



NEW PATIENT INFORMATION

DR. AUST INTERVENTIONAL PAIN

What to bring with you at your 1st appointment with Dr. Aust

1. Current Insurance Card(s)
2. Current Picture ID
3. List of current Medications (dosage, times per day)
4. Medical records pertinent to visit
(INCLUDING any related disc imaging; MRI's, X-Rays or other relevant tests.)**
5. New Patient Forms completely filled out if you haven't mailed in
6. Co-pay (if applicable)

**Please mail back New patient forms to make your first visit with us a little easier

Thank you,

Debbie Moser

Office Manager



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Please describe what you are being seen for:

[Large text input area for describing the reason for the visit]

Do you have a pain pump?

YES NO If yes, What kind? Flowonix Medtronic St. Jude Other

What year was it put in?

[Text input field for year of pain pump implantation]

Name of Doctor that implanted Pain pump:

[Text input field for doctor's name]

Medication (if known)

[Text input field for medication]

Do you have a Spinal Cord Stimulator?

YES NO If yes, What kind? Boston Scientific St. Jude Other (name) _____

What year was it put in?

[Text input field for year of stimulator implantation]

Name of Doctor that implanted Stimulator?

[Text input field for doctor's name]

Is this visit related to a motor vehicle accident (MVA) or workplace injury?

MVA Workplace Injury Not Applicable

Do you have an attorney representation related to the MVA or workplace injury? If yes, please provide name and contact information.

Attorney Name:

Phone:

Email:

[Input fields for attorney name, phone, and email]

If this is related to a workplace injury, please provide a brief description of incident, the name of your worker's compensation adjuster and contact information.

Adjuster Name:

Phone:

Email:

[Input fields for adjuster name, phone, and email]

Brief Description:

[Large text input area for brief description]

Claim number:

Date of injury:

[Input fields for claim number and date of injury]



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PLEASE COMPLETE THE FOLLOWING INFORMATION:

Name: DOB:

SEX: MARITAL STATUS: MARRIED WIDOWED SEPARATED DIVORCED SINGLE

SSN: DL Driver License #: eMail:

Address: City: State: Zip Code:

Home Phone: Cell phone: Preferred: Home: Cell: eMail:

Ethnicity/Race: P

Emergency Contact Name: Number: Relation:

INSURANCE INFORMATION

Primary Insurance Name: Member ID:

Subscriber Name: Subscriber DOB: Relation to Subscriber:

Secondary Insurance Name: Subscriber/Member/Policy ID:

Subscriber Name: Subscriber DOB: Relation to Subscriber:



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PLEASE COMPLETE THE FOLLOWING INFORMATION:

OTHER

Race/Ethnicity:

- African American/Black
- White/Caucasian, Non Hispanic
- Hispanic/Latino
- Other _____

Primary Language:

- English Spanish
- Other _____

INSURANCE INFORMATION

Primary:

Member ID#

Secondary:

Member ID#

Is this visit related to a motor vehicle accident (MVA) or workplace injury?

- MVA
- Workplace Injury
- Not Applicable

Do you have an attorney representation related to the MVA or workplace injury? If yes, please provide name and contact information.

Attorney Name:

Phone:

Email:

If this is related to a workplace injury, please provide a brief description of incident, the name of your worker's compensation adjuster and contact information.

Adjuster Name:

Phone:

Email:

Brief Description:

Claim number:

Date of injury:

Patient Name:

DOB:

Age:

Height

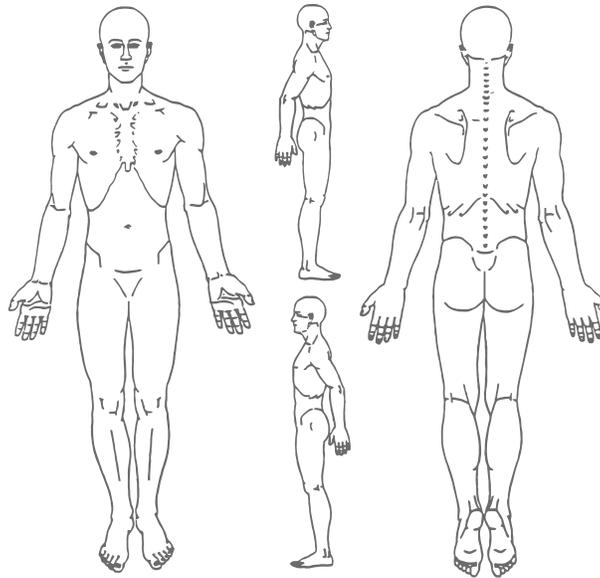
Weight

Which is your dominant hand?

 Right Left

Chief Complaint: In your own words why are you here today:

Please shade in areas of pain:



Mark a number below to indicate your usual pain intensity daily:

 0 1 2 3 4 5 6 7 8 9 10

Pain Score:

Referring Physician:

How did you hear about us:

When did the pain start:

Where is it located?

Does it radiate into your arms?

 Right Left Both

Does it radiate into your legs?

 Right Left Both

Was this due to a MVA or Work Injury:



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Quality of Pain: (please circle all that apply to your pain)

- Tenderness
- Aching
- Burning
- Cramping
- Muscle weakness
- Pins/needles
- Pressure
- Shocking
- Shooting
- Spasms
- Stabbing
- Stinging
- Throbbing
- Tightness
- Tingling
- Other:

What makes the pain WORSE?

What makes the pain BETTER?

Do you have any bladder or bowel incontinence:

- YES
- NO

PAST TREATMENTS

- Nerve Blocks
- Epidural Steriod Injection
- Chiropractor
- Physical Therapy
- Other:

With Who/How long ago

RADIOLOGY TESTING

- Xrays
- MRI
- CT Scan

Date: _____ Where: _____

SOCIAL HISTORY

Smoker: Yes No Quit Packs per day: _____ Number of years: _____

Alcohol: None Occasional Daily How much per week: _____ Recreational Drugs: Yes No

Do you have any history of prescription medication Abuse/Overuse

- YES
- NO

Do you have any history of addiction:

- YES
- NO
- If yes what was the treatment?

WORK STATUS

- Currently working
- Retired
- Unemployed
- Disabled

Occupation:



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MARITAL STATUS/CHILDREN

Married Single Divorced Widowed

How many children do you have you?

Have you ever been treated by another Pain Management Physician:

Who: When:

Who is your Primary Care Physician:

Who is your Cardiologist:

Who is your Psychiatrist/Psychologist:

MEDICAL HISTORY

Please list any medical conditions you have been diagnosed with

High Blood Pressure Diabetes Cancer Heart Disease
 COPD Anemia HIV Hepatitis
 Other:

PSYCHIATRIC

Please circle if you have any of the following:

Anxiety Depression Memory Loss Suicidal Ideation ADHD/ ADD
 Other:

SURGICAL HISTORY

Please list any surgical procedures you have had

Year	Describe	Doctor



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ALLERGIES

No known Allergies

Medication	Reaction

CURRENT MEDICATIONS

List all medications you are currently taking including over the counter medication, herbs, and vitamins. Please use additional sheet of paper if more room is needed.

Medication Name	Strength	Dose	Prescriber

FAMILY HISTORY

Please list any outstanding medical conditions:

Mother:

Father:

Siblings:

Maternal Grandfather:

Maternal Grandmother:

Paternal Grandfather:

Paternal Grandmother:

Other:



RELEASE OF MEDICAL FORM

DR. AUST INTERVENTIONAL PAIN

Name: DOB:

RELEASE OF INFORMATION

I authorize the release of information including the diagnosis, records, examination results, medication dose changes and claims information. This information may be released to:

Spouse (Name)

Child(ren) (Name)

Other (Name)

MESSAGES

Please call

My home phone at

My cell phone at

If unable to reach me:

You may leave a detailed message

You may leave a message asking me to return your call

DO NOT LEAVE ANY MESSAGES ON MY PHONE/VOICEMAIL

**Best time to reach me is (day of week):

Between (times):

E-MAIL MESSAGES

Use my e-mail address to send messages for me to contact the nurse for information

Use my e-mail address to leave detailed messages and information.

My E-mail address is:

This Release of Information will remain in effect until terminated by me in writing. This release **specifically excludes** any psychiatry and psychology evaluation/records which are further restricted by HIPAA regulations.

Patient Signature:

Date:

Witness Signature:

Date:



PAIN MANAGEMENT AGREEMENT

DR. AUST INTERVENTIONAL PAIN

I _____ DOB _____ agree to use controlled substances (narcotics/pain killers, sleeping pills) in the treatment of my pain only as prescribed for me by Aust Interventional Pain physician(s). I understand that the goal of treatment can include physical therapy, minimally invasive procedures, psychological services, and may or may not include prescription strength medication. The overall GOAL will be to DECREASE the amount of narcotics used concurrently with other treatments. **(*If your intention is to be treated solely with narcotic medications, then you may not be a qualified patient for this practice.)**

PLEASE INITIAL EACH ITEM AND SIGN BELOW:

_____ I understand that if I violate any of the terms of this agreement, my treating physician(s) may discharge me from the practice.

_____ I will take my medication as instructed and not change the way I take it without first speaking to the doctor or other member of my treatment team with Aust Interventional Pain. I understand stopping controlled substances suddenly may result in withdrawal symptoms that can lead to possible heart attack and seizures.

_____ I understand that the physicians of Aust Interventional Pain do not write prescriptions for Soma, Xanax, Valium, Ativan or Klonopin.

_____ I will keep all prescribed medications in a safe and secure location and out of the reach of children. If my prescribed medication is misplaced, lost or stolen I understand that IT WILL NOT be replaced until my appointment and may not be replaced at all. I take full responsibility for safe guarding my medication and storing them properly.

_____ I have not been involved in the sale of, illegal possession of, diversion of or transport of prescribed controlled substances nor am I currently abusing illicit drugs or prescription medication. I am not currently undergoing treatment for substance dependence or abuse.

_____ I will not misuse or abuse prescribed controlled substances, which means that I agree to take my medication as it is written for me and it will last for the period of time it was written for. My medications are NOT to be shared, given away or sold. I am NOT to take anyone else's medication. I will NOT go to the Emergency room for pain management of my chronic condition for which my doctor is currently treating me.

_____ I consent for my doctor, his associates and medical staff to communicate directly with my pharmacy to obtain information regarding my prescription history. I agree to waive any applicable privilege or right of confidentiality with respect to the prescribing of my pain medication. I authorize my pain management physician and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the Louisiana Board of Pharmacy in the investigation of my possible misuse, sale, or diversion of my pain medication: I authorize a copy of this agreement to be provided to my pharmacy and my consulting physician.

_____ I agree to refrain from all mind/mood altering drugs including alcohol and I consent to random urine, blood and saliva screens as well as random pill counts. My failure to comply will result in immediate dismissal from the practice. I understand that the screen results can be given to my other healthcare providers, insurance company or other reimbursing agencies. I also authorize any healthcare provider, pharmacy and law enforcement or judiciary body to release any pertinent information regarding my prescription or specimen results.

_____ I will make sure I have an appointment for medication refills and will notify a member of my treatment team immediately if I am having trouble making an appointment. I will not call in between appointments, at night or on weekends requesting refills. I understand that prescriptions for opioids will ONLY be filled during scheduled office visits with my treatment team.

_____ I understand that I must arrive in a timely manner for my scheduled appointments and if I am late I can/will be rescheduled. I also understand that an appointment does NOT guarantee a prescription.

_____ I will keep all scheduled appointments. In the event an office visit has to be cancelled, I will do so with at least 24 hours notice. In the event a procedure appointment has to be cancelled, I will do so with at least 72 hours notice. I understand that Aust Interventional Pain reserves the right to charge a cancellation fee for any cancelled appointments.

_____ I understand that in order to have narcotic medication refilled, in accordance with LA State Law (Act 488), I will need to be seen in an office visit a minimum of every 60 days. A fill may be written for the medication to last a period of no longer than 30 days without a refill.

_____ I will be COURTEOUS and RESPECTFUL to ALL office staff. This includes any family members or representatives speaking on my behalf and I understand that if I or my representatives are not courteous and respectful at all times that it is grounds for immediate dismissal from Aust Interventional Pain.

_____ I understand that failure to comply with my treatment plan may result in dismissal from Aust Interventional Pain. This includes failure to attend physical therapy, failure to undergo imaging such as X-Rays and MRI's and failure to attend procedure appointments. *Multiple re-schedules, no-shows and more than TWO cancellations for procedures or regular appointments may result in dismissal from the practice.



PAIN MANAGEMENT AGREEMENT

DR. AUST INTERVENTIONAL PAIN

_____ FEMALES ONLY: I certify that I am not pregnant, and do not plan to become pregnant. I also certify that I am taking all precautions, which may include use of contraceptives to prevent my becoming pregnant while undergoing treatment. In the event I become pregnant or decide I would like to try to become pregnant, I will notify Dr. Aust and/or Aust Interventional Pain physician(s).

_____ I agree to keep up to date with any bills due from Aust Interventional Pain and tell the doctor(s) or member of the treatment team immediately if I lose my insurance or can't pay for treatment anymore.

_____ I assume full responsibility for operating any type of vehicle, machinery, or any potentially hazardous task while taking controlled substances that are prescribed by my physician as well as I assume full responsibility in making any important decisions legal or otherwise while taking controlled substances as controlled substances can decrease mental functions.

_____ I am NOT allowed to flush, throw away, give away or otherwise dispose of controlled pain medication(s). I MUST bring in any remaining medication to the office to be disposed of and documented properly by an Aust Interventional Pain provider or team member. Medication changes WILL NOT be made unless I comply with this policy.

_____ I agree to adhere to all conditions from my doctor and pharmacy for safe use of my prescribed medication(s).

_____ I am responsible to make certain I do not run out of my medication on weekends, holiday and vacations. I will not ask for my medication to be phoned in to my pharmacy. If I require a refill I will call the office FIVE days in advance for my request. Most medications WILL NOT be dispensed without an office visit. Medications are NOT phoned in after hours or on weekends. I also take full responsibility for knowing when my refills are and making sure my follow up appointments correspond with my refill date.

_____ I understand that Aust Interventional Pain utilizes a Nurse Practitioner to see patients in follow up office visits when needed.

_____ I agree to use ONLY one pharmacy _____ (Name)

_____ (Location) _____ (Phone)

_____ I understand that I am responsible for personally picking up my own prescriptions. If I am physically unable to pick up my prescriptions, I authorize the following person to do so on my behalf; _____

*** This person will be required to show a picture ID as well as sign for the prescription.**

_____ I understand that if I refuse to initial or sign ANY of the items in this agreement I will NOT be prescribed ANY narcotic medications by Dr. Aust and Aust Interventional Pain.

Patient/Guardian (Please PRINT):

Patient/Guardian Signature:

Staff Signature:

Date:



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I _____ authorize _____
(healthcare provider) to release my complete health record (including X-Rays, MRI's, medical history, office visits and procedures as well as records relating to mental healthcare, communicable diseases, HIV or AIDS and treatment of alcohol or drug abuse) to Dr. Aust Interventional Pain.

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation.

I understand that I have the right to revoke this authorization, in writing at any time.

I understand that this authorization is for use or disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Signature of Patient or legal representative

Printed name of Patient or legal representative

Date of Birth

Date



HIPAA PRIVACY PRACTICES ACKNOWLEDGEMENT

DR. AUST INTERVENTIONAL PAIN

I understand it is the policy of Dr. Aust Interventional Pain to comply with the privacy rules and regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I have received a copy of Aust Interventional Pain HIPAA Privacy Policies and have read it carefully.

I hereby acknowledge that I have reviewed and understand the above referenced policies and procedures.

Print Name:

Patient Signature:

Date:



DR. AUST INTERVENTIONAL PAIN

Dear Patient,

Current practice and regulatory requirements require frequent office visits for medication management. Therefore most medication refills will be provided at office visits only.

An office visit is required for any new prescriptions OR changes to prescriptions (NO exceptions)

Controlled substances cannot be phoned in to your pharmacy; therefore you **MUST** make an appointment to receive your prescription.

Please understand that it is your (the patient) responsibility to keep up with your medication refills.

As a courtesy to other patients, we reserve the right to reschedule your appointment if you are more than 15 minutes late.

Thank you for your understanding and cooperation.

Sincerely,
Dr. Tod Aust MD
Dr. Aust Interventional Pain

My signature below acknowledges I understand, medication refills and medication changes both require and can **ONLY** be done at an appointment.

Signature

Date



MEDICATION REFILL PROCESS & APPOINTMENT POLICY

DR. AUST INTERVENTIONAL PAIN

Patient Name:

Date:

Please see and read the attached article outlining the dangers of certain medication interactions with chronic opioid use. It is **Dr. AUST INTERVENTIONAL PAIN** practice policy to **NOT** prescribe Benzodiazepines (Xanax, Ativan, Valium, Klonopin) and Soma. Once you have read this article, please sign below to **acknowledge that you understand** and are aware that extreme sleepiness, respiratory depression, coma and death can occur with the use of these medications at the same time and **you also agree NOT to take Benzodiazepines from another provider while using opioids from out practice.**

Thank you

Patient Signature

Date:

Staff Member Signature

Date

FDA News Release

FDA requires strong warnings for opioid analgesics, prescription opioid cough products, and benzodiazepine labeling related to serious risks and death from combined use

Action to better inform prescribers and protect patients as part of Agency's Opioids Action Plan

For Immediate Release

August 31, 2016

Release

[En español \(/NewsEvents/Newsroom/ComunicadosdePrensa/ucm518790.htm\)](/NewsEvents/Newsroom/ComunicadosdePrensa/ucm518790.htm)

After an extensive review of the latest scientific evidence, the U.S. Food and Drug Administration announced today that it is requiring class-wide changes to drug labeling, including patient information, to help inform health care providers and patients of the serious risks associated with the combined use of certain opioid medications and a class of central nervous system (CNS) depressant drugs called benzodiazepines.

Among the changes, the FDA is requiring boxed warnings – the FDA's strongest warning – and patient-focused Medication Guides for prescription opioid analgesics, opioid-containing cough products, and benzodiazepines – nearly 400 products in total – with information about the serious risks associated with using these medications at the same time. Risks include extreme sleepiness, respiratory depression, coma and death. Today's actions are one of a number of steps the FDA is taking as part of the agency's Opioids Action Plan, which focuses on policies aimed at reversing the prescription opioid abuse epidemic, while still providing patients in pain access to effective and appropriate pain management.

"It is nothing short of a public health crisis when you see a substantial increase of avoidable overdose and death related to two widely used drug classes being taken together," said FDA Commissioner Robert Califf, M.D. "We implore health care professionals to heed these new warnings and more carefully and thoroughly evaluate, on a patient-by-patient basis, whether the benefits of using opioids and benzodiazepines – or CNS depressants more generally – together outweigh these serious risks."

Given the importance of reaching health care professionals and the public with information about the risks of using these products together, today the FDA also issued a Drug Safety Communication. Through the Drug Safety Communication and by requiring patient Medication Guides, the agency also provides information for anyone who is taking, or who knows someone taking, either of these types of medications and encourages them to better understand the risks of taking them together; and, when it is medically necessary, for health care providers to be careful to prescribe them as directed, without increasing the dose or dosing frequency for either drug.

Opioid analgesics are powerful pain-reducing medications that include prescription oxycodone, hydrocodone, and morphine, among other drugs, under both brand and generic names. Certain other opioid medications are also approved to treat cough. Opioid analgesic misuse and abuse have increased significantly in the United States over the past two decades, and represent major public health concerns due to the risk of coma and fatal respiratory depression associated with opioid analgesic overdose. Benzodiazepines are drugs typically prescribed for the treatment of neurological and/or psychological conditions, including anxiety, insomnia and seizure disorders. Both classes of drugs depress the central nervous system (“CNS depressants”); however, each has unique pharmacology, safety risks, and labeling information related to its use. Therefore, the FDA is requiring opioid analgesics, prescription opioid cough products, and benzodiazepines to have slightly different labeling. Additionally, due to the unique medical needs and benefit/risk considerations for patients undergoing medication-assisted therapy treatment (MAT) to treat opioid addiction and dependence, the FDA is continuing to examine available evidence regarding the use of benzodiazepines and opioids used as part of MAT.

The FDA’s data review showed that physicians have been increasingly prescribing them together, and this has been associated with adverse outcomes. Among the data reviewed by the FDA, the agency concluded that from 2004 to 2011, the rate of emergency department visits involving non-medical use of both drug classes increased significantly, with overdose deaths (from taking prescribed or greater than prescribed doses) involving both drug classes nearly tripling during that period. Additionally, the number of patients who were prescribed both an opioid analgesic and benzodiazepine increased by 41 percent between 2002 and 2014, which translates to an increase of more than 2.5 million opioid analgesic patients receiving benzodiazepines.

Clinical guidelines from the U.S. Centers for Disease Control and Prevention (CDC) and existing labeling warnings regarding combined use caution prescribers about co-prescribing opioids and benzodiazepines to avoid potential serious health outcomes. The actions of the FDA today are consistent with the CDC.

In February 2016, the FDA received a citizen petition from numerous local and state public health officials and other stakeholders asking the agency to make certain changes to the existing labeling for benzodiazepines and opioid analgesics. The FDA had already initiated a review of the scientific information on concomitant use of these two drug classes when the agency received the petition, and was encouraged that these public health officials shared the agency’s concerns. Today, the FDA also responded to the citizen petition.

Working with the health care community and federal and state partners to help reduce opioid misuse and abuse and improve appropriate opioid prescribing, while ensuring that patients in pain continue to have appropriate access to opioid analgesics, is a top priority for the FDA and part of HHS’ targeted approach focused on prevention, treatment, and intervention. The agency is committed to continuing to monitor these products and take further actions as needed.

The FDA, an Agency within the U.S. Department of Health and Human Services, protects the public health by assuring the safety, effectiveness, and security of human and veterinary drugs, vaccines and other biological products for human use, and medical devices. The Agency also is responsible for the safety and security of our nation’s food supply, cosmetics, dietary supplements, products that give off electronic radiation, and for regulating tobacco products.

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DR. AUST INTERVENTIONAL PAIN

Please answer each question as honestly as possible. Keep in mind that we are only asking about the past 30 days. There are no right or wrong answers. If you are unsure about how to answer the question, please give the best answer you can.

Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?	<input type="checkbox"/>				
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments)	<input type="checkbox"/>				
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e., another doctor, the Emergency Room, friends, street sources)	<input type="checkbox"/>				
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?	<input type="checkbox"/>				
5. In the past 30 days, how often have you seriously thought about hurting yourself?	<input type="checkbox"/>				
6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?	<input type="checkbox"/>				
7. In the past 30 days, how often have you been in an argument?	<input type="checkbox"/>				
8. In the past 30 days, how often have you had trouble controlling your anger (e.g., road rage, screaming, etc.)?	<input type="checkbox"/>				
9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?	<input type="checkbox"/>				
10. In the past 30 days, how often have you been worried about how you're handling your medications?	<input type="checkbox"/>				
11. In the past 30 days, how often have others been worried about how you're handling your medications?	<input type="checkbox"/>				
12. In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?	<input type="checkbox"/>				
13. In the past 30 days, how often have you gotten angry with people?	<input type="checkbox"/>				
14. In the past 30 days, how often have you had to take more of your medication than prescribed?	<input type="checkbox"/>				
15. In the past 30 days, how often have you borrowed pain medication from someone else?	<input type="checkbox"/>				
16. In the past 30 days, how often have you used your pain medicine for symptoms other than for pain (e.g., to help you sleep, improve your mood, or relieve stress)?	<input type="checkbox"/>				
17. In the past 30 days, how often have you had to visit the Emergency Room?	<input type="checkbox"/>				

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