Twin Cities Pain Clinic

Hello, and thank you for choosing Twin Cities Pain Clinic!

During your first visit with us, you will be seen by a provider who is certified in the field of pain management and has extensive experience treating patients with pain conditions.

Here is the date, time, and clinic location of your upcoming appointment:

_____	_____	_____
Date	**Time**	**Location** *(address & directions enclosed)*

Please complete this packet of paperwork PRIOR to checking in for your appointment. If you are unable to complete it, we ask that you arrive 30 minutes early or we may have to reschedule your appointment.

Please bring the following to your first appointment:

- ☐ Driver's license or other photo identification
- ☐ Insurance card(s)
- ☐ Copay, which is due at time of service
- ☐ A list of medications you're currently taking as well as the original bottles so we can see the dosage, the prescriber, and the pharmacy
- ☐ Any relevant medical records and/or imaging reports

***Please note, you will not be prescribed medications at your first visit, so plan accordingly.**

Please respect our other patients' time by giving at least 24 hours' notice to cancel or reschedule an appointment. If you miss an appointment or cancel more than two appointments less than 24 hours in advance, we reserve the right to discontinue your care at our clinic.

If you have questions about your forms or appointment, please call us at **952-204-3547** between 8:00 am and 4:15 pm. The address and directions to the clinic are enclosed.

We look forward to meeting you!

Twin Cities Pain Clinic

Patient Intake Form

Twin Cities Pain Clinic

Date:_____/_____/_____

Name:_____ **Maiden/Other:**_____

Date of birth:____/____/_____ **Birth Sex:** ☐ Male ☐ Female **Current Gender Identity:** ☐ Male ☐ Female ☐ Other_____

Preferred pronoun: ☐He/him ☐She/her ☐They/them ☐Other:_____

What problem(s) are you seeking treatment for today?_____

_____

What types of treatment are you interested in?_____

_____

How long have you had your current problem? _____

How did the pain begin? ☐ Suddenly ☐ Gradually ☐ After Injury ☐ Other:_____

How often do you have the pain? ☐ Constant ☐ Intermittent ☐ Infrequent

Was this problem a result of an accident or injury? ☐ Yes ☐ No **If yes,** give date:_____

Is this condition covered under workers' compensation or auto?: ☐ YES (☐ Work Comp ☐ Auto) ☐ NO

If yes, what is the name of the Work Comp and/or Auto carrier?_____

Are you having troubles with health insurance claims, related to this problem? ☐ Yes ☐ No

What number best describes your <u>pain on average</u> in the past week:

No pain 0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐ Pain as bad as you can imagine

On the scale below, how has your pain interfered with your enjoyment of life during the past week:

Does not interfere 0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐ Completely Interferes

On the scale below, how has your pain interfered with your general activity during the past week:

Does not interfere 0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐ Completely Interferes

How do the below actions affect your pain?

	Better	**Worse**
Bending forward	☐	☐
Bending backward	☐	☐
Reaching overhead	☐	☐
Standing	☐	☐
Sitting	☐	☐
Walking	☐	☐

What makes your pain better?
(Check all that apply)

☐ Chiropractic care
☐ Physical therapy
☐ Home exercise program/home stretching program
☐ TENS
☐ Medications
☐ Other:_____

In the space below, describe how the pain began (details about the injury or pain onset):

_____

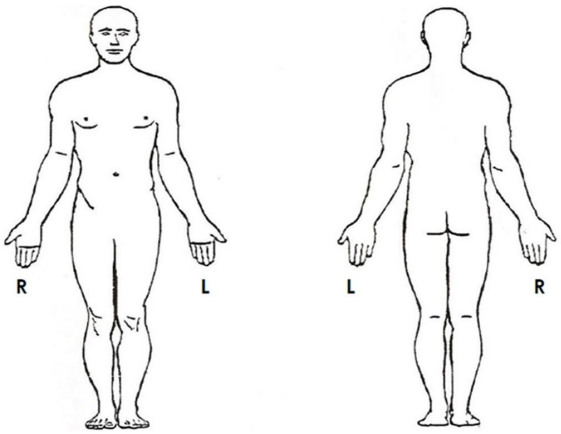
_____

_____

Mark the drawing where you hurt, using the letter that best describes the pain in that particular area.

For example: Put an "**A**" over the low back if you have aching pain in the low back.

A = Aching	**S** = Stabbing	**P** = Pins & needles
B = Burning	**N** = Numbness	



Have you had physical therapy for your area of current pain? ☐ Yes ☐ No

If yes, where did you complete your therapy? _____

Please list the approximate dates of treatment: _____

What body region(s) were targeted with physical therapy? (check all that apply):

☐ Neck ☐ Mid back ☐ Low back ☐ Upper extremities ☐ Lower extremities ☐ Other

About how many visits were completed?_____ Were you discharged from PT? ☐ Yes ☐ No

Do you continue a home exercise program? ☐ Yes ☐ No

Have you tried injections for your area of current pain? ☐ Yes ☐ No

If yes, where did you have those injections? _____

What type? ☐ Epidural ☐ Radiofrequency ☐ Nerve block ☐ Unknown/Other: _____

Were these injections helpful? ☐ Yes ☐ No

Have you had advanced imaging (MRI or CT scan) within the past three years for this condition?

☐ Yes ☐ No **If Yes**: Location of imaging:_____ Imaging date:____/____/_____

Have you had other diagnostic testing (MRI or CT scan) for your pain?

☐ EMG ☐ X-Ray ☐ CT or MRI more than three years ago

If you checked one : Location of testing:_____ testing date:____/____/_____

Have you tried medications for your pain? ☐ Yes ☐ No **If yes,** please check below:

☐ Gabapentin Dose:_____ When taken:_____
☐ Lyrica Dose:_____ When taken:_____
☐ Topamax Dose:_____ When taken:_____
☐ Cymbalta Dose:_____ When taken:_____
☐ Amitriptyline Dose:_____ When taken:_____
☐ Nortriptyline Dose:_____ When taken:_____

☐ Muscle relaxants:
☐ Cyclobenzaprine ☐ Metaxalone ☐ Methocarbamol ☐ Tizanidine ☐ Orphenadrine

☐ Anti-inflammatory medications:
☐ Ibuprofen ☐ Naproxen ☐ Prednisone

☐ Opioid medications:
☐ Tramadol ☐ Codeine ☐ Hydrocodone ☐ Oxycodone ☐ Morphine
☐ Fentanyl ☐ Hydromorphone ☐ Methadone ☐ Buprenorphine

List any other medications you have tried for your pain: _____

_____

Past medical history (check all that apply):

- ☐ Heart attack
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart failure
- ☐ Atrial fibrillation
- ☐ Stroke
- ☐ COPD
- ☐ Asthma
- ☐ Sleep apnea
- ☐ Home oxygen
- ☐ Heartburn/stomach ulcers
- ☐ Hepatitis/HIV
- ☐ Seizures
- ☐ Osteoporosis
- ☐ Diabetes
- ☐ Anemia
- ☐ Anxiety/depression
- ☐ PTSD
- ☐ MRSA
- ☐ Arthritis
- ☐ Immune disorder:_____
- ☐ Kidney disease: _____
- ☐ Liver disease: _____
- ☐ Bleeding disorder: _____
- ☐ Problems with anesthesia
  *Date of occurrence:*_____
- ☐ Other: _____

Surgical history (list surgeries related to why you are seeking care first):

Surgery/Date:

_____

_____

_____

_____

Surgery/Date:

_____

_____

_____

_____

Is there a history of back pain or chronic pain in your family? ☐ Yes ☐ No

If yes, please describe: _____

Some of the medications we may prescribe could be addictive or abused. Please answer the following questions honestly so we may pursue the best course if pain medication is necessary.

Do you smoke? ☐ Yes ☐ No ☐ Former **If yes:** _____ packs per ☐ Day ☐ Week ☐ Month

Do you drink alcohol? ☐ Yes ☐ No **If yes:** _____ drinks per ☐ Day ☐ Week ☐ Month

Do you use recreational street drugs? ☐ Yes ☐ No ☐ Formerly

Do you use marijuana/cannabis products? ☐ Yes ☐ No ☐ Formerly

Do you have a history of drug abuse? ☐ Yes ☐ No

If yes, did you undergo treatment? ☐ Yes ☐ No

If yes, please describe the treatment, including what the treatment was for and the year(s):

_____

_____

Do you have a history of alcohol abuse? ☐ Yes ☐ No

If yes, did you undergo treatment? ☐ Yes ☐ No

If yes, please describe the treatment, including what the treatment was for and the year(s):

_____

_____

Have you ever had any traffic violations related to drugs or alcohol (DWI, DUI, etc.)? ☐ Yes ☐ No

If yes, please describe w/ dates: _____

The following questions are to help us understand your situation better so we can help you deal with any social or work stresses that this medical problem may be causing you.

Marital status:

☐ Single, never married ☐ Single, divorced ☐ Single, widowed
☐ Married ☐ Separated ☐ Significant other

Do you have children? ☐ YES ☐ NO

Last level of school you completed: _____

Are you currently working? ☐ Yes ☐ No **If yes,** answer the next 3 questions:

1. What is your current type of work? _____
2. Are you currently working: ☐ Full time ☐ Part time
3. Are you working: ☐ Without restrictions ☐ With restrictions written by a physician

Are you receiving any financial compensation now for lost income due to disability? ☐ Yes ☐ No
Are you involved in any litigation regarding your pain condition? ☐ Yes ☐ No

DEMOGRAPHIC INFORMATION

Address:_____ **APT#:**_____ **City:**_____

State: _____ **ZIP:**_____ **Day Phone:**_____ **Cell Phone:**_____

Email:_____ **Social Security Number:**_____-_____-_____

Language:_____ **Race:**_____

SSN is required for work comp and auto cases

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Current living situation: ☐ House ☐ Apartment ☐ Assisted living ☐ Nursing home ☐ Group home

☐ Independent living ☐ Homeless/Transitional housing ☐ Other:_____

Emergency Contact:_____ **Phone:** _____

Pharmacy Name:_____ **Pharmacy Phone:**_____

Primary Care Physician:_____ **Primary Care Clinic:** _____

Primary insurance:

Insurance company: _____ Policy #: _____ Group #: _____

Secondary insurance:

Insurance company: _____ Policy #: _____ Group #: _____

How did you hear about our clinic?

☐ Referring Physician/Clinic ☐ Internet ☐ Family/Friend ☐ Other:_____

Name of Physician or Referral source:_____

LIST ALL ALLERGIES YOU HAVE, including medications, food, latex or other substances. Describe what kind of reaction you had to each (for example, rash, shortness of breath, etc.)

Allergy/Reaction:

_____
_____
_____
_____

Allergy/Reaction:

_____
_____
_____
_____

Do you have an allergy to contrast dye, iodine, or shellfish? □ YES □ NO

LIST THE NAMES OF ALL THE MEDICATIONS YOU ARE CURRENTLY TAKING IN THE TABLE BELOW. You may also bring a medication list with you to your appointment.

Medication:	**Dose:**	**When taken:**

HEALTH ASSESSMENT QUESTIONNAIRE (HAQ-DI)©

Name:_____ Date: _____

Please place an "x" in the box which best describes your abilities OVER THE PAST WEEK:

	WITHOUT ANY DIFFICULTY	WITH SOME DIFFICULTY	WITH MUCH DIFFICULTY	UNABLE TO DO
DRESSING & GROOMING				
Are you able to:				
Dress yourself, including shoelaces and buttons?	☐	☐	☐	☐
Shampoo your hair?	☐	☐	☐	☐
ARISING				
Are you able to:				
Stand up from a straight chair?	☐	☐	☐	☐
Get in and out of bed?	☐	☐	☐	☐
EATING				
Are you able to:				
Cut your own meat?	☐	☐	☐	☐
Lift a full cup or glass to your mouth?	☐	☐	☐	☐
Open a new milk carton?	☐	☐	☐	☐
WALKING				
Are you able to:				
Walk outdoors on flat ground?	☐	☐	☐	☐
Climb up five steps?	☐	☐	☐	☐

Please check any categories for which you usually need HELP FROM ANOTHER PERSON:

☐ Dressing and grooming ☐ Arising ☐ Eating ☐ Walking

Please place an "x" in the box which best describes your abilities OVER THE PAST WEEK:

	WITHOUT ANY DIFFICULTY	WITH SOME DIFFICULTY	WITH MUCH DIFFICULTY	UNABLE TO DO
HYGIENE				
Are you able to:				
Wash and dry your body?	☐	☐	☐	☐
Take a tub bath?	☐	☐	☐	☐
Get on and off the toilet?	☐	☐	☐	☐
REACH				
Are you able to:				
Reach and get down a 5-pound object (such as a bag of sugar) from above your head?	☐	☐	☐	☐
Bend down to pick up clothing from the floor?	☐	☐	☐	☐
GRIP				
Are you able to:				
Open car doors?	☐	☐	☐	☐
Open previously opened jars?	☐	☐	☐	☐
Turn faucets on and off?	☐	☐	☐	☐
ACTIVITIES				
Are you able to:				
Run errands and shop?	☐	☐	☐	☐
Get in and out of a car?	☐	☐	☐	☐
Do chores such as vacuuming or yard work?	☐	☐	☐	☐

Please check any categories for which you usually need HELP FROM ANOTHER PERSON:

☐ Hygiene ☐ Reach ☐ Gripping and opening things ☐ Errands and chores

PRIVACY POLICY

Patient Consent for Use and Disclosure of Protected Health Information

Twin Cities Pain Clinic

I hereby give my consent for TWIN CITIES PAIN CLINIC ("Clinic") to use and disclose protected health information (PHI) for performing any activity for **treatment**: providing, coordinating, and managing quality patient care; **payment**: ensuring that the practice gets paid for services; and **operations of the practice**: internal management activities. This is also referred to as **TPO**.

Clinic's Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have reviewed the Notice of Privacy Practices prior to signing this consent.

With this consent:

1. Clinic may call my home or other alternative location and leave a message on the recorder or in person in reference to any items that assist the practice in carrying out TPO, such as insurance items and my clinical care including laboratory results.
2. Clinic may mail to my home, or any other alternative location, any items that assist the practice in carrying out TPO, such as patient statements.
3. Clinic may send me text messages and/or emails for the purpose of carrying out TPO, including messages related to appointment management, continuity of care, announcements, and obtaining feedback. I understand that Clinic may share my information with an authorized third-party for the sole purpose of sending me messages related to TPO, and that Clinic will never sell my information to a third party. I acknowledge that message frequency may vary, and that I may opt out of these messages anytime. ***DISCLOSURE: Message and data rates may apply.***
4. I acknowledge that Dr. Andrew Will has ownership interest in Twin Cities Pain Clinic, Twin Cities Surgery Center, Burnsville Surgery Center, Twin Cities Anesthesia, and Twin Cities Pain Clinic Transportation, and I consent to the sharing of my personal health information between these entities for the purpose of continuity of care.
5. I authorize the following person(s) to be my personal representative(s), which means the doctor andstaff may speak freely to the named representative(s) regarding all my PHI, Medical and Treatment matters and Billing:

Name	**Relationship**

I have the right to request that Clinic restrict how it uses or discloses my protected health information to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I was notified of the Privacy Practices and am consenting to Clinic's use and disclosureof my protected health information to carry out treatment, payment, and operations. Clinic reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Twin Cities Pain Clinic at 7235 Ohms Lane, Edina, MN 55439.

Federal law permits Twin Cities Pain Clinic to use and disclose medical information about you for research purposes, either with your specific, written authorization or when the study has been reviewed for privacy protection by an Institutional Review Board or Privacy Board before the research begins. In some cases, researchers may be permitted to use information in a limited way to determine whether the study or the potential participants are appropriate. Minnesota law generally requires that we get your consent before we disclose your health information to an outside researcher. We will make a good faith effort to obtain your consent or refusal to participate in any research study, as required by law, prior to releasing any identifiable information about you to outside researchers. (Minn. Stat. § 144.295 subd.1)

Patient Signature	Date
Patient Printed Name	Date of Birth

TCPC OFFICE USE ONLY	Patient was given Notice of Privacy Practices and refused to sign this consent on: DATE:_____ EMPLOYEE INITIALS:_____

Twin Cities Pain Clinic

Financial Policy

Our practice is committed to providing you with the best health care possible. It is your responsibility to understand your insurance plan benefits. This includes co-payments, co-insurance and any deductible amounts for the services you receive. We are happy to assist you with any questions you may have about your account or balance with us.

INSURANCE

As your medical provider, our relationship is with you. Your insurance is a contract between you and your insurance carrier. While insurance can be confusing, it is ultimately your responsibility to know your insurance plan. Not all services may be covered by your insurance plan. As a courtesy to you, we will file your claim in a timely manner. **You must present a valid health insurance card, photo ID and any co-payment or past-due balances at each visit. We accept cash, check, or credit/debit cards. We are also able to accept credit/debit card payments over the phone or online.** If your insurance has changed, you may need to pay the full cost of your visit. In these cases, we will assist you in obtaining reimbursement or credit from your insurer.

Twin Cities Pain Clinic verifies insurance benefits, however exact coverage and benefits cannot be determined until the claim is received and reviewed by the insurance carrier. I understand that this is not a guarantee of payment from the insurance carrier & all benefits are subject to the conditions and limitations of the plan and are subject to change. I understand that I am financially responsible for charges not covered by an assignment of benefits or for charges which the insurance carrier declined to pay. In accordance with the No Surprise Act, the Center will provide an estimate of medical items & services to any patient who does not have insurance or does not intend to use insurance for their care.

FORMS / APPEALS

Insurance covers only your medical care. It does not cover submitting forms that may assist you in collecting disability benefits and maintaining employment. There are fees for these services which reflect the resources diverted to the effort. Your insurance may not cover all treatments or medications. You may pay cash, forego treatment or appeal to your insurer. If you ask us to appeal, we may bill you an hourly rate as this is not medical care. When health plan denies some or all of the charges, Twin Cities Pain Clinic will attempt to appeal this adverse determination and will bill me for any amounts which remain outstanding after the appeals are exhausted.

REFERRALS

Some insurers require a referral from your primary doctor; refer to your medical policy. Please have your primary care provider send a referral prior to your appointment. Without a referral, insurers may require you to pay for your visit in full.

ASSIGNMENT OF BENEFITS

I authorize all insurance benefits to be paid directly to Twin Cities Pain Clinic, DBA Andrew J. Will, MD, PA. I authorize the release of all necessary information to file and complete all insurance claims.

ACCOUNT BALANCES

Payment for services is expected within 30 days of your first statement. Accounts that are 90 days past due may be sent to collections if acceptable arrangements have not been made. Returned checks are subject to a $30.00 service charge.

MISSED AND CANCELLED APPOINTMENTS

Your appointment time is set aside specifically for you. If you are unable to keep an appointment, you are responsible for providing us with a minimum of 24-hour notice. Failure to do so will result in a $50.00 cancellation fee. This fee is not covered by insurance. You are responsible for paying this fee before you are allowed to schedule another appointment. Three (3) or more instances may result in discharge from the Center.

I FURTHER ACKNOWLEDGE:

- Twin Cities Pain Clinic may be a non-participating provider, status of which I have been informed of, and I have chosen to obtain services at this facility.
- Where contractual rates do not apply, patient & health plans may be offered discounts.
- Fees for anesthesia services, professional fees, & facility fees will be billed separately.
- This form is valid for 1 year from date of signature.

I have read and understand all information on this financial policy. I agree to its terms and assignment of benefits and release of information as described above.

With my signature I am also authorizing medical treatment to be performed by Twin Cities Pain Clinic.

Patient/Guardian Signature: _____ Date: _____

PRINT Patient/Guardian Name: _____ Date of birth: _____

STAY INFORMED

We want to help you make the most out of your experience with Twin Cities Pain Clinic.

Subscribe to our newsletter and be the first to hear about exciting treatment innovations, exclusive education opportunities, important announcements, and much more.

To subscribe, visit **tcpain.co/subscribe**

Or scan the below QR code with your mobile device:

***If you do not wish to subscribe, you may disregard this page.**