Cedar Rapids pain associates

Please complete the attached new patient paperwork and bring it with you to your appointment.

- Please only compete the highlighted areas on the first 4 pages.
    - The **first two pages** look similar but they are different. One is to Obtain records and the other is to Release records. We will keep these consents on file and this allows us to obtain and release records for you upon your request.

- Please complete all sections of the last 4 pages.
    - **Family History** only relates to immediate family members – your mother, father, brothers, sisters, and children.
    - **Review of Systems** includes symptoms you have had in the last 30 days (1 month).

# CONSENT TO OBTAIN INFORMATION

Cedar Rapids pain associates

4205 Glass Road N.E. Cedar Rapids, Iowa 52402
Phone: 319-294-0094 Fax: 844-464-3303

**Please PRINT all (except signature at bottom) and provide complete information in each section.**

Patient's Legal Name _____ Date of Birth _____

By signing this form I am authorizing Advanced Spine & Rehab Center/Cedar Rapids Pain Associates to obtain medical information concerning the above named patient from the person/facility listed below.

_____
Name of Person and/or Institution requesting information from

_____ _____
Complete Mailing Address/Street/P.O. Box City, State, Zip Code

**Check the information to be disclosed (include dates where indicated):** ❑Minimum necessary or specify below

- ❑ Entire Record
- ❑ Medication list
- ❑ Most recent history and physical or specify date(s)
- ❑ Clinical notes related to visit(s), specify visits or date(s)
- ❑ CD of Images (X-ray, MRI, CT), specify type and date(s)
- ❑ Report of test results (i.e. lab, X-ray, etc.), specify type and date(s)
- ❑ Billing information
- ❑ Other, specify _____

As per my request, the reason for obtaining information is:

❑ Continued medical care ❑ Legal ❑ Insurance ❑ Personal ❑ Other (specify) _____

I understand that this authorization is voluntary and that I may cancel this consent to release information at any time by sending written notice to Cedar Rapids Pain Associates, 4205 Glass Road N.E., Cedar Rapids, IA 52402 I understand that any release which was made prior to my cancellation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized re-disclosure, and once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting the Office Manager at the above address.

I understand that Cedar Rapids Pain Associates may not require completion of this form as a condition of treatment. However, when the provision of services is solely for the purpose of creating a medical report (protected health information) for a third party, refusal to sign may result in a denial of those services.

I understand that the information to be released may include information in the following categories unless I specifically deny the release (***initial*** any category ***not*** to be released).
Substance Abuse_____Mental Health_____HIV-related information _____

This agreement will expire one year from the date of signature, unless previously revoked or otherwise indicated (specify number of days or months) _____

_____ _____
**Signature of Patient or Legal Guardian** **Date**

_____ _____
Address/Street/P.O. Box City, State, Zip Code

_____ _____
Relationship, if Not the patient Witness Signature

**CRPA use only:**

Form Sent: _____
Name Date

Original – medical record
Copies – deliver as requested above
– to patient

# CONSENT TO RELEASE INFORMATION

Cedar Rapids pain associates

4205 Glass Road N.E. Cedar Rapids, Iowa 52402
Phone: 319-294-0094 Fax: 844-464-3303

**Please PRINT all (except signature at bottom) and provide complete information in each section.**

Patient's Legal Name _____ Date of Birth _____

By signing this form I am authorizing Advanced Spine & Rehab Center/Cedar Rapids Pain Associates to release medical information concerning the above named patient to the person/facility listed below.

_____
Name of Person and/or Institution requesting information from

_____ _____
Complete Mailing Address/Street/P.O. Box City, State, Zip Code

**Check the information to be disclosed (include dates where indicated):** ❑Minimum necessary or specify below

Entire Record

- ❑ Medication list
- ❑ Most recent history and physical or specify date(s)
- ❑ Clinical notes related to visit(s), specify visits or date(s)
- ❑ CD of Images (X-ray, MRI, CT), specify type and date(s)
- ❑ Report of test results (i.e. lab, X-ray, etc.), specify type and date(s)
- ❑ Billing information
- ❑ Other, specify _____

As per my request, the reason for release of information is:

❑ Continued medical care ❑ Legal ❑ Insurance ❑ Personal ❑ Other (specify) _____

I understand that this authorization is voluntary and that I may cancel this consent to release information at any time by sending written notice to Cedar Rapids Pain Associates, 4205 Glass Road N.E., Cedar Rapids, IA 52402 I understand that any release which was made prior to my cancellation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized re-disclosure, and once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting the Office Manager at the above address.

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This agreement will expire one year from the date of signature, unless previously revoked or otherwise indicated (specify number of days or months) _____

_____ _____
**Signature of Patient or Legal Guardian** **Date**

_____ _____
Address/Street/P.O. Box City, State, Zip Code

_____ _____
Relationship, if Not the patient Witness Signature

**CRPA use only:**

Form Sent: _____
Name Date

Original – medical record
Copies – deliver as requested above
– to patient

# Patient Authorization

**CEDAR RAPIDS PAIN ASSOCIATES/ADVANCD SPINE AND REHAB CENTER FINANCIAL POLICY**

As a courtesy, Cedar Rapids Pain Associates/Advanced Spine and Rehab Center will verify your insurance benefits; however, it is ultimately your responsibility to be aware of your specific coverage. We will also bill your insurer on your behalf. If your insurer designates that a copayment, deductible, and/or co-insurance is your responsibility, we are obligated to collect it. The ultimate payment responsibility is yours – you will be billed for any balance not paid by your insurance.

**ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION / FINANCIAL RESPONSIBILITY**

I authorize my insurer to pay benefits directly to Cedar Rapids Pain Associates/Advanced Spine and Rehab Center. I authorize Cedar Rapids Pain Associates/Advanced Spine and Rehab Center to release all information necessary to secure payment including documentation on the medical record which may include present or past history of mental illness, alcohol abuse, drug abuse or HIV/AIDS related information. In understand that I am financially responsible for all charges incurred at Cedar Rapids Pain Associates/Advanced Spine and Rehab Center. Any portion of these charges not covered by my insurer must be paid by me. I further understand that copayments are due at the time of my Cedar Rapids Pain Associates/Advanced Spine and Rehab Center visit and that payment of any deductibles and coinsurance are my responsibility as stated by my contract with my insurer.

**HIPAA NOTICE OF PRIVACY PRACTICES**

I understand that Cedar Rapids Pain Associates/Advanced Spine and Rehab Center and its staff will make every effort to keep my protected health information confidential and private. My signature below acknowledges that: I understand that Cedar Rapids Pain Associates/Advanced Spine and Rehab Center may use and disclose my protected health information for treatment, billing to obtain payment, and for related health care operations; I have been offered a copy of, read or received Cedar Rapids Pain Associates/Advanced Spine and Rehab Center's Notice of Protected Health Information Practices (Privacy Notice); and I may obtain a copy of the Privacy Notice at any time or view it on the Cedar Rapids Pain Associates web site at www.crpainfree.com.

**I have read and agree to the terms to the information stated above.**

_____ _____

Signature of Patient or Patient Representative or Parent/Legal Guardian of Minor Date

If signed by patient representative or parent/legal guardian, indicate relationship to patient_____

**CONSENT FOR TREATMENT OF MINOR PARTY**

In the event that I am unable to accompany my minor child (under 18 years of age) to his/her Cedar Rapids Pain Associates/Advanced Spine and Rehab Center appointments, I permit Cedar Rapids Pain Associates/Advanced Spine and Rehab Center to render treatment to my child while I am not present.

_____ _____

Signature of Patient or Patient Representative or Parent/Legal Guardian of Minor Date

If signed by patient representative or parent/legal guardian, indicate relationship to patient_____

**MEDICAL HISTORY AND CONSENT FOR TREATMENT**

I certify the medical information I have provided is accurate, complete and true.

I authorize Cedar Rapids Pain Associates/Advanced Spine and Rehab Center and any associates, assistants and other health care providers it may deem necessary to treat my condition. I understand in no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

_____ _____

Signature of Patient or Patient Representative or Parent/Legal Guardian of Minor Date

If signed by patient representative or parent/legal guardian, indicate relationship to patient_____

# Cedar Rapids Pain Associates

## Late Appointment Policy

At Cedar Rapids Pain Associates we strive to keep appointments on time for both our patients and providers.

In order to keep our providers on schedule and the wait time for our patients as little as possible, we do not take late appointments.

By signing this, you understand that if you are late to any appointment, you may not be seen and will need to be re-scheduled.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

### Statement of Nondiscrimination

English: Cedar Rapids Pain Associates complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-319-294-0094.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-319-294-0094。

Patient Name:_____ Date: _____

**Surgical History – All surgical procedures since birth.**

| Surgery | Year |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**Family History – immediate family only: mother, father, siblings, children**

| | YES | NO | COMMENTS |
|---|---|---|---|
| Cancer | ☐ | ☐ | Type: |
| Diabetes | ☐ | ☐ | |

**Medications: Please list ALL medication you take, both prescription and non-prescription OR provide us with a medication list.**

| Name of Medication | Dose | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Allergies:** Please list drug and non-drug allergies (ex: lidocaine, iodine, chlorhexidine)

| Drug or Allergen | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

Patient Name:_____ Date: _____

## Health History

**Are you currently, or have you previously, taken medication or been treated for ANY of the following conditions?**

| | YES | NO | COMMENTS |
|---|---|---|---|
| Respiratory Disease | ☐ | ☐ | ☐ COPD ☐ Asthma ☐ Other |
| Obstructive Sleep Apnea | ☐ | ☐ | |
| High Blood Pressure | ☐ | ☐ | |
| Heart Attack / Heart Disease | ☐ | ☐ | |
| Stroke | ☐ | ☐ | |
| Liver Disease | ☐ | ☐ | ☐ Hepatitis ☐ Cirrhosis ☐ HIV/AIDS ☐ Other |
| Kidney Disease | ☐ | ☐ | ☐ Kidney Failure |
| Gastrointestinal Disease | ☐ | ☐ | ☐ Ulcers ☐ Reflux ☐ Colitis ☐ |
| Bleeding or Clotting Disorders | ☐ | ☐ | |
| Diabetes | ☐ | ☐ | ☐ Insulin |
| Thyroid Disorders | ☐ | ☐ | ☐ Hyper ☐ Hypo ☐ Hashimoto's |
| Arthritis | ☐ | ☐ | ☐ Osteoarthritis ☐ Rheumatoid (confirmed by lab test) |
| Osteoporosis | ☐ | ☐ | |
| Cancer | ☐ | ☐ | Type:<br>☐ Chemotherapy ☐ Radiation |
| Fibromyalgia | ☐ | ☐ | |
| HIV/AIDS | ☐ | ☐ | |
| Psychiatric Disease | ☐ | ☐ | ☐ Depression ☐ Anxiety ☐ Bipolar Disorder<br>☐ Schizophrenia ☐ PTSD |
| Neurological Disease | ☐ | ☐ | ☐ Parkinson ☐ Cerebral Palsy ☐ Seizures<br>☐ Multiple Sclerosis ☐ Vertigo / Meniere's ☐ Dementia |
| Migraines | ☐ | ☐ | |
| Skin Conditions | ☐ | ☐ | ☐ Lupus ☐ Psoriasis ☐ MRSA ☐ Shingles |
| Neuropathy | ☐ | ☐ | Areas affected: |
| Drug Use / Abuse | ☐ | ☐ | ☐ Recovered ☐ In treatment ☐ Socially |
| Alcohol Use / Abuse | ☐ | ☐ | ☐ Recovered ☐ In treatment ☐ Socially |
| Tobacco Use / Abuse | ☐ | ☐ | ☐ Current smoker ☐ Former smoker, quit date |
| Other conditions you've seen a doctor for or have taken medication for currently or in the past. | ☐ | ☐ | Please list: |

Patient Name:_____ Date: _____

## Review of Systems

**IN THE LAST MONTH** - Have you experienced any of the following symptoms?

| **GENERAL** | **YES** | **NO** |
|---|---|---|
| Unexplained weight loss | | |
| Fever | | |
| Fatigue | | |
| | | |
| **EYES** | **YES** | **NO** |
| Sudden change of vision | | |
| | | |
| **CARDIOVASCULAR** | **YES** | **NO** |
| Chest pain | | |
| Fast or irregular heartbeat | | |
| | | |
| **RESPIRATORY** | **YES** | **NO** |
| Coughing up blood | | |
| Shortness of breath | | |
| | | |
| **NEUROLOGICAL** | **YES** | **NO** |
| Frequent headaches | | |
| Lightheaded or dizzy | | |
| | | |
| **PSYCHIATRIC** | **YES** | **NO** |
| Anxiety | | |
| Depression | | |
| | | |
| **GASTROINTESTINAL** | **YES** | **NO** |
| Sudden or complete loss of bowel control | | |
| | | |
| **GENITOURINARY** | **YES** | **NO** |
| Sudden loss of bladder control | | |
| Unable to urinate | | |
| | | |
| **SKIN** | **YES** | **NO** |
| Rash | | |
| Skin infection | | |
| | | |
| **MUSCULOSKELETAL** | **YES** | **NO** |
| Muscle weakness | | |
| Joint pain (If yes, list where) | | |
| | | |
| Muscle pain or cramps | | |
| Back pain | | |
| Neck Pain | | |

Patient Name:_____ Date: _____

## CURRENT PROBLEM

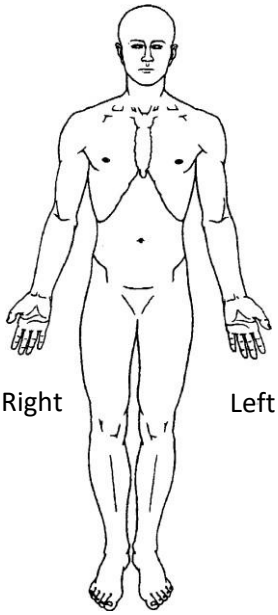
Please shade in where you have pain using the diagrams below.

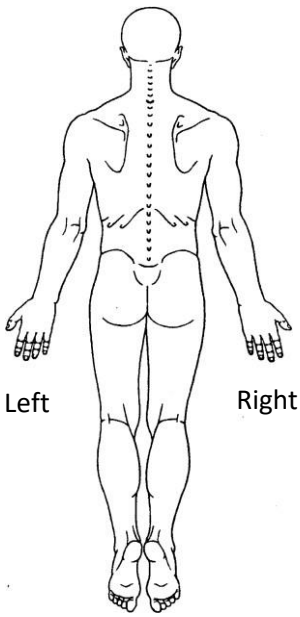
What one area would you like to focus on today?

_____

_____

Using the area of pain you would like to focus on today, please answer the following questions.




Have you seen any other healthcare providers for this issue? Yes / No

- If yes, please list _____

When is the **FIRST** time you ever had pain in this area? _____

What do you think caused your pain? _____

Please circle the words that describe your pain:

Dull Achy Sharp Stabbing Shooting Burning Radiating

Numbness Weakness Pins & Needles Constant Intermittent Pressure

Please circle the treatments you have you tried for this pain:

Chiropractic Physical Therapy Medical Equipment (ex: TENS, Braces) Surgery

Medications: Ibuprofen Tylenol Aleve Topical Rubs Muscles Relaxants Narcotics

Other: _____

Injections: Joint Injection Epidural Trigger Point Injections Other:_____

What is your occupation (if retired, what was your previous occupation)? _____

Are there activities or hobbies that your pain interferes with? _____