Center for Pain and Headache Medicine

Guardian Medical Care

New Patient Paperwork

Thank you in advance for taking the time to complete our paperwork. We are aware that it is extensive and time consuming. We hope you understand that this is our first introduction to you and your medical history and the best way for us to begin to understand your pain. Below is a checklist to help guide you through this process. We welcome you to the Center for Pain and Headache Medicine and we look forward to helping you find relief from your pain and getting you back to your normal daily activities.

Please bring the following items with you to your first appointment:

□Current Insurance Card

□Photo ID

□Most Recent MRI or Other Imaging Reports (If applicable)

□Current Medications (Bring in their original bottle to your first appointment)

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St. Marys, GA 31558

2600 Parkwood Drive
Brunswick, GA 31520

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Guardian Medical Care

<table>
<tr><td colspan="2">First Name</td><td colspan="3">Middle Initial Last Name</td></tr>
<tr><td colspan="2">Street Address</td><td colspan="3">City, State Zip Code</td></tr>
<tr><td>Date of Birth</td><td>Age</td><td>Gender
Male Female</td><td colspan="2">Marital Status
Single Married Divorced Widowed</td></tr>
<tr><td colspan="2">Preferred Language</td><td colspan="2">Race</td><td>Ethnicity</td></tr>
<tr><td colspan="2">Home Phone</td><td colspan="2">Cell Phone</td><td>Work Phone</td></tr>
<tr><td colspan="2">Social Security Number (for insurance & record keeping only)</td><td colspan="3">E-mail Address</td></tr>
<tr><td colspan="2">Occupation</td><td colspan="3">Employer</td></tr>
<tr><td colspan="2">Guarantor Full Name/Person Responsible for Payment</td><td colspan="3">Relation to Patient:
Self Spouse Legal Guardian</td></tr>
<tr><td colspan="5">Primary Medical Insurance Policy Information:</td></tr>
<tr><td colspan="2">Insurance Co. Name</td><td colspan="3">Insurance ID/Contract Number</td></tr>
<tr><td colspan="2">Policy Holder’s/Insured’s Full Name</td><td colspan="3">Patient’s relation to insured:
Self Spouse Legal Guardian</td></tr>
<tr><td colspan="2">Policy Holder/Insured’s Date of Birth</td><td colspan="3">Insured’s Employer Name</td></tr>
<tr><td colspan="5">Secondary Medical Insurance Policy Information (if applicable):</td></tr>
<tr><td colspan="2">Insurance Co. Name</td><td colspan="3">Insurance ID/Contract Number</td></tr>
<tr><td colspan="2">Policy Holder’s/Insured’s Full Name</td><td colspan="3">Patient’s relation to the insured:
Self Spouse Legal Guardian</td></tr>
<tr><td colspan="2">Policy Holder/Insured’s Date of Birth</td><td colspan="3">Insured’s Employer Name</td></tr>
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HISTORY & PHYSICAL

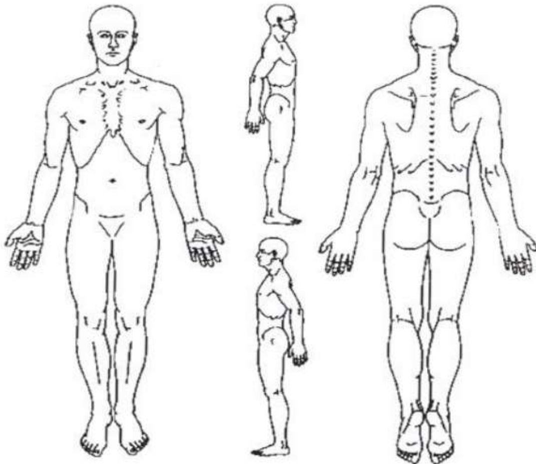
Patient Name: ____ Date of Birth: __________________
Sex: _____ Age: ________ Height: ________ Weight: ________ R or L Handed (please circle)

Consultation/Referral: Patient comes referred by ____
Primary Care Physician's Name ____

Worker's Compensation Case? Yes No Auto Accident? Yes No Lawsuit Pending? Yes No
Represented by Attorney? Yes No Attorney's Name ___________________________________

Chief Complaint, Location of Pain:

On the diagram below **"SHADE"** all areas where you feel pain and **"X"** the areas that hurt the most.



Mark "X"	Location	Right	Left
	Neck		
	Shoulder		
	Arm Forearm Hand		
	Thoracic		
	Low back		
	Leg		
	Hip		
	Knee		
	Foot		
	Headache		

Events associated with the onset of pain:
□ Car accident □ Lifting □ Fall □Work Related □ Unknown □ Other________________________

When did the first sign/symptom occur? Year ____________ Month ___________________
Quality of Pain: Use one box per body site where you experience pain TODAY. (Example: one box for back, one for leg and another for neck). Circle the words that **best** describe the pain at that site. Also indicate the intensity of the pain.

Body Site______________________ Circle the words that best describe the pain

Sharp	**Numb**	**Burning**	**Intermittent**	**Exhausting**
Shooting	**Throbbing**	**Cramping**	**Continuous**	**Miserable**
Stabbing	**Aching**	**Gnawing**	**Penetrating**	**Unbearable**

Intensity Scale 0 1 2 3 4 5 6 7 8 9 10
No pain Worst Pain

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Stabbing	**Aching**	**Gnawing**	**Penetrating**	**Unbearable**

Intensity Scale 0 1 2 3 4 5 6 7 8 9 10
No pain Worst Pain

Does any of the following make your pain worse?

Y N Coughing or sneezing
Y N Sitting If yes, after how many minutes? ___________________
Y N Standing If yes, after how many minutes? ____________________
Y N Walking If yes, after how many minutes? ____________________
Y N Physical activity If yes, what types?________________________
Y N Do you use either a cane or walker because of your pain?
Y N Does leaning on a shopping cart or counter top decrease your pain?

Do you have any of the following symptoms where your pain is?

Y N Numbness or Tingling (“pins and needles”). If yes, Where? ______________________
Y N Bladder or Bowel problems (incontinence or leakage without your control)
Y N Muscle spasms or cramps (“Charley horses”). If yes, At night or day (circle one)?
Y N Muscle Weakness. If yes, Where? _______________________________________

Modifying Factors: Circle the number below that best describes the amount of pain relief that treatment is providing or has provided in the past.

	Never Tried	No Relief — Complete Relief	If Receiving Now
Physical Therapy	□	0 1 2 3 4 5 6 7 8 9 10	□
Surgery	□	0 1 2 3 4 5 6 7 8 9 10	□
Injection/Nerve Block	□	0 1 2 3 4 5 6 7 8 9 10	□
Medications	□	0 1 2 3 4 5 6 7 8 9 10	□
Chiropractic Treatment	□	0 1 2 3 4 5 6 7 8 9 10	□
TENS	□	0 1 2 3 4 5 6 7 8 9 10	□
Acupuncture	□	0 1 2 3 4 5 6 7 8 9 10	□
Biofeedback	□	0 1 2 3 4 5 6 7 8 9 10	□

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Specific Studies Done: (circle)

MRI X-Rays CT/Myelogram Bone Scan

Where? When? ____

Where? When? ____

Where? When? ____

Previous Surgeries: (Year and surgery performed)

____

____

____

____

Past Medical History: Please check Medical problems you have had in the past or still have

Yes	**No**	**Musculoskeletal Disease**	**Yes**	**No**	**Cardiovascular Disease**
□	□	Fibromyalgia	□	□	Heart Attack
□	□	Arthritis	□	□	High Blood Pressure
□	□	Raynaud's Disease	□	□	Low Blood Pressure
□	□	Scoliosis	□	□	Arrhythmias or Palpitations
□	□	Lupus	□	□	Heart Failure
□	□	Osteoporosis	□	□	Valvular Disease
Other______________________			□	□	Pacemaker
			□	□	Defibrillator
Yes	**No**	**Neurologic Disease**	□	□	Angioplasty
□	□	Seizures/Epilepsy	Other ______________________		
□	□	Stroke			
□	□	Mini-Stroke/TIA	**Yes**	**No**	**Pulmonary Disease**
□	□	Alzheimer's	□	□	Asthma
□	□	Parkinson's	□	□	Emphysema/COPD
□	□	Multiple Sclerosis	□	□	Lung Surgery
Other______________________			□	□	Bronchitis
			□	□	Sleep Apnea
Yes	**No**	**Gastrointestinal Disease**	Other ______________________		
□	□	Acid Reflux/GERD			
□	□	Hiatal Hernia	**Yes**	**No**	**Liver Disease**
□	□	Gastric Ulcer	□	□	Hepatitis/Jaundice
Other______________________			Other ______________________		
Yes	**No**	**Skin Disease**	**Yes**	**No**	**Immunologic Disease**
□	□	Psoriasis	□	□	HIV/AIDS
Other ______________________			Other ______________________		

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Yes No Kidney Disease	**Yes No Psychiatric Disease**
☐ ☐ Kidney Failure	☐ ☐ Depression
Last Dialysis ______________________	☐ ☐ Anxiety
Other_____________________________	☐ ☐ Schizophrenia
	☐ ☐ Bipolar Disorder
Yes No Cancer	☐ ☐ Drug Addiction
☐ ☐	☐ ☐ Alcoholism
Type/Location______________________	☐ ☐ Eating Disorders
	Other ______________________
Yes No Blood Disease	
☐ ☐ Sickle Cell Anemia	**Other Significant Medical Conditions/Diseases**
☐ ☐ Clotting/Bleeding Problems	____
Other_____________________________	____
	____
Yes No Endocrine Disease	____
☐ ☐ Diabetes (High Blood Sugar)	____
☐ ☐ Thyroid Problems	____
Other_____________________________	____

Previous Pain Treatment Procedure:

Date	Procedure Type	Physician	Any help/relief?

Allergies:	Allergic to Latex?	Yes	No
	Allergic to Iodine or Shellfish?	Yes	No
	Allergic to IV Dye or Contrast Dye?	Yes	No
	Allergic to Steroid/Cortisone?	Yes	No
	Allergic to Adhesives?	Yes	No

List ALL Medications to which you are allergic to:

____

____

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Medications – prescribed, over-the-counter, and supplements (currently used)

Name	Dose	Frequency	Reason
____________	______	______	________________
____________	______	______	________________
____________	______	______	________________
____________	______	______	________________
____________	______	______	________________
____________	______	______	________________
____________	______	______	________________
____________	______	______	________________
____________	______	______	________________
____________	______	______	________________
____________	______	______	________________
____________	______	______	________________
____________	______	______	________________

Medications that you have tried in the past for your chronic pain and you no longer take:

Medication Name	Reason you are no longer taking it
________________	____________________
________________	____________________
________________	____________________
________________	____________________

Family History: Describe any relevant medical history in your family that relates to your pain.

Relationship	Alive/Deceased	Medical Conditions(s)
__________	________	________________
__________	________	________________
__________	________	________________
__________	________	________________

Social History: □ Single □ Married □ Divorced □ Widowed
□ Children How Many? ____

Domestic Situation: Do you live alone? Yes No
Are you able to take care of yourself? Yes No

If no, please enter name of caregiver ____

Employment (circle one)**:** Retired Disabled Employed

If employed, please describe job performed _________________________ Years worked? _____

Smoke?: □ Yes □ No _____Packs/Per day _____Years □ Quit When? _____

Are there any substance abuse issues in the household? Yes No

If yes, please explain____

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Substance Abuse: Next to each drug or substance that you circle, indicate if you use or have used:
Never (N) Infrequently (I) Frequently (F) Regularly (R)

Which of the following drugs or substances, if any, have you used in the **past**? (circle all that apply)
Alcohol_____Barbiturates_____Cocaine_____Heroin_____Amphetamines_____Marijuana____

Are you **presently** using any of the following drugs or substances? (circle all that apply)
Alcohol_____Barbiturates_____Cocaine_____Heroin_____Amphetamines_____Marijuana____

Are you or could you be pregnant?: □ Yes □ No □ Not Applicable

Review of Systems: Signs & Symptoms that you have TODAY (circle all that apply)

Constitutional:	fever	chills	unexpected weight loss/gain	sleep difficulty	falls
Neurological:	tremor	speech difficulty	dizziness	difficulty walking	seizures
Visual problems:	wear glasses or contacts	poor vision	light sensitivity		
Hearing problems:	hearing aids	poor hearing			
Cardiovascular:	chest pain	palpitations	poor circulation	leg swelling	
Pulmonary:	cough	shortness of breath	snoring		
Gastrointestinal:	nausea/vomiting	diarrhea	incontinence	constipation	heartburn jaundice
Renal/Urinary:	kidney stones	blood in urine	pain upon urination	incontinence	
Endocrine:	high blood sugar	low blood sugar	sexual problems	increased thirst	
Allergy/Skin:	itching	rash	open wounds		
Hematology/Oncology:	mass or lump	easy bleeding	easy bruising		
Psychiatric:	hallucinations sex abuse	suicidal ideation/attempts child abuse	anxiety	depression	

____ ________________
Signature of Patient or Guardian **Date**

**STAFF ONLY **

BP: __________HR: ____ RR: ____ SPO2: _____RA or L/min Height: _________ Weight: _________

[ ] Packet completed/signed [ ] Opioid agreement signed [ ] SOAPP-R or ORT [ ] PDI [ ] Drug test

[ ] PMP (including GA, FL, military health, etc.) printed;

MA Name: ________________________________

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FINANCIAL RESPONSIBILITY - I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Guardian Medical Care and/or its affiliated entities, for any charges not covered by my healthcare benefits. It is my responsibility to notify Guardian Medical Care 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 Guardian Medical Care 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.

______________________ ____________________________ _____________

Patient Signature Patient Printed Name Date

Or person legally authorized to sign for the above-mentioned patient:

______________________ _____________________ ______________ _____________

Signature Printed Name Relationship Date

ASSIGNMENT OF BENEFITS - I authorize direct remittance of payment of all insurance benefits, including Medicare if I am a Medicare beneficiary, to Guardian Medical Care for all covered medical services and supplies provided to me during all courses of treatment. This includes care provided by Guardian Medical Care 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 Guardian Medical Care, which will authorize and allow for direct payment to Guardian Medical Care, of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by Guardian Medical Care.

______________________ ____________________________ _____________

Patient Signature Patient Printed Name Date

Or person legally authorized to sign for the above-mentioned patient:

______________________ _____________________ ______________ _____________

Signature Printed Name Relationship Date

SIGN BELOW IF YOU HAVE MEDICARE PART B FOR YOUR HEALTH INSURANCE -I request that payment of authorized Medicare benefits be made to Harsh Dangaria, M.D. for services rendered to me by him. I authorize any holder of medical information about me to be released to the Centers of Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits. I understand my signature request that payment be made and authorizes release of medical information necessary to pay this claim. If other health insurance is listed in Item 9 of the CMS 1500 or elsewhere, my signature authorizes release of medical information to the insurer or agency shown. In Medicare assigned cases, Harsh Dangaria, M.D. agrees to accept the charge determination of the Medicare carrier

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as the full charge and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

______________________	____________________________	_____________
Patient Signature	Patient Printed Name	Date

Or person legally authorized to sign for the above-mentioned patient:

______________________	_____________________	______________	_____________
Signature	Printed Name	Relationship	Date

OWNERSHIP DISCLOSURE - I understand that Guardian Medical Care is a physician-owned medical practice comprised of the doctors 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 Guardian Medical Care ancillary department.

______________________	_____________
Patient Signature	Date

Or person legally authorized to sign for the above-mentioned patient:

______________________	_____________________	______________	_____________
Signature	Printed Name	Relationship	Date

NO SHOW FEE

Please give us 48 hours advance notice if you cannot make your appointment. A No-Show fee of $50.00 will be charged if you do not make your appointment and fail to give us advanced notice.

______________________	_____________
Patient Signature	Date

Or person legally authorized to sign for the above-mentioned patient:

______________________	_____________________	______________	_____________
Signature	Printed Name	Relationship	Date

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PRIVACY AUTHORIZATION & VERIFICATION

Please answer the following questions to help us protect your privacy.

1. Is it okay to leave a detailed message on your answering machine? **YES OR NO**

Is it okay to leave a detailed message for you at Work? **YES OR NO**

If the answer is **NO,** please let us know how you wish to be notified by our office:
____

2. Is it okay to release information to anyone **other than** you or a physician? **YES OR NO**

If the answer is **YES,** please list each person, relationship to you, and contact phone number:
Name ________________________ Relationship ______________ Phone ___________________
Name ________________________ Relationship ______________ Phone ___________________

REMINDER! WE WILL NOT RELEASE INFORMATION TO ANYONE NOT LISTED ABOVE.

This is to verify that I have read and understand the above information. By signing this statement, I Authorize the Guardian Medical Care and its' staff consent to release my medical information as described above.

I acknowledge that I have read a copy of the Guardian Medical Care's Privacy Policy and have been given an opportunity to ask questions.

______________________ _____________
Patient Signature Date

Or person legally authorized to sign for the above-mentioned patient:

______________________ ______________________ ______________ _____________
Signature Printed Name Relationship Date

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CONSENT TO RECEIVE TEXT MESSAGE APPOINTMENT REMINDERS

I ____________________________ authorize Guardian Medical Care and its affiliates to contact me by automated SMS text message for appointment reminders.

I understand that message/data rates may apply to messages sent by Guardian Medical Care or its affiliates under my cell phone plan.

My text/mobile number is: (______)______________________ Patient Initials __________

I know that I am under no obligation to authorize Guardian Medical Care or its affiliates to send me text messages. I may opt out of receiving these communications at any time by informing us.

I understand that text messaging is not a secure form of communication. There is some risk that individually identifiable health information or other sensitive or confidential information contained in such text may be misdirected, disclosed to or intercepted by unauthorized third parties. Information included in text messages may include your first name, date and time of your appointment, name of physician, and physician phone number, or other pertinent information.

______________________ _____________

Patient Signature Date

Or person legally authorized to sign for the above-mentioned patient:

______________________ ______________________ ______________ _____________

Signature Printed Name Relationship Date

ACCESSING PHARMACY DATABASE

By signing below, I authorize my doctor and staff team members to access my prescribed medication list through the pharmacy database, which will help my provider deliver comprehensive care to me.

______________________ _____________

Patient Signature Date

Or person legally authorized to sign for the above-mentioned patient:

______________________ ______________________ ______________ _____________

Signature Printed Name Relationship Date

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Guardian Medical Care

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: ____

DOB: ____________________________ Phone Number: _______________________________________

I authorize the release of my medical records to Guardian Medical Care, PLLC 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: Guardian Medical Care, PLLC
Center for Pain and Headache Medicine
2060 Dan Proctor Drive, Suite 3300
St. Marys, GA 31558
PH: (912)324-4080 FAX: (912)324-4097

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

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 this Authorization request is fulfilled
_____ until the following event occurs: __________________________________

______________________ ____________________________ _____________
Patient Signature Patient Printed Name Date

Or person legally authorized to sign for the above-mentioned patient:

______________________ _____________________ ______________ _____________
Signature Printed Name Relationship Date

Center for Pain and Headache Medicine

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PATIENT RIGHTS DISCLOSURE FORM

Welcome to Guardian Medical Care – Center for Pain and Headache Medicine. We would like you to know that we are a specialist office in the management of pain, and our goal is to improve quality of life with minimization of dependence of opioid pain medication through the use of a multimodality treatment regimen and multidisciplinary approach. The treatment plan offered in this office may be different than the treatment plan offered in the past by other physicians. The initial consultation at our office will be used to determine the appropriate plan of treatment, which may include procedures, physical therapy, massage therapy, psychological evaluation, medications, and/or a referral to another specialist. In order to receive treatment, we ask you to follow the treatment plan determined by our physicians.

A patient's rights occur at many different levels, and in all specialties. The American Medical Association (AMA) outlines fundamental elements of the doctor-patient relationship in their Code of Medical Ethics. These rights include the following:

(i) The right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives. (ii) The right to make decisions regarding the health care that is recommended by the physician. (iii) The right to courtesy, respect, dignity, responsiveness, and timely attention to health needs. (iv) The right to confidentiality: see **Notice of Privacy Practices.** (v) The right to continuity of health care. (vi) The basic right to have adequate health care.

Patients often have certain responsibilities for ensuring their rights. According to the AMA, physicians should also serve as advocates for patients and promote these basic rights. Every time a patient visits a doctor, both parties are seeking answers to these questions:

(i) Diagnosis: What is wrong with the patient? (ii) Prognosis: What does the diagnosis mean for the patient? (iii) Caring and management component: What can be done for the patient? (iv) Research dimension: What can the doctor learn from this patient? (v) Public health dimension: How can others benefit from the treatment process of this patient? (vi) Educational opportunities: What can the patient and the professionals learn from this experience and teach others?

Notice of Privacy Practices available for patients by request and available on our website anytime at www.guardianpainrelief.com. Patients may ask at any time for a copy of the Notice of Privacy Practices. Guardian Medical Care is HIPAA compliant. For more information about HIPAA please visit the federal government website link that follows: http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html.

By signing the document below, you are acknowledging that you have read and understand the information stated above.

______________________	____________________________	_____________
Patient Signature	Patient Printed Name	Date

Or person legally authorized to sign for the above-mentioned patient:

______________________	_____________________	______________	_____________
Signature	Printed Name	Relationship*	Date

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ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. Payment and Explanation of Benefits for services rendered to me should be sent directly to the above healthcare provider directly or if my policy prohibits payment to said health care provider then the check should be made out to me care of the above health care provider and send to the address shown on the medical claim form. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such healthcare benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

______________________	____________________________	_____________
Patient Signature	Patient Printed Name	Date

Or person legally authorized to sign for the above-mentioned patient:

______________________	_____________________	______________	_____________
Signature	Printed Name	Relationship	Date

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Center for Pain and Headache Medicine

Guardian Medical Care

OUT-OF-NETWORK PATIENT BILLING CONSENT

I hereby give my consent for Guardian Medical Care to bill my insurance for the services rendered.

I have been informed that Guardian Medical Care is an out-of-network provider.

I understand that when my Insurance Statement (Explanation of Benefits) arrives in the mail it is not a bill, instead it is a statement from my insurance company detailing what has been paid to and what has not been paid to Guardian Medical Care for services rendered to me. I understand that it is not a bill from Guardian Medical Care. Should my insurance process my claim and forward the payment to me I agree to endorse the payment/check and deliver it promptly to Guardian Medical Care. I understand that, in the event I fail to do so, I will be fully responsible for the balance due on my account and that failure to pay may lead to my account being placed with an outside agency for collections.

Should my insurance company deny my claim, I hereby authorize Guardian Medical Care to appeal the denial on my behalf with my insurance carrier.

By signing the document below, you are acknowledging that you have read and understand the information stated above.

______________________ ____________________________ _____________

Patient Signature Patient Printed Name Date

Or person legally authorized to sign for the above-mentioned patient:

______________________ _____________________ ______________ _____________

Signature Printed Name Relationship Date

NOTICE TO SELF PAY PATIENTS

Please be advised that your appointment is for CONSULTATION with the doctor to diagnose your condition and determine the most appropriate treatment plan. There is NO GUARANTY that the doctor will prescribe any medications or refill any medications that were previously given to you by another doctor.

NO REFUNDS WILL BE ISSUED FOR ANY DRUG SEEKING PATIENTS FOR WHOM SOUGHT MEDICATIONS ARE NOT PRESCRIBED.

By signing the document below, you are acknowledging that you have read and understand the information stated above.

______________________ ____________________________ _____________

Patient Signature Patient Printed Name Date

Or person legally authorized to sign for the above-mentioned patient:

______________________ _____________________ ______________ _____________

Signature Printed Name Relationship Date

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Guardian Medical Care

INFORMATION AND AGREEMENT REGARDING CONTROLLED SUBSTANCES

This agreement is a tool to protect both you and your physician by establishing guidelines, within the laws, for proper controlled substance use. The words "we" and "our" refer to the facility, and the words "I", "you", "your", "me", or "my" refer to you, the patient.

We are committed to doing all we can to treat your chronic pain condition. In some cases, controlled substances are used as a therapeutic option in the management of chronic pain and related anxiety and depression, which is strictly regulated by both state and federal agencies. The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the **risk of addictive disorder** developing or risk of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason, you, the patient, as consideration for and a condition of the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain agree to the following policies:

1. I understand that chronic opioid therapy has been associated with not only addiction and abuse, but also multiple medical problems including the suppression of endocrine function resulting in low hormonal levels in men and women which may affect mood, stamina, sexual desire, and physical and sexual performance.

2. **For female patients:** If I plan to become pregnant or believe that I have become pregnant while taking this medication, I am aware that, should I carry the baby to delivery while taking these medications unless my obstetrician recommends otherwise; the baby will be physically dependent upon opioids. I will immediately call my obstetrician and this office to inform them of my pregnancy. I am also aware that opioids may cause a birth defect, even though it is extremely rare.

3. I understand that long-term and/or high doses of pain medications may also cause increased levels of pain known as opioid induced hyperalgesia (pain medicine causing more pain) where simple touch will be perceived as pain and pain gradually increases in intensity and also the location with hurting all over the body. I understand that opioid-induced hyperalgesia is a normal, expected result of using these medicines for a long period of time. This may be helped with addition of non-steroidal anti-inflammatory drugs such as Advil, Ibuprofen, etc., or by reducing or stopping opioids.

4. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine use is markedly decreased, stopped, or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome.

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5. I understand that withdrawal syndrome means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body, and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable, and could even result in heart attack, stroke, or death.

6. I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. If it occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment, reduce the dose, or stop it. The best way to prevent or slow down tolerance is not to take opioids every day or at most once, targeted to specific activities during the day.

7. All controlled medications for pain must come from the physician whose signature appears below, or during his/her absence by the covering healthcare provider, unless specific authorization is obtained for an exception. Multiple sources of controlled medications can lead to risky drug interactions or poor coordination of treatment.

8. I understand that I must tell the physician whose signature appears below, or during his/her absence the covering healthcare provider, all drugs that I am taking, have purchased, or have obtained, even over-the-counter medications. Failure to do so may result in drug interactions or overdoses that could result in harm to me, including death.

9. I will not seek prescriptions for controlled medications for chronic pain from any other physician, health care provider, or dentist. I understand it is unlawful to be prescribed the same type of controlled medication (opioids) by more than one physician at a time without each physician's knowledge. Prescriptions for pain from a surgical procedure given by the surgeon, are exceptions if all doctors are informed in advance and authorized. Your chronic pain doctor should not treat your acute post-operative pain.

10. I also understand that it is unlawful to obtain or to attempt to obtain a prescription for a controlled medication by knowingly misrepresenting facts to a physician or his/her staff or knowingly withholding facts from a physician or his/her staff (including failure to inform the physician or his/her staff of all controlled medication and substances that I have been prescribed or have obtained).

11. You are expected to inform our office of any new medications or medical conditions and of any adverse effects you experience from any of the medications that you take.

12. You may not share, sell, or otherwise permit others to have access to these medications.

13. These drugs should not be stopped abruptly, as abstinence or withdrawal syndrome will likely develop.

14. I will not consume excessive amounts of alcohol in conjunction with controlled substances. I will not use, purchase, or otherwise obtain any other legal drugs except as specifically authorized by the

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physician whose signature appears below or during his/her absence by the covering healthcare provider, as set forth in Section 1 above. I will not use, purchase, or otherwise obtain any illegal drugs, including marijuana, cocaine, heroin, methamphetamine, etc.

15. I understand that driving while under the influence of any substance, including a prescribed controlled substance or any combination of substances (e.g., alcohol and prescription drugs), may impair my driving ability and may result in DUI charges. I acknowledge that opioids may impair my ability to drive. I acknowledge that I should avoid driving or operating machinery while impaired.

16. **Unannounced urine or serum toxicology testing may be requested and your cooperation is required.** Presence of unauthorized substances may prompt referral for assessment for addictive disorder, cessation of controlled medications, and/or dismissal from this practice.

17. **I understand that the facility may call me for a medication review and count at any time.** I will go the same day that I am called with the original vials and all remaining pills. If I don't go the same day, I might not be eligible to continue receiving these medications.

18. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescriptions. They should not be left where others might see or otherwise have access to them.

19. Original containers of my opioid medications with full amount of remaining pills should be brought in to each office visit.

20. Since the drugs may be hazardous and/or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.

21. **Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc.** If the medication has been stolen I understand that more medications will not be supplemented. It is my responsibility to keep my opioid medications safe.

22. Medication changes will not be made between appointments unless medically necessary, which will be determined by the physician or during his/her absence the covering healthcare provider. Early refills will not be given.

23. Unscheduled "drop in" visits for prescription refills are not allowed, as the physicians are busy seeing scheduled patients.

24. Prescription refill requests or appointments for that may be phoned at least 48 hours prior to needing the refill.

25. Prescriptions cannot be mailed to you.

Patient Initials ____

26. Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours, on weekends, or on holidays. Since this would be considered a next day call and 48 hours will apply from next day.

27. It should be understood that any medical treatment is initially a trial and that continued prescription is contingent on evidence of benefit.

28. The risks and potential benefits of these therapies are explained elsewhere (and you acknowledge that you have received such explanation).

29. In the event you are arrested or incarcerated related to legal or illegal drugs (including alcohol), refills on controlled substances will not be given.

30. I also understand that the prescribing physician has permission to discuss all diagnostic and treatment details, including medications, with dispensing pharmacists, other professionals who provide your health care or appropriate drug and law enforcement agencies for the purpose of maintaining accountability.

31. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.

32. I understand that failure to adhere to these policies may result in cessation of therapy with controlled medications prescribed by this physician and other physicians at the facility and that law enforcement officials may be contacted. I affirm that I have full right and power to sign and to be bound by this agreement, that I have read it, and understand and accept all of its terms. A copy of this document has been given to me. A copy of this document is uploaded to guardianpainrelief.com for my review at any time.

33. All controlled substances must be obtained at the same pharmacy, where possible, our office must be informed. Complete with your selected pharmacy:

Pharmacy Name and Address:
____Phone:______________________

____________________ | _________________________ | ___________
Patient Signature | Patient Printed Name | Date

Or person legally authorized to sign for the above-mentioned patient:

____________________ | ___________________ | _____________ | ___________
Signature | Printed Name | Relationship* | Date

__________________________ | ___________
Physician Signature | Date

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Patient Name:_________________________________ Date:_________________________

PAIN DISABILITY INDEX

Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/Home Responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school).
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Recreation: This disability includes hobbies, sports, and other similar leisure time activities.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Social Activity: This category refers to activities, which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Occupation: This category refers to activities that are part of or directly related to one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Sexual Behavior: This category refers to the frequency and quality of one's sex life.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Self Care: This category includes activities, which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed, etc.)
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Life-Support Activities: This category refers to basic life supporting behaviors such as eating, sleeping and breathing.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

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Patient Name:________________________________ Date:________________________

OPIOID RISK TOOL©

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 – 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder Obsessive Compulsive Disorder Bipolar Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
TOTAL		[ ]		

Total Score Risk Category Low Risk 0 – 3 Moderate Risk 4 – 7 High Risk ≥8

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