

|                                                                                                                      |  |         |                    |                                                                                                                                                     |  |                                                                  |                          |                                                                                                                 |  |
|----------------------------------------------------------------------------------------------------------------------|--|---------|--------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------|--------------------------|-----------------------------------------------------------------------------------------------------------------|--|
| Patient Name/Last:                                                                                                   |  | Suffix: |                    | First:                                                                                                                                              |  | Middle:                                                          |                          | SSN:                                                                                                            |  |
| Residence Address:                                                                                                   |  |         |                    | City:                                                                                                                                               |  | State:                                                           |                          | Zip:                                                                                                            |  |
| Mailing Address: (Check here if same as above) <input type="checkbox"/>                                              |  |         |                    |                                                                                                                                                     |  |                                                                  |                          |                                                                                                                 |  |
| Email Address:                                                                                                       |  |         | Cell Phone Number: |                                                                                                                                                     |  | Home Phone Number:                                               |                          |                                                                                                                 |  |
| Date of Birth/Month:                                                                                                 |  | Day:    |                    | Year:                                                                                                                                               |  | <input type="checkbox"/> Male<br><input type="checkbox"/> Female |                          | Race: Ethnicity: <input type="checkbox"/> Hispanic or Latino<br><input type="checkbox"/> Not Hispanic or Latino |  |
| Employer's Name:                                                                                                     |  |         |                    | Work Telephone Number:                                                                                                                              |  |                                                                  | Ext:                     |                                                                                                                 |  |
| Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other |  |         |                    | Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |                                                                  |                          |                                                                                                                 |  |
| Communication Needs: <input type="checkbox"/> Hearing <input type="checkbox"/> Speech <input type="checkbox"/> Other |  |         |                    | Preferred Pharmacy:                                                                                                                                 |  |                                                                  | Address:                 |                                                                                                                 |  |
| Who referred you to our office?                                                                                      |  |         |                    | Telephone Number:                                                                                                                                   |  |                                                                  |                          |                                                                                                                 |  |
| Responsible Party: (check here if same as above) <input type="checkbox"/>                                            |  |         |                    |                                                                                                                                                     |  |                                                                  |                          |                                                                                                                 |  |
| Name/Last:                                                                                                           |  | First:  |                    | Middle:                                                                                                                                             |  | Responsible party's SSN:                                         |                          | Date of birth:                                                                                                  |  |
| Mailing Address:                                                                                                     |  |         |                    | City:                                                                                                                                               |  | State:                                                           |                          | Zip:                                                                                                            |  |
| Home Phone Number:                                                                                                   |  |         |                    | Relationship to Patient:                                                                                                                            |  |                                                                  |                          |                                                                                                                 |  |
| Employer's Name:                                                                                                     |  |         |                    | Work Phone Number:                                                                                                                                  |  |                                                                  | Ext:                     |                                                                                                                 |  |
| <b>In Case of an Emergency, who may we notify?</b>                                                                   |  |         |                    |                                                                                                                                                     |  |                                                                  |                          |                                                                                                                 |  |
| Name #1:                                                                                                             |  |         |                    | Telephone Number:                                                                                                                                   |  |                                                                  | Relationship to patient: |                                                                                                                 |  |
| Name #2:                                                                                                             |  |         |                    | Telephone Number:                                                                                                                                   |  |                                                                  | Relationship to patient: |                                                                                                                 |  |
| <b>Insurance Coverage</b>                                                                                            |  |         |                    | Is your illness/injury due to an auto/work accident? Yes <input type="checkbox"/> No <input type="checkbox"/>                                       |  |                                                                  |                          |                                                                                                                 |  |
| Insurance #1 Name of insurance company:                                                                              |  |         |                    |                                                                                                                                                     |  |                                                                  |                          |                                                                                                                 |  |
| Policy Number                                                                                                        |  |         |                    | Group Number:                                                                                                                                       |  |                                                                  |                          |                                                                                                                 |  |
| Employer:                                                                                                            |  |         |                    | Subscriber:                                                                                                                                         |  |                                                                  | Subscriber DOB:          |                                                                                                                 |  |
| Insurance # 2 Name of Insurance company:                                                                             |  |         |                    |                                                                                                                                                     |  |                                                                  |                          |                                                                                                                 |  |
| Policy Number                                                                                                        |  |         |                    | Group Number:                                                                                                                                       |  |                                                                  |                          |                                                                                                                 |  |
| Employer:                                                                                                            |  |         |                    | Subscriber:                                                                                                                                         |  |                                                                  | Subscriber DOB:          |                                                                                                                 |  |
| Insurance # 3 Name of insurance company:                                                                             |  |         |                    |                                                                                                                                                     |  |                                                                  |                          |                                                                                                                 |  |
| Policy Number                                                                                                        |  |         |                    | Group Number:                                                                                                                                       |  |                                                                  |                          |                                                                                                                 |  |
| Employer:                                                                                                            |  |         |                    | Subscriber:                                                                                                                                         |  |                                                                  | Subscriber DOB:          |                                                                                                                 |  |
| I declare that the above information is true and correct to the best of my knowledge.                                |  |         |                    |                                                                                                                                                     |  |                                                                  |                          |                                                                                                                 |  |
|                                                                                                                      |  |         |                    | Date: _____                                                                                                                                         |  |                                                                  | Signature: _____         |                                                                                                                 |  |

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
MRN

\_\_\_\_\_  
Responsible Party's Name (Please Print)



**HIGHLAND CLINIC**  
**A Professional Medical Corporation**

### **Assignment of Benefits**

I authorize payment of medical benefits under any insurance policy(ies) or other settlement, if any, to Highland Clinic, A.P.M.C., for any medical services.

### **INDEMNITY INSURANCE ASSIGNMENT OF BENEFITS:**

I agree to pay Highland Clinic, A.P.M.C., for all charges in excess of the amounts paid by my insurance policy(ies). I understand it is my responsibility to determine whether your services are covered by my insurance policy(ies). A photostatic copy of this authorization shall be considered as valid as the original.

### **MANAGED CARE ASSIGNMENT OF BENEFITS (HMO/PPO):**

I agree to pay Highland Clinic, A.P.M.C., for copayments, deductibles or charges for services which are not covered under my Member's Benefits contract.

### **Medication History**

I understand that the providers and staff at Highland Clinic, A.P.M.C., use the Surescripts Medication History search to see which medications I've been prescribed in the past to gain a more accurate understanding of my medical history.

I understand that I can opt out of participating in this service at any time by making such request to my provider or their staff.

### **Authority to Release Information**

Highland Clinic, A.P.M.C., is authorized to release information or facts, including substance abuse or mental diagnosis to my insurance carrier or their representative for their use in determining a claim for payment on my behalf or for use in any audit of the records of Highland Clinic, A.P.M.C. by any insurance carrier, HMO or third party payor. A photostatic copy of this authorization shall be considered as valid as the original.

### **Disclosure Statement and Billing Information**

I hereby acknowledge that I have read the Authority to Release Information and Billing Rights (on the reverse) and agree to all terms herein and further acknowledge receipt of copy of disclosure statement.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

The right to review the notice prior to signing this consent, and

The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations as long as I pay for the services in full. If I do not pay in full, entity is not required to abide by such restriction.

**I wish to allow the following individuals access to my health information:**

**(A separate authorization will have to be filled out for actual copies of the Medical Record)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Responsible Party  
(if patient is a minor)



HC 0121AF

## **Your Billing Rights - Keep this Notice For Personal Use**

This notice contains important information about your rights and our responsibilities under The Fair Credit Billing Act.

### **Notify Us In Case of Errors or Questions About Your Bill**

If you think your bill (statement) is wrong, or if you need more information about a transaction on your bill, write us (on a separate sheet) at the address listed on your bill. Write to us as soon as possible. We must hear from you no later than 60 days after we sent you the first bill on which the error or problem appeared. You can telephone us, but doing so will not preserve your rights.

In your letter, give us the following information:

- Your name and account number.
- The dollar amount of the suspected error.
- Describe the error and explain, if you can, why you believe there is an error. If you need more information, describe the item you are not sure about.

### **Your Rights and Our Responsibilities After We Receive Your Written Notice.**

We must acknowledge your letter within 30 days, unless we have corrected the error by then. Within 90 days, we must either correct the error or explain why we believe the bill was correct.

After we receive your letter, we cannot try to collect any amount you question, or report you as delinquent. We can continue to bill you for the amount you question, including finance charges, and we can apply any unpaid amount against your credit limit. You do not have to pay any questioned amount while we are investigating, but you are still obligated to pay the parts of your bill that are not in question. If we find that we made a mistake on your bill, you will not have to pay any finance charges related to any questioned amount. If we did not make a mistake, you may have to pay finance charges, and you will have to make up any missed payments on the questioned amount. In either case, we will send you a statement of the amount you owe and the date that it is due.

If you fail to pay the amount that we think you owe, we may report you as delinquent. However, if our explanation does not satisfy you and you write to us within ten days telling us that you still refuse to pay, we must tell anyone we report you to that you have a question about your bill. And, we must tell you the name of anyone we report you to. We must tell anyone we report you to that the matter has been settled between us when it finally is.

If we do not follow these rules, we cannot collect the first \$50.00 of the questioned amount, even if your bill was correct.

If you have any questions about this notice or any aspect of the statement, please let us know.

**FINANCE CHARGE:** The Finance Charge is computed as a periodic Rate of 1 ½ % per month which is an Annual Percentage Rate of 18% applied to the 90 day balance after deducting payments and credits appearing on this statement. For balances less than \$50.00 there will be a minimum Finance Charge of 50¢.

### **MANAGED CARE INSURANCE:**

Highland Clinic has agreements with many Managed Care Insurance Companies and will abide by the agreement including Billing and Collecting. The patient will be responsible for any co-pays, deductibles or non-covered services as directed by their Managed Care Plans.

It is the patient's responsibility, before making an appointment, to confirm with your Managed Care Carrier as to whether or not Highland Clinic physicians are providers and/or In-Network providers for their plan. The patient will be responsible for payment of their services if Highland Clinic physicians are not providers or In-Network providers for their plan.

### **COMMERCIAL INSURANCE:**

As a courtesy to our patients, Highland Clinic will file your insurance claims. Accurate insurance information and a copy of the insurance card must be supplied by the patient. Although every attempt is made to help patients with filing for insurance benefits, **the patient has final responsibility for payment of services rendered.** When your account has been paid in full, if an over payment occurs, Highland Clinic will refund the patient or the insurance company within a reasonable length of time.

Services are payable upon date performed or upon receipt of monthly statement if credit has been established. If extended terms are required on larger balances, the Credit Office will establish a payment schedule. For your convenience, we accept VISA, MASTERCARD and DISCOVER.

In the event it becomes necessary to refer the account to an attorney or outside collection agency, you hereby agree to pay attorney fees of no less than 33.33% of the amount due together with all court costs and judicial interest.

**HIGHLAND CLINIC**  
A Professional Medical Corporation  
1455 E. Bert Kouns Industrial Loop  
Shreveport, LA 71105  
318-798-4500

**All Accounts Are Due In Full Upon Receipt Of Statement**



## HIGHLAND CLINIC

A Professional Medical Corporation

### IDENTIFICATION DATA (Please print the following information)

Date \_\_\_\_\_ Age \_\_\_\_\_  
Patient Name \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ Marital Status: ☐ Married ☐ Separated ☐ Divorced  
\_\_\_\_\_ ☐ Widowed ☐ Single  
\_\_\_\_\_ Residence Phone ( ) \_\_\_\_\_  
\_\_\_\_\_ Business Phone ( ) \_\_\_\_\_

### FAMILY HISTORY – List Immediate family members who have died (Father, Mother, etc.):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Circle Illnesses immediate family members have had:

|              |                     |                    |          |
|--------------|---------------------|--------------------|----------|
| Tuberculosis | Heart Disease       | Hay Fever          | Glaucoma |
| Diabetes     | High Blood Pressure | Asthma             |          |
| Cancer       | Allergies           | Sickle Cell Anemia |          |

PATIENT HISTORY: Please check if your medical history includes:

Date of last dental exam: \_\_\_\_\_

### REVIEWER NOTES

#### EYE, EAR, NOSE

1. Hay Fever \_\_\_\_\_
2. Ear Infection \_\_\_\_\_
3. Hearing Loss \_\_\_\_\_
4. Eye Problems \_\_\_\_\_

#### GASTROINTESTINAL

5. Stomach Pain \_\_\_\_\_
6. Ulcers \_\_\_\_\_
7. Change In bowel Habits \_\_\_\_\_
8. Rectal Bleeding \_\_\_\_\_
9. Jaundice (Hepatitis) \_\_\_\_\_

#### CARDIO-RESPIRATORY

10. Trouble Breathing \_\_\_\_\_
11. Cough (If chronic) \_\_\_\_\_
12. Asthma \_\_\_\_\_
13. High Blood Pressure \_\_\_\_\_
14. Rheumatic Fever \_\_\_\_\_
15. Heart Disease \_\_\_\_\_
16. Activity Limitation \_\_\_\_\_
17. EKG-Last Date \_\_\_\_\_
18. Chest X-Ray - Date \_\_\_\_\_

#### GENITOURINARY

19. Difficulty starting stream \_\_\_\_\_
20. Night time urination \_\_\_\_\_
21. Kidney Disease \_\_\_\_\_
22. Urinary Infection \_\_\_\_\_

#### FOR WOMEN ONLY

43. Irregularity of Periods \_\_\_\_\_
44. Abnormal Flow \_\_\_\_\_
45. PID/Pelvic Pain \_\_\_\_\_
46. Breast Disease \_\_\_\_\_
47. Last Menstrual Period, Date: \_\_\_\_\_
48. Last Pelvic/Pap Smear Date: \_\_\_\_\_
49. Birth Control? If so, what type: \_\_\_\_\_
50. Number of Pregnancies: \_\_\_\_\_ Number of Births: \_\_\_\_\_

#### NEURO-MUSCULAR

23. Weakness \_\_\_\_\_
24. Numbness/Tingling \_\_\_\_\_
25. Muscle Pain \_\_\_\_\_
26. Seizures/Epilepsy \_\_\_\_\_
27. Paralysis \_\_\_\_\_
28. Migraine/Headaches \_\_\_\_\_

#### SKELETAL

29. Joint Pain or Swelling \_\_\_\_\_
30. Back Problems \_\_\_\_\_
31. Arthritis \_\_\_\_\_

#### ENDOCRINE

32. Diabetes \_\_\_\_\_
33. Thyroid Problems \_\_\_\_\_
34. Recent Weight Gain/Loss (10 pounds) \_\_\_\_\_

#### HEMATOLOGIC

35. Sickle Cell Disease \_\_\_\_\_
36. Anemia \_\_\_\_\_
37. Bleeding Tendencies \_\_\_\_\_
38. Thrombophlebitis/blood clots \_\_\_\_\_

#### OTHER (Additional space on back)

39. Cancer \_\_\_\_\_
40. Mental/Emotional Problems \_\_\_\_\_
41. Venereal Disease History \_\_\_\_\_
42. Tetanus Immunization \_\_\_\_\_  
Last Date: \_\_\_\_\_



**HIGHLAND CLINIC**

A Professional Medical Corporation

**IDENTIFICATION DATA continued**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\ \_\_\_\_\ \_\_\_\_ Patient History. Cont'd.

PLEASE LIST ALL SURGERIES, HOSPITALIZATIONS, AND/OR SERIOUS INJURIES:

\_\_\_\_\_  
\_\_\_\_\_

PLEASE INCLUDE ALL CURRENT PRESCRIPTIONS, OVER THE COUNTER MEDS, HERBALS, PATCHES, INHALER, EYE DROPS & SUPPLEMENTS:

|       |       |       |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

PREFERRED PHARMACY: \_\_\_\_\_

PLEASE NAME ANY DRUG ALLERGIES/ADVERSE REACTIONS:

|       |       |       |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**CURRENT LIFE STYLE:** Name your current occupation \_\_\_\_\_

|                                                   | NO    | YES   |
|---------------------------------------------------|-------|-------|
| Do you use alcohol more than four times per week? | _____ | _____ |
| Do you smoke?                                     | _____ | _____ |
| Do you ever use drugs recreationally?             | _____ | _____ |
| Do you feel safe in your environment?             | _____ | _____ |

| <b>Indicate any abnormality</b> | YES   | NO    | Description                       |
|---------------------------------|-------|-------|-----------------------------------|
| A) Eyes                         | _____ | _____ | _____                             |
| B) Ears, Nose, Throat           | _____ | _____ | _____                             |
| C) Skin                         | _____ | _____ | _____                             |
| D) Nervous System               | _____ | _____ | _____                             |
| E) Chest                        | _____ | _____ | _____                             |
| F) Heart                        | _____ | _____ | _____                             |
| G) Abdomen                      | _____ | _____ | _____                             |
| H) Genito-Urinary System        | _____ | _____ | _____                             |
| I) Pelvic                       | _____ | _____ | _____                             |
| J) Extremities                  | _____ | _____ | _____                             |
| K) Back                         | _____ | _____ | _____                             |
| L) Pain – Location              | _____ | _____ | Pain Scale 0 1 2 3 4 5 6 7 8 9 10 |

Completed by: \_\_\_\_\_  
Signature Printed Name Date/Time

Reviewed with patient by: \_\_\_\_\_  
Provider Signature Printed Name Date/Time

**HIGHLAND CLINIC**

A Professional Medical Corporation

**ORT Assessment Questionnaire****Patient Name:** \_\_\_\_\_**Date of Birth:** \_\_\_\_\_**Today's Date** \_\_\_\_\_**Check EACH box that applies**

| <b>Gender</b>                                                           | <input type="checkbox"/> <b>Female</b> | <input type="checkbox"/> <b>Male</b> |
|-------------------------------------------------------------------------|----------------------------------------|--------------------------------------|
| <b>Family history of substance abuse</b>                                | <b>Yes</b>                             | <b>No</b>                            |
| <i>Alcohol</i>                                                          | <input type="checkbox"/>               | <input type="checkbox"/>             |
| <i>Illegal Drugs</i>                                                    | <input type="checkbox"/>               | <input type="checkbox"/>             |
| <i>Prescription Drugs</i>                                               | <input type="checkbox"/>               | <input type="checkbox"/>             |
| <b>Personal History of substance abuse?</b>                             | <b>Yes</b>                             | <b>No</b>                            |
| <i>Alcohol</i>                                                          | <input type="checkbox"/>               | <input type="checkbox"/>             |
| <i>Illegal Drugs</i>                                                    | <input type="checkbox"/>               | <input type="checkbox"/>             |
| <i>Prescription Drugs</i>                                               | <input type="checkbox"/>               | <input type="checkbox"/>             |
|                                                                         | <b>Yes</b>                             | <b>No</b>                            |
| <b>Age: Are you between 16-45 years old?</b>                            | <input type="checkbox"/>               | <input type="checkbox"/>             |
| <b>Personal history of preadolescent sexual abuse</b>                   | <input type="checkbox"/>               | <input type="checkbox"/>             |
| <b>Personal history of any of the following psychological diseases?</b> | <b>Yes</b>                             | <b>No</b>                            |
| <i>Attention Deficit Disorder (ADD)</i>                                 | <input type="checkbox"/>               | <input type="checkbox"/>             |
| <i>Obsessive Compulsive Disorder (OCD)</i>                              | <input type="checkbox"/>               | <input type="checkbox"/>             |
| <i>Post Traumatic Stress Disorder (PTSD)</i>                            | <input type="checkbox"/>               | <input type="checkbox"/>             |
| <i>Bipolar Disorder</i>                                                 | <input type="checkbox"/>               | <input type="checkbox"/>             |
| <i>Schizophrenia</i>                                                    | <input type="checkbox"/>               | <input type="checkbox"/>             |
| <i>Depression</i>                                                       | <input type="checkbox"/>               | <input type="checkbox"/>             |

**Patient Signature****Date Signed****\*\*\*For Clinic Use Only\*\*\*****Russell Stuermann, MD****Provider Signature****Date Signed**



## HIGHLAND CLINIC

A Professional Medical Corporation

# Brief Pain Inventory

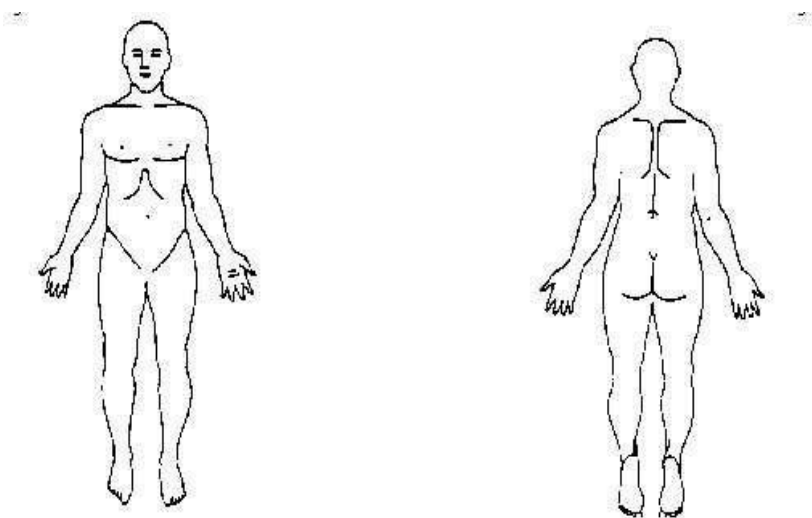
Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Middle Initial

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

How long has it been since you first learned of your diagnosis? \_\_\_\_\_

On the diagram, shade the areas where you feel pain. Put an "X" on the area that hurts the most.



1. Current level of pain **0 -10 (10 is worst)** \_\_\_\_\_
2. Describe the frequency of your pain: ☐ Intermittent ☐ Constant ☐ Occasional ☐ Rare
3. How would you describe your pain? Check all those that apply.  
☐ Ache ☐ Burning ☐ Deep ☐ Discomforting ☐ Dull ☐ Numbness ☐ Piercing ☐ Sharp  
☐ Shooting ☐ Stabbing ☐ Throbbing
4. What makes your pain worse? Check all those that apply.  
☐ Movement ☐ Sitting ☐ Standing ☐ Walking ☐ Stress ☐ Other \_\_\_\_\_
5. What relieves your pain? Check all those that apply.  
☐ Exercise ☐ Heat ☐ Ice ☐ Injections ☐ Medication ☐ Physical Therapy ☐ Rest ☐ Sitting  
Other \_\_\_\_\_
6. Other methods I have used to relieve my pain include: (Check all those that apply)  
☐ Warm Compress ☐ Cold Compress ☐ Relaxation Techniques ☐ Distraction Techniques ☐ Biofeedback  
☐ Hypnosis  
☐ Other \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Use the scale below to answer the questions below to rate your pain by indicating **ONE** number that best describes your pain in the **last week** for each

0      1      2      3      4      5      6      7      8      9      10

**Does not interfere**

**Completely interferes**

**WORST** pain score in the last week      0   1   2   3   4   5   6   7   8   9   10

**LEAST** pain score in the last week      0   1   2   3   4   5   6   7   8   9   10

**AVERAGE** pain score in the last week      0   1   2   3   4   5   6   7   8   9   10

Use the scale below to indicate how **PAIN** has interfered with the following in the **PAST WEEK**

0      1      2      3      4      5      6      7      8      9      10

**Does not interfere**

**Completely interferes**

General Activity:      0   1   2   3   4   5   6   7   8   9   10

Mood:      0   1   2   3   4   5   6   7   8   9   10

Walking ability:      0   1   2   3   4   5   6   7   8   9   10

Normal work      0   1   2   3   4   5   6   7   8   9   10

Relations with other people      0   1   2   3   4   5   6   7   8   9   10

Sleep      0   1   2   3   4   5   6   7   8   9   10

Enjoyment of life      0   1   2   3   4   5   6   7   8   9   10

7. In the past week, how much relief have pain treatments or medications provided? Please select the ONE percentage that most shows how much relief you received

☐ 0%   ☐ 10%   ☐ 20%   ☐ 30%   ☐ 40%   ☐ 50%   ☐ 60%   ☐ 70%   ☐ 80%   ☐ 90%   ☐ 100%

**No relief**

**Complete relief**

12. Have you ever had pain due to your present disease? ☐ Yes   ☐ No
13. When you first received your diagnosis, was pain one of your symptoms? ☐ Yes   ☐ No   ☐ Uncertain
14. Have you had surgery in the past month? ☐ Yes   ☐ No
- If Yes, what kind: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

15. Check the appropriate response to each item.

***I believe my pain is due to:***

- ☐ Yes ☐ No    A. The effects of treatment (for example medication, surgery, radiation, prosthetic device).
- ☐ Yes ☐ No    B. My primary disease (meaning the disease currently being treated and evaluated).
- ☐ Yes ☐ No    C. A medical condition unrelated to my primary disease (for example, arthritis).

16. What treatments or medication are you receiving for your pain?

17. I prefer to take my pain medicine: Choose **ONE**

- ☐ On a Regular Basis    ☐ Only when necessary    ☐ Do not take pain medicine

18. If you take pain medication, how many hours does it take before the pain returns?

- ☐ Pain medication doesn't help at all    ☐ Four hours
- ☐ One hour    ☐ Five to Twelve hours
- ☐ Two hours    ☐ More than twelve hours
- ☐ Three hours    ☐ I do not take pain medication

19. I take my pain medicine (in a 24-hour period):

- ☐ Not every day    ☐ 5 to 6 times per day
- ☐ 1 to 2 times per day    ☐ More than 6 times per day
- ☐ 3 to 4 times per day

20. Do you feel you need a stronger type of pain medication?

- ☐ Yes    ☐ No    ☐ Uncertain

21. Do you feel you need to take more of the pain medication that your doctor has prescribed?

- ☐ Yes    ☐ No    ☐ Uncertain

22. Are you concerned that you use too much pain medication?

- ☐ Yes    ☐ No    ☐ Uncertain    If yes, why? \_\_\_\_\_

23. Are you having problems with side effects from your pain medication?

- ☐ Yes    ☐ No    ☐ Uncertain    If yes, which side effects? \_\_\_\_\_

24. Do you feel you need to receive further information about your pain medication? ☐ Yes    ☐ No

25. Medications not prescribed by my doctor that I take for pain are:

\_\_\_\_\_  
\_\_\_\_\_

26. Marital status at present? ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Patient Name:\_\_\_\_\_

Patient DOB:\_\_\_\_\_

27. Education (Circle only the highest grade or degree completed)

Grade    ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11 ☐12 ☐13 ☐14 ☐15 ☐16 ☐ M.A./M.S.

Professional degree (please specify) \_\_\_\_\_

28. Current occupation: \_\_\_\_\_ (specify times; if you are not working tell us your previous occupation)

29. Which of the following best describes your current job status?

- ☐ Employed outside the home, full-time
- ☐ Homemaker
- ☐ Employed outside the home, part-time
- ☐ Retired
- ☐ Unemployed
- ☐ Other

30. Spouse’s occupation:\_\_\_\_\_

Please list ALL **medications, doses**, and any **side effects** that you have experienced:

| Name | Dose | TimesTakenPerDay | Prescribing MD | Side Effects |
|------|------|------------------|----------------|--------------|
|      |      |                  |                |              |
|      |      |                  |                |              |
|      |      |                  |                |              |
|      |      |                  |                |              |
|      |      |                  |                |              |
|      |      |                  |                |              |
|      |      |                  |                |              |
|      |      |                  |                |              |
|      |      |                  |                |              |



**HIGHLAND CLINIC**

A Professional Medical Corporation

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems

|                                                                                                                                                                      | Not at all |   | the days |   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|---|----------|---|
| 1. Little interest or pleasure in doing things                                                                                                                       | 0          | 1 | 2        | 3 |
| 2. Feeling down, depressed, or hopeless                                                                                                                              | 0          | 1 | 2        | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much                                                                                                           | 0          | 1 | 2        | 3 |
| 4. Feeling tired or having little energy                                                                                                                             | 0          | 1 | 2        | 3 |
| 5. Poor appetite or overeating                                                                                                                                       | 0          | 1 | 2        | 3 |
| 6. Feeling bad about yourself; Feeling that you are a failure or have let yourself or your family down                                                               | 0          | 1 | 2        | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television                                                                             | 0          | 1 | 2        | 3 |
| Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual                                                                | 0          | 1 | 2        | 3 |
| 9. Thoughts that you would be better off dead, or of hurting yourself                                                                                                | 0          | 1 | 2        | 3 |
| 10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? | 0          | 1 | 2        | 3 |

Total

Total

Total

Total

FORM TOTAL: \_\_\_\_\_



## HIGHLAND CLINIC

A Professional Medical Corporation

### Controlled Substance Agreement

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 are controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or 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 and diversion, strict accountability is necessary when use is prolonged. For this reason, the following policies are agreed to by you, the patient and 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.

---

**Patient Name (Printed)**

**Date of Birth**

- |                       |                                                                                                                                                                                                                                                                                                                                                |
|-----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Initials</b> _____ | 1. All controlled substances must come from the physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization of obtained for an exception. (Multiple sources can lead to untoward drug interaction or poor coordination of treatment.)                                      |
| <b>Initials</b> _____ | 2. All controlled substances must be obtained at the same pharmacy, when possible. Should the need arise to change pharmacies, our office must be informed.                                                                                                                                                                                    |
| <b>Initials</b> _____ | 3. 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.                                                                                                                                                                    |
| <b>Initials</b> _____ | 4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.                                                                                                                        |
| <b>Initials</b> _____ | 5. You may not share, sell or otherwise permit others to have access to these medications.                                                                                                                                                                                                                                                     |
| <b>Initials</b> _____ | 6. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.                                                                                                                                                                                                                                                  |
| <b>Initials</b> _____ | 7. Unannounced urine or serum toxicology screen may be requested and your cooperation is required. Presence of unauthorized substances may prompt referral for assessment of addictive disorder.                                                                                                                                               |
| <b>Initials</b> _____ | 8. 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 prescription. They should not be left where others might see or otherwise have access to them. |
| <b>Initials</b> _____ | 9. Original containers of medications should be brought in to each office visit.                                                                                                                                                                                                                                                               |
| <b>Initials</b> _____ | 10. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of the reach of such people.                                                                                                                                                                       |
| <b>Initials</b> _____ | 11. Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made.                                                                                                                     |
| <b>Initials</b> _____ | 12. Early refills will generally not be given.                                                                                                                                                                                                                                                                                                 |

## Controlled Substance Agreement Continued

- Initials**\_\_\_\_\_ 13. Prescriptions may be issued early if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they are not to be filled prior to the appropriate date.
- Initials**\_\_\_\_\_ 14. 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.
- Initials**\_\_\_\_\_ 15. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.
- Initials**\_\_\_\_\_ 16. Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.
- Initials**\_\_\_\_\_ 17. It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit.
- Initials**\_\_\_\_\_ 18. The risks and potential benefits of these therapies are explained elsewhere (and you acknowledge that you have received such explanation).
- Initials**\_\_\_\_\_ 19. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all terms.

**\*\*\*I agree by signing below that I will not accept medical care for pain by any other physician other than the physician below, except during an emergency. I will notify my primary doctor of record and understand that I may be discharged from the practice if I accept pain care from another doctor."**

**\*\*OFFICE USE ONLY\*\***

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Physician Name (Printed)

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Patient Name (Printed)

\_\_\_\_\_  
Date of Birth

Approved by the AAPM Executive Committee on April 2, 2001.  
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