SPINE & PAIN SPECIALISTS

2026

THIS PACKET MUST BE COMPLETED IN ITS ENTIRETY PRIOR TO ARRIVING FOR YOUR APPOINTMENT.

PRINT THIS PACKET SINGLE-SIDED.
COMPLETE EVERY PAGE.

INCOMPLETE PAPERWORK WILL RESULT IN YOUR APPOINTMENT BEING RESCHEDULED.

NEW PATIENT / CONSULT PACKET

FOR YOUR FIRST SAPS VISIT

New Patient, Consult, or Injection with Consult

WK Spine & Pain Specialists Clinic Policies Attestation

Please initial each line below acknowledging receipt & understanding of each of the policies outlined in the WK Spine & Pain Clinic Policies which is included in your "Patient Copy" packet.

_____ Initials — Policy regarding our office hours

_____ Initials — Ambulatory Clinic Policy (Mobility restricted or impaired patients)

_____ Initials — Appointment Policy

_____ Initials — Policy Regarding Surgeries with other Physicians

_____ Initials — Patient Payment Responsibility & Changes in Insurance Coverage Policy

_____ Initials — Clinic Policy Regarding Returning Patient Calls & Medication Refill

_____ Initials — Request's: Prescription Pickup's & Exchange Policy

_____ Initials — Opioid Treatment Policy

_____ Initials — Disability Forms, Letters, & Work Excuse Policy

Patient Name (Printed)	Patient Signature	Date Signed

WK Spine & Pain Specialists Appointment Non-Compliance Policy

1. WK Spine & Pain Specialists has implemented a new Appointment Non-Compliance Policy **EFFECTIVE 06/01/2025.**
2. **Our office MUST be contacted 24 business hours in advance of your scheduled** appointment to cancel or reschedule an appointment.
3. Failure to comply with our Appointment Compliance Policy will result in the fees listed below.
    a. **NEW PATIENTS: $200 FEE**
    b. **ESTABLISHED PATIENTS: $50 FEE**
4. **This fee is NOT billable to your insurance company.**
5. **Your appointment will NOT be rescheduled until this fee is paid in full.**
6. **This policy applies to ALL patients, regardless of insurance carrier.**
7. **Three or more missed appointments, without adequate notice, in a 6-month period may** result in dismissal from the practice.

Patient Name (Print)	Patient Signature	Date Signed

Driver and Companion Policy

Driver or Companion Rules:

- No more than ONE companion may accompany you to this appointment.
- Must be over the age of 18
- Must be able to fully assist you with any mobility or cognitive limitations you may have
- Multiple companions are NOT permitted in the waiting room, exam room, or prep/recovery area
- When a Driver is MANDATORY, they must accompany you to our office AND remain with you in our prep/recovery area for the entirety of your appointment. They may NOT wait in the car or drop you off

When is a Driver or Companion MANDATORY:

- If you plan to take a Sedative or are scheduled to receive IV sedation, you MUST have a capable driver that meets the companion/driver requirements below
- If you are NOT driving yourself to this appointment, your driver MUST accompany you to our office & remain with you in our prep/recovery area for the entirety of your appointment. This applies whether you plan to take a sedative or not
- If you are unable to walk without the use of an assistive device (walker, cane, wheelchair, etc.)
- If you have any cognitive limitations preventing you from appropriately communicating or understanding information requested or received

Patients' Undergoing In-Office Procedures

- Your doctor strongly recommends that you bring a capable driver with you to this appointment, regardless of if you are receiving any type of sedative or sedation
- Patients who decline any type of sedation and plan to drive themselves will be able to sign a self-driver waiver

If you have any questions or concerns prior to your appointment, please contact our office.

Patient Name (PRINT)	Patient Date of Birth
Patient Signature	Date Signed

SPINE & PAIN SPECIALISTS

Clinic Patient Information Record

Highlighted fields are required.

Patient Name/Last:	First:	Middle:	SSN:
Residence Address:	City:	State:	Zip:
Mailing Address: (Check here if same as above) [ ]			
Home Telephone Number:	Cell Phone Number:	Email Address:	
Date of Birth/Month: / Day: / Year:	[ ] Male [ ] Female	Race:	Ethnicity: [ ] Hispanic/Latino [ ] Not Hispanic/Latino
Employer's Name:	Work Telephone Number:	Ext:	
Preferred Language: [ ] English [ ] Spanish [ ] Other	Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Divorced		
Communication Needs			

Responsible Party: (check here if same as above) [ ]

Name/Last:	First:	Middle:	Responsible party's SSN:	Date of birth:
Mailing Address:	City:	State:	Zip:	
Home Telephone Number:	Relationship to Patient:			
Employer's Name:	Work Telephone Number:	Ext:		
Responsible Party's Spouse's Name (if applicable):	SSN:			

In Case of an Emergency, who may we notify (other than someone living with you) Relationship: _____

Name:	Date of Birth:	Telephone Number:	
Address:	City:	State:	Zip:
Who referred you to our office?	Telephone Number:		

Insurance Coverage Is your Illness/injury due to an Auto/Work Accident? [ ] Yes [ ] No

Insurance # 1 Name of Insurance Company:	
Policy Number:	Group Number:
Employer:	Guarantor:
Insurance # 2 Name of Insurance Company:	
Policy Number:	Group Number:
Employer:	Guarantor:
Insurance # 3 Name of Insurance Company:	
Policy Number:	Group Number:
Employer:	Guarantor:
Preferred Pharmacies:	

ASSIGNMENT OF BENEFITS

1. Hospital Care Consent: I/we consent to hospital services, treatment and diagnostic procedures by the hospital as may be deemed necessary or advisable by my physician and/or consultants selected by my physician. The consent to hospital care includes permission for x−ray examinations, laboratory procedures, I.V. treatments, hepatitis test administration of blood and blood products, injections, medications, recording, filming or video monitoring for internal purposes only, and hospital services rendered the patient under the general and special instruction of doctors. The patient acknowledges responsibility for any or all of these procedures. It is the hospital policy that the patient has the opportunity to discuss surgery and procedures with the patient's doctor before hand. The patient has the right to consent to surgery and procedures. Except in emergencies or unusual circumstances, the hospital does not allow its facilities to be used without this discussion and patient's consent. I voluntarily give my consent to hospital care and accept the condition of hospitalization listed.

2. Authorizations for Release of Information: The employees and agents of this hospital and copy services and electronic claims processing services under contract with this hospital and any third party billing agents for this hospital or any of its staff physicians involved with patient care are given permission to release any and all information relating to the patient, including but not limited to the medical record of the patient's hospitalization, to another healthcare provider if the patient was transferred to that facility from this hospital and to any and all insurance companies or other third−party paying or obligated to pay, in whole or in part, the charges incurred by the patient in this hospital; and they are also given permission to release the above described information to any agent or firm working for or with the above described insurance companies or other third−party payors for the purpose of performing pre−certification, concurrent and/or retrospective review and/or other utilization review of any kind. I hereby authorize the hospital to release all test results to my insurer(s).

3. Valuables: I understand and acknowledge that the hospital assumes no responsibility for personal possessions including cash, jewelry, bridgework, eyeglasses or any other personal possession which I choose to keep in my room. I have been advised that such valuables should be placed in the care of my family or deposited in the hospital vault located in the Business Office.

4. Safety Code for Hospital: Safety Codes for hospitals issued by the National Fire Protection Association prevent the use in the hospital of any electrical equipment or accessories until they have been safety checked by the hospital's electrical engineer. Exceptions to this rule are hair and blow dryers, curling irons, hot rollers, radios, clocks, electric razors, shavers, contact lens sterilizers, electric toothbrushes and calculators.

5. Payment Guaranty and Assignment of Insurance Benefits: I, the undersigned patient, guardian, and/or guarantor (hereinafter "Debtor") hereby promise to pay in full Willis Knighton Health (WKH) customary charges for the goods and services rendered to the patient identified on the reverse side hereof during this period of hospitalization (hereinafter "Indebtedness''). Debtor acknowledges and agrees that, unless waived in full by WKH as set forth below, the Indebtedness accruing during this hospitalization is due and payable in such amounts and at such times during this hospitalization as WKH may, in its sole discretion, determine, that the entire Indebtedness is due and payable in full at discharge. I acknowledge that, upon proof of acceptable insurance coverage, WKH, in its sole discretion, may reduce the amount of indebtedness due and payable during this hospitalizations and the balance due at discharge. In such event, I understand that all deductibles, co−insurance, non−covered charges and other items not paid by insurance or other third−party payors shall be due and payable during this period of hospitalization and upon discharge as set forth hereinabove. I acknowledge and agree that in the event that WKH, in its sole discretion, accepts proof of insurance coverage, claims for payment for benefits will be filed on behalf of the Debtor and/or the insured and that these benefits will be considered by WKH in determining the amounts due as set forth hereinabove. I understand and agree that WKH will accept payments from third−party payors and insurers on behalf of the Debtor and apply such payment to the indebtedness to the extent that they are received. I acknowledge and agree that the filing of such insurance and other third−party claims is performed as a service by WKH and in no way relieves me of the obligation to pay the Indebtedness as agreed herein above.

Patient hereby appoints WKH as Patient's authorized representative to file any necessary claim appeal(s) on Patient's behalf. In consideration for this appointment. WKH agrees only to collect only applicable copayments, deductibles, and coinsurance for covered benefits from the Patient and waives any right to collect any other payments related to those covered benefits from the Patient.

Debtor hereby absolutely assigns to WKH all insurance benefits on all policies of insurance under which Debtor is an insured, whether hospital, medical, liability or other insurance, and also hereby absolutely assigns to WKH the proceeds of any judgment or settlement of any claim against any third party and any and all other amounts which may be determined in any manner to be payable to Debtor in connection with any injury suffered by the patient which gives rise to the Indebtedness incurred during this period of treatment. I hereby authorize WKH to obtain any and all information related to such injuries, including, but not limited to, accident reports and agree to cooperate with WKH in connection with the procurement of any information or documents WKH deems in its sole discretion, necessary or appropriate in connection with the assignment made pursuant to this paragraph. I hereby authorize and direct that all such payments and proceeds shall be made directly to WKH under the terms of this assignment. Any receipts from WKH shall be applied towards Indebtedness but such application shall not relieve the Debtor from the Debtor's obligation to pay any remaining portion to the Indebtedness. Debtor acknowledges and agrees that, to the extent that the Indebtedness has not been satisfied by such receipts, that portion of the Indebtedness for which payment has been deferred pursuant to the preceding paragraph shall be due and payable in full on the thirtieth day following the date of service. In the event that WKH receives proceeds and/or payments in excess of the Indebtedness, WKH may apply such excess payment to any outstanding Indebtedness of Debtor to WKH arising out of any other period(s) of treatment as well as any attorneys' fees and expenses for which Debtor may be liable hereunder. In the event that all Indebtedness has been paid

Admission Date:

Admission Time:

AD0005

ASSIGNMENT OF BENEFITS

in full, then WKH will refund the Debtor any such excess payment. Notwithstanding anything herein to the contrary, the assignments made hereby shall remain in full force and effect until the entire Indebtedness and any and all attorneys' fees and expenses for which Debtor may be liable have been paid in full. In the event that the Indebtedness is not paid when and as due as determined by WKH hereunder, and the Indebtedness is placed in the hands of an attorney for purposes of collection, Debtor agrees to pay reasonable attorneys' fees, which are hereby acknowledged to be one−third (1/3) of the amount of the Indebtedness at the time the matter is placed in the hands of an attorney, plus any and all court costs and other expenses incurred in connection with the collection of the Indebtedness.

Financial assistance is available to all patients who meet the requirements of our charity care policy. Patients are encouraged to contact the Business Office if they have any concerns or need assistance in paying their bills. Our charity care policy is limited to hospital charges and does not include physician, anesthesiologist or professional charges that are not billed by the hospital. In addition, financial assistance is not offered for cosmetic, elective, experimental or other treatments and all hospital services must be ordered by your physician.

6. Assignment to Physicians: I understand that my physician as well as other physicians who treat me or otherwise involved in my care while a patient at the hospital are not employees or agents of the hospital and the hospital is not responsible for their actions. I further understand that my physician or other physicians will send me a separate bill for their services, in addition to the hospital bill. I hereby assign to all physicians who treat me the benefits due to me for these services covering medical and/or surgical expenses. I agree that should be the amount be insufficient to cover the entire medical/surgical expense, I will be responsible to said physicians for payment of the entire bill.

7. Medicare Consent: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act (SSA) is correct. I authorize Willis Knighton Health (WKH) to provide (SSA) or its intermediaries with access to my medical/hospital record for the purpose of processing the Medicare claim for this or a related Medicare claim. I further request that WKH provide such copies thereof as may be requested. Copies may be made by WKH or its agents or contractors providing copy service and electronic claims processing services and said third party billing agents for hospital and staff physicians involved with patient care.

8. Champus/Medicare Notice: Champus/Medicare will not pay for private rooms unless medical justified, personal convenience items, diagnostic admissions or test or hospital stays not medically necessary. My signature below acknowledges my receipt of this information regarding Champus/Medicare from the hospital on the date indicated.

9. Willis Knighton Health (and our Medical Staff) will use and disclose your personal health information to treat you, to receive payment for the care we provide and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website and have copies available for distribution. I acknowledge that I have received a copy of the Notice of Privacy Practices.

This form has been fully explained to me. My signature reflects my understanding of the information contained herein. I further understand and acknowledge that all references to myself as the patient shall be deemed to apply as if rewritten in their entirety to a dependent for whom I am responsible for and/or who is unable to consent on their behalf for reasons indicated below.

I acknowledge that I have been informed of my rights and obligations as a patient.

Signature of Patient/Guardian	Date/Time	Guarantor	Date/Time	Witness	Date/Time

Print Name	Date of Birth	Print Name	Print Name

If Patient/Guarantor is unable to sign, I, _____ , do hereby state that I have been given the authority to sign for

_____ , either expressed or implied and that he or she is fully aware of this authority.

Signature of Authorized Party	Authorized Party's Relationship to the Patient	Date/Time	Witness	Date/Time

Admission Date:

Admission Time:

AD0005

AM3349
Revised 10/03/2019
Committee Approved 10/3/2019
Page 2 of 2

Payment Policy
Willis Knighton
Network Physicians

Patient Name: _____ Date of Birth: _____

Payment arrangements are understood and agreed upon by the patient and provider prior to services being rendered.

Willis Knighton Health participates with and accepts most insurance plans. **Patients are required to furnish proof of insurance at the time of service.** As a courtesy to our patients, we will be happy to file the insurance claim(s) for services rendered by any of the 80+ providers participating within the Willis Knighton Physician Network.

Monthly statements are generated and mailed to patients/guarantors to make them aware of any outstanding balance after insurance coverage has been exhausted. **Any outstanding balance is considered the guarantor's responsibility regardless of insurance coverage.**

An account will be deemed delinquent after 90 days from the date of service or from the date services were denied or paid by the insurance carrier.

Annual deductible amounts will be the obligation of the guarantor. If the patient has met his/her deductible for the current year and can verify this with an Explanation of Benefits from his/her insurance carrier, the remainder of the patient responsibility (such as 20% for most insurance plans) will be due at the time of visit.

Co−payments for HMO's, PPO's, and other managed care plans must be paid at the time of service. Balance billing patients for their co−pays is a violation of many managed care contracts and will not be allowed. **Co−payments will be collected at check−in before the physician sees the patient.** If the patient does not have the co−pay at the time of visit, the patient may reschedule the appointment in order to meet the co−pay requirement.

Should the patient or responsible party express an inability to pay, alternate payment plans and assistance are available upon request. The physician and/or clinic manager must approve monthly payment plans and discounts. Patients must agree in writing to the payment plan prior to seeing the physician.

My signature below verifies that I have read and understand the payment policy outlined above.

_____ _____

Patient (if over 18 years of age) Date/Time

_____ _____

Guarantor (if patient is under 18 years of age) Date/Time

PC872
Revised 10/06/2017
Committee Approved 10/10/2017
Page 1 of 1

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT
METHODS OF COMMUNICATION

Willis Knighton Health

2600 Greenwood Road Shreveport LA 71103 (318) 212−4000

Willis Knighton Health (WKH) and our medical staff will use and disclose your personal health information ***to treat you, to receive payment for the care we provide and for other healthcare operations***. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regard to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities and on our website and have copies available for distribution.

Occasionally we may communicate with patients via text or email regarding things such as **appointment reminders, requests to share your opinion of providers and services, news and notices about providers, treatments, technology, medications or other services/information that could benefit your health**. (In some instances, depending on your mobile plan, text and data rates may apply.) Willis Knighton will communicate for Willis Knighton purposes only and will not sell or share your mobile number or email with companies not contracted with Willis Knighton.

I hereby acknowledge the receipt of Willis Knighton Health's Notice of Privacy Practices and have been provided an opportunity to review it.

WK SPINE & PAIN SPECIALISTS

_____ _____

Patient's Name (Please Print) **Date of Birth**

_____ _____

Patient/Representative Signature **Date**

If you are not the patient, indicate your relationship below:

☐ parent or legal guardian of the minor ☐ spouse

☐ personal representative of the patient ☐ other_____

Name_____

Address _____ Phone Number_____

Willis Knighton takes your medical confidentiality very seriously. We will not and cannot release information without your written authorization. This authorization allows our staff to speak with an individual(s) you designate in the event you are not available to receive phone calls or you have another adult who helps coordinate your medical care.

☐ I DO NOT authorize anyone to receive information regarding my medical care

☐ I authorize my physician and employees of Willis Knighton to speak with the following:

Person_____ Relationship _____ Phone_____

Person_____ Relationship _____ Phone_____

Person_____ Relationship _____ Phone_____

If you wish to opt out of electronic communications as noted in the second paragraph of this document, you may do so by checking this box: ☐

If at some point in the future you wish to receive these communications, you may request a new form to update your preferences at any registration desk at Willis Knighton.



AM2363
Revised 02/01/2020
Committee Approved 02/28/2020
Page 1 of 1

WILLIS KNIGHTON HEALTH (WKH)
AMBIENT SCRIBE PATIENT CONSENT
Patient Informed Consent to the Use of Ambient Scribe Tools

Dear Patient,

WKH Providers may use certain artificial intelligence (AI) enabled ambient listening (ambient scribe) tools, provided by WKH, to support providing care to you. This consent provides you with information regarding ambient scribe used in the clinical setting.

- ***What are Ambient Intelligence Tools?*** Ambient intelligence tools use AI to "listen" to clinical conversations during your provider visit and write draft notes or summaries of the visit in real−time as if there was another person in the room scribing your visit. This helps providers focus more on you, the patient, instead of entering information into the computer during your visit. Some ambient scribe tools do other activities to help support providers to help them make diagnoses or decisions regarding your care and treatment.
- ***What will be recorded and what will the recording be used for?*** We will be recording the audio or verbal conversation with your provider and other health care personnel at this office. We will not be recording any video. The ambient scribe tool will be transcribing the spoken conversation to digital text uniquely for each of the participants in the examination room. The recording content, using artificial intelligence technology and computer algorithms, will generate documentation reflecting the conversation. The provider will then review and develop the clinical documentation using the content provided by the ambience tool.
- ***How long will my recording be kept for?*** The recording(s) will be destroyed following digital transcription, and the digital transcription will be retained electronically no longer than thirty (30) days.
- ***Who will listen to my recordings?*** In general, no one will listen to your recordings. The recording digital transcription will be used to develop the clinical documentation on your chart, which will be available to you in the Patient Portal.
- ***How Will Use of the Ambient Tool Affect You?*** It is not necessary for you to interact with the ambient tool as it will not be asking you for any information, instead it will be working behind the scenes to create a draft clinical note or summary of your encounter for your provider to review after your visit. This allows the provider to focus more of their time and attention on you during your visit, rather than documenting what occurs during your visit.
- ***How Do Ambient Intelligence Tools Impact the Privacy and Security of Your Health Information?*** Your Provider assures you that your privacy is an utmost priority and that your Provider and WKH keeps your health information private and secure. Willis Knighton Health complies with all applicable laws, including without limitation the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH).
- ***Who Do You Contact with Additional Questions?*** If you have any questions about ambient scribe, or this consent form, please ask the front desk personnel or your provider.

I acknowledge the use of and agree to the use of ambient scribe technology during my visits.

Patient Name / Guarantor: _____ **Signature:** _____

Patient DOB: _____ **Date/Time:** _____

Controlled Substance Agreement

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

The long−term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives are controversial because of uncertainty regarding the extent to which they provide long−term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential for abuse and diversion, strict accountability is necessary when use is prolonged. For this reason, the following policies are agreed to by you, the patient and the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

Patient Name (Printed) **Date of Birth**

Initials_____ 1. All controlled substances must come from the physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization of obtained for an exception. (Multiple sources can lead to untoward drug interaction or poor coordination of treatment.)

Initials_____ 2. All controlled substances must be obtained at the same pharmacy, when possible. Should the need arise to change pharmacies, our office must be informed.

Initials_____ 3. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.

Initials_____ 4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.

Initials_____ 5. You may not share, sell or otherwise permit others to have access to these medications.

Initials_____ 6. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.

Initials_____ 7. Unannounced urine or serum toxicology screen may be requested and your cooperation is required. Presence of unauthorized substances may prompt referral for assessment of addictive disorder.

Initials_____ 8. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.

Initials_____ 9. Original containers of medications should be brought in to each office visit.

Initials_____ 10. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of the reach of such people.

Initials_____ 11. Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made.

Initials_____ 12. Early refills will generally not be given.

MI0005

Controlled Substance Agreement Continued

***Initials*_____ 13. Prescriptions may be issued early if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they are not to be filled prior to the appropriate date.

***Initials*_____ 14. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies all confidentiality is waived, and these authorities may be given full access to our records of controlled substances administration.

***Initials*_____ 15. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.

***Initials*_____ 16. Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.

***Initials*_____ 17. It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit.

***Initials*_____ 18. The risks and potential benefits of these therapies are explained elsewhere (and you acknowledge that you have received such explanation).

***Initials*_____ 19. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all terms.

*****I agree by signing below that I will not accept medical care for pain by any other physician other than the physician below, except during an emergency. I will notify my primary doctor of record and understand that I may be discharged from the practice if I accept pain care from another doctor."**

OFFICE USE ONLY

Physician Signature	Patient Signature
Physician Name (Printed)	Patient Name (Printed)
Date Signed	Date of Birth

Approved by the AAPM Executive Committee on April 2, 2001.
AARM
4700 W. Lake Avenue
Glenview, IL 60025−1485
847−345−4731 **Fax**: 877−734−8750
E−mail: aapm@amctec.com
Website: http://www.painmed.org

MI0005

IC1021
Revised 10/07/2024
Committee Approved 10/23/2024
Page 2 of 2

SPINE & PAIN SPECIALISTS

ORT Assessment Questionnaire

Patient Name: _____ **Date of Birth:** _____

Today's Date _____

Check each box that applies

Gender	☐ Female	☐ Male
Family history of substance abuse	**Yes**	**No**
Alcohol	☐	☐
Illegal Drugs	☐	☐
Prescription Drugs	☐	☐
Personal History of substance abuse?	**Yes**	**No**
Alcohol	☐	☐
Illegal Drugs	☐	☐
Prescription Drugs	☐	☐
	Yes	**No**
Age: Are you between 16-45 years old?	☐	☐
Personal history of preadolescent sexual abuse	☐	☐
Personal history of any of the following psychological diseases?	**Yes**	**No**
Attention Deficit Disorder (ADD)	☐	☐
Obsessive Compulsive Disorder (OCD)	☐	☐
Post Traumatic Stress Disorder (PTSD)	☐	☐
Bipolar Disorder	☐	☐
Schizophrenia	☐	☐
Depression	☐	☐

Patient Signature: **Date Signed**

Provider:

☐ Dr. John Noles
☐ Bridget Whittington, PA-C
☐ Sarah Brantley, PA-C
☐ Jordan Wyatt, PA-C
☐ Dr. David Hirsch
☐ Tyra Brown, PA-C
☐ Stephanie Ledoux, PA-C
☐ Dr. Nancy Germany

Provider Signature ***Date Signed***

IDENTIFICATION DATA (Please print the following information)

Date _____ Age _____

Patient Name _____ Male___ Female____ Date of Birth _________

Address _____ Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

_____ Residence Phone ( )_____

_____ Business Phone ( )_____

FAMILY HISTORY − List Immediate family members who have died (Father, Mother, etc.):

_____

_____

_____

Circle Illnesses immediate family members have had:

Tuberculosis	Heart Disease	Hay Fever	Glaucoma
Diabetes	High Blood Pressure	Asthma	
Cancer	Allergies	Sickle Cell Anemia	

PATIENT HISTORY; Please check if your medical history includes:

Date of last dental exam: _____

REVIEWER NOTES

EYE, EAR, NOSE
1. Hay Fever ____
2. Ear Infection ____
3. Hearing Loss ____
4. Eye Problems ____

GASTROINTESTINAL
5. Stomach Pain ____
6. Ulcers ____
7. Change In bowel Habits ____
8. Rectal Bleeding ____
9. Jaundice (Hepatitis) ____

CARDIO−RESPIRATORY
10. Trouble Breathing ____
11. Cough (If chronic) ____
12. Asthma ____
13. High Blood Pressure ____
14. Rheumatic Fever ____
15. Heart Disease ____
16. Activity Limitation ____
17. EKG−Last Date _____
18. Chest X−Ray − Date _____

GENITOURINARY
19. Difficulty starting stream ____
20. Night time urination ____
21. Kidney Disease ____
22. Urinary Infection ____

NEURO−MUSCULAR
23. Weakness ____
24. Numbness/Tingling ____
25. Muscle Pain ____
26. Seizures/Epilepsy ____
27. Paralysis ____
28. Migraine/Headaches ____

SKELETAL
29. Joint Pain or Swelling ____
30. Back Problems ____
31. Arthritis ____

ENDOCRINE
32. Diabetes ____
33. Thyroid Problems ____
34. Recent Weight Gain/Loss (10 pounds) ____

HEMATOLOGIC
35. Sickle Cell Disease ____
36. Anemia ____
37. Bleeding Tendencies ____
38. Thrombophlebitis/blood clots ____

OTHER (Additional space on back)
39. Cancer ____
40. Mental/Emotional Problems ____
41. Venereal Disease History ____
42. Tetanus Immunization
Last Date: _____

FOR WOMEN ONLY
43. Irregularity of Periods_____ 44. Abnormal Flow_____ 45. PID/Pelvic Pain_____ 46. Breast Disease____
47. Last Menstrual Period, Date:_____ 48. Last Pelvic/Pap Smear Date:_____
49. Birth Control? If so, what type:_____ 50. Number of Pregnancies:_____ Number of Births:_____

Willis Knighton Health

Patient Name _____ Date of Birth _________ Patient History. Cont'd.

PLEASE LIST ALL SURGERIES, HOSPITALIZATIONS, AND/OR SERIOUS INJURIES:

_____

_____

_____

PLEASE INCLUDE ALL CURRENT PRESCRIPTIONS, OVER THE COUNTER MEDS, HERBALS, PATCHES, INHALER, EYE DROPS & SUPPLEMENTS:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

PREFERRED PHARMACY: _____

PLEASE NAME ANY DRUG ALLERGIES/ADVERSE REACTIONS:

_____ _____ _____

_____ _____ _____

_____ _____ _____

CURRENT LIFE STYLE: Name your current occupation _____

	NO	YES
Do you use alcohol more than four times per week?	_____	_____
Do you smoke?	_____	_____
Do you ever use drugs recreationally?	_____	_____
Do you feel safe in your environment?	_____	_____

Indicate any abnormality	YES	NO	Description
A) Eyes	_____	_____	_____
B) Ears, Nose, Throat	_____	_____	_____
C) Skin	_____	_____	_____
D) Nervous System	_____	_____	_____
E) Chest	_____	_____	_____
F) Heart	_____	_____	_____
G) Abdomen	_____	_____	_____
H) Genito−Urinary System	_____	_____	_____
I) Pelvic	_____	_____	_____
J) Extremities	_____	_____	_____
K) Back	_____	_____	_____
L) Pain − Location	_____	_____	Pain Scale 0 1 2 3 4 5 6 7 8 9 10

Completed by: _____
Signature Printed Name Date/Time

Reviewed with patient by: _____
Provider Signature Printed Name Date/Time

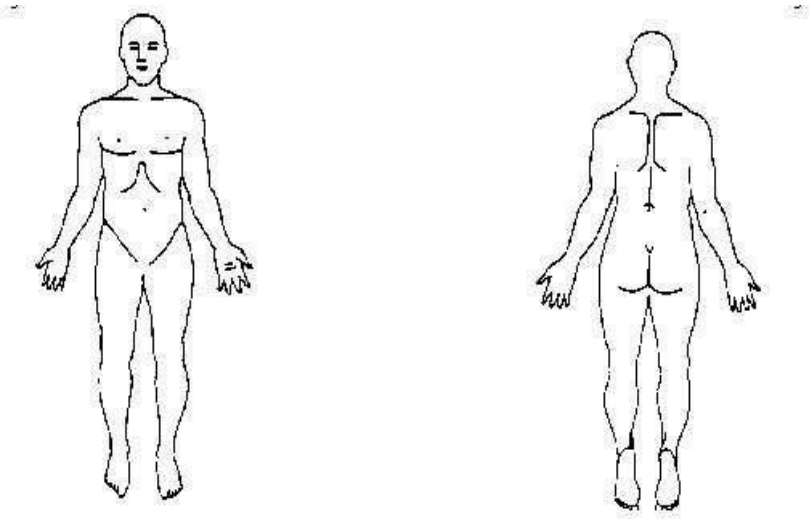
Brief Pain Inventory

Date: _____

Name: _____
Last **First** **Middle Initial**

Date of Birth: ____/_____/_____

How long has it been since you first learned of your diagnosis? _____
On the diagram, shade the areas where you feel pain. Put at "X" on the area that hurts the most.



1. Current level of pain **0 -10 (10 is worst)** _____
2. Describe the frequency of your pain: ☐Intermittent ☐ Constant ☐ Occasional ☐ Rare
3. How would you describe your pain? Check all those that apply.
   ☐Ache ☐ Burning ☐ Deep ☐ Discomforting ☐ Dull ☐ Numbness ☐ Piercing ☐ Sharp
   ☐ Shooting ☐ Stabbing ☐ Throbbing
4. What makes your pain worse? Check all those that apply.
   ☐Movement ☐ Sitting ☐ Standing ☐ Walking ☐Stress ☐ Other _____
5. What relieves your pain? Check all those that apply.
   ☐Exercise ☐ Heat ☐ Ice ☐ Injections ☐Medication ☐ Physical Therapy ☐ Rest ☐Sitting
   Other _____
6. Other methods I have used to relieve my pain include: (Check all those that apply)
   ☐Warm Compress ☐ Cold Compress ☐ Relaxation Techniques ☐ Distraction Techniques ☐Biofeedback ☐ Hypnosis
   ☐ Other _____

Patient Name:_____ **Patient DOB:**_____

Use the scale below to answer the questions below to rate your pain by indicating **ONE** number that best describes your pain in the **last week** for each

0 1 2 3 4 5 6 7 8 9 10

Does not interfere ***Completely interferes***

WORST pain score in the last week	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
LEAST pain score in the last week	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
AVERAGE pain score in the last week	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*

Use the scale below to indicate how **PAIN** has interfered with the following in the **PAST WEEK**

0 1 2 3 4 5 6 7 8 9 10

Does not interfere ***Completely interferes***

General Activity:	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
Mood:	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
Walking ability:	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
Normal work	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
Relations with other people	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
Sleep	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
Enjoyment of life	*0*	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*

7. In the past week, how much relief have pain treatments or medications provided? Please select the ONE percentage that most shows how much relief you received

☐ 0% ☐10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐70% ☐ 80% ☐ 90% ☐ 100%

No relief ***Complete relief***

12. Have you ever had pain due to your present disease? ☐ Yes ☐ No
13. When you first received your diagnosis, was pain one of your symptoms? ☐ Yes ☐ No ☐ Uncertain
14. Have you had surgery in the past month? ☐ Yes ☐ No

If Yes, what kind:_____

Patient Name:_____ **Patient DOB:**_____

15. Check the appropriate response to each item.

I believe my pain is due to:

☐ Yes ☐ No A. The effects of treatment (for example medication, surgery, radiation, prosthetic device).

☐ Yes ☐ No B. My primary disease (meaning the disease currently being treated and evaluated).

☐ Yes ☐ No C. A medical condition unrelated to my primary disease (for example, arthritis).

16. What treatments or medication are you receiving for your pain?

17. I prefer to take my pain medicine: Choose ***ONE***

☐ On a Regular Basis ☐ Only when necessary ☐ Do not take pain medicine

18. If you take pain medication, how many hours does it take before the pain returns?

☐ Pain medication doesn't help at all ☐ Four hours

☐ One hour ☐ Five to Twelve hours

☐ Two hours ☐ More than twelve hours

☐ Three hours ☐ I do not take pain medication

19. I take my pain medicine (in a 24-hour period):

☐ Not every day ☐ 5 to 6 times per day

☐ 1 to 2 times per day ☐ More than 6 times per day

☐ 3 to 4 times per day

20. Do you feel you need a stronger type of pain medication?

☐ Yes ☐ No ☐ Uncertain

21. Do you feel you need to take more of the pain medication that your doctor has prescribed?

☐ Yes ☐ No ☐ Uncertain

22. Are you concerned that you use too much pain medication?

☐ Yes ☐ No ☐ Uncertain If yes, why? _____

23. Are you having problems with side effects from your pain medication?

☐ Yes ☐ No ☐ Uncertain If yes, which side effects? _____

24. Do you feel you need to receive further information about your pain medication? ☐ Yes ☐ No

25. Medications not prescribed by my doctor that I take for pain are:

_____

_____

26. Marital status at present? ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Patient Name:_____ **Patient DOB:**_____

27. Education (Circle only the highest grade or degree completed)

    Grade ☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ M.A./M.S.

    Professional degree (please specify) _____

28. Current occupation: _____(specify times; if you are not working tell us your previous occupation)

29. Which of the following best describes your current job status?

    ☐ Employed outside the home, full-time ☐ Homemaker

    ☐ Employed outside the home, part-time ☐ Retired

    ☐ Unemployed ☐ Other

30. Spouse's occupation:_____

Please list ALL ***medications***, ***doses***, and any ***side effects*** that you have experienced:

Name	Dose	TimesTakenPerDay	Prescribing MD	Side Effects

Patient Name: _____ **Date of Birth**: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself; Feeling that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	0	1	2	3
	Total	**Total**	**Total**	**Total**

FORM TOTAL: _____