Kansas Pain and Wellness, LLC

Kansas Pain and Wellness, LLC is committed to meeting your pain management health care needs. The following information will allow us to serve you better.

Office Hours: 8:00am – 4:30pm, Monday through Thursday / Friday 8:00am – 12:00pm
Phone Number: 785-783-7771 (Topeka) ; 785-530-5505 (Junction City)
Fax Number: 785-730-3796 (Topeka) ; 785-530-6885 (Junction City)
Address: 1131 SW Winding Road, Ste 400, Topeka, KS 66208
715 Southwind Drive, Junction City, KS 66441

***Calls to the office:** Calls after 4pm will not be returned until the following business day.

***Referrals and Insurance:** A referral from your primary care provider is required before you can be seen at our office. Please bring your current insurance card(s) with you to each appointment and let us know as soon as possible if you change insurance companies.

***________Cancellation and Missed Appointments:** We understand that circumstances can occur that make it necessary for you to cancel or reschedule an appointment. Please contact us at least 24 hours ahead of your scheduled appointment, otherwise there will be a no-show fee of $35 charged to your account. If you are more than 15 minutes late to your appointment, you may be asked to reschedule. After 3 missed/no-show visits, you may be dismissed as a patient. Due to the nature of our service, we may have to reschedule appointments when the Doctor is called away to an emergency situation. We regret this inconvenience and will make every effort to notify and reschedule you as soon as possible.

***Your films (MRIs, CT scans, X-Rays, etc.):** Please make sure that your film written reports (no disc please) of any imaging studies be available for the Doctor to review at your first office visit. We need to be able to compare your symptoms, your exam, and your test results to make an accurate diagnosis and treatment plan.

***________Medications: All requests for prescriptions or refills MUST be completed during office hours. We will NOT refill any prescriptions after hours or on weekends. Keep in mind that multiple calls to the office will not expedite your request and could lead to your dismissal as a patient. If your prescription is lost or stolen, it will not be refilled until the appropriate due date. You do not need to call ahead of time to fill your prescription, it will be sent out automatically every 30 days. If your prescription is not at the pharmacy on the day your prescription is due, please let us know.**

***Vacations/Family Emergencies:** If you are not able to pick up your prescription the day it is due because of extenuating circumstances. Please let us know so we can plan accordingly with you and your pharmacy. If we refill your prescription early it will be filled on its normal due date the following month, NOT on the early fill date.

***Medical Records:** There is a $10 charge for medical records, due at the time of pick-up.

***________Billing:** If you have an outstanding balance at our office it MUST be paid in full by your next appointment or no further appointments will be scheduled and no prescriptions will be sent. If you need to set up a payment plan please talk to the receptionist. It is patient responsibility to pay their co-pays at the time of service. If you cannot make your payment at the time of your appointment, you may be asked to reschedule. It is your responsibility to know what is covered by your insurance company.

***Walk-ins:** WE DO NOT ACCEPT WALK-INS; YOU MUST MAKE AN APPOINTMENT!

By signing this paper, I am stating that I have read, understand, and agree to all of the office policies.

Patient Signature: ______________________________ **Date:** ______________

URINE DRUG SCREENING

Our office outsources the urine drug screen and oral swab testing to the contracting laboratory, 4M HEALTHCARE. What does this mean? Our office collects the samples, we send them out through FedEx Express Delivery to ensure overnight delivery. There ,at 4M HEALTHCARE, the test will be processed and the results will be sent to Kansas Pain and Wellness, LLC., who will in turn share the results with you.

4M HEALTHCARE will submit a claim to your insurance company on your behalf and will work with them to cover as much of the cost as possible.

Next Steps Include:

In 30-45 days, you should receive an Explanation of Benefits (EOB) from your insurance company detailing the amounts allowed and/or paid by your insurance plan for the services rendered.

The EOB is not a bill. Should you have questions regarding the EOB you have received, please contact the billing department of 4M HEALTHCARE, rather than Dr. Southwick's office. Their billing department can be reached at 913-222-5600.

Blue Cross and Blue Shield of Kansas mails payments directly to you with the EOB. ***Should you receive a check for payment of the test sent directly to you, please endorse the back of the check and send a copy of the EOB with the check directly to 4M HEALTHCARE at 15110 Glenwood, Olathe KS 66223.***

Once the insurance had processed the claim, you will receive a bill for your portion of the urine drug screen or oral swab cost. If your insurance denies or partially denies the claim, **4M Healthcare** will appeal to your insurance on your behalf. Patient out-of-pocket responsibility max that is billable to you is $99.00 after insurance payment and co-pays, unless otherwise specified by **4M Healthcare.**

Please call 4M Healthcare within 30 days of receiving your bill for a prompt payment discount or to discuss 4M Healthcare's financial assistance program with Sherry at 913-222-5600.

As always, our office medical assistant, Raquan, is always happy to assist you and answer any questions or concern you may have about your **EOB/bill** or get your in contact with the correct person.

If you have read and understand this agreement, please sign below.

Patient Signature:______________________________ **Date:**______________

PATIENT INFORMATION

Name: Last:_________________________ First:_________________________ MI:________ Sex: M F

Date of Birth:_____/_____/_____ Age:_____ Social Security #:____________________ Occupation:____________________

Phone: Home:____________________ Cell:____________________ Work:____________________

E-Mail Address:____

Mailing Address:______________________________ City:____________________ St:______ Zip:________

Marital Status: ( ) Married ( ) Divorced ( ) Widow ( ) Living with Partner ( ) Single

Emergency Contact:_________________________ Phone:____________________ Relationship:____________________

Physicians Information – Important, please complete:

Referring Physician:______________________________ Phone:____________________

Address:______________________________ City:____________________ St:________ Zip:__________

IF DIFFERENT FROM ABOVE

Primary Care Physician:______________________________ Phone:____________________

Address:______________________________ City:____________________ St:________ Zip:__________

INSURANCE INFORMATION

Primary Insurance Name:____

Subscriber:______________________________ Date of Birth:____________________

Relation to Subscriber:____________________ Policy Number:____________________ Group Number:____________

Effective Date:____________________ Policy Holder's Employer______________________________

Secondary Insurance Name:____

Subscriber:______________________________ Date of Birth:____________________

Relation to Subscriber:____________________ Policy Number:____________________ Group Number:____________

Effective Date:____________________ Policy Holder's Employer______________________________

***Worker's Comp/Auto**____

Is the diagnosis due to an accident? ( ) NO ( ) YES Date of Injury:____________________

Type of accident: ( ) Auto ( ) Work ( ) Home ( )Other Please specify:____________________

Attorney Name ______________________________ Case Number:____________________

Case Manager Name:______________________________ Phone:____________________

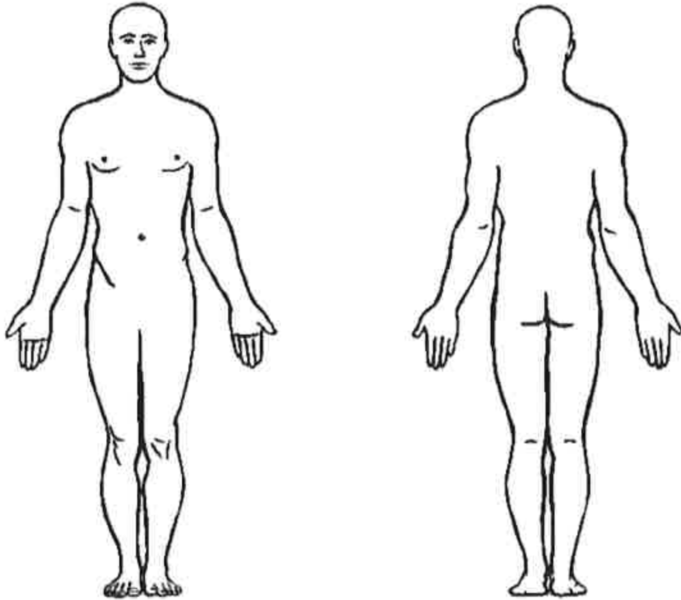
Send Bills to: Name:____

Address:______________________________ City:____________________ St:______ Zip:______

PATIENT CONDITION

Reason for Visit/Current Problem?____

Using the symbols below, please draw the location of your symptoms on the diagrams provided.
XXXX = Pain   OOOO = Numbness/Tingling



What position/activity makes your condition better or worse?

	BETTER	WORSE	NO CHANGE
Bending			
Standing			
Lifting			
Lying Down			
Sitting			
Walking			
Coughing/Sneezing			

CIRCLE THE NUMBER BELOW INDICATING THE USUAL DEGREE OF PAIN
(0 means no pain, and 10 is the worst pain that you have ever felt in your life)

0 1 2 3 4 5 6 7 8 9 10

HEALTH HABITS

( ) I smoke cigars and/or cigarettes: _______________ pack(s) a day

( ) I drink alcoholic beverages: _______________ per week

( ) I use caffeine: _______________ per day

( ) I use recreational drugs. Please specify:______________________

OCCUPATIONAL/SOCIAL

( ) Stress   ( ) Around Hazardous Materials

( ) Heavy Lifting ( ) I have used athletic steroids

HEALTH HISTORY

Please indicate which **DIAGNOSTIC TESTS** you have had in **the last 12 months.**

TEST	Y/N	DATE	TEST	Y/N	DATE
X-Ray			EMG/NCT		
Bone Scan			MRI		
CT Scan			Pelvic Ultrasound		
Discogram			Other:		
Mammogram			Other:		

Please mark which **TREATMENTS** you have had for your main problem and indicate whether they were helpful.

TREATMENT	Y/N	RELIEF? Y/N	TREATMENT	Y/N	RELIEF? Y/N
Trigger Point Injections			T.E.N.S Unit		
Epidural Steroid Injections			Manipulations		
Physical Therapy			Traction		
Electrical Stimulation			Aqua Therapy		
Ultrasound			Whirlpool		
Heat Packs			Acupuncture		
Cold Packs			Other:		
Brace			Other:		

Have you seen a **Pain Management Specialist** before? YES NO If yes, when?______________________

Have you taken any of these drugs previously?

DRUG	Y/N	DRUG	Y/N	DRUG	Y/N
Aleve (naproxyn)		MS IR (morphine)		Vicodin	
Bextra		Norco		Ultracet (tramadol/APAP)	
Baclofen (lioresal)		Oxycontin		Ketoprofen (orudis)	
Darvocet (propoxyphene)		Percodan		Aspirin	
Demerol (meperidine)		Prednisone		Arthrotec	
Durgesic patches (fentanyl)		Robaxin (methocarbamol)		Celebrex	
Flexeril (cyclobenzaprine)		Soma (carisoprodol)		Daypro	
Motrin		Toradol		Dilaudid	
Feldene (piroxicam)		Etodolac (iodine)		Norflex	
Parafon Forte		Percocet		Relafen	
Skelaxin (metaxalone)		Talwin (pentazocine)		Tylenol #3	
Ultram (tramadol)		Zanaflex		Roxicet	
Ibuprofen (advil)		Methadone		MS Contin	

High Risk Past Medical/Surgical History

( ) Cancer ( ) Hysterectomy with removal of ovaries ( ) Hysterectomy only ( ) Oophorectomy = removal of ovaries

Hospitalizations/Surgeries

YEAR	Hospital/Treating Physician	Reason for Hospitalization/Surgery & Outcome

Have you ever had any issues with anesthesia? YES NO If yes, please explain ____________________

Current Hormone Replacement Therapy? ____________________

Past Hormone Replacement Therapy? ____________________

Nutritional/Vitamin Supplements:____________________

Last menstrual period (estimate year, if unknown):____________________

Birth Control Method: ( ) Menopause ( ) Hysterectomy ( ) Tubal Ligation ( ) Birth Control Pills

( ) Vasectomy ( ) Other:____________________

Notes:

____

____

____

____

____

____

ALLERGIES

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

(   ) No known allergies (   ) No known drug allergies

MEDICATIONS

We encourage you to bring a list of your current medications to your appointment. If you do not have a list, please fill out the information below, including over-the-counter medication.

Are you taking anything to thin your blood? YES   NO

Medication: ______________________________ __________mg __________ times per day

Medication: ______________________________ __________mg __________ times per day

Medication: ______________________________ __________mg __________ times per day

Medication: ______________________________ __________mg __________ times per day

Medication: ______________________________ __________mg __________ times per day

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Medication: ______________________________ __________mg __________ times per day

Medication: ______________________________ __________mg __________ times per day

Medication: ______________________________ __________mg __________ times per day

By signing below, I am stating that the information provided on this form is accurate to the best of my knowledge.

_______________________________________ _______________________

Patient Signature   **Date/Time**

SYMPTOMS for conditions you currently have or have had in the past **ONE** year. **(circle all that apply)**

GENERAL

Chills
Fever
Dizziness
Fainting
Depression
Forgetfulness
Headache
Loss of Sleep
Loss of Weight
Nervousness
Numbness

EYE, EAR, NOSE, THROAT

Difficulty Swallowing
Coughing Blood

PSYCHIATRIC

Disturbing Thoughts
Memory Loss
Psychiatric Disorders
Hallucinations

NEUROLOGICAL

Loss of Consciousness
Blackouts
Tremors
Head Injury
Stroke

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

Arms	Hips
Back	Legs
Feet	Hands
Neck	Shoulder

Back Problems
Muscle Cramps
Restrcited Motion
Muscle Stiffness
Joint Stiffness
Paralysis

GASTROINTESTINAL

Poor Appetite
Bloating
Bowel Changes
Constipation
Diarrhea
Excessive Thirst
Loss of Bowel Control
Hemorrhoids
Indigestion
Vomiting/Nausea
Vomiting Blood
Rectal Bleeding
Stomach Pain

CARDIOVASCULAR

Chest Pain
Irregular Heartbeat
Low Blood Pressure
High Blood Pressure
Poor Circulation
Rapid Heartbeat
Swelling of Legs
Varicose Veins
Short of Breath
Short of Breath - Sleeping
Short of Breath - Exertion
Short of Breath – Lying Flat
Thrombophlebitis
Heart Murmur

CONDITIONS you currently have or have had in the past **ONE** year. **(circle all that apply)**

AIDS/HIV	Heart Bypass	Polio	Rheumatic Fever
Hemochromatosis	Diabetes	Kidney Stones	Scarlet Fever
Elevated PSA	Emphysema/COPD	Kidney Disease	Stroke
Appendicitis	Epilepsy/Seizures	Liver Disease	Suicide Attempt
Arthritis	Fibromyalgia	Trouble Passing Urine	Thyroid Issues
Asthma	Blood clot &/or PE	Migraines	Tuberculosis
Bleeding Disorders	Arrhythmia	Mitral Valve Prolapse	Ulcers
Bronchitis	Lupus/auto-immune disease	CHF	UTI
Bulimia	Gout	Multiple Sclerosis	Venereal Disease
Cancer	Heart Disease	Pacemaker	
Cataracts	Hepatitis	Parkinson's	
Chronic Fatigue Syndrome	Hernia	Pneumonia	
Chemical Dependency	Herpes	Prostate Issues	
High Cholesterol	High Blood Pressure	Psychiatric Care	

Kansas Pain and Wellness
1131 SW Winding Road, Ste 400
Topeka, Kansas 66615

Kansas Pain and Wellness
715 Southwind Drive
Junction City, Kansas 66441

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your protected Health Information will be used by Kansas Pain and Wellness, LLC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health of health information, including your demographic information, collected from you and created or received by this office.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Heath Information.
- This office may or may not agree to restrict the use or disclosure of your Protect Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected by the revocation.

By my signature below, I give permission to use and disclose my health information.

______________________________ ______________
Patient or Legally Authorized Individual Signature **Date**

____
Print Patient's Full Name

Kansas Pain and Wellness
1131 SW Winding Road, Ste 400
Topeka, Kansas 66615

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Patient Authorization

Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used and Disclosed
This is for information to be used for billing/insurance purposes, records to be released to your current or future doctor (at your request), and records requests (with a signed approval by the patient).

The information covered by this authorization includes:

All Chart Information (my entire record) – including electronic and paper
My entire record: I understand that for "my entire record" authorizes the use or disclosure of all information in my medical record including, but not limited to: demographic information, patient histories, medication lists, tests, and diagnoses. I understand that my medical record may contain sensitive information. I specifically authorize the use or disclosure of any information in my medical record related to:
Alcohol and Drug Abuse Treatment
HIV/Acquired Immune Deficiency Syndrome (AIDS)
Mental and Behavioral Health (other than psychotherapy notes) and Developmental
Disability Treatment
Genetic Information (including, but not limited to, Genetic Test Results)

Persons Authorized to Use or Disclose Information
Information listed above will be used or disclosed by:

Kansas Pain and Wellness, LLC

Expiration Date of Authorization

This authorization is effective through 12/31/2099 unless revoked or terminated by the patient or patient's personal representative. The revocation or termination of this authorization must be done in writing.

Patient Rights

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to this office and contacting the Office Manager.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

If you understand and agree with all the above polices, please sign your name below.

____ ____________________
Patient or Legally Authorized Individual Signature **Date**

____
Print Patient's Full Name

Kansas Pain and Wellness
1131 SW Winding Road, Ste 400
Topeka, Kansas 66615

Kansas Pain and Wellness
715 Southwind Drive
Junction City, Kansas 66441

I understand that my family members, friends, and co-workers may ask questions about my medical condition over the telephone or in person. I also understand that it is a break of physician-patient confidentiality for my doctors to discuss my medical information in any way with anyone without my expressed written consent. By signing this form, I am designating the parties below with whom I wish Kansas Pain and Wellness, LLC to be able to discuss my medical condition.

I understand this form will be updated every calendar year. If I were to decide to make any changes regarding the release of information to any of the listed people, it is my responsibility to inform Kansas Pain and Wellness, LLC in writing of my decision.

I accordance with the above, I (print name) ____,
hereby authorize Kansas Pain and Wellness, LLC to discuss with and release my medical information to the following individuals, if no one, please write NONE:

Name	**Relationship**	**Telephone Number**

The below individuals are authorized to pick up any written prescriptions and/or medication samples on my Behalf, if no one, please write NONE.

Name	**Relationship**	**Telephone Number**

If you understand and agree with all the above polices, please sign your name below.

____ ____________________
Patient or Legally Authorized Individual Signature **Date**

____
Print Patient's Full Name

Kansas Pain and Wellness, LLC

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records or summary or narrative of my protected health information, to the physician/person/facility/entity listed below. This form also allows Kansas Pain and Wellness to request medical records from a physician/person/facility/entity on my behalf for the continuity of my care.

The information you may release and/or receive subject to this signed release for is as follows:

- Complete Medical Records
- X-Ray Reports
- MRI Reports
- CT Reports
- Lab Reports
- Treatment Records
- Radiology Reports
- Physician Notes

Please release my protected health information to the following physician/person/facility/entity and or those directly associated in my medical care:

Kansas Pain and Wellness
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Topeka, Kansas 66615
P: 785-783-7771
F: 785-730-3796

Kansas Pain and Wellness
715 Southwind Drive
Junction City, Kansas 66441
P: 785-530-5505
F: 785-530-6885

Authorization:

X______________________________
Patient Name (Print)

X______________________________
Signature of Patient/Personal Representative

X______________________________
Patient DOB or Social Security Number

____
If applies – Personal Representative (Print)

X______________________________
Date

____
Description of Personal Representative's Authority

Patient Agreement for Long-term Opioid Therapy

1. I, ______________________________ agree that Dr. ___________________________ will be the <u>only physician</u> prescribing OPIOID (also known as NARCOTIC) pain medication for me and that I will obtain all of my prescriptions for opioids at <u>one pharmacy</u>. The exception would be an emergency situation or in the unlikely event that I run out of medication. Should such occasions occur, I will inform my physician as soon as possible.
2. I will take the medication <u>at the dose and frequency prescribed</u> by my physician. I agree not to increase the dose of opioid without first discussing it with my physician. I will not request earlier prescription refills.
3. I will <u>attend</u> all reasonable appointments, treatments and consultations as requested by my physician. I agree to <u>other pain consultations/management strategies</u> as necessary.
4. I understand that the common <u>side effects</u> of opioid therapy include nausea, constipation, sweating and itchiness of the skin. Drowsiness may occur when starting opioid therapy or when increasing the dosage. I agree to <u>refrain from driving a motor vehicle</u> or operating dangerous machinery until such drowsiness disappears.
5. I understand that using long-term opioids to treat chronic pain may result in the development of a physical dependence on this medication, and that sudden decreases or discontinuation of the medication will lead to the symptoms of <u>opioid withdrawal</u>. I understand that opioid withdrawal is uncomfortable but not life threatening.
6. I understand that there is a <u>small risk</u> that I may become addicted to the opioids I am being prescribed. As such, my physician may require that I have blood, urine or hair testing and/or see a specialist in addiction medicine should a concern about addiction arise.
7. I understand that the use of a <u>mood-modifying substance</u>, such as tranquilizers, sleeping pills, alcohol or illicit drugs (such as cannabis, cocaine, heroin or hallucinogens), can cause adverse effects or interfere with opioid therapy. Therefore I agree to refrain from the use of all of these substances without prior agreement from my physician.
8. I understand that I should check with my physician or pharmacist before taking other medications including over-the-counter and herbal products.
9. I agree to be responsible for the <u>secure storage</u> of my medication at all times. I agree not to give or sell my prescribed medication to any other person. Depending on the circumstances, lost medication may not be replaced until the next regular renewal date.
10. I consent to <u>open communication</u> between my doctor and any other health care professionals involved in my pain management, such as pharmacists, other doctors, emergency departments, etc.
11. I understand that <u>if I break this agreement</u>, my physician reserves the right to stop prescribing opioid medications for me.

Date: ________________________

______________________________	______________________________
(Signature - Patient)	(Signature Physician)

YOUR SAFETY RISKS WHILE WORKING UNDER THE INFLUENCE OF OPIOIDS:

You should be aware of potential side effects of opioids such as decreased reaction time, clouded judgment, drowsiness and tolerance. Also, you should know about the possible danger associated with the use of opioids while operating heavy equipment or driving.

SIDE EFFECTS OF OPIOIDS:

- Confusion or other change in thinking abilities
- Problems with coordination or balance that may make it unsafe to operate dangerous equipment or motor vehicles
- Breathing too slowly – overdose can stop your breathing and lead to death
- Nausea
- Sleepiness or drowsiness
- Vomiting
- Constipation
- Aggravation of depression
- Dry mouth

THESE SIDE EFFECTS MAY BE MADE WORSE IF YOU MIX OPIOIDS WITH OTHER DRUGS, INCLUDING ALCOHOL.

RISKS:

- Physical dependence. This means that abrupt stopping of the drug may lead to withdrawal symptoms characterized by one or more of the following:

  Runny nose
  Diarrhea
  Sweating
  Rapid heart rate
  Difficulty sleeping for several days
  Abdominal cramping
  'Goose bumps'
  Nervousness

- Psychological dependence. This means it is possible that stopping the drug will cause you to miss or crave it.
- Tolerance. This means you may need more and more drug to get the same effect.
- Addiction. A small percentage of patients may develop addiction problems based on genetic or other factors.
- Problems with pregnancy. If you are pregnant or contemplating pregnancy, discuss with your physician.

RECOMMENDATIONS TO MANAGE YOUR MEDICATIONS:

- Keep a diary of the pain medications you are taking, the medication dose, time of day you are taking them, their effectiveness and any side effects you may be having.
- Use of a medication box that you can purchase at your pharmacy that is already divided in to the days of the week and times of the day so it is easier to remember when to take your medications.
- Take along only the amount of medicine you need when leaving home so there is less risk of loosing all your medications at the same time.

I have read this document, understand and have had all my questions answered satisfactorily. I consent to the use of opioids to help control my pain and I understand that my treatment with opioids will be carried out as described above.

______________________________ ______________________________

Patient Signature Date Physician Signature Date