LA PAIN DOCTOR

Name: _____ Date: _____
Last First MI

Address: _____
Street Apt/Ste City State Zip Code

Telephone: Hm _____ Cell: _____ Gender (Circle): M / F Status: Married ___ Single ___ Child ____ Race: _____

Date of birth: _____ SS #: _____ Email address: _____

Name, date of birth, and social security number of insurance policy holder: _____

Insurance Co.: _____ Employer Name/Phone #: _____

Emergency Contact Name/Relationship/Phone #: _____

Pharmacy Name: _____ Address: _____ Ph no: _____

PCP Name: _____ Ph no: _____ Surgeon: Name: _____ Ph no: _____

How you were referred to Dr. Hijazi's office? Friends Family Sign Internet Dr. _____

MEDICAL HISTORY

High Blood Pressure	Yes No	Liver Problems	Yes No	Osteoporosis	Yes No
Lung Disease	Yes No	Anxiety	Yes No	HIV	Yes No
Depression	Yes No	Seizure Disorder	Yes No	Pacemaker	Yes No
Stroke	Yes No	Glaucoma	Yes No	Cancer	Yes No
Acid Reflux	Yes No	Heart Disease	Yes No	Stomach Ulcers	Yes No
Constipation	Yes No	Kidney Disease	Yes No	Hepatitis	Yes No
Diabetes	Yes No	Prostate Problems	Yes No	Other: _____	

PREVIOUS SURGERIES

Tonsillectomy	Yes No	Eye Surgery	Yes No	Shoulder Surgery	Yes No
Hysterectomy	Yes No	Kidney Stone	Yes No	Heart Bypass	Yes No
Knee Replacement	Yes No	Knee Surgery	Yes No	Hernia Repair	Yes No
Appendectomy	Yes No	Carpal Tunnel	Yes No	Other: _____	
Hip Surgery	Yes No	Gallbladder	Yes No		

Allergies: Yes or No **If yes please list allergies**: _____

_____

Please list all current medications: _____

_____

SOCIAL HISTORY

Marital Status: Single Married Divorced Widowed

Tobacco Use: Current Every Day Smoker Currant Some Days Smoker Former Smoker Never Smoked

Years Smoking: _____ Cigarettes/Packs per day: _____

Alcohol Use: Currently Drinks Alcohol Denies Any Use of Alcohol Quit Drinking Alcohol

Illicit Substance Abuse: Currently Using Quit Using Never Used

Work Statues: Employed Unemployed Disabled Retired Other: _____

Family History: (cancer, diabetes, heart disease, bleeding problems, painful conditions, etc.)

_____ Relative: _____

_____ Relative: _____

ACKNOWLEDGEMENT AND CONSENT

I understand that all responsibility for payment for services provided in this office for myself, payable and due at the time services are rendered. I understand that it is my responsibility to advise the appropriate office staff of any changes in the information contained on this form. I certify that I have read and understand all the information above and that, to the best of my knowledge, all the information provided by me is accurate and correct. If you do not cancel or reschedule your appointments there will be a fee of $25.00 for a no show office visit appointments and a $50.00 fee for a no show procedure appointment.

Patient Name (Print): _____ **Date:** _____

Signature of Patient/Guardian: _____ **Relationship to Patient:** _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TOP) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your case and treatment for providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information may be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you may be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations, without your authorization. These situations include: as Required by Law, Public Health Issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect: Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates: Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician of the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect 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 use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to 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 purposes 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. You request must state the specific restriction requested and to whom you want the restriction to apply.

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

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

You may 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 our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of privacy Practices from the office.

Complaints You may complain to us or to 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 complaints. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **February 1, 2010**.

Print Name:_____

Patient Signature:_____

Date:_____

Patient – Physician Agreement for Opioid Use

I have agreed to use opioids (morphine-like medications), also called narcotics, as part of my treatment for Chronic Pain. I understand these medications can be very useful but have potential for misuse and are therefore closely controlled by the local, state, and federal government. I understand my physician is prescribing this medication to help manage my pain and increase my function. By signing this agreement, I agree to the following rules and regulations listed below.

1. I am responsible for my opioid pain medications. I agree to take medications only as directed. I understand that increasing my dose without the supervision of my physician could lead to drug overdose. Drug overdose can cause severe sedation, slowed breathing and possible death. I understand that decreasing or stopping my opioids medication without the supervision of my physician could lead to withdrawal. Withdrawal symptoms may include yawning, abdominal cramps and diarrhea. These symptoms can occur 24-48 hours after the last dose of medication and last up to 3 weeks.
2. I will not request or accept opioid pain medication from any other physician or individual while I am receiving medication unless it is an emergency, and then I am responsible for notifying the office.
3. I understand there are side effects related to opioid pain medication. Common side effects are nausea and vomiting (similar to motion sickness), drowsiness and constipation. Less common side effects are mental slowing, flushing, sweating, itching, urinary difficulty, and jerkiness. These side effects would occur at the beginning of my treatment and often go away within a few days of treatment. It is my responsibility to notify my physician if any side effect continue or are severe. I am also responsible for notifying my pain physician immediately if I become pregnant or plan to become pregnant.
4. I understand that opioid medication is strictly for my own use. The opioid should never be given to others. If children are in the house, a childproof top is necessary and the medication should be kept in a safe place out of the reach of children.
5. I understand I must contact my pain physician before taking benzodiazepines (such as valium, Xanax or Ativan, sedatives (such as soma, fiorinal, or sleep medications) and antihistamines (such as Benadryl). The use of these medications with alcohol with opioid medications may produce drowsiness, slowed breathing, blood pressure drop, or even death.
6. I will not use street drugs while on opioid medication. If I do, the opioid medication will be discontinued.
7. I agree to submit to urine and blood screens at any time as determined by my physician to detect both the use of prescribed and non-prescribed medications.
8. During the time my dose is adjusted I will be expected to return to the office for my scheduled visits. Once I have been placed on a stable dose, I will return to my primary care physician as instructed.
9. I am responsible for my opioid medications. I understand:
    a. Prescriptions should be filled at the same pharmacy
    b. Prescriptions should be obtained at regular clinic appointments. Prescriptions cannot be obtained at night, on holidays, or weekends
    c. If a conflict arises such as travel plans or moving, I am responsible for notifying the office well in advance to discuss a plan for prescriptions.
    d. Prescriptions will not be given if I "run out early", or lose a prescription, spill or misplace my opioid medication. I am responsible for taking my medication in the dose prescribed and for keeping track of the amount remaining.
    e. If my medication is stolen, I will notify the police and obtain a stolen item report, replacement prescriptions will be given at the discretion of the pain physician.
10. While physical dependence is to be expected after long term use of opioids, signs of addiction and psychological dependence shall be taken as a need for weaning or discontinuing the opioid medication.
    a. Physical Dependence- is common to many medications such as blood pressure medications, anti-seizure medications, and opioids. Taking these types of medications results in biochemical changes in your body. Should you abruptly stop taking the opioid medication you may go through withdrawal.
    b. Addiction- is a physiological and behavioral syndrome that is recognized when a patient abuses the opioid medication to obtain mental numbness or "get high" or drug craving behavior such as "doctor shopping" or being rude or manipulative to the physician or staff in an effort to obtain opioid medication.
11. If it appears to the physician that there is no improvement in my daily function or quality of life from the opioid medication, my medication will be tapered down and discontinued. I further understand if I do not follow the above agreement, I will no longer receive any opioid medication. It is my responsibility to contact LA Pain Doctor to clarify or discuss any issues before a problem of crisis arises. I understand that I may be required to make a follow up appointment to see a physician.

I _____ have read the above information (or it has been read to me)

I have the right to receive a copy of the contract. I hereby give my consent to participate in opioid medication therapy.

Patient Signature: _____

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME (Last, First, Middle)	DOB

ADDRESS	SSN

CITY	STATE	ZIP

PROVIDER AUTHORIZED TO RELEASE THE PHI:		ENTITY REQUESTING / RECEIVING THE PHI:
NAME		LA PAIN DOCTOR 3901 Houma Boulevard Suite 410 Metairie, LA 70068 Phone: (504) 229-4866 Fax: (504) 229-4860
ADDRESS		
CITY		
PHONE:	FAX:	

This authorization will expire on the following date or event. If date or event is not indicated, authorization will expire 12 months from date signed.

Date: **Event:**

Purpose of this Disclosure:

PHI AND DATES OF PHI AUTHORIZED FOR USE OR DISCLOSURE

Description	Start Date	End Date
❑ All PHI in the record		
❑ Progress Notes		
❑ Laboratory Tests		
❑ X-Ray Tests / Reports		
❑ History and Physical Examination		
❑ Discharge Summary		
❑ Consultation Reports		
❑ Itemized Billing Statement		
❑ Other:		

The following information will be released when included in the above information unless you indicate otherwise:

[ ] AIDS or HIV test results
[ ] Alcohol, drug or substance abuse treatment
[ ] Psychiatric or mental care / treatment
[ ] Other (specify):

I UNDERSTAND THAT:

1. I MAY REFUSE TO SIGN THIS AUTHORIZATION AND IT IS STRICTLY VOLUNTARY.
2. MY TREATMENT, PAYMENT, ENROLLMENT OR ELIGIBILITY FOR BENEFITS MAY NOT BE CONDITIONED ON SIGNING THIS AUTHORIZATION.
3. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING TO THE PROVIDER AUTHORIZED TO RELEASE THE PROTECTED HEALTH INFORMATION, BUT IF I DO, IT WILL NOT HAVE ANY AFFECT ON ANY ACTIONS TAKEN PRIOR TO RECEIVING THE REVOCATION.
4. IF THE REQUESTER OR RECEIVER IS NOT A HEALTH PLAN OR HEALTH CARE PROVIDER, THE RELEASED INFORMATION MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS AND MAY BE REDISCLOSED.
5. I HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM AFTER I SIGN IT.

Signature of Patient:	Date:

Signature of Patient's Representative (if necessary):	Date:

Personal Representative's Relationship to Patient:

Disclosure of Ownership

State and federal guidelines may require physicians that may have an ownership interest in a facility to which the physician refers patients disclose the information listed below. In the interest of providing our patients with complete information, we are providing the names of the outside facilities where the physicians of this practice may have an ownership interest.

Harvest Labs – 230 T C Jester Blvd, suite 201 Crowley, LA 70526

You have the right to choose the provider of your healthcare services. Therefore, you have the option to use a health care facility other than the ones listed above. You will not be treated differently by your physician if you choose to obtain services at a facility other than the ones listed above. This Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician may have an ownership interest in the facilities listed above. If you have any questions about this, please contact and ask for the practice administrator.

PRINT NAME:_____

Signature of Patient: _____

Date:_____

Name: _____ Score: _____

Date: _____ Date of Birth: _____

SOAPP®-R

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you feel that your pain is "out of control?"	0 1 2 3 4
2. How often do you have mood swings?	0 1 2 3 4
3. How often do you do things that you later regret?	0 1 2 3 4
4. How often has your family been supportive and encouraging?	0 1 2 3 4
5. How often have others told you that you have a bad temper?	0 1 2 3 4
6. Compared with other people, how often have you been in a car accident?	0 1 2 3 4
7. How often do you smoke a cigarette within an hour after you wake up?	0 1 2 3 4
8. How often have you felt a need for higher doses of medication to treat your pain?	0 1 2 3 4
9. How often do you take more medication than you are supposed to?	0 1 2 3 4
10. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	0 1 2 3 4
11. How often have any of your close friends had a problem with alcohol or drugs?	0 1 2 3 4
12. How often have others suggested that you have a drug or alcohol problem?	0 1 2 3 4
13. How often have you attended an AA or NA meeting?	0 1 2 3 4
14. How often have you had a problem getting along with the doctors who prescribed your medicines?	0 1 2 3 4
15. How often have you taken medication other than the way that it was prescribed?	0 1 2 3 4
16. How often have you been seen by a psychiatrist or a mental health counselor?	0 1 2 3 4
17. How often have you been treated for an alcohol or drug problem?	0 1 2 3 4
18. How often have your medications been lost or stolen?	0 1 2 3 4
19. How often have others expressed concern over your use of medication?	0 1 2 3 4
20. How often have you felt a craving for medication?	0 1 2 3 4
21. How often has more than one doctor prescribed pain medication for you at the same time?	0 1 2 3 4
22. How often have you been asked to give a urine screen for substance abuse?	0 1 2 3 4
23. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0 1 2 3 4
24. How often, in your lifetime, have you had legal problems or been arrested?	0 1 2 3 4

Please include any additional information you wish about the above answers. Thank you.

 The SOAPP® was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

PAIN MANAGEMENT QUESTIONNAIRE

Name: _____ Date of Birth: _____

Please answer all question:

1. Is your pain the result of a work-related injury? _____ If yes, please advise Front Desk immediately to obtain authorization

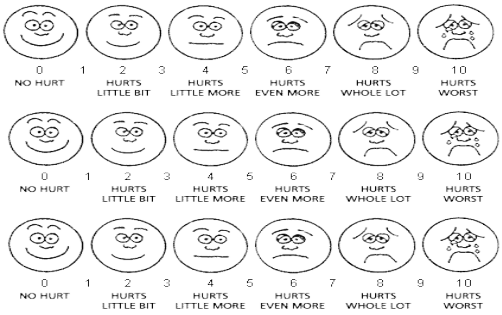
2. Circle the words that MOST describe your pain:

Constant	Nagging	Cramping	Pins & Needles	Aching	Burning	Tender	Dull
Shooting	Electric	Numbness	Pressure Like	Throbbing	Stabbing	Tingling	Sharp

3. What is your level of pain at its WORST?

4. What is your level of pain at the BEST?

5. What is your pain level NOW?



6. What makes your pain worse? (Circle all that apply)

Walking	Driving	Movement	Night time	Going up or down stairs	Turning to affected side
Sitting	Sneezing	Morning	Coughing	Prolonged standing	Turning to side to side
Lifting	Lying flat	Bending	Standing up straight	Increased activity	Laying on affected side

7. What makes your pain better? (Circle all that apply)

Lying Down	Manipulations	Changing positions	Sitting	Massage	Exercise	Resting	Medication
Nothing	Resting	Physical Therapy	Cold	Walking	Standing	Heat	Injections

8. Have you received psychiatric treatment in the past? Yes or No **If yes, who was your treating physician?** _____

9. Have you had any spinal surgeries? Type: _____ Year: _____

Please Circle the symptoms or side affects you are having:

Gastrointestinal	**Cardiovascular**	**Lungs**	**Urological**	**Endocrine**
Abdominal Pain	Chest Pain	Shortness of breath	Leakage of urine	Diabetes
Nausea or vomiting	Feet swelling	COPD	Urine Incontinence	Thyroid Disease
Black stool	High blood pressure	Asthma/Wheezing	Kidney stones	Anemia
Constipation	Irregular heart beat	Sleep apnea	Blood in urine	Hepatitis
Heart burn	Blood clot		Loss of control	
Colitis	Heart Murmur			
Diarrhea				

Head & Neck	**Musculoskeletal**		**Neurologic**	
Headache	Back pain	Neck pain	Depression	Anxiety
Hearing loss	Knee pain	Shoulder pain	Panic attack	Fatigue
Sinus problems	Joint pain	Gout	Weakness	Seizures
Visual problems	Muscle cramps	Arthritis	Trouble sleeping	Incoordination
	Legs give out when walking		Numbness & Tingling	Difficulty thinking
			Poor Concentration	

Please circle The areas of your pains: