Physician Partners OF AMERICA

NEW PATIENT PACKET

First Name: Middle Name: Last Name:
DOB: / / Sex: ☐Male ☐Female SSN: - -
Ethnicity: ☐Not Hispanic/Latino ☐Hispanic/Latino
Race: ☐African American ☐Asian ☐White ☐American Indian ☐Other:
Primary Language: English ___ Spanish ___ Other: ______________
Martial Status: ☐Married ☐Single ☐Widowed ☐Divorced ☐Domestic Partner
Address:
City: State: Zip:
Cell ☎: Home ☎: Work ☎: E-mail:

Employment Status: ☐Employed ☐Retired ☐Student ☐Unemployed
Employer: Occupation:_____________________ Employer Phone:
Employer Address:

Emergency Contact Full Name: Relationship:
Primary ☎: Work ☎:

Is the Patient Financially Responsible? ☐Yes ☐No If No, please complete this section:
Relationship: Sex: ☐Male ☐Female SSN:
First Name: Middle Name: Last Name:
Address:
City: State: Zip:
Primary ☎: Cell ☎: Home ☎:
Employer: Occupation: Employer ☎:
Employer Address:

Is the reason for your visit the result of an accident? ☐Yes ☐No
If yes, what type of accident? ☐Workman's Comp ☐Automobile ☐Other:_______________
Date of accident: / / Claim #: Claim Adjuster:

Insurance company: Insured DOB: / /
Insured/Card holder's name: Relationship:
ID#: Group #: Phone:
Secondary insurance company: Insured DOB:
Insured/Card holder's name: Relationship:
ID#: Group #: ☎:

Patient Signature:____ Date: / /

TELL US ABOUT YOUR MOST SIGNIFICANT PROBLEM

Where is your pain located? Please circle. List all that apply:

Neck

Thoracic/midback

Low back

Sacral/coccyx (tailbone)

Shoulder(s): Left / Right/ Both

Hip(s): Left / Right/ Both

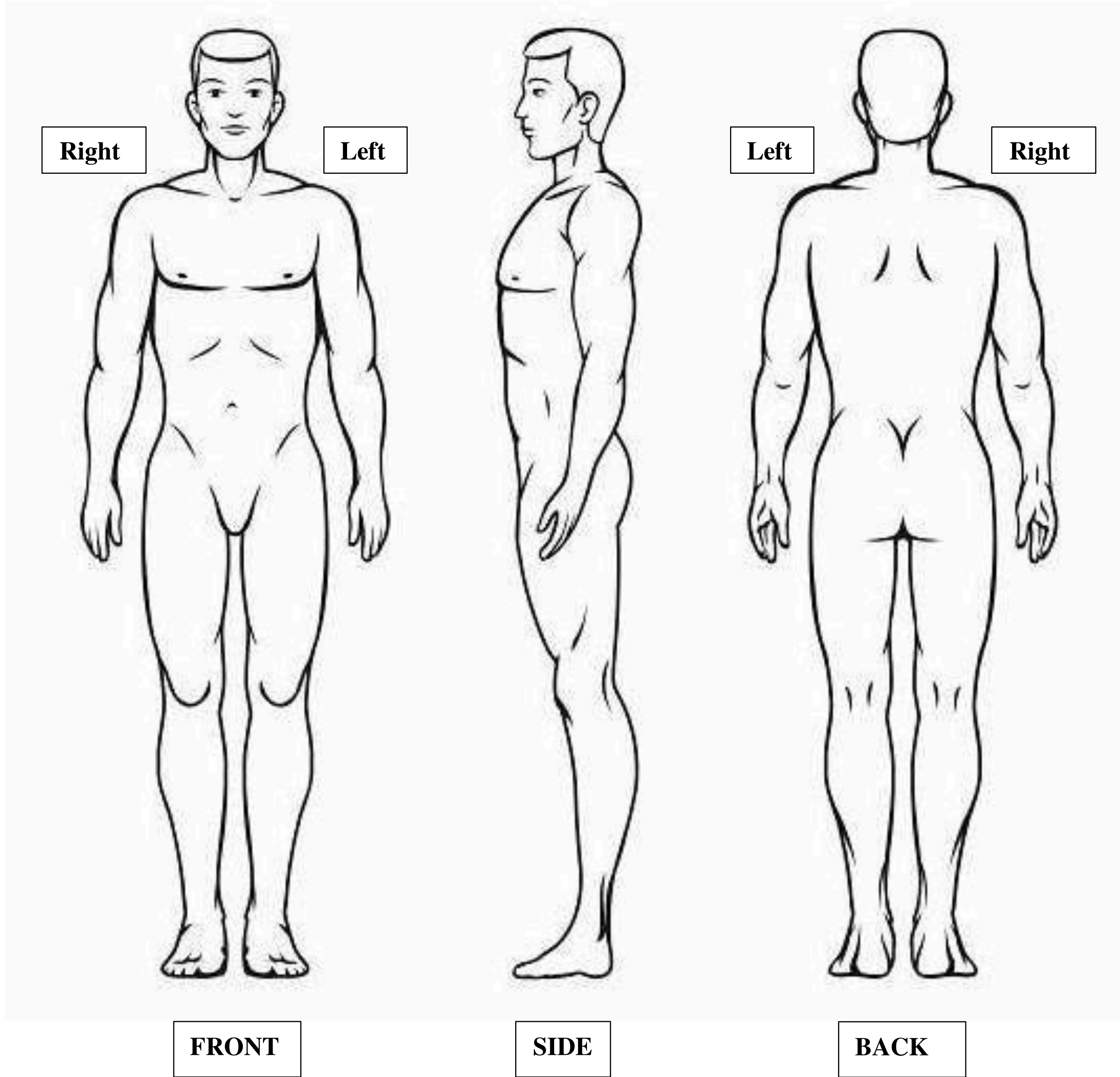
Knee(s): Left / Right/ Both

Ankle(s): Left / Right/ Both

Other (please list):____

Physician Partners
OF AMERICA

Where is your pain located? Please mark on graphic below:



How long has your pain been present? Years_____ Months_____ Weeks_____ Days_____

Is your pain <u>(Please Circle):</u> Constant or Intermittent?

Please describe your pain. <u>Circle All That Apply:</u>
Achy Burning Dull Sharp Shooting Stabbing Numbness/Tingling ____________________________

What makes your pain worse? Circle All that Apply:

Activity Bending Stretching Sitting Standing Twisting Walking

What improves your pain? Circle All that Apply:

Heat/ice packs Laying Down Pain Medication Rest Standing Sitting Stretching

What is your pain on a scale of 0-10 (zero=no pain, 10= worst pain)

Current/Today:_______ Worst:_________ Best:________

Have you had any prior treatment(s) for this condition? Circle All that Apply

Physical Therapy Chiropractor Spine Injection Anti-Inflammatory Medications Pain Medications

Bed Rest TENS unit Previous Pain Management Doctor (Please List):________________________________

What recent studies/imaging have you had relating to this condition in the last 12 MONTHS? Please circle all that apply. Please list imaging facility and location:
Ex: Touchstone/ Envision/ Prime/ Gateway/ MRI Centers of Texas/ Rayus or CDI/ Other:_______________________

X-Ray MRI CT Scan Ultrasound EMG (Needle testing of Muscles)/Nerve Conduction Study

Do you have a Primary Care Provider? If yes, please list here:

Pharmacy: ____________________ Pharmacy Address:____
____

Any other Healthcare Providers, we should know about? Please list here

Primary Care Doctor (PCP):____

Cardiologist (Heart Doctor):____

Pulmonologist (Lung doctor):____

Neurologist (Nerve Doctor):____

_________________________________ _____________________________________

PAST MEDICAL, SURGICAL, FAMILY MEDICATION AND SOCIAL HISTORY

Have you had any sports injuries? Work related injuries? If yes, when?

Have you ever been disabled? YES NO

Are you currently disabled? If yes, what type? SSD SSI

MUSCULOSKELETAL: Fibromyalgia Osteoarthritis Osteoporosis

CARDIAC: Cardiac Pacemaker Cardiac Stent Coronary Artery Disease DVT (blood clot)
Anemia CHF(heart failure) Heart Attack, if yes, when? _____________ Hypertension Peripheral Vascular

ENDOCRINE/Metabolic: Diabetes Mellitus Immune Disorder:________________ Thyroid Disorder

LIVER DISEASE: Cirrhosis Hepatitis (Type: A / B /C/ Unknown)

NEOPLASM: Cancer– Type___________________

INFECTIOUS DISEASE: HIV Positive

PSYCHIATRIC: A.D.D./ADHD Anxiety Depression Bipolar PTSD

RESPIRATORY: Asthma COPD/Emphysema Lung Disease Pulmonary Embolism Tuberculosis

UROLOGY/NEPHROLOGY: Kidney Disease Kidney Stone Prostate Issues

PAST SURGICAL HISTORY: Please list any major Surgical Procedures and Dates

Neck?____
Lower back?______________________________________
Hip?____
Shoulder?____
Knee?____
Other:____
____
____

ALLERGIES: Drugs

____
____
____
____
____
____
____
____

FAMILY HISTORY: Circle All that Apply

NONE Family History of Alcoholism Family History of Drug Addiction Heart Disease Hypertension

Stroke Diabetes Bleeding Disorder Rheumatoid Arthritis Back/Neck Osteoarthritis Asthma

SOCIAL HISTORY: Please answer the following about yourself

Do you Drink Alcohol: If yes #____ drinks per day/week/month
Do you have a history of heavy alcohol use or Alcoholism?

Do you have a history of drug addiction? Yes / No
Do you use any street drugs? IF yes, what? Marijuana, Cocaine, other:___________________

Do you Smoke: If yes what? Cigar, Pipes, Cigarettes, e-Cigarettes #_____packs per day

FOR FEMALES OF CHILDBEARING AGE ONLY. Many pain medication, X Rays and injections are potentially dangerous to an unborn baby. Is there any chance you may be pregnant? YES NO

MEDICATIONS: Please list all medications currently prescribed or over the counter:			
Medication	**Dosage**	**Prescribing doctor**	**For which condition**

Review of Symptoms: Have you recently experienced any of the following? Circle or mark answers below		
General/Constitutional ☐Fevers /Chills ☐Infection anywhere ☐Sleep Problems	**Cardiovascular** ☐Chest Pain (any) ☐Rapid Heartbeat ☐Heart murmur	**Respiratory** ☐Shortness of Breath ☐Wheezing ☐Sleep Apnea/CPAP/Oxygen
Gastrointestinal ☐Nausea / Vomiting ☐Constipation ☐Stomach/Abdominal Pain	**Genitourinary** ☐Kidney stone pain ☐Painful Urination ☐Blood in Urine	**Neurological** ☐ Numbness ☐ Tingling ☐ Incontinence of bladder
Muscle/Bones/ Joints ☐Muscle Spasms ☐Muscle weakness ☐Joint Pain/ extremity	**Endocrine** ☐Severe Thirst ☐Severe Fatigue ☐Decreased Sex Drive	**Psychiatric** ☐ Anxiety nervousness ☐ Feeling Sad /Depressed ☐ Suicidal Ideation ☐ Addiction to anything
Hematological ☐Easy bleeding bruising ☐Bleeding disorder/problem ☐Lymph node enlargement	**Allergy / Immunology** ☐Environmental Allergies ☐HIV	**Cancer** ☐Prostate/Colon ☐Breast ☐Lung ☐Other _______________

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: ____

DOB:_____/_____/_____ Phone Number: ____________________________________

I authorize the release of my medical records to Physician Partners of America (PPOA) for review and continuation of my medical care. I authorize the following physician offices, clinics, legal offices, diagnostic centers, and medical providers to provide copies of my health records to:

Persons/organizations receiving

(List all facilities, clinics, and offices from which information may be requested)

PHYSICIAN OFFICES (please list all physicians you have seen in the past two years)

Physician Name	Address	Phone Number

HOSPITAL/OTHER FACILITIES (surgeries/procedures, radiology reports, laboratory results)

Facility Name	Address	Phone Number

Restrictions: _____ there are NO restrictions to the information that can be released
_____ the following information CAN NOT be released:
____

DURATION: This Authorization will remain in effect: (please check selection):
_____ from the date of this Authorization until ____/_____/_____
_____ until the provider fulfill this Authorization request
_____ until the following event occurs: ____

Patient/Guardian Signature _________________________________ Date:_____/_____/________

Patient Initials:_____________________ **Date: / /**

PATIENT PERSONAL HEALTH INFORMATION CONSENT FORM

Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, Physician Partners of America originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

Physician Partners of America's *Notice of Privacy Practices* provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of the *Notice of Privacy Practices* and acknowledge that I have reviewed the notice prior to signing this consent. I understand that the Physician Partners of America reserves the right to change the *Notice of Privacy Practice at any time, and I as a patient have the right to review changes at any time*. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment or healthcare operations and that the Physician Partners of America is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that the Physician Partners of America has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

I request the following restrictions on the use and/or disclosure of my personal health information.

____

____

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have reviewed Physician Partners of America's Notice *of Privacy Practices* dated July 30, 2015.

I acknowledge that I may request a copy of Physician Partners of America's Notice of Privacy Practices dated January 1, 2024 at any time.

Signature of Patient or Legal
Representative,____Date_____________

Print Name of Patient or Legal Representative ____

Witness's Signature_____________________________________Date________ ______

Witness's Printed Name____

Patient Initials:____________________ **Date: / /**

Opiate Agreement

I, ________________________, am requesting treatment with opiate pain medication(s) because other therapies, treatments, and/or medication(s) that I have previously received and had not provided me with adequate relief of pain. I understand:

- That it is unlikely that any medication(s) will completely remove or eliminate my pain.
- Opiate pain medication(s) will be prescribed for me for humane reasons as long as my pain continues at the present level or intensity, provided that I follow all terms of this agreement/ Agreement.

My provider has discussed potential long-term opiate therapy with me in detail and I understand some of the possible complications that may occur are: □ Chemical/Physical dependence and addiction

- Severe constipation which could require medical treatment difficulty with urination
- Drowsiness
- Nausea
- Itching

Slowed breathing or respirations
Reduced or absent sexual desire and/or function

- Coma
- Organ damage, failure; or death

I further understand that if I take all my medication(s) sooner than prescribed or if I suddenly stop taking my medication(s), that I could have opiate withdrawal symptoms that can be very painful and life threatening.

Female patients only: I understand that there are both known and unknown risks/ hazards to an unborn infant if the mother takes opiate medication(s). The risks/hazards include but are not limited to opiate addiction of the infant with opiate withdrawal after birth.
I assume full responsibility for notifying my provider if I suspect or confirm that I am pregnant. I further understand that a different plan of treatment, without the use of opiates, will be tried during pregnancy.

Terms/Agreements

This opiate agreement is contingent on compliance with ALL of the following patient and provider terms: □ Only one pharmacy will be used at any one time for filling my opiate prescriptions. The selected pharmacy is:

____

- I agree to receive opiate medication prescriptions ONLY from the providers at Provider Partners of America (hereinafter "PPOA")
- In order to obtain a refill for opiate medication(s), I understand that an appointment must be scheduled with the provider. I further understand that it is my responsibility to sure that I have enough medication to last through the weekend, holiday and/or after hours (**5pm- 8 am**).
- I understand PPOA does not accept telephone requests for opiate prescriptions and I must be seen at my regularly scheduled appointment with the provider to receive an opiate prescription.

Patient Initials:____________________ **Date: / /**

Opiate Agreement

In the case of another provider(s) on-call after hours, on holidays, and/or on weekends, he/she will **NOT** refill my medication(s). It has been explained to me that they may not have charts available for review to make decisions regarding medications.

- I agree to be under the care of a primary care provider. I will inform PPOA if I change my primary care provider. My primary care provider is ____
- I hereby authorize a release of information that allows the providers(s) and/or staff to communicate and collaborate with any other health care provider in my care.
- I understand that at PPOA there are many different professionals on staff who work together with a team approach to treatment plan and progress, and I give permission for the team to discuss my treatment plan and progress.
- I will notify PPOA immediately if I experience medication side effects.
- I understand that if a serious issue effect occurs after hours, on a holiday or during the weekend, that I should immediately seek Emergency assistance from the nearest hospital.
- Prescription dosage(s) have been thoroughly explained to me by my provider and I understand that I SHALL NOT change dosage amounts and/or alter the time schedule of the prescribed medication(s) without directions to do so by my provider.

I understand that opiate medications(s) should be kept in a safe place at all times and that I am responsible for the security of my medication. It has been thoroughly explained to me that the policy does not allow for replacement of misplaced, spilled, inaccessible, or lost opiate medication(s) or prescription (s). I understand that if my medication(s) or prescriptions(s) are stolen that I must deliver a police report to my provider and they will contact the police for verification of the report. A second event such as above may lead to termination of this Agreement.

 I understand the benefits of opiate medications will be evaluated regularly using the following criteria:

○ Increase in general level of functioning, increase in life activities, decrease in the intensity of pain, absence of unacceptable or intolerable adverse side effects, and improvement in mood.

- I agree to participate in psychotherapy sessions and psychological testing as deemed appropriate by my provider and/or the team of health care provider(s).
- I agree to submit a random urine and or/blood screens for other medications and drugs.
- I have been given information about the use of opiate medication, including possible ricks and adverse side effects such as the development of tolerance, dependence, addiction, and withdrawal and after thoroughly reviewing the information; I believe the benefits will be greater than the risks. I will not hoard or alter opiate prescription.
- I will not drink alcohol within 24-48 hours of taking opiate medication(s).
- I understand that a nurse may notify me of noted violations to this agreement and such notification will be considered appropriate violations in the agreement may result in Opiate Treatment Monitoring for six (6) months.
- I agree to allow PPOA to contact other pharmacies to discuss my medications.

Patient Initials:____________________ **Date: / /**

Opiate Agreement

Opiate Treatment Monitoring:
During this period, I understand that I might have my opiate medication discontinued at any time for any reason, per a decision by my provider and the health care team. Upon notification of such discontinuance, I will be provided with a 30 day supply of appropriate medication(s). I further understand that during this period, I might be referred to an addiction specialist or to a drug detoxification program. In addition, I also realize that I might be immediately referred to an inpatient drug detoxification program and NO further medication will be provided. I attest to the following (initial below):

_____I am not using illegal drugs or prescription drugs prescribed for someone other than myself.
_____I (**am/am not**) not undergoing treatment for substance (drugs or alcohol) dependence or abuse.
_____I have never been involved in the sale, illegal possession, or transport of drugs.

(**Female only)** I am not pregnant and I will inform the medical staff at PPOA if I become pregnant or intend to become pregnant. I understand there may be harmful effects on an unborn infant if I take opiate medication(s). (**Initial below**).

_____ An opiate information form was provided.
_____ I have read or had it read to me
_____ I understand the possible side effects and complications of opiate therapy.

Release
I release my provider, the team of health care providers, the team of health care providers, and PPOA from liability for any medical and social conditions or consequences related to opiate medication(s) therapy and/or discontinuance of opiate medication(s).

Acknowledgement/Agreement
I hereby acknowledge that the content of this agreement has been explained to me. In addition, I have either read the agreement or had it read to me. I was offered many opportunities to ask questions and discuss any unclear aspects of this Agreement.

I acknowledge that I fully understand that my failure to comply with any term(S) set forth within this agreement will result in a termination of this agreement and possibly of my care and medications at PPOA.

Patient Signature & Date: ____

Witness Signature & Date: ____

Patient Initials:____________________ **Date:** / /

Opioid Risk Tool (ORT)

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction.

MARK EACH BOX THAT APPLIES	FEMALE	MALE
FAMILY HISTORY OF SUBSTANCE ABUSE		
Alcohol	☐ 1	☐ 3
Illegal drugs	☐ 2	☐ 3
Rx drugs	☐ 4	☐ 4
PERSONAL HISTORY OF SUBSTANCE ABUSE		
Alcohol	☐ 3	☐ 3
Illegal drugs	☐ 4	☐ 4
Rx drugs	☐ 5	☐ 5
AGE BETWEEN 16–45 YEARS	☐ 1	☐ 1
HISTORY OF PREADOLESCENT SEXUAL ABUSE	☐ 3	☐ 0
PSYCHOLOGIC DISEASE		
ADD, OCD, bipolar, schizophrenia	☐ 2	☐ 2
Depression	☐ 1	☐ 1
SCORING TOTALS		

ADMINISTRATION

- On initial visit
- Prior to opioid therapy

SCORING (RISK)

0–3: low
4–7: moderate
≥8: high

Patient Name:________________________________ **Date:**______________

Ordering Provider:____________________________

Patient Initials:________________ **Date: / /**

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.

SOAPP®-R *Source: http://www.opioidrisk.com/node/1209*	**Patient Score:** ________________ **Tech Initials:** ________________	**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?		☐	☐	☐	☐	☐
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?		☐	☐	☐	☐	☐

Has any relative had a problem with the following? Circle Y/N for each.

- ☐ Alcohol? Y / N
- ☐ Addiction? Y / N
- ☐ Mental Illness? Y / N

Patient Initials:____________________ **Date: / /**

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Physician Partners of America (hereinafter "PPOA") and/or its affiliated entities, for any charges not covered by my healthcare benefits. It is my responsibility to notify PPOA of any changes in my healthcare coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill and/or balance of the bill as determined by PPOA and/or my healthcare insurer, if the submitted claims or any part of the claim are denied for payment. I understand that by signing this form, I am accepting financial responsibility as explained above, for all payment for medical services and/or supplies received.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare if I am a Medicare beneficiary, to PPOA for all covered medical services and supplies provided to me during all courses of treatment. This includes care provided by PPOA and/or its affiliated entities or otherwise at its discretion. I understand and agree this Assignment of Benefits will constitute a continuing authorization, maintained on file with PPOA, which will authorize and allow for direct payment to PPOA, of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by PPOA.

Ownership Disclosure

I understand that PPOA is a physician-owned medical practice comprised of the offices of primary care providers, specialty care providers, and associated ancillary services. These ancillaries include, but may not be limited to, laboratory, pathology, radiology/diagnostic, physical therapy, pharmacy, and ambulatory surgery center services. During the course of my care, I may be referred to one or more of these ancillary departments. I have the right to choose where to receive these services, and I understand that I am not obligated to receive these services at a PPOA ancillary department.

______________________________	______________________________
Printed Name of Patient	Name of Guardian/Personal Representative
______________________________	______________________________
Signature of Patient	Signature of Guardian or Personal Representative

Patient Initials:____________________ **Date: / /**