

Patient Agreement for Outpatient Services

In order to provide the best quality of care, it is critical for you to be compliant with your treatment program. You will be asked to sign an exact copy of this document upon your first visit.

By signing below, I understand I agree to the following:

1. I will comply with the orders and/or recommendations of my treatment team.
2. I will receive two separate charges billed to my insurance company for every office visit and procedure. (a facility charge and a provider charge).
3. In the event I am a self-pay patient, I am expected to pay in full at the time of the appointment, unless other arrangements have been made with Shepherd Center Financial Services prior to my visit.
4. I am required to schedule an appointment to be seen by a provider at the Shepherd Center. I cannot be seen as an emergency walk in appointment.
5. I am required to arrive 30 minutes prior to my appointment time. If I am late for physician appointments, I will be rescheduled for another day. Walk-ins will not be accepted.
6. I am required to give **48 hours notice for cancellations/rescheduling by calling (404) 352-2020**. Cancellation and no show for your scheduled appointment is considered a serious event and negatively effects your treatment plan. Your provider has the right to terminate services based on your attendance record for your appointment.
7. All patients receiving a procedure must have a driver (not bus or taxi).
8. It is my responsibility to inform the Shepherd Center of any changes in my insurer, address, and telephone number.
9. If I am a worker's compensation patient, it is my responsibility to inform the Shepherd Center staff of any changes in my insurer, adjustor, or case manager, or if my claim is settled.
10. Any request for completion of disability papers should be directed to my primary Shepherd Center treating physician and that the Shepherd Pain Institute does not complete disability papers.
11. Threatening, intimidating, hostile, sexual explicit, violent and/or verbally abusive behavior will not be tolerated.
12. No illegally controlled substances/recreational drugs may be used during my treatment at the Shepherd Center. I agree to have random drug and alcohol screens upon request by my provider. If any screen is found to be positive, I agree to address this issue through the recommendation of my treatment team.
13. Shepherd Center is a smoke-free facility and I agree not to smoke in the facility.
14. Possession of weapons and destroying or stealing Institute property will result in immediate discharge from all Shepherd Center programs.
15. Seven business days notice is necessary for medication refills

Failure to comply with one or more of the above statements may result in discharge from all Shepherd Center Programs for three years upon the recommendation from your treatment team after a review of your behavior at Shepherd Center. Thank you for choosing the Shepherd Center.

Patient

Date

Shepherd Center Staff

Title

Date



SHEPHERD CENTER

Shepherd Pain Institute

2020 Peachtree Road NW
Atlanta, GA 30309

PATIENT INTAKE FORM

Patient Name : _____

Account #: _____

MR # : _____

Date : _____

WHO REFERRED YOU?

WHO IS YOUR PRIMARY CARE PHYSICIAN?

PAIN HISTORY

WHAT IS YOUR PAIN COMPLAINT/REASON FOR VISIT?

WHEN DID YOUR PAIN BEGIN?

WAS THERE AN INJURY? YES NO (IF YES, PLEASE EXPLAIN)

IS YOUR PAIN THE RESULT OF AN ACCIDENT? YES NO (IF YES, PLEASE DESCRIBE)

WHAT RELIEVES YOUR PAIN?

WHAT MAKES YOUR PAIN WORSE?

PREVIOUS TREATMENT FOR PAIN

PLEASE CIRCLE ONE HELPFUL?

NERVE BLOCKS	YES	NO	YES	NO
EPIDURALS	YES	NO	YES	NO
SURGERY	YES	NO	YES	NO
MEDICATIONS	YES	NO	YES	NO
TENS UNIT	YES	NO	YES	NO
PHYSICAL THERAPY	YES	NO	YES	NO
BIOFEEDBACK	YES	NO	YES	NO
HYPNOSIS	YES	NO	YES	NO
COUNSELING	YES	NO	YES	NO
CHIROPRACTOR	YES	NO	YES	NO
ACUPUNCTURE	YES	NO	YES	NO

MEDICAL HISTORY

LIST ANY MEDICAL CONDITIONS YOU HAVE BEEN DIAGNOSED WITH
(DIABETES, HIGH BLOOD PRESSURE, HEART ATTACK, THYROID PROBLEMS ETC):

SURGICAL HISTORY

LIST ANY SURGERIES YOU HAVE HAD
TYPE OF SURGERY

DATE:

SOCIAL HISTORY

MARITAL STATUS: MARRIED SINGLE WIDOWED DIVORCED
CHILDREN?:



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WHO LIVES WITH YOU?

DO YOU SMOKE? NO YES IF YES, HOW MUCH?

DO YOU DRINK ALCOHOLIC BEVERAGES: NO YES IF YES HOW MUCH?

ARE YOU PREGNANT OR PLAN TO BECOME PREGNANT? YES NO

HIGHEST EDUCATION LEVEL COMPLETED:

OCCUPATION: NAME OF EMPLOYER:

DO YOU HAVE ANY HISTORY OF ADDICTION TO ANY SUBSTANCE? NO YES (IF YES, DESCRIBE)

FAMILY HISTORY

DO ANY DISEASES RUN IN YOUR FAMILY? PLEASE LIST BELOW:

ALLERGIES

ARE YOU ALLERGIC TO LATEX PRODUCTS? YES NO

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO

IF YES, WHICH ONES?

MEDICATIONS

WHAT MEDICATIONS, IF ANY, ARE YOU TAKING NOW?

(PLEASE LIST ALL MEDICATIONS BOTH PRESCRIPTION AND OVER THE COUNTER)

MEDICINE	DOSE/STRENGTH	HOW OFTEN?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DIAGNOSTIC STUDIES

PLEASE LIST THE *APPROXIMATE* DATE OF TEST, THE NAME OF THE FACILITY WHERE THE TEST WAS PERFORMED, THE NAME OF THE ORDERING PHYSICIAN AND THE RESULTS, IF KNOWN.

TEST	DATE	FACILITY	PHYSICIAN	RESULTS
X-RAY	_____	_____	_____	_____
CT SCAN	_____	_____	_____	_____
MRI	_____	_____	_____	_____
EMG	_____	_____	_____	_____



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MR # : _____

Date : _____

REVIEW OF SYSTEMS

Please check any symptoms below that you currently have:

HEAD

- Headaches
- Trouble with hearing
- Trouble with eyesight
- Nasal discharge
- Hay Fever, frequent sneezing
- Sinus trouble, post nasal drip

THROAT

- Hoarseness
- Ulcer of tongue or mouth
- Trouble with gums or teeth
- Sore throat

LUNGS

- Asthma, wheezing
- Cough
- Cough up blood
- Tuberculosis
- Shortness of breath

CARDIOVASCULAR

- High blood pressure
- Chest pain
- Irregular beat or palpitation of heart
- Awaken at night with shortness of breath

ENDOCRINE

- Increased thirst, hunger
- Sudden weight change
- Sensitive to heat/cold
- Change in skin, body hair
- Change in sex drive

SKIN

- Rash
- Tumor on skin

BLADDER AND KIDNEY

- Frequency urgency or pain with urination
- Passed blood or kidney stone
- Trouble starting or stopping of urinary stream

STOMACH AND BOWELS

- Trouble swallowing
- Abdominal pain, nausea, vomiting
- Acid Reflux ("Heartburn")
- Stomach ulcer/Duodenal ulcer
- Black bowel movements
- Diarrhea
- Constipation
- Hemorrhoids or rectal itching

MUSCULAR

- Low back pain
- Joint pain
- Arthritis
- Neck pain

NERVOUS

- Backache
- Balance problems
- Numbness or tingling anywhere
- Weakness
- Trouble walking

MISCELLANEOUS

- Problems with sleep
- Dizziness
- Depression
- Fatigue
- Anemia or difficulty with bleeding
- Sexual problems

OTHER? (Please describe)

PROBLEM LIST

Please check any of the following below that you have had or currently have a problem with:

- | | | |
|--|---|---|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Drugs | <input type="checkbox"/> Paraplegia |
| <input type="checkbox"/> Acquired Brain Injury | <input type="checkbox"/> Dysreflexia | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> ALS | <input type="checkbox"/> Frequent UTI | <input type="checkbox"/> Post Polio |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gynecological Problems | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Bladder Pain / Spasms | <input type="checkbox"/> Hay Fever / Allergies | <input type="checkbox"/> Respiratory Failure |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Quadriplegia / Tetraplegia |
| <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> HIV (or AIDS) | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Impaction | <input type="checkbox"/> Skin Problem |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Kidney Failure | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Cigarettes | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Spinal Problems |
| <input type="checkbox"/> Current Pregnancy | <input type="checkbox"/> Neurogenic Bladder | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurogenic Bowel | <input type="checkbox"/> Ventilator Use |



Please fill out this form by checking the appropriate boxes and sign where indicated.

YES NO

- 1. Have you ever undergone sedation before?
- 2. Have you/family member had major problems (severe nausea, high fever, breathing difficulty) with surgery or anesthesia?

Do you now have or have you ever had:

- 3. Diabetes on pills on insulin
- 4. High Blood Pressure on medicine
- 5. Cardiovascular Disease Angina/Chest pain Heart Failure Heart Attack
 Irregular heart beat/Pacer/AICD Prior heart surgery/angioplasty
 Valve disease/murmur(including Mitral valve Prolapse)
- 6. Activity Level Limited Climb 1 or more flight of stairs Regular exercise
- 7. Lung Disease Emphysema Shortness of breath Asthma/wheezing
 Sleep Apnea CPAP: Yes No
- 8. Neuromuscular Disease Muscle Weakness Paralysis Seizures Rheumatoid Arthritis
 Stroke/TIA
- 9. Kidney Disease On dialysis
- 10. Liver Disease Hepatitis/jaundice
- 11. History of Abnormal Bleeding Blood transfusion
- 12. Have you donated blood for this procedure?
- 13. Hiatal Hernia Acid reflux
- 14. Back problems or chronic headaches
- 15. Have you had a cold, "flu" or fever within the past week?
- 16. Do you smoke or have you in the past? Packs per day: _____ Yrs. Smoking: _____ Quit when: _____
- 17. Do you drink alcohol? Drinks/beers per day: _____
- 18. Have you taken oral or IV steroids within the past 6 months?
- 19. Do you take any of the following medications? Glucophage, Glucovance, Aspirin, Coumadin, Herbal medicines
- 20. Do you have any loose teeth, caps, bridges, dentures or other dental work?

NOTE: Dental injury is a risk despite every precaution

- 21. Could you be pregnant? Date of last menstrual period: _____
- 22. Do you have a history of pregnancy related complications?
If pregnant, have you experienced any difficulties? Yes No
- 23. Do you have any other medical problems not listed above? Describe: _____
- 24. Are you taking blood thinners?
- 25. Do you have an allergy to contrast dye?
- ALLERGIES** - please describe any drug/latex allergies: _____

List all medication you are taking (including "over the counter") _____

MATERIAL RISKS: Georgia law requires that material risks be disclosed to you. These include but are not limited to: infection, allergic reaction, scarring, blood loss requiring transfusion with associated risk of AIDS and/or hepatitis, loss of function of any limb or organ, paralysis, brain damage, cardiac arrest or death. **OTHER RISKS:** Anesthetic procedures may also result in lung injury, headaches, backache, or trauma to adjacent structures. **By signing below, you acknowledge that these risks have been disclosed to you.**

Signature of person completing form: _____



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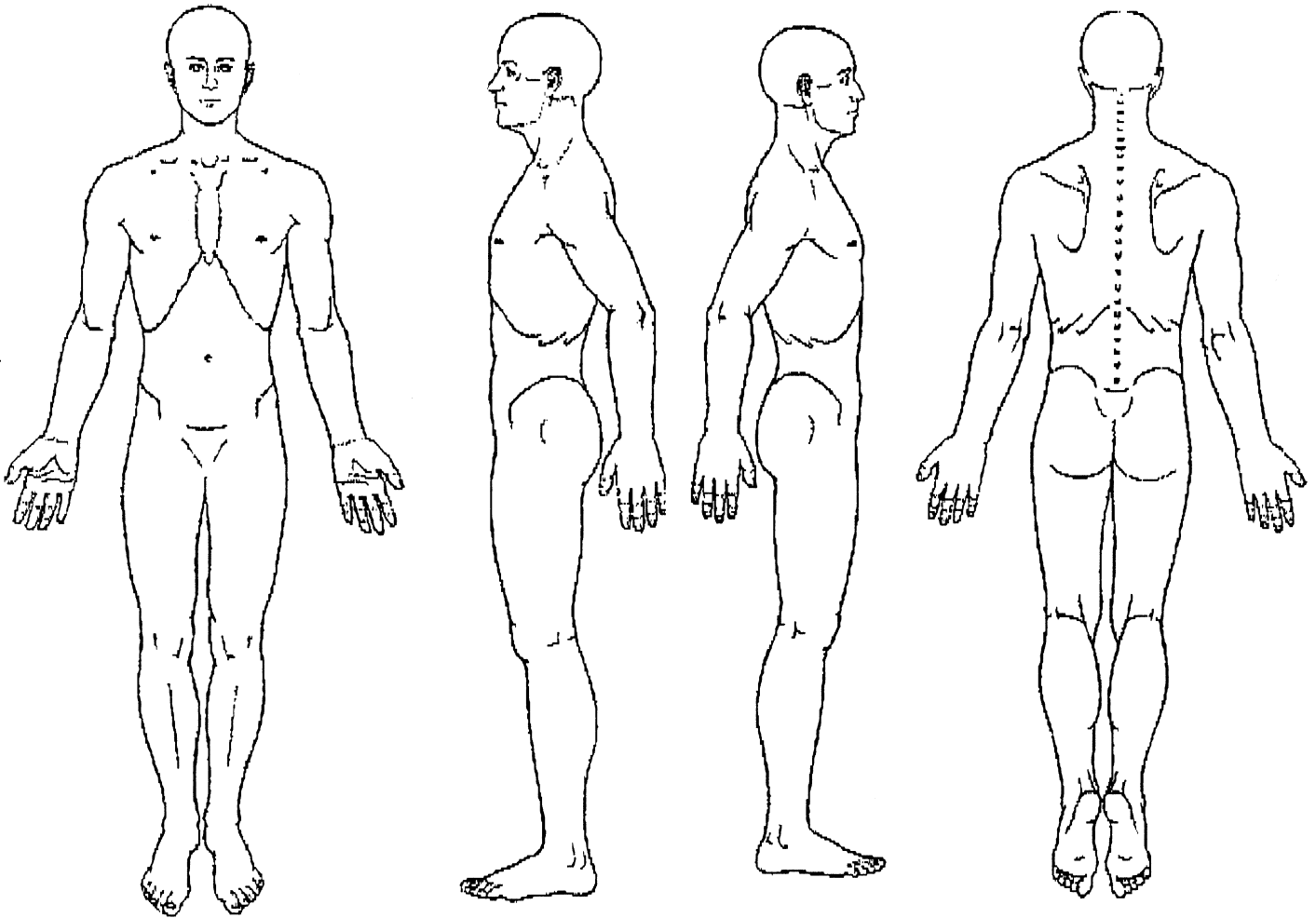
Account #: _____

MR #: _____

Date : _____

PAIN DIAGRAM

Please indicate where you are experiencing pain on the drawing below



Rate Your Current Back Pain on the Scale Below

