**Pain Institute**

**Patient Name_____**

**LOCATION OF PAIN**

**_____**

**My pain is**

**Throbbing** **Stabbing** **Pinching**

**Localized** **Dull** **Acute**

**Aching** **Chronic** **Steady**

Use the scale below to better estimate the level of pain you are experiencing.

0 1 2 3 4 5 6 7 8 9 10

1-1 Very little or hardly noticeable pain.

2-3 Pain is present, but you may have to stop and think about it to really tell if it is there or gone. You seem just fairly comfortable.

4-5 You how notice your pain, perhaps at rest or during activity. It may interfere with your activities. Level 4 is the level at which it is a good idea to start introducing some avenues of relief.

6-7 Your pain is distracting you, but you may be able to focus on something else rather than the pain for a short period of time. You may be grinding your teeth to carry out activities.

8-9 Your pain may be severe enough that it makes you stop in the middle of an activity, or not be able to complete it at all. It is difficult to think of anything else but your pain at this level. You may be uncomfortable even at rest of quiet times.

10 Your pain is now the worst you can imagine. It is important to remember that the best way to treat the pain is to stay ahead of its increasing intensity and to maintain a regular schedule of pain relief. **Do not wait for level 10 before you discuss options with your healthcare provider.**

**Patient Signature_____Date_____**

**OFFICE USE ONLY**

**NAME_____INSURANCE_____Date_____**

**HT: _____ WT: _____ BP: _____ P:_____**

| | ORDER | DATE/TIME | | ORDER | DATE/TIME |
|---|---|---|---|---|---|
| **CMBB**: | _____ | _____ | **C T L – SPINE:** | _____ | _____ |
| **TMBB**: | _____ | _____ | **R / L – SHOULDER**: | _____ | _____ |
| **LMBB**: | _____ | _____ | **R / L – KNEE:** | _____ | _____ |
| **SI JOINT**: | _____ | _____ | **BACK BRACE:** | _____ | _____ |
| **TPI:** | _____ | _____ | **PAIN CREAM:** | _____ | _____ |
| **Joint:** | _____ | _____ | **Pregnancy Test** | **Pos** | **Neg** |

**Records Request: _____**

**_____**

**Temperature: _____** **YES NO**

**FOLLOW UP IN _____ DAY**

**APPT DATE _____ TIME_____**

**MED > 120 YES NO**

**Need Med Director Visit YES NO**

**Current Therapy _____**

**Medication: _____**
**Strength: _____**
**Date filled:_____**
**Qty filled:_____**
**Qty remaining:_____**
**Verified/bottle:_____**

**Medication: _____**
**Strength: _____**
**Date filled:_____**
**Qty filled:_____**
**Qty remaining:_____**
**Verified/bottle:_____**

**PROVIDER SIGNATURE: _____**

**Patient Registration Form**

**Pain Institute, LLC**

Date_____ Primary Care Dr._____

Patient Last Name_____ First _____

DOB_____ Marital Status_____ Is this your legal name_____

Address_____

City_____ ST_____ Zip Code_____

Home #_____Cell# _____

Social Security _____ Occupation_____

Employer _____ Work # _____

**Insurance Information**

Person responsible for bill_____DOB_____

Phone _____Occupation_____Employer_____

Address if different from above_____

**Primary Insurance**_____ Subscriber's name_____

DOB _____ ID#_____ Policy _____Group_____

Relationship to subscriber _____spouse _____ child _____ self

**Secondary Insurance_____** Policy _____Group _____

**Who may we release your medical information to (ie: appt day and time)_____**

**In Case Of Emergency**

Local friend or relative not living with you _____

Relationship_____ Cell _____Phone_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any unpaid balance. I also authorize **The Pain Institute** to release any information required to process my claims.

**Patient/Guardian Signature_____Date_____**

**Pain Institute**

**Narcotic Medication Agreement**

***Please initial before each and sign at the end of the agreement**

_____ You will be receiving narcotics for the treatment of your pain. It is important that you understand the risks and responsibilities that go along with this treatment. Please read each statement carefully and sign this agreement /contract below. If you have any questions regarding this information or office policy regarding the prescribing of narcotics, please request clarification. I _____understand that any medical treatment is initially a trial, and that continued prescription is based on evidence of benefit. I understand the goal of using narcotics is to decrease my pain and increase my functional level. If my pain does not significantly decrease and /or my function increase, the medication will stopped.

_____ I am aware that the use of such medications have certain risks associated with them, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, light headedness, dizziness, confusion, allergic reaction, slow breathing rate, slowing of reaction time or reflexes, kidney or liver disease, sexual dysfunction, physical dependence, tolerance to analgesia, addiction withdrawal, and the possibility that the medication will not provide complete relief.

_____ The overuse of narcotic medication can result in serious health risks including respiratory depression or even death. This medication will be strictly monitored and all mediation will be filled at the same pharmacy. (Should you need to change pharmacies, the clinic must be informed.) The pharmacy I have selected to use is Pharmacy_____.

_____ I cannot receive this medication by phone. I will not call the office to have a prescription called in. I am responsible for making and keeping scheduled appointments. Early refills are not permitted.

_____ I will take the narcotic medications only as prescribed. Any changes must be made by the provider and discussed with me and agreed upon. The provider has the right to increase/decrease/change medication as deemed necessary per results reported by me and by findings of my physical exam, urine drug screen results, and any other information important in the treatment of pain.

_____ Medications will not be replaced if they are lost, stolen, get wet, are destroyed, left in vehicle etc. even with police report. It is expected that you will take the highest degree of responsibility with your medication and health care. Your medication should not be left where others may see them or have access to them, especially children.

_____ Do not tell anyone that you are a patient of a pain clinic because of a high risk of stealing your medication. If anyone approaches you in the parking lot or asks you about your medication, please do not give them information even though it may seem like casual conversation. Report such activity to the clinic immediately.

_____ I agree that only my Pain Institute provider will prescribe my narcotic medication. I will not obtain or use narcotics or other controlled substances from a source other than the Pain Institute. I will advise all other providers that I see to confer with the Pain Institute Providers for any changes or need for additional narcotic

medications. If it is brought to the attention of the clinic that other providers are prescribing medications for me, the Pain Institute reserves the right to discontinue prescribing medications and/or discharge me from the clinic.

_____ I will inform my provider at the **Pain Institute** of any changes in my medication condition, any changes in my prescriptions and/or over the counter medications that I take and any adverse effects that I may experience from any medications that I take.

_____ I understand that the use of chronic narcotic medication carries the risk of addiction as well as side effects from the medication. I understand that narcotics may impair my ability to operate a motor vehicle or heavy equipment. The **Pain Institute** will not be held liable while under the influence of prescribed medications.

_____ I will not use illegal "street drugs" while receiving medication from **Pain Institute.** I will communicate fully and honestly with my providers about the character and intensity of my pain, the effect of pain on my daily life, and how well the medications is helping to relieve my pain.

_____ Random supervised urine screens will be a part of my treatment plan. I agree to have them done when the provider requests it. The prescribing provider has my permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide my health care for purpose of maintaining accountability. If the responsible legal authorities have questions concerning my treatment, as it may occur that I may be obtaining or trying to obtain medications at several pharmacies, doctor shopping, etc. All confidentiality is waived and these authorities may be given full access to my records, including to be reported to the **Drug Enforcement Agency (DEA).**

_____ It is a felony to obtain narcotic medication under false pretenses. This includes getting medication from more than one provider, misrepresenting myself to obtain medications, using them in a manner other than prescribed or diverting the medications in any other way (selling). Males will need to have their primary care provider monitor testosterone levels. Females need to notify clinic of possible pregnancy to prevent birth defects and/or dependency in newborns.

_____ I will discontinue the use of all previous prescribed narcotics and pain medications unless the **Pain Institute** provider instructs me to continue them. I will take medications as prescribed. I will not break or dissolve them in a liquid, melt, crush, inject, or snort them. Potential toxicity and rapid absorption may lead to DEATH!

_____ Any patient caught sleeping or nodding off in the waiting room will have their medication decreased. Additionally, patients that come to the clinic clearly under the influence will also have their medication decreased.

_____ All patients on opioid pain medication in conjunction with benzodiazepines/CNS depressants will be counseled by a provider and required to sign the opioid and benzo use policy. Once this is signed patient will be required to: (1) titrate down off of the benzo, (2) titrate down off of the opiate, or (3) obtain letter of medical necessity from a mental health provider.

_____ I understand that narcotic medication will be stopped or tapered down if any of the following occur:

1. I trade, sell, or misuse or abuse the medications
2. The clinic finds that I have broken any part of this agreement.
3. I do not comply with a random urine test when asked.
4. My urine tests shows the presence of any medications that the staff are not aware of, the presence of illegal drugs, or does not show medications that I am receiving for, or the level in my system is not therapeutic for the prescription (too high/low/no metabolites for long term use).
5. If I get narcotics from sources other than the Pain Institute
6. If any member of the professional staff of **Pain Institute** feels that it is in my best interests that narcotics be stopped.
7. I display any aggressive/hostile/threatening behavior toward staff or **Pain Institute.**
8. If I consistently miss scheduled appointments.
9. If patient is called in for pill count and does not have it done.

It is understood that failure to adhere to this agreement may result in cessation of therapy with controlled substance prescribing (no narcotic prescriptions will be written).

I have read and understand the Narcotic Medication Agreement. By signing this agreement, I affirm that I have read, understand, and accept all terms of this agreement.

**Patient Signature**_____Date_____

**Staff Witness**_____Date_____

**Three Strike Policy**

This practice has a 3 strike policy regarding narcotic medications. This means that you can be DISCHARGED on the 3rd strike. A strike is any unusual or irregular behavior regarding your narcotic prescription, including but not limited to the following.

1. Running out of medication early: Your medication is written on a 28 day basis. If you do not believe it is working well for you, you have an opportunity to discuss this at your monthly appointment. Do not increase the dose on your own. If you do, you will run out early. Your medication will not be refilled early. This will also count as a strike.
2. Lost or stolen medication: Consider your medication as a valuable. If your medication is stolen, you need to bring a copy of the police report stating exactly what was stolen. This will count as a strike. Remember that stolen medication even with a police report will not be replaced.
3. Using multiple pharmacies to fill narcotic medications: Pick one pharmacy, and use the same one consistently. If you would like to change pharmacies, please tell us about it.

Note that failing a urine test or refusing to take a urine test is grounds for immediate discharge. Reasons for failing a urine test include having illegal substances in your urine, having controlled substances other than those prescribed here, and having no prescribed medication in your urine. We reserve the right to obtain random drug screens to any patient at any time. This is a requirement for obtaining narcotic medications.

*This will be given to you as a reminder of our policy. If you receive a strike it will be documented in your chart as follows.

1. This is your first strike_____
2. This is your second strike_____
3. This is your third strike_____

**Patient signature**_____Date_____

__ the patient has read and indicated understanding of the agreement.

__the agreement was read to the patient who indicated understanding it.

**Staff Witness**_____Date_____

**Controlled Substance Policy**

The ability to prescribe narcotic benzodiazepines and other controlled substances is a privilege that is granted by the DEA. The Drug Enforcement Agency (DEA) has strict regulations governing the prescribing of controlled substances. The providers at the **Pain Institute** take this privilege very seriously. This policy is designed not only to safeguard this privilege but to also ensure that the Pain Institute provides appropriate patient care.

Controlled substances are prescribed for short-term use only. If required for periods longer than a few weeks, and a definitive diagnosis has not been established, a diagnostic evaluation (which may include referral for consultation with one or more specialists) will be initiated to determine the diagnosis. If the patient chooses not to pursue diagnostic evaluation, the Pain Institute will not be able to continue prescribing narcotics.

If for any reason you need a change in your RX you must have a scheduled appointment with the provider to do so. We will not write any controlled substances without being seen by a provider. No exception. We are not responsible for changing medication due to prior authorization, pharmacy lack of medications, unable to afford medications. All patients will be required to have another office visit.

If your drug screen has to be repeated, it will be filed with your insurance or a charge of $50.00 for self -pay patients. If there is an inconsistency due to a breach of narcotic agreement, no meds will be given until a clean UDS is received. Then an office visit will be scheduled. Patients with insurance will have the office visit filed and self- pay patients will have to pay for another visit.

Walk-ins are not welcome. All controlled substances that are written must have an office visit. The only exception is if the confirmation from the UDS regarding self- pay patients comes back clean.

**Patient Signature**_____Date_____

__ The patient has read and indicated understanding of the agreement

__ The agreement was read to the patient who indicated understanding

**Staff Witness**_____Date_____

**Pain Institute**

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment/cancellations policy. This policy enables us to better utilize available appointments for our patients in need of medical care

**Cancellation of an appointment**

In order to be respectful of the medical needs of other patients, please be courteous and call the Pain Institute promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance, and calling early in the day is appreciated. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

**How to cancel your appointment**

To cancel appointments, please call the office and speak with someone. If it is after business hours please leave a detailed message on the machine. If you would like to reschedule your appointment, please be sure to leave us your phone number and let us know the best time to return your call.

**Late Cancellation**

Late cancellation will be considered as a "no show" if cancelled less than 24 hours before appointment

**No Show Policy**

A "no show" is someone who misses an appointment without cancelling in an adequate manner. "No shows" inconvenience individuals who need access to medical care in a timely manner. Failure to be present at the time of an office visit will be recorded in the patients chart as a "no show". The first time there is a "no show" there will be no charge to the patient, only a warning. Any additional "no shows" will result in a $100.00 charge on the following office visit. The patient insurance will not be billed for this. This fee will be waived depending on the situation. Also if an injection is missed, you will only receive a 7 day RX and the patient had 7 days to make up the injection. After the injection is done, the patient must schedule another office visit and pay for the office visit to receive the remaining RX.

**Patient Signature**_____Date_____

**Staff Witness**_____Date_____

**The Pain Institute**

Our Policy: All patients are required to pay their co-pay and any estimated co-insurance and deductible at the time of service is rendered. If your insurance does not pay for any reason within 60 days, you will be responsible for the payment and future payments until your insurance does make payment. After that time if you are due a refund, you may be refunded a portion of what you paid out of pocket depending on what your insurance does pay.

You are responsible for all services rendered- if your insurance does not pay for any reason the balance is then your responsibility. If you are a self -pay patient you will be required to pay for your office visit before being seen. However, you are responsible for any additional cost related to the visit. Federal law requires that we bill every patient the same amount, we are not allowed to charge billing based on whether a patient has insurance or not.

Insurance Patients- It is your responsibility to

1. Provide a credit card/debit card for authorization
2. Provide us with updated and current insurance information at each visit
3. Provide us with updated contact information (numbers, address)
4. Pay for any services not covered by your insurance
5. Make sure you have a current referral if your insurance requires one.

Referrals and Authorizations- it is your responsibility to verify your insurance coverage and obtain any referrals and authorizations. As a courtesy to our patients, we will file all claims with your insurance carrier and provide them with any information necessary to process the claim.

If the insurance company denies your claim stating you were not eligible or your coverage are terminated (ended) or for any other reasons, you will be responsible for the balance. If you have new insurance, we will file your new insurance company. However, no refunds will be issued until payment is received.

Medicare/Tenncare Patients: You will be responsible for any balance if your insurance claim comes back that was denied for ineligible coverage.

Unpaid Bills: You will be responsible for any balance if delinquent accounts. If your account is placed with a collection agency you will be responsible for all collections and attorney's fees necessary to collect this debt.

I _____ have read fully and understand my financial responsibility under the policy.

**Patient Signature**_____Date_____

**Staff Witness**_____Date_____

**Pain Institute**

Every patient must have an X-Ray done within the last 12 months. If not, one will be ordered for you. This is to insure a proper diagnosis to continue prescription medication therapy.

If an X-Ray is not received by the next appointment, no prescription will be given, or a tapering dose will be started.

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(Print Name)

---

(Patient Signature)

---

(Witness)

---

(Date)

**Pain Institute**

**Patient Name**_____**Date**_____

**Drug Allergies**:_____

_____

_____

**Current Medications**:_____

_____

_____

_____

## Acknowledgement of Receipt of Privacy Practice

**Patient Name**_____

I acknowledge that I have received the Notice of Privacy Practices that explains how the Pain Institute may use or disclose my protected health information. I also acknowledge that I have the right to review the Notice of Privacy Practices, to have it explained to me, and to have my questions answered.

## Medication Change Policy

Here at the **Pain Institute** we care for your health and well -being. That being said, it is our policy that if a medication is lost, stolen, misplaced, and is not in your system, your medication will be cut in half. Not taking or having medication as prescribed and restarting at the same level may be harmful to your health and make you sick or cause accidental overdose. Any patient who misses an appointment or constantly changes their appointments due to being out of town working or for an emergency will also have their medication decreased in half.

Patients who believe their medication is not helping and believe they need it increased or changed must have recent x-rays or MRI's showing the possible need for increase. We must have current radiology per TN state law. No medication increase will be done unless we have proper documentation showing a valid reason to justify an increase in medication.;

**Patient Signature**_____Date_____

**Staff Witness**_____Date_____

# *Pain Institute*

Medical Records Release Authorization

Please "Print" and complete all sections to insure your request is handled in a timely manner.

Patient's name: _____ Patient's Date of Birth:_____/_____/_____

Patient's Phone Number: (___)_____ Patient's S.S. # _____-_____-_____

SEND RECORDS TO: **PAIN INSTITUTE Attn: Medical Records (Fax: 931-802-6827)**

Specific information requested: _____

PURPOSE OF DISCLOSURE: Continuation of care

I authorize _____ to release or disclose to the above named facility all of my medical records, including any specially protected records, such as those relating to the psychological or psychiatric impairments, drug abuse, alcoholism, sickle-cell anemia, or HIV infection for the purpose of medical treatment.
If you do not want certain portions of your medical records released, identify the information you do not want released. Otherwise, your medical records will be released as specified above.

This authorization will expire on the following date, or a year from the date of signature: _____

- I understand that I may revoke the authorization at any time prior to the expiration date or event, but that revocation will not have any effect on actions taken by the Pain Institute or its physicians, employees or agents before they received my revocation. Should I desire to revoke this authorization, I must send the written notice to the Pain Institute at the address shown below.
- I understand that I am not required to sign this authorization. The Pain institute will not condition treatment, payment, enrollment or eligibility for benefits on whether I proved this authorization.
- I understand that my records may be subject to disclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that this authorization does not limit the Pain Institute or its physicians, employees', or agents' ability to use or disclose my information for treatment, payment, or health care operations, or as otherwise permitted by law.

Signature: _____ Date: _____

CPI Phone: 931.802.6824~Fax: 931.802.6827~clarksvillepaininstitute1849@gmail.com~
1849 Madison Street Suite F Clarksville, TN 37042

**Review of Systems**

Please circle any of the things you have had within the past month or have been diagnosed with:

**General:**

High blood pressure

Fever/sweats

Fatigue

Loss of appetite/weight change

**Eyes:**

Vision change/blurred/double vision

Eye disease or injury

Glaucoma

**Ears/nose/throat/mouth:**

Hearing loss

Ear ringing

Earache/drainage

Nosebleeds

Trouble swallowing

Sore throat

Thyroid disease

Snoring

**Musculoskeletal:**

Joint pain/stiffness

Muscle pain/cramps/weakness

**Skin:**

Rash/Lesions/Ulcers

**Cardiovascular:**

Chest pain/angina

Palpitations

Shortness of breath

Leg swelling

Heart murmur

Heart disease/hypertension

**Respiratory:**

Cough/dry/productive

Shortness of breath

Wheezing

**Gastrointestinal:**

Problems with bowel movements

Nausea/vomiting

Rectal bleeding

Heartburn

Abdominal pain

**Genitourinary;**

Flank pain

Kidney stones/kidney disease

Dialysis

Blood in urine

**Neurological;**

Headaches

Numbness/tingling(location_____)

Tremors

**Blood/Lymph:**

Slow wound healing

Easy to bleed/bruise/blood clots

History of leukemia of lymphoma

**Other;**

Nervousness/anxiety

Depression

Insomnia

Confusion/memory loss

Other Health Problems

_____

**Pain Institute**

Urine Drug screens are mandatory at the Pain Institute. Any patient that brings in fake urine will forfeit their office visit and any monies that they have paid for that day. Bringing someone else's urine, tampering or falsifying information will result in loss of monies for that visit. This may also result in immediate discharge without medications from this clinic. The cups that are used are very sensitive to temperature and detect most attempts to alter drug screens. I have read and completely understand the consequences of tampering with urine drug screens at the Pain Institute. Falsifying is also considered fraud which can result in the authorities being notified.

**Patient Signature**_____Date_____

**Staff Witness**_____Date_____

**Pain Management and Contraception**

**Females Only**

According to Tennessee State Law, women in chronic pain that seek treatment through a pain clinic must be responsible to decide to continue some type of birth control until menopause. These methods include oral contraceptives, inter uterine device (IUD), abdominal ablation, tubal ligation, or hysterectomy. You must bring proof of the above. No exception. These do not include withdrawal, condoms, rhythm method, or abstinence.

If you choose to do pain management in the state of Tennessee, you must comply with the state law. If pregnancy occurs and there are any problems with the infant, the state of Tennessee can prosecute up to 15 years imprisonment.

**Patient Signature**_____Date_____

**Staff Witness**_____Date_____

# Smoking Policy

Please be advised that 1849 Madison St. is a smoke free campus. **Per Tennessee State Law 39-17-1805** anyone violating this policy will be subject to an individual violation of a **$50.00 fine.** Business violations will be subject to a **$100.00 -$500.00 fine.** Any patient caught smoking will be given one warning. If this warning is ignored and **a patient of this office is in violation the fine must be paid prior to being seen for their appointment.**

**Print Name _____**

**Signature _____**

## SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

| | Never | Seldom | Sometimes | Often | Very Often |
|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 |
| 1. How often do you have mood swings? | ○ | ○ | ○ | ○ | ○ |
| 2. How often have you felt a need for higher doses of medication to treat your pain? | ○ | ○ | ○ | ○ | ○ |
| 3. How often have you felt impatient with your doctors? | ○ | ○ | ○ | ○ | ○ |
| 4. How often have you felt that things are just too overwhelming that you can't handle them? | ○ | ○ | ○ | ○ | ○ |
| 5. How often is there tension in the home? | ○ | ○ | ○ | ○ | ○ |
| 6. How often have you counted pain pills to see how many are remaining? | ○ | ○ | ○ | ○ | ○ |
| 7. How often have you been concerned that people will judge you for taking pain medication? | ○ | ○ | ○ | ○ | ○ |
| 8. How often do you feel bored? | ○ | ○ | ○ | ○ | ○ |
| 9. How often have you taken more pain medication than you were supposed to? | ○ | ○ | ○ | ○ | ○ |
| 10. How often have you worried about being left alone? | ○ | ○ | ○ | ○ | ○ |
| 11. How often have you felt a craving for medication? | ○ | ○ | ○ | ○ | ○ |
| 12. How often have others expressed concern over your use of medication? | ○ | ○ | ○ | ○ | ○ |

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

PainEDU.org

| | Never | Seldom | Sometimes | Often | Very Often |
|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 |
| 13. How often have any of your close friends had a problem with alcohol or drugs? | ○ | ○ | ○ | ○ | ○ |
| 14. How often have others told you that you had a bad temper? | ○ | ○ | ○ | ○ | ○ |
| 15. How often have you felt consumed by the need to get pain medication? | ○ | ○ | ○ | ○ | ○ |
| 16. How often have you run out of pain medication early? | ○ | ○ | ○ | ○ | ○ |
| 17. How often have others kept you from getting what you deserve? | ○ | ○ | ○ | ○ | ○ |
| 18. How often, in your lifetime, have you had legal problems or been arrested? | ○ | ○ | ○ | ○ | ○ |
| 19. How often have you attended an AA or NA meeting? | ○ | ○ | ○ | ○ | ○ |
| 20. How often have you been in an argument that was so out of control that someone got hurt? | ○ | ○ | ○ | ○ | ○ |
| 21. How often have you been sexually abused? | ○ | ○ | ○ | ○ | ○ |
| 22. How often have others suggested that you have a drug or alcohol problem? | ○ | ○ | ○ | ○ | ○ |
| 23. How often have you had to borrow pain medications from your family or friends? | ○ | ○ | ○ | ○ | ○ |
| 24. How often have you been treated for an alcohol or drug problem? | ○ | ○ | ○ | ○ | ○ |

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

# Please be informed that children under the age of 12 are not allowed in the waiting area. Your appointment will be rescheduled if accompanied by a child, no exceptions.

---

**Patient signature**

---

**Print name**

---

**Witness**

# CELL PHONE USAGE IS NOT ALLOWED IN THE OFFICE AFTER YOUR APPOINTMENT HAS BEGUN.

# ANY USAGE WILL RESULT IN AN IMMEDIATE RESCHEDULE.

# -MANAGEMENT

**Date:_____**

**Name:_____**

**Signature:_____**

Per the State of Tennessee Regulation for a Certified Pain Management the Pain Institute will only accept cash in this matter:

TENN. CODE ANN. § 63-1-310:

(a) A pain management clinic may accept only a check or credit card in payment for services provided at the clinic, except as provided in subsection (b).

(b) A payment may be made in cash for a co-pay, coinsurance or deductible when the remainder of the charge for the services will be submitted to the patient's insurance plan for reimbursement.

X _____