Delta
SPINE AND PAIN CLINIC

Name: _____
Date of Birth: _____
Height: _____ **Weight:** _____
Sex: Male Female

PCP: _____
Treating Doctor (work comp): _____
How were you referred: _____

Chief Complaint:

Why are you here today, or where do you have pain? _____

History of Pain:

Date of Injury: _____

Compensable Area (if workers compensation): _____

Brief description of how you were injured: _____

History of Present Illness:

How would you describe your pain? CIRCLE one or more: BURNING, SHOOTING, ACHING, STABBING, SHARP, DULL, THROBBING, CRAMPING, CRUSHING, VAGUE, TINGLING, STIFF, TIGHT, HEAVY, SORE, NAGGING, PINS and NEEDLES, OTHER: _____

Do you have any of the following symptoms? Circle one or more: WEAKNESS, SPASMS, NUMBNESS, SWELLING, HEADACHES, HOT, COLD and OTHER: _____

Does the pain keep you from falling asleep? YES NO

Does the pain wake you up at night? YES NO

Do you get poor sleep for other reasons besides pain? YES, NO and what are they? _____

What makes the pain BETTER? _____

What makes the pain WORSE? _____

What have you done to treat the pain? HEAT, COLD, MEDICATIONS, ACCUPUNCTURE, PHYSICAL THERAPY, AQUA THERAPY, HOME EXERCISES, TENS UNIT, INJECTIONS, SURGERY, CHIROPRACTOR, OTHER: _____

_____

What is your pain like CURRENTLY on a scale from 0 – 10? Best 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 worst

What is your pain like at its BEST (with medication etc.)? Best 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 worst

What is your pain like at its WORST? Best 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 worst

Do you have any side effects with your current medications? _____

_____

Do you have any problems with bowel or bladder dysfunction (incontinence, constipation...)? _____

_____

Review of Systems: Please CIRCLE any that apply

General: weight gain, weight loss, fever, chills, fatigue

Head: ringing in ears, hearing loss, sore throat, difficulty swallowing, visual changes

Chest: difficulty breathing, cough, bloody or colored sputum

Heart: chest pain, slow heart rate, fast heart rate, high blood pressure, low blood pressure

GI: nausea, vomiting, abdominal pain, constipation, diarrhea, blood in stool

Musculoskeletal: muscle pain, joint pain, back pain, neck pain

Neurology: seizures, dizziness, falling, loss of bladder control, loss of bowel control

Psychiatric: depression, anxiety, panic attacks, suicidal thoughts

Male/Female: decreased sexual drive, impotence, erectile dysfunction

Blood: low blood count, easy bruising, easy bleeding, history of blood transfusion

Skin: rash, itching

Past Medical History: (High blood pressure, Diabetes, Asthma etc.)

_____

_____

_____

_____

_____

Doctor List: (cardiologist, neurologist, surgeon, orthopedic, psychiatrist, etc.)

_____

_____

_____

_____

Past Surgical History:

Surgery: Date: Surgery: Date:

Past Psychiatric History: (Depression, Anxiety, Bipolar Disorder, etc.)

Previous Pain Treatments: (Procedure, Date, and Physician)

Social History:

Do you smoke? Yes No

How much do you smoke on average (packs/day)? _____

Date if you quit _____

Do you use any other tobacco products? Yes No

Do you use alcohol? Yes No rarely occasionally heavy quit (date) _____

Do you use any illicit drugs? Yes No _____

Current Occupation: (previous if not working) _____

Current Job Status: employed full-time employed part-time homemaker retired unemployed

Are you on disability? Yes No

Any ongoing litigation? Yes No

Allergies:

Are you ALLERGIC to anything? Yes No

If yes, please list:

Allergy: Reaction: Allergy: Reaction:

List **PAIN** medications you are taking for pain (include dose and frequency). Please include prescription medications, over the counter medications, herbal remedies.

Name of Medication	Dose (mg)	How often taken	Reason for taking	Length of time taken

List OTHER medications you are taking (include dose and frequency).

Name of Medication	Dose (mg)	How often taken	Reason for taking	Length of time taken

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Provider Ownership Disclosure Form

To: Patients at the time of referral.

On the date of your first contact with Dr. Johnson Ukpede (the "Providers") or when your records were updated, you were informed that the Providers may refer you to a facility, laboratory, or other entity.

The Providers may recommend that you be referred to one or more of the Entities. In connection with such referral to the Entities, you are hereby advised again that the Providers may have an investment interest in one or more of the Entities and, therefore, may receive, directly or indirectly, remuneration as a result of such referral.

This disclosure is being provided to you at the time of your referral by one of the Providers to help you make an informed decision about your health care. You have the right to choose your health care provider. You have the option of obtaining health care ordered by your provider at a different facility other than the Entities. You will not be treated differently by your provider, the provider's staff, or the Entities if you choose to use a different facility.

Should you prefer to be referred to a facility other than one of the Entities, you will be provided with a list of alternative health care providers or facilities and you have the right to choose one of these alternative referral providers or facilities.

_____

Patient name (please print)

_____

Patient signature

Date: _____

Delta
SPINE AND PAIN CLINIC
Tel. (281) 741-3243 Fax (281) 741-8763
Johnson Ukpede, M.D.

Medical Record Release Authorization Form

1. I, _____ DOB: _____ hereby authorize:

   ☐ Printed Patient Name Patient DOB

   ☐ Delta Spine and Pain Clinic and its associates/employees to use, obtain and/or disclose the protected health information.

   ☐ _____ to release my medical record to

   Delta Spine and Pain Clinic and its associates/employees.

2. ☐ I hereby authorize the release and use of my complete health record.

   OR

   ☐ I hereby authorize the release of and use of my complete health record with the exception of: (check records that you do not want to send)

   ☐ Alcohol/drug abuse treatment
   ☐ Communicable Diseases
   ☐ Mental Health Records
   ☐ Other:

_____

3. I understand that the information released may be disclosed by the recipient and may no longer be protected.

4. I am voluntarily releasing and authorizing the use of information protected by law.

_____ _____

Signature of Patient or Authorized Individual Date

_____ _____

Printed Name of Patient or Authorized Individual Relationship to Patient

_____ _____

Witness' Signature Date

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SPINE AND PAIN CLINIC

HIPAA Privacy Acknowledgement

1. The medical information may be used by the person authorized for medical/surgical treatment, referrals, billing or claims payment, or other purposes.

2. Disclosed information may be used without your authorization in special situations as required by law, public health, communicable diseases, health oversight, in case of abuse or neglect, FDA's request, worker's compensation, and for the purpose of military and national security.

3. I understand that I may revoke this authorization at any time except to the extent that action has already been taken in reliance upon it. If I do not revoke it, this authorization will remain effective until I revoke in writing.

4. You have the right to inspect and copy all protected health information with limitations as governed by law and fees according to the guideline of state of Texas.

5. You have the right to report violation of private records to proper authorities.

6. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign the HIPAA privacy authorization form.

7. I have read and understand the information regarding Health Insurance Portability and Accountability Act (HIPAA).

8. I designate, _____, to access & inquire about my protected medical information. This person IS / IS NOT authorized to pick up prescriptions for me in the event of an emergency. (Circle one)

Individual listed is: _____.
Relationship to Patient

Emergency Contact Name and Phone Number: _____.

_____ _____
Signature of Patient or Authorized Individual Date

_____ _____
Printed Name of Patient or Authorized Individual Relationship to Patient

_____ _____
Witness' Signature Date

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SPINE AND PAIN CLINIC

USE/CAPTURE OF IMAGE AND VIDEO CONSENT FORM

Name of Patient: _____

I, the patient, hereby give consent to Delta Spine and Pain Clinic and/or other parties authorized by Delta Spine and Pain Clinic to perform image capturing and its use as outlined below.

☐ Do agree ☐ Do not agree	To the use of picture capturing devices for capturing still or moving images (i.e. X-ray, fluoroscopy, camera, video camera, etc.)
☐ Do agree ☐ Do not agree	To use the images/photographs for education (ex. Training/teaching)
☐Do agree ☐Do not agree	To use the images/photographs for publications
☐Do agree ☐Do not agree	To use the images/photographs for marketing or broadcasting

I understand that my medical information will not be disclosed unless directed by me or when required by law. I understand that by signing the consent, I am authorizing Delta Spine and Pain Clinic and its associates or other authorized parties to use my photographs, images or recordings.

I hereby waive any compensation for the use of photographs, images or recordings obtained, and I release any authorized representatives of media, agents or representatives, doctors, healthcare providers, and employees from any and all claims, demands, liabilities, and actions, causes of action, suits, and costs whatsoever that I/we may have against any of them in connection with the capturing and use of photographs, images or recordings.

By signing below, I confirm the comprehension of the consent form and agree as above.

_____ _____

Patient's Signature (Person authorized to sign for the patient) Date

_____ _____

Witness Date

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Controlled Substance for Chronic Pain Agreement

This agreement is between Delta Spine and Pain Clinic and its associate Johnson Ukpede, M.D., and the patient:

_____.

The agreement outlines the controlled substance use for chronic pain. This is a binding agreement for each party unless a written notice is given by either party to cancel or change the agreement or as noted in a medical record. Both parties, hereafter, agree that the patient suffers from long term pain which has not been relieved by other pain alleviating methods and deserves a trial, and possibly chronic use of controlled medications as an adjunctive or sole therapy.

The doctor agrees to provide prescriptions for the patient in a medically appropriate manner according to the standards of care of pain management and to his judgment and training. The doctor has provided all pertinent information regarding other treatment options and details of those treatment options as well as the details of an opioid based therapy including medication profile and potential negative effects including sedation, breathing difficulties, and sexual side effects. The patient will take appropriate action to prevent potential conflicts while on therapy. Patient has had adequate opportunity for discussion and questions and agrees to proceed with the treatment plan.

The patient understands and agrees that narcotic analgesics will be used to lessen pain and improve function. The goal is to eventually wean off of all narcotics as judged by the treating physician. The level of improvement will vary individually and patient may not receive any benefit or have worsening of symptoms from the medication therapy. Patient is expected to participate in all treatments advised by the treating physician including, but not limited to physical therapy, psychological therapy, appropriate continued treatment with other health care providers, non-opioid based medications, procedures, and surgery. If the patient makes minimal or no effort to improve or is not compliant, the medications may be discontinued and patient may be released from the practice.

Patient's confidentiality is waived and responsible legal authorities will be given full access to our records of controlled substances if the patient does not conform to the agreement.

The patient understands that narcotic use may result in negative effects including, but not limited to:

1. **Tolerance** – Body resists the action of the medication or the effect is not achieved with the same dosage. It is possible that medication needs will change and there is a possibility that the medication will be discontinued due to lack of relief even at high medication doses.

2. **Dependence** – Body over time becomes reliant on the medication to a point that if the medication is abruptly decrease or ceased, he/she may develop withdrawal symptoms.

3. **Addiction** – It is unlikely for someone to develop addiction if taking prescribed medications as directed, however, one may develop psychological and/or physical dependence leading to ill behaviors.

4. **Overdose** – Misuse of the medication can cause severe detriment to the patient's health including, but not limited to breathing failure, circulatory failure, other organ failure and death.

5. **Loss of medication** – Medication will not be refilled early regardless of the reason for the loss or not taking the medication as directed. The physician may, at his discretion, decide on an individual basis for first time offenders without history of such events. Repeated mal-behavior will not be tolerated. In the case of loss or theft of the medication, a report is to be filed with the insurance company, and/or police department and provide proof of such action. Repetitive loss or taking the medication not as prescribed is not acceptable and will result in discontinuation of therapy and/or release from the practice.

The Patient Agrees:

1. To stop all opioids, benzodiazepines, and barbiturate sedatives prescribed by other physicians unless otherwise directed by the doctor or associates of Delta Spine and Pain Clinic.
2. To stop all illegal substance use.
3. To random drug screens and/or pill counts.
4. To discuss any alterations from agreed plan/therapy, any adverse effects and change in health conditions.
5. To obtain medications from one pharmacy and will immediately notify the prescribing doctor if the location of pharmacy changes.
6. To not seek or obtain opioids, benzodiazepines, sedatives, and other pain relievers from other sources without first contacting and receiving an approval from the doctor mentioned in this agreement or another physician of Delta Spine and Pain Clinic.
7. To properly store and secure the medication.
8. To not share or sell medications.
9. To take medications as prescribed and directed.
10. To keep all physician appointments and to follow the prescribing doctor's plan of therapy.
11. To inform the prescribing doctor of any foreseeable changes that may lead to medication changes and/or treatment.

12. To inform other healthcare providers that you are under the care of a pain management physician.

13. To actively and stringently follow all therapy suggested by the prescribing physician.

14. To notify the office during hours of business at least 3 days in advance prior to running out of the medication for a refill. Compliance is the responsibility of the patient.

15. To not hold the doctor or members of Delta Spine and Pain Clinic liable for complications that may occur due to discontinuation of the medications provided that thirty day notice has been given.

16. To use _____ pharmacy

    located at: _____ phone #_____.

Medications will not be refilled after hours, on weekends or on holidays. Calls for refills shall be made Monday through Thursday before completely running out of the medication. By signing the document, the patient and doctor agree to the terms stated in his/her own accord.

_____ _____

Patient Date

_____ _____

Witness Date

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Financial Policy

We, at Delta Spine and Pain Clinic, are committed in providing the highest quality of care for our patients and are happy to discuss professional fees with our patients at any time. The intent of this letter is to inform you and not to alarm you of the financial process and fees incurred for services rendered.

As you are aware, there are many different fees associated with providing medical care and many times those services are separate entities requiring separate charges. For instance, the doctor who performs the surgery is a separate service provider than the anesthesiologist who provides anesthesia; therefore, there may be two separate bills.

Even if you have insurance coverage, there may be fees that become the responsibility of the patient. You are responsible for denied charges, amounts applied to the deductible, and fees considered a co-payment, fees considered co-insurance or any amount considered non-covered by your insurance plan. For example, after paying the deductible, co-insurance and/or co-pay, you may still have a remaining balance left that needs prompt payment in full.

It is up to you to determine whether you are covered for the services planned or provided. We do, however, offer information regarding the coverage of proposed or received service and your financial responsibility, but ultimately it is your duty to obtain the up to date information. Please contact your insurance company for covered services, network participation, or other pertinent questions.

On occasion, the quoted fees may be less or more than the actual charges incurred. In other words, sometimes the payment statement may not exactly match for multiple reasons although the estimates generally are the billed amount. It may take up to 3 to 6 months or longer for you to receive the final payment statement for processing through all the parties involved.

Assignments of Benefits:

I hereby authorize the release of any information necessary to process insurance claims associated with any medical treatment performed by Delta Spine and Pain Clinic. I authorize payment directly to Delta Spine and Pain Clinic consultants for any medical benefits due me for services performed by this clinic or its physicians. I understand that I am responsible for all non-covered services or applicable coinsurance and deductibles. I also understand that I am responsible for clinic or provider's charges that may exceed the insurance allowance depending on my insurance coverage.

Payment guidelines:

We expect FULL payment at the time of service if you do not have insurance.
Co-payments must be paid at the time of service as required by your insurance company.

Co-insurance and/or deductible will be billed to you after the date of service post processing of the claim by the insurance company.
We accept VISA, MasterCard, checks and cash.

Under-aged Patients:

If the patient is under age 18: I, _____, the caretaker/responsible individual, give permission for my child _____ to be treated by Delta Spine and Pain Clinic or its associates.

We are willing to work with you in arranging an agreement if you are having financial difficulties for the provided service.

Please feel free to discuss any concerns or questions. It is ultimately your responsibility to find out the distribution of bills and charges that will be incurred including your responsibility of that amount. We will make every effort to minimize misunderstandings and through open communication with you, come to a mutual agreement. Please be understanding and be patient through the process. Thank you for allowing us to be part of your medical care.

_____ _____

Signature Date

Delta
SPINE AND PAIN CLINIC

Pre-Evaluation Questionnaire

Age: _____

DRUG ALLERGIES: _____

Have you ever been diagnosed with any of the following: (*Check all that apply*)

_____ Procedure experienced large blood loss

_____ Cardio Vascular Disease

_____ Hypertension

_____ COPD

_____ Asthma

_____ Radiation Therapy/ Chemo

_____ Hepatic (Liver) Disease active

_____ Renal Disease Active

_____ Bleeding Disorder

_____ Diabetes

_____ Smoking >20 packs/ year

_____ Use of Diuretics

_____ Malignancy (Current)

_____ Use of Anticoagulants (Blood Thinners) – If so, What? _____

Prescribing physician _____ Phone: _____

List any past surgeries and approximate dates performed:

Procedure Name	**Date performed**