ALB PAIN MANAGEMENT & SPINE CARE

COVID Screening

All guests upon arrival are required to:

1) Wash their hands or use alcohol-based hand rub upon entry
2) Please answer the following questions:

Name: _____ DOB: _____

Date: _____ Temperature: _____

Do you have or feel any of the following symptoms:

Cough or symptoms of upper respiratory infection? ☐ Yes ☐ No

Shortness of breath? ☐ Yes ☐ No

Fever or temperature above 100.4? ☐ Yes ☐ No

Chills and or shaking?	☐ Yes	☐ No	Headache?	☐ Yes	☐ No
Sore throat?	☐ Yes	☐ No	Diarrhea or vomiting?	☐ Yes	☐ No
Skin infection?	☐ Yes	☐ No	New loss of taste or smell?	☐ Yes	☐ No
Muscle pain	☐ Yes	☐ No	Open or draining wound?	☐ Yes	☐ No

Exposure history:

Have you been exposed to anyone with COVID19 or traveled out of the country in the past 30 days (including at home or at work)? ☐ Yes ☐ No

Have you been hospitalized in the last 90 days? ☐ Yes ☐ No

Do you have a history of MRSA or MDRO infection? ☐ Yes ☐ No

Have you taken Acetaminophen or Ibuprofen today? ☐ Yes ☐ No

Are you on Dialysis? ☐ Yes ☐ No

For anyone answering “yes” to any question please exit the building and contact us via telephone to discuss the nature of your visit and how we may help you.

ALB PAIN MANAGEMENT & SPINE CARE

INITIAL INTAKE

Welcome to ALB Pain Management & Spine Care (APMSC)! We are happy that you have chosen our practice for the treatment of your pain. Our office is fully equipped to both diagnose and treat any type of pain complaint. However, in order to provide the best overall care, we need some information about you.

While we all hate to complete paperwork, **it is extremely important that this information be obtained by our office.** As many patients who suffer an injury have engaged legal representation, the information you provide here is part of the medical-legal record and will serve as the document of record for our practice regarding your injury and comprehensive medical history. While completing this *Initial Intake* form may be time-consuming, please understand that many of the recommendations made by our APMSC providers including prescription medications, imaging studies and injection therapy, will be impacted by not only the details of your injury, but your medical history as well. For example, if you have cancer, medication allergies, have metal in your body or even use blood thinners, treatment options may vary as this information will directly impact your medical care.

If the information requested in this simple questionnaire seems redundant, please understand that each medical specialist may need to obtain different information than other specialists. **Pain Management is a unique medical subspecialty** that requires some additional information that if not provided in this document, will ultimately have to be obtained at some point during your visit today. You will likely be thinking, "Why do I have to answer the same questions again?" and "I already filled this out for another doctor." Please understand that medical offices do not routinely make it a simple process to share your medical records and we rely upon the information you provide in this document as the foundation for our medical decision-making.

Thank you for taking the time to complete this informational packet**.** We welcome you to our practice and look forward to working with you throughout your recovery.

APMSC

ALB PAIN MANAGEMENT & SPINE CARE

INITIAL INTAKE

Name _____ Today's Date_____

Address _____

City _____ State _____ Zip _____

Email _____

Phone # _____ Cell # _____

Date of Birth _____ Date of Accident _____ Gender: ☐ Male ☐ Female

Accident Type ☐ Motor Vehicle ☐ Slip/Fall ☐ Other _____

City/State of Accident _____

Language Preference: ☐ English ☐ Spanish ☐ Other, please specify: _____

May we send you appointment reminders via text? ☐ Yes ☐ No

Work Status: ☐ Working ☐ Not Working ☐ Student ☐ Retired

MRI Done? ☐ Yes ☐ No If yes, where: _____

Have you been treated by any other doctors regarding this accident? ☐ Yes ☐ No

If yes, where _____

_____

_____

Law Firm Name _____

Law Firm Phone _____ Law Firm Fax _____

Case Manager _____

Notes _____

ALB PAIN MANAGEMENT & SPINE CARE

INITIAL INTAKE

DETAILS OF INJURY

1. If your injury is due to something other than a motor vehicle accident, please skip to question #11.
2. Were you "on the clock" or working at the time of the accident? □ Yes □ No If yes, what is the name of the company you were working for at the time of the accident? _____
3. What is the exact date, including year, of the accident? _____ /_____ /_____
4. How many vehicles were involved in the accident? _____
5. What make and model of motor vehicle were you in? Make: _____ Model: _____
6. Where were you sitting in the vehicle? □ Driver □ Front passenger □ Rear behind driver □ Rear behind passenger □ Rear center □ Other (please describe): _____
7. Were you wearing a seat belt? □ Yes □ No Did you anticipate the accident? □ Yes □ No
8. What make and model car(s) were involved in the accident (if known)? Make: _____ Model: _____ Make: _____ Model: _____ Make: _____ Model: _____
9. What part of your vehicle was impacted? □ Front □ Rear □ Passenger side □ Driver side
10. Did your airbags deploy? □ Yes □ No
11. Please describe how the accident / injury occurred (include location): _____
    _____
    _____
    _____
12. Were you shaken up or disoriented afterwards? □ Yes □ No
13. Did you lose consciousness? □ Yes □ No If yes, for how long? _____
14. Did the police come to the scene of the accident / injury? □ Yes □ No
15. Did an ambulance come to the scene of the accident / injury? □ Yes □ No
16. How did you leave the scene of the accident / injury? Select one: □ Did you drive the car from the accident? □ Did someone come pick you up? □ Were you transported via ambulance from the scene? □ Other (please describe): _____
    _____
17. Where did you go immediately after the accident / injury? Select one: □ Did you go to your home? □ A relative's home? □ An urgent care? □ A hospital? □ Other (please describe):
    _____
    _____

ALB PAIN MANAGEMENT & SPINE CARE

INITIAL INTAKE

MEDICAL CARE SINCE INJURY

18. What is the exact date you first sought medical care for injuries sustained in the accident? ____ /____ /_____

19. What type of medical provider(s) have you been evaluated by? ☐ Hospital emergency room?

    ☐ Urgent care? ☐ Primary care doctor? ☐ Chiropractor?

    ☐ Physical therapist? ☐ Pain doctor? ☐ Other (please describe):

    _____

    _____

    _____

20. Have you had any imaging studies performed? ☐ Yes ☐ No If yes, have you had x-rays? ☐ Yes ☐ No

    Have you had an MRI ☐ Yes ☐ No

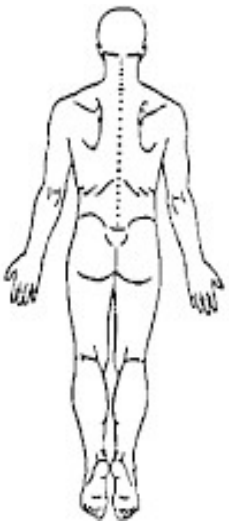
21. What body parts were imaged? ☐ Neck? ☐ Back? ☐ Shoulder? ☐ Leg? ☐ Other (please describe):

    _____

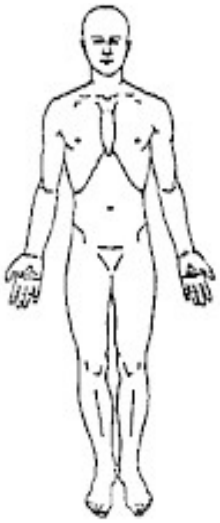
    _____

CURRENT PAIN:

22. Please mark on this drawing where you are currently experiencing pain:



Left **Right**



Right **Left**

23. Please mark your level of pain on the pain scale:

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

24. How frequent is your pain? ☐ Constant ☐ Daily ☐ Intermittent

25. Describe your pain: ☐ Aching ☐ Dull ☐ Sharp ☐ Shooting ☐ Throbbing ☐ Burning

    ☐ Other, please describe: _____

ALB PAIN MANAGEMENT & SPINE CARE

INITIAL INTAKE

26. Do you have numbness or tingling? □ Yes □ No If yes, where? _____
27. Do you have weakness? □ Yes □ No If yes, where? _____
28. What activities make your pain worse? □ Bending □ Lifting □ Sitting □ Standing □ Reaching
    □ Laying down □ Coughing/sneezing □ Car rides □ Driving □ Walking □ Working
    □ Other, please describe: _____
29. What helps your pain? □ Rest □ Medications □ Injections □ Stretching □ Chiropractic / Physical Therapy
    □ Other, please describe: _____
30. Did you have any pain before the accident / injury? □ Yes □ No If yes, where? _____
    _____
31. Please list the year, city, and state in which you have had a motor vehicle accident or traumatic injury in the past 20 years:

Year: _____ City: _____ State: _____ Year: _____ City: _____ State: _____

Year: _____ City: _____ State: _____ Year: _____ City: _____ State: _____

32. Have you had any "cortisone" injections since the accident / injury? □ Yes □ No
33. Have you had any surgery since the accident / injury? □ Yes □ No If yes, what surgery did you have done?
    _____
    _____

MEDICAL HISTORY

ALLERGIES:

34. Do you have any allergies to medications? □ Yes □ No If yes, please list:
    _____
    _____

MEDICATIONS:

35. Do you take any blood thinners (such as aspirin)? □ Yes □ No □ Unsure
36. Do you take any prescription medications? □ Yes □ No If yes, please list the names of the medications below. If you are unsure of the name of the medication, please list the reason for which you take the medication.

MEDICATION: DOSAGE: MEDICATION: DOSAGE:

_____ _____

_____ _____

_____ _____

ALB PAIN MANAGEMENT & SPINE CARE

INITIAL INTAKE

PAST MEDICAL HISTORY:

37. Do you have any medical problems ("Past medical history")? For example, diabetes, high blood pressure, thyroid disease, etc.:

_____

_____

_____

SURGICAL HISTORY:

38. Please list all past surgeries:

SURGERY:	YEAR:	SURGERY:	YEAR:
_____		_____	
_____		_____	
_____		_____	

SOCIAL HISTORY:

39. Are you married? ☐ Yes ☐ No
40. Do you smoke / vape / use tobacco-containing products? ☐ Yes ☐ No
41. Do you consume alcohol? ☐ Yes ☐ No

    If yes, how often do you consume alcohol? ☐ Daily ☐ Weekly ☐ Socially ☐ Rarely

EMPLOYMENT

42. Are you currently employed? ☐ Yes ☐ No
43. Where do you work? _____
44. Has your ability to function at your job changed since the accident? ☐ Yes ☐ No If yes, please explain:

    _____

    _____

    _____
45. Are you: ☐ Right-handed ☐ Left-handed OR ☐ Ambidextrous?
46. Height: _____ Ft _____ In Weight: _____ Lbs

ALB PAIN MANAGEMENT & SPINE CARE

General Consent For Treatment

PATIENT NAME: _____ DOB: _____
(*Full Legal Name)*

DATE OF INJURY:_____

Consent to Treatment
I consent to the procedures that may be performed during my stay at ALB Pain Management & Spine Care or "APMSC" on an outpatient basis, which may include but are not limited to: Laboratory procedures, diagnostic procedures, x-ray examination, anesthesia, medical, or surgical treatment or procedures.

Photography
I understand healthcare providers at APMSC may use photographs, films or other recordings for identification, diagnosis, treatment, education, or for any other healthcare purposes. Any other uses will require my authorization. Additionally, I grant authorization by APMSC to use any images for educational purposes.

Informed Consent
Our provider(s) are responsible for obtaining my informed consent before any proposed medical services or surgical procedures are performed. If I am unable to consent to treatment, our provider(s) are responsible for obtaining consent from my legal guardian or representative.

Financial Agreement
I understand I am fully liable for the total cost of the care and services that I receive, at the rate effective on the date received, regardless of whether any insurance proceeds or settlement funds are available to pay for them.

I am responsible for payment of any services received for this date of service. I understand that no health insurance is accepted in any way as payment for services received today.

I understand that if care and services are received as a result of an injury for which I receive a monetary award, settlement or verdict and that if the amount I receive will not pay the balance on the account, that ALB Pain Management & Spine Care will accept the amount I receive as a partial payment and that acceptance of a partial payment will not discharge my financial obligation for the remaining balance.

Retention
APMSC will retain the financial details of my account for the period required by law. Medical records of patients over the age of 18 will be destroyed after 5 years. Medical records of patients under the age of 18 will be destroyed 5 years after the patient reaches the age of 18.

Assignment of Benefits
I assign to APMSC, all applicable benefits otherwise payable to me not to exceed the established charges for the services provided. I except financial responsibility for any charges not paid by the assignment.

Release of Information
I acknowledge that APMSC, the physicians and other health professionals involved in my care will share healthcare information necessary for treatment, payment, or healthcare operations as allowed by law. Information may be released to any person or entity liable for payment on my behalf to verify coverage, answer payment questions or for any other purpose related to benefit payment.

ALB PAIN MANAGEMENT & SPINE CARE

General Consent For Treatment

Communications About My Health

Unless I request privacy restrictions, I understand my healthcare information may be disclosed for purposes of communicating results, findings, and care decisions to my family members and others responsible for my care as designated by me. My name, location, and condition will be available to them by visits from medical personnel, phone calls, or other directory services.

Other Acknowledgements

I understand that providers furnishing services may be independent contractors and not employees or agents of APMSC. Independent contractors are responsible for their own actions and APMSC is not liable for the acts or omissions of any independent contractor. Independent contractors may bill separately for their services. I understand physicians or other healthcare professionals may be called upon to provide care or services to me on my behalf, but I may not actually see or be examined by such physicians or healthcare professionals participating in my care. For example, I may not see physicians providing anesthesiology or radiology services.

Personal Valuables

I understand APMSC maintains lockers for the safe keeping of money and valuables for patients who are admitted to the procedure center. APMSC is not responsible for the loss or damage to any money, jewelry, glasses, dentures, or any other item that would be considered a loss if misplaced, and not deposited within their designated locker for specifics of safe keeping. I agree to reclaim any property in custody of this entity within 60 days of discharge. If I am unable to sign for the release of said property, my personal representative may reclaim the property.

Patient printed name: _____ Date: _____ Time: _____

Patient Signature: _____

Witness printed name: _____ Date: _____ Time: _____

Witness Signature: _____

ALB PAIN MANAGEMENT & SPINE CARE

Medical Lien Agreement / Assignment of Benefits

Patient Name: _____ Date of Birth: _____ Date of Accident: _____

Attorney's Name / Firm Name: _____ Attorney's Phone Number: _____

I hereby authorize and direct you, my attorney to pay directly to ALB Pain Management & Spine Care, LLC (forthwith known as "APMSC") such sums as may be due and owing for medical goods and services rendered to me by the above referenced Provider, related in any way to the accident or incident noted above (the "Accident") and by reason of any bills or invoices for medical goods and/or services rendered to me ("Patient"). I further authorize and direct you to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate APMSC. I hereby further give a Medical Lien/Letter of Protection (LOP) on my claim and/or lawsuit related to the Accident to APMSC against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to APMSC for all medical bills and invoices submitted by APMSC for goods and services rendered to me and that this LOP is made solely for APMSC additional protection and in consideration of APMSC awaiting payment. I further understand that full payment is not contingent on any settlement, judgment or verdict related to my claim and/or lawsuit by which I may eventually recover said fee.

Patient and Attorney acknowledge that APMSC reserves the right to assign its rights under this Agreement and the underlying accounts receivable for any consideration that APMSC deems sufficient; that Patient and Attorney shall continue to be bound by this Agreement to APMSC's Assignee as if APMSC's Assignee is the original party to this Agreement. Further, Patient agrees to remain liable to APMSC's Assignee for the fully billed/invoiced charges for any and all medical treatment, goods, services, and/or procedures rendered to Patient. Patient hereby authorizes Provider to release any and all of the Patient's medical records to APMSC and or APMSC Assignee as needed to enforce payment of any bills or services rendered by Provider to Patient.

Patient hereby authorizes Attorney to disclose any information pertaining to the status of Patient's personal injury claim and/or lawsuit to APMSC or its Assignee. Patient further directs Attorney to do everything necessary to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA).

I agree to promptly notify APMSC of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my current attorney to do the same and to promptly deliver a copy of this Agreement to any such substituted or added attorney(s). Please acknowledge this Agreement by signing below and returning to APMSC.

By signing below, Patient promises to abide by the terms of this Agreement. In the event this Agreement is litigated, the laws of the State of New Mexico will be controlling, and the prevailing party will be entitled to attorneys' fees and costs.

Dated: _____ Patient Signature: _____

Patient Name (print): _____

The undersigned being attorney for the above Patient does hereby agree to observe all of the terms outlined above, without modification, and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate APMSC or its Assignee.

Receipt of this notice, regardless of written affirmation thereof, will create in me a duty to protect the interests of APMSC or its Assignee, pursuant to relevant New Mexico law. Attorney further agrees that in the event this Agreement is litigated, the laws of the State of New Mexico will be controlling, and the prevailing party will be entitled to attorneys' fees and costs.

Dated: _____ Attorney Signature: _____

Attorney Name (print): _____

ALB PAIN MANAGEMENT & SPINE CARE

Patient Attestation

Please read this section carefully along with the documents that are referenced.

Thank you for choosing ALB Pain Management & Spine Care (APMSC). Please make sure you have received all documents listed below. It is important that you carefully read and review these documents before your consultation with our medical providers. Please initial your name once you have read, understood, and agreed with each of the documents completely. The documents listed below are used for your benefit to inform you regarding our policies & procedures.

1. Privacy Practices, Privacy Notice and HIPAA compliant release
I was given and have read, understand, and agree with the organization's Privacy Notice and Privacy Policies (this notice is located on the www.albpainclinic.com website). I was given and have read, understand, and agree with the organization's HIPAA compliant release and have completed the release form.
Initials _____

2. Patient's Rights and Responsibilities
I was given and have read, understood, and agree with the organization's Patient's Rights and Responsibilities located on the website. Included in this information was a list of contact information regarding where and to whom I may be able to express my concerns, complaints, and/or grievances.
Initials _____

3. Medical Lien Agreement / Assignment of Benefits
I was given and have read, understood and agree with the Medical Lien Agreement/Assignment of Benefits given to me by the organization. Any questions, concerns, and/or disagreements to these terms will be my responsibility to bring to the attention of the appropriate staff and/or my attorney.
Initials _____

I understand that me and / or if applicable, my attorney will receive all signed documents included in this packet (see medical lien / assignments of benefits agreement)**.**
☐ I would like copies ☐ I do not want copies

I certify that I have received written documentation of the items list above, prior to my scheduled initial consultation and/or my procedure date. By signing below, I understood and agreed to the above documents, including with regards to APMSC policies and procedures. I am also validating that the initials next to each of the corresponding documents, listed above, were written by me. Furthermore, I have understood that should I have any questions regarding its content, I should contact appropriate management or staff for any clarification.

_____ _____ _____
Signature Printed Name Date

ALB PAIN MANAGEMENT & SPINE CARE

Patient Authorization / Emergency Contact Form

Authorization to release Information to Family Members

- Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures, and financial information. Under the requirements for HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic/test results and/or financial information released to any family members you must sign this form.
- You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize ALB Pain Management & Spine Care (APMSC) to release my records and any information requested to the following individuals:

1. _____ _____
   Name Relation to patient
2. _____ _____
   Name Relation to patient
3. _____ _____
   Name Relation to patient

Authorization Regarding Messages
(please check all that apply)

___ I authorize APMSC to leave a detailed message on my home or cell number regarding appointments.

___ I authorize APMSC to leave a detailed message on my home or cell number regarding medical treatment, care, test/diagnostic results, or financial information.

___ I authorize APMSC to leave a message with anyone who answers the phone.

___ Messages may only be left with _____

IN CASE OF EMERGENCY CONTACT:

1. _____ _____ (____)_____
   Name Relation to patient Phone

   _____
   Street Address City State Zip

2. _____ _____ (____)_____
   Name Relation to patient Phone

   _____
   Street Address City State Zip

_____ _____
Patient Name (PLEASE PRINT) Date

_____
Patient Signature

ALB PAIN MANAGEMENT & SPINE CARE

Authorization for Release of Confidential Records and Protected Health Information / Medical Information- HIPAA Compliant

Patient Name: _____ Date of Accident: _____

Patient Date of Birth: _____ Patient Phone Number: _____

Attorney's Name / Firm Name: _____

Date(s) of Service: _____

I, _____ ("Patient") hereby authorize and request for you to release to ALB Pain Management & Spine Care, LLC (APMSC) the following requested records for the above listed date of accident and/or date(s) of service:

_____1. All medical reports, charts, notes, letters, history, physical findings, diagnosis, prognosis, x-rays, MRI films, CT-scans, radiology or other imaging records, pharmacy records, prescriptions, itemized statements of charges, billing and any other medical records, which may include records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse;
_____2. X-rays, MRI films, CT-Scans, Radiology or other imaging records, only; or,
_____3. Only the following items (please specify):

_____

With the exception of the following information:
_____ Mental health records
_____ Communicable diseases (including HIV and AIDS)
_____ Alcohol/drug abuse treatment
_____ Other (please specify items to be excluded):
_____

I understand that the information used or disclosed may be subject to re-disclosure by the person, class of persons and/or facility receiving such, and would then no longer be protected by federal privacy regulations.

I may revoke this Authorization by notifying the above office in writing to revoke such. However, I understand that any action already taken in reliance on this Authorization cannot be reversed, and my revocation will not affect those actions. This Authorization expires in three (3) years, or upon the resolution of the matter that underlies this authorization, whichever is later. A photocopy of this is to be treated as an original.

Signature of Patient/Client or Claimant or Guardian if a minor: _____
Date: _____

If signed by other than the Patient, select authority and provide documentation:
_____Parent of minor _____Power of Attorney _____Other, (explain): _____

ALB PAIN MANAGEMENT & SPINE CARE

Authorization for Release of Confidential Records and Protected Health Information / Medical Information- HIPAA Compliant

Patient Name: _____ Date of Accident: _____

Patient Date of Birth: _____ Patient Phone Number: _____

Attorney's Name/ Firm Name: _____

I, _____ ("Patient") hereby grant permission and authorization for ALB Pain Management & Spine Care, LLC (APMSC), to disclose to _____ ("Assignee"), as Assignee of APMSC Professional and of APMSC Facilities, pursuant to the Medical Lien Agreement/ Assignment of Benefits, and for Assignee to receive, review, inspect, and/or copy, any and all of the following in the possession or control of APMSC Professional and APMSC Facilities (please initial):

_____1. All medical reports, charts, notes, letters, history, physical findings, diagnosis, prognosis, x-rays, MRI films, CT-scans, radiology or other imaging records, pharmacy records, prescriptions, itemized statements of charges, billing and any other medical records, which may include records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse;
_____2. X-rays, MRI films, CT-Scans, Radiology or other imaging records, only; or,
_____3. Only the following items (please specify):

_____

With the exception of the following information:
_____ Mental health records
_____ Communicable diseases (including HIV and AIDS)
_____ Alcohol/drug abuse treatment
_____ Other (please specify items to be excluded):
_____

I understand that the information used or disclosed may be subject to re-disclosure by the person, class of persons and/or facility receiving such, and would then no longer be protected by federal privacy regulations.

I may revoke this Authorization by notifying the above office in writing to revoke such. However, I understand that any action already taken in reliance on this Authorization cannot be reversed, and my revocation will not affect those actions. This Authorization expires in three (3) years, or upon the resolution of the matter that underlies this authorization, whichever is later. A photocopy of this is to be treated as an original.

Signature of Patient/Client or Claimant or Guardian if a minor: _____
Date: _____

If signed by other than the Patient, select authority and provide documentation:
_____Parent of minor _____Power of Attorney _____Other, (explain): _____