANTOR RESPONSIBILITY:** Our office requires payment in full for any balance not paid by insurance within three months from the date of service. If you are unable to pay your balance in full it is the patient's responsibility to make arrangements with our business office.

**RETURNED CHECKS:** There is a \$30 returned check fee payable in cash or money order.

**NO SHOW APPOINTMENTS:** You are expected to show for the appointments made for us to adequately provide care. Failure to provide notice of 24 hours that you will not be keeping your appointment may result in termination from the practice.

**I understand I may be charged for any appointments missed without giving 24 hours prior notice.**

**By signing this from I acknowledge that I have read this policy and understand the terms outlined above. Failure to comply with the financial policy of APMA may result in suspension of services or dismissal.**

\_\_\_\_\_  
**Patient Name – please print**

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

PATIENT MEDICATION CONTRACT

This contract is between [PRINT PT. NAME]: \_\_\_\_\_ and the providers and staff of Advanced Pain Medicine Associates indicating my agreement and understanding to follow office protocol regarding the use of pain controlling medications as well as all other prescriptions prescribed by these providers. Both the provider and patient agree this contract is essential in maintaining the trust and confidence necessary in a Doctor/Patient relationship. As a patient of APMA, I hereby agree to take an active role with the providers and staff to help manage my pain. I understand following the medical advice of the providers and clinical staff at APMA is key to achieving any reduction in pain levels as well as any improvement in functionality as well as my quality of life.

\*\*\* Signing this contract acknowledges my full understanding of the terms outlined below and my agreement to accept these terms as a patient of ADVANCED PAIN MEDICINE ASSOCIATES \*\*\*

1. I agree and understand that I am not to use ANY illegal controlled substances such as Marijuana, Cocaine etc...

THE USE OF ANY ILLEGAL DRUGS WILL BE SUBJECT TO IMMEDIATE TERMINATION FROM THIS PRACTICE.

2. I will not share, sell or trade my medication for money, goods or services.
3. During the course of my treatment with APMA it is my responsibility to maintain current contact information in my file so the doctors and staff of APMA can communicate my care to myself or the designated party signed below. Failure to provide changes could be subject to discharge from the practice.
4. I will not obtain controlled substances from any other physician with out informing them first of my signed medication contract with APMA. The providers at APMA will approve any arrangements for medication use between this practice and any outside physician's office to insure there is no duplication of medications.
5. I fully understand that I alone will be held responsible for my medications and will secure them from loss or theft. Failure to do so will result in the absence of those particular medications until the next refill date. I understand APMA's office policy:

LOST OR STOLEN MEDICATIONS WILL NOT BE REFILLED UNDER ANY CIRCUMSTANCE.

6. I agree to waive any applicable privilege, right of privacy or confidentiality with respect to the prescribing of my pain medications. I authorize the providers at APMA and my designated pharmacy to fully cooperate with any city, state or federal law enforcement agency, as well as the Kansas Board of Pharmacy, with the investigation of any possible misuse, sale or other diversion with my pain medications. APMA has my full permission to provide a copy of this agreement to my pharmacy and referring physician's office.
7. The providers at APMA have my permission to obtain information of all medications from any pharmacy with relation to my care in pain management by this office.
8. I agree to use my medication as documented in my chart and prescribed by my provider. I UNDERSTAND THAT I AM NOT TO SELF ADJUST MY MEDICATIONS without calling my provider for prior approval.
9. I understand my medication regimen is documented in my permanent record, which includes any prior approved adjustments. I understand self-adjustment of my medications without documented approval is a clear violation of this contract and grounds for termination from this practice.
10. I agree to monthly follow up visits including pill counts when being prescribed narcotic medication to determine my compliance with medications.
11. I fully understand this office may perform RANDOM DRUG SCREENS AND AGREE to submit to testing if requested by my provider to determine compliance with my pain medication regimen.
12. Should termination of my medical care be deemed necessary, I understand my pain medications may be replaced with medications to aid in the symptoms of withdrawal.

13. I hereby declare [Pharmacy] \_\_\_\_\_ [Phone #] \_\_\_\_\_ as my choice for all pain medications. I understand changing pharmacies for any reason requires notifying APMA before receiving any scripts.