

Coastal Anesthesia and Pain Relief Specialists, P.C.

Dr. Amy Pearson, MD
Tommy Hersch, PA-C

2701 Highway 17 Suite 1B
Richmond Hill, GA 31324
912-756-3005 phone
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New Patient Paperwork

Dear Patients,

In order for our staff to better serve you we ask that you please fill out our new patient packet completely. The more information you provide us the better we can assist you with your pain. Once completed please return this packet to our office with any paper MRI, CT, X-Ray reports. If you do not have any reports available to you, please inform our office where you had the test done so that we can request the report and have it here for your initial visit. Feel free to fax or mail your packet in. We look forward to meeting you and helping you conquer your pain.

The Staff of Coastal Pain Relief Specialists

Constal Anesthesia and Pain Relief Specialists, PC
Registration (Please print clearly)

Date _____ Home phone number _____

Patient name _____

Responsible party (if a minor) _____

Street address _____ City _____ State _____ Zip _____

Sex M F Marital Status: single married separated divorced

Age _____ Birth date _____

Patient employed by _____ Occupation _____

Spouse (or responsible party) name _____ Birth date _____

Spouse's occupation _____ Business phone _____

Spouse's business name and address _____

Who is responsible for this account? _____ Relationship to patient _____

Social Security number _____ Spouse's SSN _____

Do you have medical insurance? yes no If yes,.....

Primary insurer name _____ Contract # _____ Group # _____ Subscriber # _____

Secondary insurer (if any) _____ Contract # _____ Group # _____ Subscriber # _____

Do you have Medicare Medicaid If yes,..... Claim ID# _____

In case of an emergency, who should be notified? _____ Phone # _____

Whom may we thank for your referral to our practice? _____

I, the undersigned, have insurance coverage with _____ (Insurance company name) and assign directly to Constal Anesthesia & Pain Relief Specialists, PC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian

Date

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Constal Anesthesia and Pain Relief Specialists, PC for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HDFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature

Date

Name _____ Date _____

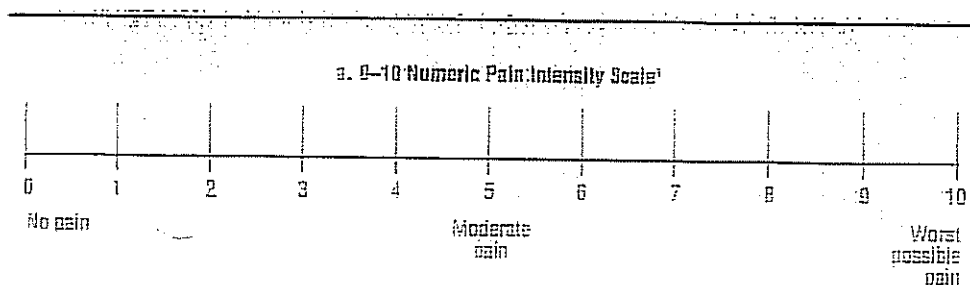
Chief Complaints

- Where is the main location of your *worst* pain?

- What date did your pain begin? _____

- Does your pain *travel* to another part of your body? Yes No If so, where?

- Please indicate your current level of pain *today*, on a 0-10 scale, where 0 is no pain at all, and 10 is the worst pain you can imagine:



- Please check off each line for a description of you chronic pain problem:

<i>Do you have any..</i>	None	Mild	Moderate	Severe
Throbbing				
Shooting				
Stabbing				
Sharp				
Cramping				
Gnawing				
Hot-Burning				
Aching				
Heavy				
Tender				

Splitting				
Tiring/Exhausting				
Sickening				
Fearful				
Punishing/Cruel				

- What other symptoms accompany your pain? None weakness (where _____)
numbness (where _____) weight loss problem with bladder function problems with
 bowel function trouble sleeping other _____

• If your pain began with an injury, please describe:

• If pain began at work, please describe:

Place of employment when pain began _____

- What makes your pain better? Nothing at all ice weather heat physical activity
distraction medications walking sitting bending forward bending backwards
position (if so, which one? _____) other _____

• What makes your pain worse, or what triggers your pain?

- Nothing at all ice weather heat physical activity standing medications walking
bending forward bending backwards sitting stress
position (if so, which one? _____) other _____

• Are you frequently awakened by pain at night? Yes No

If so, how often? 1-2 times 3-4 times 5-6 times more than 6 times

• On average, how many hours of sleep do you get at night?

1-2 2-4 4-6 6-8 more than 8 hours

• Are you presently involved in a lawsuit because of your pain? Yes No

If yes, please explain: _____

Were you treated in a *Pain Clinic* before? Yes No

If so, when and where:

• Please indicate if you have had previous treatments for your pain:

- physical therapy (when? _____) TENS unit surgical intervention/type _____
- psychological Techniques (if so, which ones) relaxation training biofeedback
- imagery distraction therapy
- injections(s): into muscles into a joint epidural steroid nerve block
- other _____

Alternative Medical Treatments

- chiropractor acupuncture homeopathy hypnotism
- herbal remedies(which ones? _____)
- other _____

Past Medical History

Neurological

- seizure disorder
- stroke
- other _____

Cardiac

- heart attack
- high blood pressure
- heart failure
- pacemaker
- rheumatic fever
- other _____

General

- diabetes
- blood disease
- easy bleeding
- glaucoma
- eye problems
- bladder infections
- kidney infections
- thyroid disease
- hepatitis
- kidney problems
- cancer _____
- arthritis
- other _____

Pulmonary

- chronic bronchitis
- asthma
- emphysema
- other _____

Gastrointestinal

- stomach ulcers
- colitis
- irritable bowel
- hiatal hernia
- other _____

• If you are a female, is there a chance that you are currently pregnant? Yes No

• Are you currently using blood thinner medication? Yes No

Past Surgical History

Type of Surgery	Date of Surgery	Location of Surgery	Who Performed it?
<input type="checkbox"/> Back Surgery			
<input type="checkbox"/> Neck Surgery			
<input type="checkbox"/> Appendectomy			
<input type="checkbox"/> Gall Bladder			
<input type="checkbox"/> Hysterectomy			
<input type="checkbox"/> Other			

Past Social History

•Do you currently smoke or have you ever smoked? Yes No

If so, how many packs a day?_____ For how long?_____ When did you quit?_____

•Do you drink alcohol? Yes No If so, what type and how much?_____

•Do you or have you ever used recreational drugs? Yes No

If you no longer use recreational drugs, when did you quit? _____ days/months/years (circle one)

Marital Status

married never married divorced/separated widowed

• What previous tests were done for your pain problem?

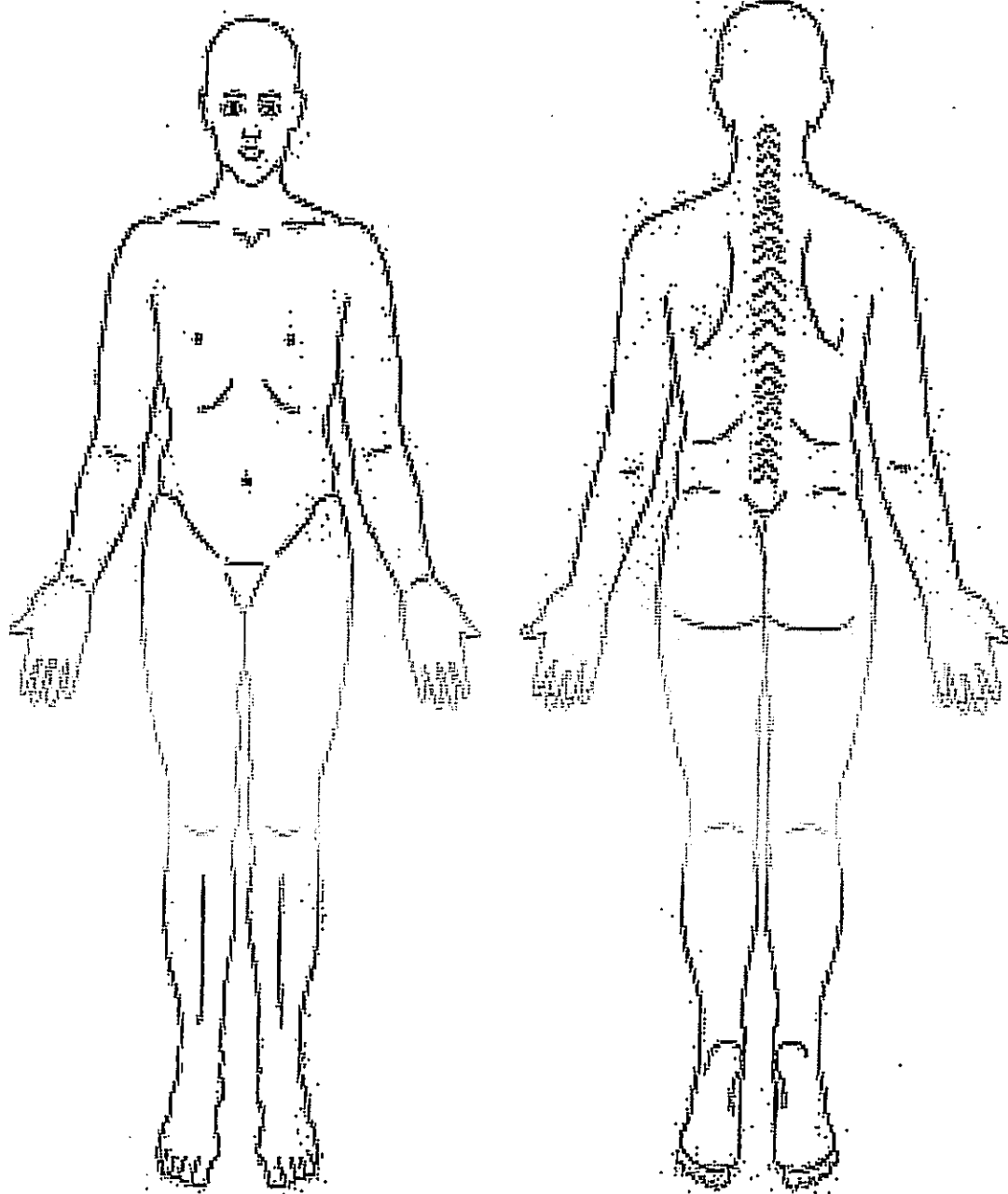
Test	When	Where	Who Ordered It	Results(if known)
X-ray				
Cat Scan				
Bone Scan				
MRI				
EMG				
Other				

If you have taken pain medications in the past, please indicate:

Relafen Daypro Motrin/Advil Aleve/Naprosyn Celebrex/Vioxx Lodine
Elavil Desyrel Prozac Ultram Paxil/Zoloft Darvocet
Lortab Vicodin Demerol Dilaudid Morphine Soma
Neurontin Flexeril OxyContin Methadone Duragesic Klonopin
Zanaflex Ms Contin

Other:

- Please shade in your area(s) of pain on the diagrams below:



- Which statement best describes your pain?
 - always present, always the same intensity
 - always present, intensity varies
 - usually present, but have short intervals without pain
 - often present, but have pain free periods lasting one to several hours
 - often present, but I am pain free most of the day
 - occasionally present—have brief pain 1 to several times a day, lasting a few minutes to an hour
 - occasionally present for brief periods, a few seconds to a few minutes
 - rarely present, have pain every few days or weeks

Please check any symptoms you are experiencing:

General

- usual weight _____ lbs
- recent weight change
- generalized weakness
- fatigue
- fever

Skin

- rashes lumps
- itching dryness
- changes in hair
- changes in nails

Head

- headaches
- previous head injury

Eyes

- glaucoma cataracts
- eye pain redness
- visual changes
- glasses/contacts
- excessive tearing
- double vision

Ears

- hearing loss
- ringing in ears
- earaches vertigo
- infections discharge

Nose/Sinuses

- frequent colds
- nasal stuffiness
- sinus problems
- hay fever nosebleeds

Mouth/Throat

- hoarseness sore tongue
- bleeding gums
- frequent sore throats
- poor condition of teeth

Neck

- goiter lumps in neck
- swollen glands

Breasts

- lumps pain
- discharge

Respiratory

- tuberculosis pneumonia
- emphysema bronchitis
- short of breath asthma
- chronic cough
- blood in sputum
- pain on breathing

Cardiac

- heart murmur heart trouble
- rheumatic fever angina
- high blood pressure
- irregular heart beats
- previous heart attacks

Gastrointestinal

- nausea vomiting
- diarrhea constipation
- hepatitis liver problems
- trouble swallowing
- abdominal pain
- heartburn/indigestion
- vomiting blood hemorrhoids
- bleeding from rectum
- change in bowel habits
- food intolerance
- excessive belching
- excessive passing of gas
- gallbladder trouble

Urinary

- urgency hesitancy
- increased frequency
- burning on urination
- blood in urine kidney stones
- frequent urinary tract infections
- trouble "holding your water"

Genito-Reproductive Male

- hernias testicular pain
- decreased sex drive
- problems with erection

Female

- currently pregnant
- abnormal periods
- vaginal discharge
- vaginal pain
- decreased sex

Musculoskeletal

- joint pains gout
- arthritis
- joint stiffness
- muscle aches/pains
- backache

Neurologic

- fainting spells
- seizure disorder
- memory loss
- tremors

Psychiatric

- nervousness
- tension/stress
- mood swings
- depression

Endocrine

- thyroid trouble
- excessive sweating
- diabetes
- excessive thirst
- excessive hunger
- excessive urination

Hematologic

- anemia
- easy bruising/
bleeding
- transfusion
- reaction
- sickle cell
disease

COASTAL ANESTHESIA AND PAIN RELIEF SPECIALISTS

Amy Pearson, MD
Tommy Hersch, PA-C
2701 Hwy 17 Ste. 1-B
Richmond Hill, GA 31324
(912) 756-3005 phone / (912) 756-5921 fax

PATIENT/DOCTOR TREATMENT & MEDICATION AGREEMENT

The purpose of this agreement is to prevent misunderstandings about certain medicines you might be prescribed for pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

By signing this agreement you have read, understood, and agreed to these rules:

1. If recommended, I will submit to an evaluation by an addictionologist, which may include a psychiatric evaluation.
2. If I break this agreement, my doctor may stop prescribing these pain control medicines and I may be DISCHARGED from the practice.
3. I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.
4. I will not use alcohol or ANY ILLEGAL controlled substances, including but not limited to: marijuana, cocaine, methamphetamines, etc.
5. I will not SHARE, SELL, or TRADE my medications with anyone.
6. I will not attempt to obtain any controlled medications, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctors or practice.
7. I will SAFEGUARD my pain medicine from loss or theft. Loss or stolen medicines WILL NOT be replaced.
8. **Refills of any prescriptions for pain medicine will be made only during regular office hours. All refill requests must be made FIVE business days in advance. NO REFILLS WILL BE AVAILABLE DURING EVENING, WEEKENDS, OR HOLIDAYS. Please initial _____**
9. I understand that I MUST BE SEEN IN THE OFFICE AT LEAST EVERY NINETY DAYS or more often if recommended to request a refill or my refill will be denied until I am seen.
10. I will submit to random urine testing as requested by my doctor to determine compliance with my program of pain control medicine.
11. I will use my medicine at a rate **no greater than the prescribed rate** use of my medicine at a greater rate will result in my being without medicine for a period of time.
12. If at any time I break the law with regards to my pain medicine, I am aware that the appropriate law enforcement department may be notified and my records could be released to them. It is illegal to sell, trade, or share prescription medication. It is illegal to obtain controlled substances from more than one doctor without telling the other doctor. It is illegal to alter or fabricate prescriptions.

13. I understand there is a small risk that opioid addiction could occur. This means I might become psychologically dependent on the medication, using it to change my mood or get high, or be unable to control my use of it. If this occurs, the medication will be discontinued and I will be referred to a drug treatment program for help with this problem.
14. I understand that if I am pregnant or become pregnant while taking opioid medications, my child could become physically dependant on opioid medications, and withdrawals can be life-threatening for a baby.
15. **While interacting with the staff of Coastal Pain Relief Specialists, my behavior will be becoming of a rationale, reasonable, and well mannered person. The staff is expected to respond in an equally courteous and respectful way. If the interactions between the staff and myself are deemed to be repeatedly rude or confrontational, Dr. Pearson will request for me to seek treatment at another facility. Please initial _____**
16. I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment and medications have been adequately answered. A copy of the Agreement has been given to me.

OFFICE HOURS:

PATIENT DAYS: MON-THURS 9AM-5PM

NON PATIENT DAY: FRI 9AM-12PM

This Agreement has been reviewed and signed on this _____ day of _____ in the year of _____.

Patient Name: _____ Patient Signature: _____

Witnessed by: _____ Doctor Signature: _____

Coastal Anesthesia & Pain Relief Specialist, PC

Privacy Notice

THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

- Your confidential healthcare information may be released to other healthcare professionals within Coastal Anesthesia & Pain Relief Specialist, PC (CAPRS) for the purpose of providing you with quality healthcare.
- Your confidential healthcare information may be released to your insurance provider for the purpose of CAPRS receiving payment for providing you with needed healthcare services.
- Your confidential healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
- Your confidential healthcare information may be released to other healthcare providers in the event you need emergency care.
- Your confidential healthcare information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication)
- Your confidential healthcare information may not be released for any other purpose than that which is identified in this notice.
- Your confidential healthcare information may be released only after receiving written authorization from you. You may revoke your permission to release confidential healthcare information at any time.
- You may be contacted by CAPRS to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.
- You may be contacted by CAPRS for the purposes of raising funds to support the organizations operations.
- You have the right to restrict the use of your confidential healthcare information. However, CAPRS may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.
- You have the right to receive confidential communication about your health status.
- You have the right to review and photocopy any/all portions of your healthcare information.
- You have the right to make changes to your healthcare information.
- You have the right to know who has accessed your confidential healthcare information and for what purpose.

- You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.
- CAPRS is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information and will provide patients with a list of duties or practices that protect confidential healthcare information.
- CAPRS will abide by the terms of this notice. The organization reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information. Patients will receive a mailed copy of any changes to this notice within 60 days of making changes.
- You have the right to complain to CAPRS if you believe your rights have been violated. If you feel your privacy rights have been violated, please mail your complaint to:

ATTN: Dan Reeves
Coastal Anesthesia & Pain Relief Specialist, PC
2701 Hwy 17 Ste 1-B
Richmond Hill, Ga 31324

- All complaints will be investigated. No personal issue will be raised for filing a complaint with the organization.

For further information about this privacy Notice, please contact

Dan Reeves
Office Manager
Phone (912) 756-3005
Fax (912) 756-5921

- This notice is effective as of Date of Effectiveness. This date must be earlier than the date on which the notice is printed or published.

**Coastal Anesthesia & Pain Relief Specialists
Receipt of Notice of Privacy Practices
Written Acknowledgement Form**

I have received a copy of the Coastal Anesthesia & Pain Relief Specialists Notice of Privacy Practices, The notice details how my personal health information may be used and disclosed as permitted under federal and state laws. I have read and understand the contents of the notice.

Print Patient's Name

Patient's Signature

Witness

Date

If not signed by the patient, please indicate the relationship to the patient of the person

Relationship _____ Witness _____

Cancellation / No Show / Missed Appointment Policy

If you do not give us 24 hours' notice that you will miss your appointment, a charge will be added to your account that must be paid before we can schedule another appointment for you. **Your insurance will not pay for this charge.**

Charges will be as follows:

\$35.00 if you do not provide a 24 hour notice for your office visit.

\$50.00 if you do not provide a 24 hour notice for any injection / procedure (including those done in the office)

\$25.00 returned check fee.

Reminder calls are a courtesy and cannot always be provided. It is your responsibility to report for your appointment on the scheduled date and time.

Your signature below conveys that you have read and understand our policy regarding missed appointments.

Patient Name Printed

Patient Signature or legally authorized individual signature

Date

COASTAL ANESTHESIA AND PAIN RELIEF SPECIALISTS
Dr. Amy Pearson

Patient's name _____

Date of Birth _____

SSN: _____

Previous name: _____

Patient consent for Use/Disclosure of Health Care Information

I understand that the patient's health information is private and confidential. I understand that Coastal Anesthesia and Pain Relief Specialists (further referred in this document as CAPRS) work very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that CAPRS may use and disclose the patient's personal health information to help provide health care to this patient, to handle billing and payment, and to take care of other health operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.

CAPRS may update this "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice" before signing this agreement.

CAPRS may update this "Notice of Privacy Practices". If I ask, CAPRS will provide me with the most current "Notice".

Under the terms of this consent, I can ask CAPRS to limit how the patient's personal health information is used or disclosed to carry out treatment, payment or health care operations; I understand that CAPRS does not have to agree to my request. If CAPRS does not agree to my request, I understand that CAPRS would follow the agreed limits.

I may cancel this consent in writing any time by doing the following:

Writing, signing, and dating a letter to CAPRS. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of the patient's personal health information for treatment, payment and health care options.

If I revoke this consent, CAPRS does not have to provide any further health care to the patient.

My signature below indicates that I have been given the chance to review a current copy of CAPRS' "Notice of Privacy Practices". My signature means that I agree to allow CAORS to use and disclose the patient's health information to carry out treatment, payment, and health care options.

Patient or legally authorized individual signature

Witness

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, etc.)

Date

Physician's Assistant (PA)

Coastal Anesthesia and Pain Relief Specialist, PC the office of Dr. Amy Pearson uses a Physician's Assistant (PA) for those levels of this practice that have been approved by the Georgia State Board of Medical Examiners.

Your signature on this approval form conveys that you are in agreement with being treated by my PA, who is acting under my supervision.

Patient Signature or legally authorized individual signature

Date

Step 1—Questionnaire

Patient's Name:		Date:	
Drug Abuse Screening Test—DAST-10			
These Questions Refer to the Past 12 Months			
1	Have you used drugs other than those required for medical reasons?	Yes	No
2	Do you abuse more than one drug at a time?	Yes	No
3	Are you unable to stop using drugs when you want to?	Yes	No
4	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5	Do you ever feel bad or guilty about your drug use?	Yes	No
6	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7	Have you neglected your family because of your use of drugs?	Yes	No
8	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10	Have you had medical problems as a result of your drug use (eg, memory loss, hepatitis, convulsions; bleeding)?	Yes	No

Interpretation (Each "Yes" response = 1)

Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	Encouragement and education
1-2	Low level	Risky behavior – feedback and advice
3-5	Moderate level	Harmful behavior – feedback and counseling; possible referral for specialized assessment
6-8	Substantial level	Intensive assessment and referral

COASTAL ANESTHESIA AND PAIN RELIEF SPECIALISTS

Dr. Amy Pearson

Phone (912) 756-3005 Fax (912) 756-5921

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Patient Information

Patient Last Name _____ First Name _____ MI _____
Street Address _____ Apt # _____
City _____ State _____ Zip _____
Date of Birth _____ Telephone Number _____

Information Requested (Please check all that apply):

_____ Complete Record _____ Records of care from (dates) _____ to _____
_____ Other (Specify) _____ Restrictions of Exclusions (please specify):

Coastal Anesthesia and Pain Relief Specialists will SEND the information requested above TO:

Facility Name _____
Attention of _____ Telephone _____
Street Address _____ Suite/Room _____
City _____ State _____ Zip _____

Coastal Anesthesia and Pain Relief Specialists will REQUEST the information listed above FROM:

Facility Name _____
Attention of _____ Telephone _____
Street Address _____ Suite/Room _____
City _____ State _____ Zip _____

I voluntarily authorize and direct Dr. Pearson to use or disclose my health information during the term of this Authorization to the recipient that I have identified above. I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Signature Date

If Individual is unable to sign this Authorization, please complete the information below:

Name of Guardian/Representative Legal Relationship Date