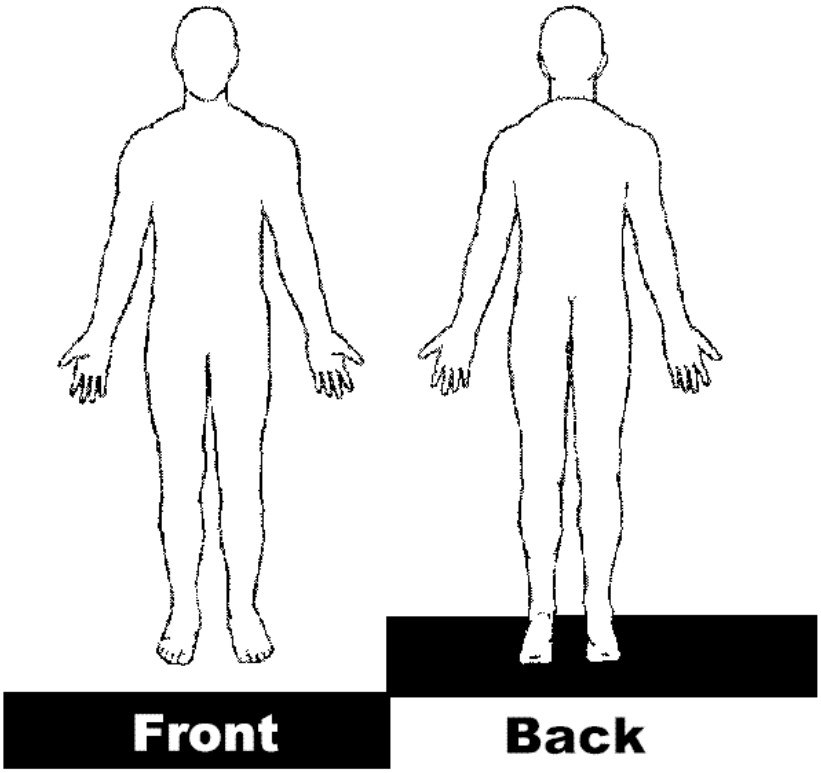
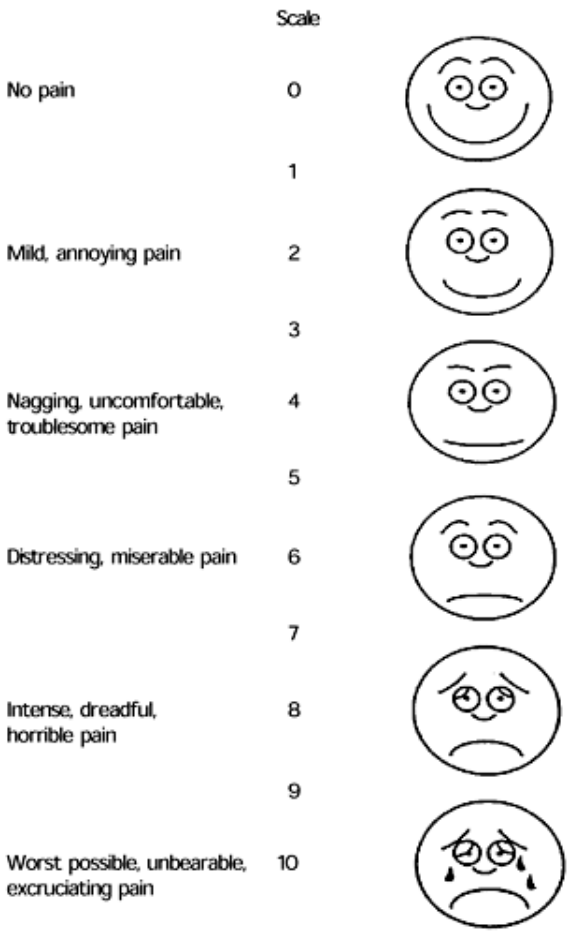
PATIENT NAME:_____ **TODAY'S DATE:**_____

Please put an X in all areas where you are currently experiencing pain

Please circle your pain level on the 0-10 scale.





Are you currently prescribed any pain medications? YES NO

Are you being prescribed and medications to help your Mood, sleep (i.e.: antidepressants, sleeping pills, or anxiety medications) YES NO

When is your pain at its worst?

☐ Constant ☐Worse in morning ☐Worse in afternoon ☐ Worse at night

Which of these terms best describe your pain?

☐ Superficial/Skin ☐Muscular ☐ Deep/Bone ☐Deep/ Internal Organs

How would you rate your pain on a 0 to 10 scale **WITHOUT** medications? _____

How would you rate your pain on a 0 to 10 scale **WITH** medications? _____

Please rate your pain on the scale (0-10) the number that best describes your pain
ON AVERAGE: _____

Circle the number that best describes how, during the past 24 hours, **PAIN HAS INTERFERED** with your:

a. **GENERAL ACTIVITY**

Does not interfere Completely Interferes
0 1 2 3 4 5 6 7 8 9 10

b. **MOOD**

Does not interfere Completely Interferes
0 1 2 3 4 5 6 7 8 9 10

c. **WALKING ABILITY**

Does not interfere Completely Interferes
0 1 2 3 4 5 6 7 8 9 10

d. **NORMAL WORK (includes both work outside the home and housework)**

Does not interfere Completely Interferes
0 1 2 3 4 5 6 7 8 9 10

e. **RELATIONSHIPS WITH OTHER PEOPLE**

Does not interfere Completely Interferes
0 1 2 3 4 5 6 7 8 9 10

f. **SLEEP**

Does not interfere Completely Interferes
0 1 2 3 4 5 6 7 8 9 10

g. **ENJOYMENT OF LIFE**

Does not interfere Completely Interferes
0 1 2 3 4 5 6 7 8 9 10

Name: _____ Date: _____

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?	○	○	○	○	○

CENTER FOR SYMPTOM RELIEF, LLC
1161 BETHEL ROAD, SUITE 204

	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.

COLUMBUS, OH 43220
PH: 614-459-0350 FAX: 614-459-0355

REGISTRATION FORM

Today's date:					PCP:	
PATIENT INFORMATION						
Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Social Security no.:		Home phone No:		
P.O. box:	City:	State:	ZIP Code:			
Occupation:	E-mail:	Alternate Phone No:				
May we leave a detailed voicemail regarding your medical care?	❑ Yes	Provide number:	❑ No			
Do you have an Advanced Directive including living will or Power of Attorney?	❑ Yes ❑ No					
Primary Care Physician:		Phone No. ( )				
Referring Physician:		Phone No. ( )				
Pharmacy:		Phone No. ( )				
Spouse's last name: First:		Birth date: / /				

MEDICATION LIST

Please list all medication that you're currently prescribed and taking.

Medication:	Dose:	Directions:

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

AUTHORIZATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION:

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT, NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVCIES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. ALL COPAYS ARE PAYABLE AT THE TIME OF SERVICE.

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I HERBY AUTHORIZE THE CENTER FOR SYMPTOM RELIEF, LLC TO FURNISH INSURANCE COMPANIES OR THEIR REPRESENTATIVES INFORMATION CONERNING MY (MY DEPENDENTS) ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE CENTER FOR SYMPTOM RELIEF, LLC ALL PAYMENTS FOR MEDICAL SERVICES RENDERED BY MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

I HEREBY AUTHORIZE AND RELEASE THE DOCTOR AND WHOMEVER HE/SHE MAY DESIGNATE AS HIS/HER ASSISTANT TO ADMINISTER TREATMENT, PHYSICAL EXAM, X-RAY STUDIOS, LABORATORY PROCEDURES, MEDICAL CARE OR ANY CLINICAL SERVICE THAT HE/SHE DEEMS NECESSARY IN MY CASE, AND I FURTHER AUTHORIZE HIM/HER TO DISCLOSE ALL OR PART OF MY (PATIENTS) RECORD TO ANY PERSON OR CORPORATION WHICH IS OR MAY BE LIABLE UNDER CONTRACT TO THE CLINIC OR TO THE PATIENT OR TO A FAMILY MEMBER OR EMPLOYER OF THE PATIENT FOR ALL OR PART OF THE CLINIC CHARGE, INCLUDING BUT NOT LIMITED TO HOSPITAL OR MEDICAL SERVICES COMPANY, INSURANCE COMPANY, WORKERS COMPENSATION CARRIERS, WELFARE FUNDS, OR THE PATIENTS EMPLOYER.

HIPPA ACKNOWLEDGEMENT:

I HAVE RECEIVED AND HAVE READ THE CENTER FOR SYMPTOM RELIEF, LLC NOTICE OF PRIVACY PRACTICES.

IN MY ABSENCE OR FOR THE BENEFIT OF GAINING MEDICAL ADVICE ON MY BEHALF, I AUTHORIZE THE FOLLOWING PERSON TO GAIN PAITENT HEALTH INFORAMTION FOR OR WITH ME: _____

(Please list authorized Representative (s) or mark N/A

Patient/Guardian signature _____ *Date* _____

Additional Questions: Please circle one that applies

1. **Race:** American Indian or Other Pacific

   Black or Native American

   White

   Hispanic

   Other Race

   Other Pacific Islander

2. **Ethnicity:** Hispanic or Latin

   Not Hispanic or Latin

***Please note, any cancellations not made within 24 hours of your scheduled appointment may result in a fee.**

AUTHORIZATION FOR RELEASE OR USE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____

I, _____(patient name), hereby authorize _____ (physician) to disclose protected health information to **The Center for Symptom Relief** for continuity of care. This authorization is valid from today's date and will expire when medical care is no longer being provided by Drs. Bourn, Patel and/or Seidensticker or if patient cancels authorization.

I authorize the following to be released:

- Medical Records/Progress Notes
- Imaging
- Hospital Visits
- Operative reports/lab results

By signing below, I understand that:

- I have the right to revoke or cancel this authorization at any time by providing notice in writing to The Center for Symptom Relief
- If I revoke or cancel this authorization, it is not effective for the use or for the disclosure of my protected health information that has already occurred.
- Any information used or disclosed as per this specific authorization may be re-disclosed by the person/entity receiving the information. In such a situation, it may no longer be protected by federal or state law
- I am not required to sign this authorization
- I have the right to inspect/copy the protected health information that will be used/disclosed

Signature: _____ Date: _____

Print Name: _____

Please fax or mail requested information to:
The Center for Symptom Relief
1161 Bethel Road, Suite 204
Columbus, Oh 43220
(P)-614-459-0350 (F)- 614-459-0355

No-show and Same Day Cancellation Policy
For Established Patients

In an effort to provide excellent and quality healthcare for our patients, we have made changes to our no-show and same day cancellation policy.

No-show/ Same Day Cancellation Policy:

- 1st Occurrence (with valid reason): No charge, however this will generate a warning that upon your second missed appointment you will be charged $20.
- 2nd Occurrence: You will be assessed a fine of $20.
  (This is also a warning that upon your third missed appointment you may be dismissed from the practice.)
- 3rd Occurrence: You will be assessed a fine of $20 and are in jeopardy of being dismissed from the practice.

In the event you do not show up to a scheduled appointment, you will first receive a call from our office to make sure you are okay. Any fees accrued due to the cancellation for not showing up for this appointment are due prior to scheduling your next appointment.

In order to avoid penalty, **we require at least a 24-hour notice for all appointment changes or cancellations.** During normal business hours, please mention the reason for the cancellation.

If you check in for your appointment and need to leave before being seen by the doctor it is also considered a same day cancellation. A fee of $20 will be automatically assessed at that time. Any further occurrences can also result in dismissal.

Center for Symptom Relief believes that a good physician/patient relationship is based upon understanding and good communication. Questions about the policy should be directed to the Office Manager. We are here to help you.

By signing below, you agree to the terms of this policy and acknowledge that you have received a copy.

Patient Name (Print):_____

Patient Signature: _____

Date: _____

PATIENT MEDICATION MANAGEMENT AGREEMENT

The purpose of this agreement is to give you information about the medications you will be taking for pain management and to assure that you and the Center for Symptom Relief providers comply with all state and federal regulations concerning the prescribing of controlled substances. A trial of Opiate therapy can be considered for moderate to severe pain with the intent of reducing pain and increasing function. This needs to be seen as a trial and not a permanent part of ongoing care. The Center for Symptom Relief provider's goal is for you to have the best function possible given the reality of your clinical condition and inherent safety concerns. The success of treatment depends on mutual trust and honesty in the physician/patient relationship and full agreement and understanding of the risks and benefits of using opioids to treat pain. Opiate therapy is reserved as a last resort option and patients are expected to be actively involved and participating in all parts of the treatment plan.___

1. **You understand that the prescribing and managing of medications, doses and schedules are solely based on medical decisions made by Center for Symptom Relief providers with the information available to them. Decisions to change dosing schedules, discontinue, increase or decrease medications are medical decisions your doctors will make. Your pain doctor has no obligation to continue opioids if they are not effective, have intolerable side effects or are felt to present a larger risk than benefit.**
2. **You will use only Center for Symptom Relief providers to prescribe and monitor all opioid medications and adjunctive analgesics. You agree not to ask for opioid medications or fill prescriptions for opioid medications written by any other doctor, emergency room or hospital without the knowledge and consent of your pain doctor.**
3. **You agree to keep all scheduled appointments, not just with Center for Symptom Relief providers, but also with recommended therapists and psychological counselors. Three or more missed appointments or same day cancellations may lead to discontinuation of the physician/patient relationship.**
4. **You agree to provide regular samples for urine drug screens. Positive test results for any illegal substances, or opioids not prescribed by your pain doctor, will result in discontinuation of opiate therapy and referral for substance abuse evaluation and management. Illegal activity will be reported to law enforcement.**
5. **You will use one pharmacy to obtain all opioid prescriptions and adjunctive analgesics prescribed by Center for Symptom Relief providers.**
6. **No prescriptions will be refilled early.**
7. **No prescriptions will be refilled if you lose, destroy, or have any of your medication stolen.**

8. **You are responsible for keeping your pain medication in a safe and secure place, such as a locked cabinet or safe. You are expected to protect your medications from loss or theft. Stolen medications should be reported to the police and to your physician immediately.**
9. **You may not give or sell your medications to any other person under any circumstances. If you do, you may endanger that person's health. It is also against the law.**
10. **Any evidence of drug hoarding, unauthorized dose escalation or reduction, failure to follow the plan of care or other unsafe actions will result in discontinuation of opioids.**
11. **You will communicate fully to Center for Symptom Relief providers to the best of your ability at the initial and all follow-up visits your pain level and functional activity along with any side effects of the medications. This information allows Center for Symptom Relief providers to adjust your treatment plan accordingly.**
12. **You will not use any illicit substances, such as cocaine, marijuana, etc. while taking these medications. This may result in a change to your treatment plan, including safe discontinuation of your opioid medications when applicable or complete termination of the doctor/patient relationship.**

13. **The use of alcohol and opioid medications is contraindicated. Please note that using medical marijuana is not in line with our treatment recommendations and would be considered a violation of this agreement.**
14. **Prescription refills will be authorized only during regular office hours.**
15. **You agree to comply fully with all aspects of your treatment program including behavioral medicine (psychology/psychiatry) and physical therapy, if recommended. Failure to do so may lead to discontinuation of opioid medication and referral to another provider or treatment center.**
16. **You should inform the Center for Symptom Relief providers of all medications you are taking, including herbal remedies, since opioid medications can interact with over-the-counter medications and other prescribed medications, especially cough syrup that contains alcohol, codeine or hydrocodone.**
17. **You agree to a family conference or a conference with a close friend or significant other if the Center for Symptom Relief providers feels it necessary.**
18. **I shall not hold the provider responsible for any harmful act which I may commit, error in judgement, or faulty legal decision, which may result from controlled substance therapy.**
19. **You agree to random pill counts to assure compliance with treatment plan and minimize risk of misuse/diversion.**

Informed Consent for Long term Opiate use

The use of chronic opioid therapy has not been established as a safe or effective medical treatment for all patients or conditions. This needs to be viewed as an elective therapy that is potentially lethal or harmful. (i.e. overdose)___

Opioids may cause drowsiness that can be worsened with alcohol, benzodiazepines, and other sedating medications. Use care when driving or operating machinery. Do not drive or operate machinery within a week of any dosage or medication schedule changes.___

Common side effects include nausea, itching, and sweating. Psychological depression and lowered testosterone levels may also occur. Sleep apnea, if present, may be worsened by opioids. Constipation commonly occurs, and often does not improve with time. It is impossible to predict opioid side effects in any individual patient. Sedation, breathing difficulty, loss of consciousness and death can occur.

Not all pain conditions respond to opioids. Some pain may only be partially responsive to opioid therapy. Total elimination of pain is an unrealistic goal. Escalating doses may indicate that opioids are not effective or that there is an underlying problem with addiction/physical dependence. Discontinuation of opioid medications may need to be done under these circumstances.

Physical dependence and/or tolerance, and/or addiction can occur with the use of opioid medications. Physical dependence means that if the opioid medication is abruptly stopped or not taken as directed, a withdrawal symptom can occur. This is a normal physiological response. The withdrawal symptoms can include, but not exclusively, sweating, nervousness, abdominal cramps, diarrhea, goose bumps and alterations in one's mood.

It should be noted that physical dependence does not equal addiction. Addiction is a primary, chronic neurobiological disease. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm and cravings. This means the drug decreases one's quality of life. Your pain physicians will address this with you if this disease is suspected.

Tolerance is a state of adaptation in which exposure to the drug induces changes that result in diminution of one or more of the drug's effects over time. The dose of the opioid may have to be titrated up or down to a dose that produces maximum function and a realistic decrease of the patient's pain. This decision is the discretion of the Center for Symptom Relief providers.

I, the undersigned, agree to follow these guidelines that have been fully explained to me. I understand the purpose of this agreement is to help assure safe, effective and legal use of opioids. All of my questions and concerns about treatment have been adequately answered.___

I give permission to the Center for Symptom Relief providers to contact my other healthcare providers, for the purpose of sharing information concerning my situation, as deemed necessary for coordinated, high quality care.

If I do not follow these guidelines fully, the Center for Symptom Relief providers may taper and stop opioid treatment.___

I have been given a copy of this document.___

Patient signature: _____ Date: _____

Print Name: _____

Witness signature: _____ Date: _____