portland PAIN CARE | Joseph P. Stapleton, MD

UNDERSTANDING YOUR INSURANCE COVERAGE

Your insurance policy is an agreement between you and your insurance company. The policy lists a package of medical benefits, such as tests, drugs and treatment services. The insurance company agrees to cover the cost of certain benefits listed in your policy. These are called "covered services".

Your policy also lists the kinds of services that are not covered by your insurance company. You have to pay for any uncovered medical care that you receive. Keep in mind that a medical necessity is not the same as a medical benefit. A medical necessity is something that your provider has decided is necessary. A medical benefit is something that your insurance plan has agreed to cover. In some cases, your provider might decide that you need medical care that is not covered by your insurance policy.

Insurance companies determine what tests, drugs and services they will cover. These choices are based on their understanding of the kinds of medical care that most patients need. Your insurance company's choices may mean that the test, drug or service you need isn't covered by your policy.

Your provider will try to be familiar with your insurance coverage so he or she can provide you with covered care. However, there are so many insurance plans that it's not possible for your provider to know the specific details of each plan. By understanding your insurance coverage, you can help your provider recommend medical care that is covered by your plan.

- Take the time to read your insurance policy. It's better to know what your insurance company will pay for before you receive a service, get tested, or fill a prescription. Some kinds of care may have to be approved by your insurance company before your provider can provide them.
- If you still have questions about your coverage, call your insurance company and ask a representative to explain it.
- Remember that your insurance company, not your provider, makes decisions about what will be paid for and what will not.
- Remember that your physician not your insurance company, makes medical decisions and recommendations about what will benefit your health status.

Most of the things your provider recommends will be covered by your plan, but some may not. When you have a test or treatment that isn't covered or if you get a prescription filled for a drug that isn't covered, your insurance company won't pay the bill. This is often called "denying the claim." You can still obtain the treatment your provider recommended, but you will have to pay for it yourself.

If your insurance company denies your claim, you have the right to appeal (challenge) the decision.
Before you decide to appeal, know your insurance company's appeal process. This should be discussed in your plan handbook.

Johnson Creek Office
9300 SE 91st Ave, Suite 400
Happy Valley, OR 97086

Hillsboro Office
1849 NE 106th Ave, Suite 201
Hillsboro, OR 97006

Providence Plaza Office
5050 NE Hoyt, Suite 418
Portland, OR 97213

Wilsonville Office
8995 SW Miley Rd, Suite 202
Wilsonville, OR 97070

Phone: 503-775-6500 Fax: 503-775-2275

portland PAIN CARE

FINANCIAL AGREEMENT

Thank you for choosing Portland Pain Care! We are committed to providing you with the best possible care.
Please read the following carefully, as it is an agreement that you are responsible for payment and will pay in a timely manner.

Private Insurance, Workers' Compensation, Auto Accidents and Third Party Liability:

- Current proof of medical coverage must be presented at the front reception desk. If the insurance plan requires a co-payment, it will be collected at time of service. If proof of insurance or the co-pay are not provided at the time of service, the appointment may be rescheduled.
- Copayments and outstanding balances are due prior to procedure scheduling or rendering new services.
- The patient, or legal guardian, is responsible for contacting their insurance company and understanding their plan and what it covers. Additionally, the patient is responsible for contacting their primary care physician and requesting a referral if required. If such referrals are not in place, some insurance companies may deny payment and the patient will then be responsible for the entire bill.
- The patient is responsible for any services received at Portland Pain Care. We will bill insurance as a courtesy. We cannot delay charges while liability claims or legal actions are pending. Full payment remains the responsibility of the patient, including co-insurance, deductibles or any "non-covered services" per the insurance policy provisions.

Please notify our office of any changes in your health insurance carrier immediately

No Insurance- full payment due at time of service: Patients are responsible for all charges related to the first and all subsequent visits. If a procedure is recommended additional deposit or pre-payment is required prior to scheduling.

Monthly Statements: After insurance has paid or at month end, patients will receive a monthly statement indicating balance due, which is payable upon receipt. Itemized bills are not automatically mailed. However, patients may request an itemized copy by calling our billing department.

***Payment Options*:**

- **Payment in full** – Cash, Personal Check, Care Credit, Debit or Credit Card.
- **Three equal payments** within 90 days from time of service, autopay required.
- **Extended payment plan**, subject to a minimum payment schedule and autopay.

Refunds:
A credit balance under $5.00 will be applied to your account which can be used at your next appointment. If no appointment is scheduled within 6 months, we will issue a refund.

Patients will be charged $25 for any returned check

I acknowledge receipt and understanding of the above financial policy. I agree to the terms as noted above. I authorize my insurance benefits be paid directly to Portland Pain Care. I agree to all collections costs in the event of default of payment.

If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty-dollar ($50) fee; this will not be covered by your insurance company.
Call: 503-775-6500

Signed_____ **Date**_____

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HIPAA Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to undergo training so that they may understand and comply with government rules and regulations regarding Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all that we can to secure and protect your privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information about treatment, payment, or health care operations, to provide health care that is in your best interest. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain personal consent.

***Other Uses or Disclosures**:* We may also use or disclose your information for certain other purposes allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following:
To avoid a serious threat to your health or safety or the health or safety of others.
As required by state or federal law such as reporting abuse, neglect or certain other events.

- As allowed by workers compensation laws for use in workers compensation proceedings.
- For certain public health activities such as reporting certain diseases.
- For certain public health oversight activities such as audits, investigations, or licensure actions.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.
- For certain specialized government functions such as the military or correctional institutions.
- For research purposes if certain conditions are satisfied.
- In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent. If you have any questions regarding this form, please ask to speak to our HIPAA Compliance Officer. We will be happy to provide you with a copy of this form upon your request.

_____ _____

Patient Name (Print) Date

_____ _____

Patient Name (Signature) Witness (Office Staff Member)

Updated 7-23-2018

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DISCLOSURE OF PHYSICIAN OWNERSHIP FORM

Please carefully review the information contained in this notice.

1. In order to allow you to make a fully informed decision about your health care, Dr. Stapleton would like to advise you that at some point during the course of your treatment, you may be referred to one of the following organizations, of which he has a financial interest.

For your reference, the following is a list of organizations of which Dr. Stapleton is an investor:

- Precision Laboratories
- Clearview MRI
- Willamette Neuromonitoring

2. Please note that you have the right to choose the provider of your healthcare service. Therefore, you have the option to use a healthcare facility other than those listed above for your services.

3. You will not be treated differently if you choose to use a different facility. If desired, we can provide information about alternative options.

4. If you have any questions concerning this notice, please feel free to ask our staff at Portland Pain Care. We welcome you as a patient and value our relationship with you.

By signing this Disclosure of Physician Ownership Form, you acknowledge that you have read the foregoing notice.

_____ _____

Name of Patient *Signature of Patient*

_____ _____

Name of Parent or Guardian (if applicable) *Signature of Parent or Guardian (if applicable)*

_____

Date

_____OFFICE USE ONLY_____

The patient identified above was provided with verbal disclosure of the above information on this date.

_____ _____

Employee Signature *Date*

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PATIENT REGISTRATION FORM

Primary Care Provider:	Referred By:	Date:

Is treatment related to a work comp injury? YES NO If yes, Attending Physician:

PATIENT INFORMATION

Legal Name: (Last, First, Middle)	Preferred Name:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Email Address:	Age: / Date of Birth:	Gender: ☐ Male ☐ Female
Street Address:	City/State/Zip Code:	
Social Security #:	Cell Phone:	
Home Phone:	Work Phone:	Employer:

RESPONSIBLE PARTY

Legal Name: (Last, First, Middle) ☐ (Check if Same as Patient)	Date of Birth:	Gender: ☐ Male ☐ Female	Relationship to Patient:
Street Address:	City/State/Zip Code:		
Social Security #:	Cell Phone:	Email Address:	
Home Phone:	Work Phone:	Employer:	

INSURANCE COVERAGE

Primary Insurance:	Phone:		
Billing Address:	City/State/Zip Code:		
Subscriber Legal Name: (Last, First, Middle) ☐ (Check if Same as Patient)	Date of Birth:	Gender: ☐ Male ☐ Female	Relationship to Patient:
ID & Group #:	Employer:	Work Phone:	
Secondary Insurance:	Phone:		
Billing Address:	City/State/Zip Code:		
Subscriber Legal Name: (Last, First, Middle) ☐ (Check if Same as Patient)	Date of Birth:	Gender: ☐ Male ☐ Female	Relationship to Patient:
ID & Group #:	Employer:	Work Phone:	
Accident Insurance: ☐ Auto ☐ Worker's Compensation ☐ Other	Name of Accident Insurance Company:		
Billing Address:	City/State/Zip Code:		
Claim #: / Date of Injury:	Phone:	Adjuster/Case Manager:	

DO YOU HAVE, OR HAVE YOU APPLIED FOR STATE HEALTH COVERAGE THROUGH HEALTHSHARE, MEDICAID OR OREGON HEALTH PLAN? ☐ **YES** ☐ **NO**

EMERGENCY CONTACT INFORMATION

Name of Local friend/relative:	Phone:

PERSONAL HEALTH INFORMATION RELEASE & CONTACT INFORMATION

Portland Pain Care *can* share or discuss my health information with the following people:

Permission to Pick Up RX: **YES** **NO**

The above information is true to the best of my knowledge. I understand I am financially responsible for any balance not covered by my insurance carrier.

MEDICARE – I request that the payment of authorized medical benefits be made on my behalf to Joseph P Stapleton MD PC, for any services related to me. I hereby authorize Joseph P Stapleton MD PC to release to the health care administrator and its agents any medical information needed to determine these benefits payable for related services under Title XVIII of Social Security Act.

COMMERCIAL – I hereby authorize the release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to Joseph P Stapleton MD PC.

Patient/Guardian Signature: _____ Date: _____

portland PAIN CARE | Joseph P. Stapleton, MD

Please fill this form out before your appointment and bring it with you.

New Patient Intake Form

Patient Information

Name:	**Date:**
Referring Physician:	**Primary Care Provider:**
Height:	**Weight:**

Current Medications/Allergies:

Have you had a flu shot this season? ☐ Yes ☐ No **Have you ever had a pneumonia immunization?** ☐ Yes ☐ No

Medication	Dose	How often		Medication	Dose	How often

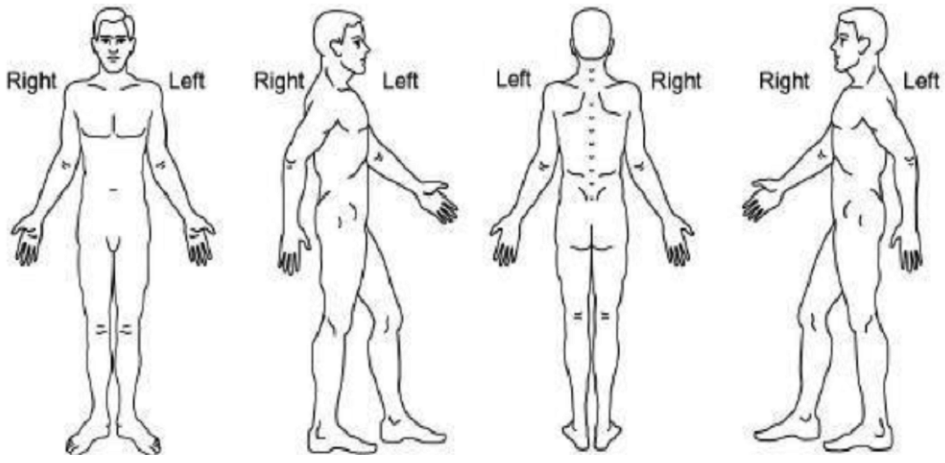
Do you currently take any blood thinning medication (Aspirin, Coumadin, Warfarin, Plavix, Lovonox)? ☐ Yes ☐ No **If yes, when was your last dose?** _____

Allergies:	☐ I have No Known Drug Allergies

Pain History

Chief Complaint: (Reason for your visit today)

Use diagram to indicate the area of your pain. Mark location(s) with an 'X'



---*For Office Use Only*---

PHQ-9_____ Imaging _____ Onset _____ PT _____ Blood Thinners _____

Pain History Continued...

Circle the number that best describes your pain. (0 being no pain, 10 being worst pain)

Average Pain	0	1	2	3	4	5	6	7	8	9	10	With Activity	0	1	2	3	4	5	6	7	8	9	10
Worse Pain	0	1	2	3	4	5	6	7	8	9	10	With Meds	0	1	2	3	4	5	6	7	8	9	10
Current Pain	0	1	2	3	4	5	6	7	8	9	10	Without Meds	0	1	2	3	4	5	6	7	8	9	10

Activities that make pain worse:

- ☐ NONE
- ☐ Bending forward
- ☐ Exertion/Exercise
- ☐ Getting out of chair
- ☐ Lifting
- ☐ Lying down
- ☐ Moderate physical activity
- ☐ Nonspecific activity
- ☐ Position change
- ☐ Reaching
- ☐ Significant physical activity
- ☐ Sitting
- ☐ Standing
- ☐ Turning the head
- ☐ Twisting
- ☐ Walking

Activities that make pain better:

- ☐ NONE
- ☐ Bending forward
- ☐ Injections
- ☐ Lying down
- ☐ Medications
- ☐ Moving
- ☐ Position change
- ☐ Physical activity
- ☐ Procedures
- ☐ Rest
- ☐ Sitting
- ☐ Standing

Qualities of your pain:

- ☐ NONE
- ☐ Aching
- ☐ Burning
- ☐ Dull
- ☐ Sharp
- ☐ Shooting
- ☐ Stabbing
- ☐ Throbbing
- ☐ Pressure
- ☐ Crushing
- ☐ Cramping
- ☐ Spasmodic
- ☐ Pulling
- ☐ Tender
- ☐ Tight
- ☐ Knife like
- ☐ Hot
- ☐ Sore
- ☐ Radiating - Where: _____
- ☐ Tingling - Where: _____
- ☐ Numbness - Where: _____

Duration of your pain *Please check only one

☐ No pain ☐ Constant pain ☐ Intermittent pain

Functional Assessment: *Place an X in the box that best answers each question.*

During the Past Month, how much did pain interfere with the following activities?

Activity	None	Little	Moderate	A lot
Physical exercise				
Going to work				
Performing household chores				
Recreation				
Shopping				
Sleep				
Other				

Review of Systems--Check the box if you *currently* are experiencing any of the following:

- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Poor appetite
- ☐ Poor sleep
- ☐ Weight gain
- ☐ Weight loss
- ☐ Hearing loss
- ☐ Sore throat
- ☐ Blurred vision
- ☐ Decreased vision
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Swelling in legs
- ☐ Rash
- ☐ Itching
- ☐ Lesions
- ☐ Bruise easily
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Stiffness
- ☐ Weakness
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Loss of bowel/bladder
- ☐ Heartburn
- ☐ Constipation
- ☐ Sexual problems
- ☐ Problems urinating
- ☐ Headache
- ☐ Dizziness
- ☐ Loss of consciousness
- ☐ Numbness
- ☐ Tingling
- ☐ Depression
- ☐ Anxiety

Screening: *Place an X in the box that best answers the question*

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several days	More than half the days	Nearly Every Day
Little interest or pleasure in doing things.....				
Feeling down, depressed, or hopeless.....				
Trouble falling or staying asleep, or sleeping too much....				
Feeling tired or having little energy.....				
Poor appetite or overeating.....				
Feeling bad about yourself — or feeling that you are a failure or have let yourself or your family down.....				
Trouble concentrating on things, such as reading the newspaper or watching television.....				
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.....				
Thoughts that you would be better off dead of or hurting yourself in some way.....				

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?

Not Difficult At All	Somewhat Difficult	Very Difficult	Extremely Difficult

History –Check the box if you have ever been diagnosed with the following:

HEAD/EARS/EYES/NOSE/THROAT

- ☐ Headaches
- ☐ Migraines
- ☐ Seasonal allergies
- ☐ Sinusitis

CARDIOVASCULAR

- ☐ Angina
- ☐ Arrhythmia
- ☐ Coronary artery disease
- ☐ Deep venous thrombosis
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Past heart attack
- ☐ Mitral valve prolapse
- ☐ Heart murmur
- ☐ Pace maker
- ☐ Peripheral vascular disease

RESPIRATORY

- ☐ Asthma
- ☐ COPD
- ☐ Obstructive sleep apnea

GASTROINTESTINAL

- ☐ Gallstones
- ☐ GERD
- ☐ GI bleed
- ☐ Hiatal hernia
- ☐ Irritable bowel syndrome
- ☐ Pancreatitis
- ☐ Ulcers

GENITOURINARY

- ☐ Enlarged prostate
- ☐ Frequent bladder infections
- ☐ Kidney stones
- ☐ Renal failure
- ☐ Renal insufficiency

ENDOCRINE

- ☐ Diabetes
- ☐ Obesity
- ☐ Thyroid disorder

BLOOD

- ☐ Anemia
- ☐ Bleeding disorder
- ☐ Blood transfusion

INFECTIONS

- ☐ Hepatitis
- ☐ HIV
- ☐ Shingles

NEUROLOGICAL

- ☐ Stroke
- ☐ Parkinson's disease
- ☐ Peripheral neuropathy
- ☐ Seizure disorder
- ☐ TIA

PSYCHOLOGICAL

- ☐ ADD
- ☐ Anxiety
- ☐ Bi-Polar disorder
- ☐ Dementia
- ☐ Depression
- ☐ Schizophrenia

CANCER

- ☐ Bladder cancer
- ☐ Breast cancer
- ☐ Colon cancer
- ☐ Lung cancer
- ☐ Melanoma
- ☐ Prostate cancer

MUSCULOSKELETAL

- ☐ Back pain
- ☐ Connective tissue disorder
- ☐ Fibromyalgia
- ☐ Kyphoscoliosis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid arthritis
- ☐ Scoliosis

History - Prior Procedures (Example: Epidural Steroid Injections, Trigger Point Injections)

List all past procedures for pain & approximate dates	

History - Surgery

List all past surgeries & approximate dates.	

History -What Prior Treatments Have You Had?

Treatment	Helpful	Not Helpful
Acupuncture	☐	☐
Biofeedback relaxation therapy	☐	☐
Botox injections	☐	☐
Chiropractic	☐	☐
Heat	☐	☐
Home exercise	☐	☐
Ice	☐	☐

Treatment	Helpful	Not Helpful
Massage	☐	☐
Minimally invasive procedures	☐	☐
Occupational therapy	☐	☐
Physical therapy	☐	☐
Surgery	☐	☐
TENS	☐	☐

History –What Prior Medications Have You Taken?

Medication	Helpful	Not Helpful	Medication	Helpful	Not Helpful
NSAIDS	☐	☐	Percocet| Oxycodone	☐	☐
Celebrex | Celecoxib	☐	☐	Duragesic	☐	☐
Diclofenac	☐	☐	Methadone	☐	☐
Flector Patch	☐	☐	Morphine	☐	☐
Motrin| Ibuprofen	☐	☐	Oxycontin	☐	☐
Mobic | Meloxicam	☐	☐	Oxymorphone| Opana	☐	☐
Relafen| Nabumetone	☐	☐	Cymbalta| Duloxetine	☐	☐
Naproxen	☐	☐	Lyrica | Pregablin	☐	☐
Voltaren Gel	☐	☐	Neurontin| Gabapentin	☐	☐
Flexeril| Cyclobenzaprine	☐	☐	Savella	☐	☐
Skelaxin| Metaxalone	☐	☐	Topamax	☐	☐
Soma	☐	☐	Trileptal	☐	☐
Zanaflex| Tizanidine	☐	☐	Lidoderm Patch	☐	☐
Actiq	☐	☐	Tramadol| Ultracet	☐	☐
Hydrocodone| Vicodin	☐	☐	Tylenol | Acetaminophen	☐	☐
Hydromorphone| Dilaudid	☐	☐			

Social History—Check the box that best answers questions about you.

- ☐ Single
- ☐ Married
- ☐ Domestic partner
- ☐ Widowed
- ☐ Separated
- ☐ Divorced
- ☐ Children, How Many _____

- ☐ Retired
- ☐ Disabled
- ☐ Unemployed
- ☐ Self-employed
- ☐ Employed part-time
- ☐ Employed full-time

Current occupation _____

Previous occupation _____

- ☐ Elementary school
- ☐ Some high school
- ☐ High school
- ☐ GED
- ☐ Some college
- ☐ College degree
- ☐ Master's degree
- ☐ Doctorate degree

- ☐ Currently smoke every day
- ☐ Currently smoke some days
- ☐ Former smoker
- ☐ Never smoker

Cigarettes packs per day _____

Pipe times per day _____

Chew cans per day _____

Total years _____

- ☐ No alcohol use
- ☐ Rarely use alcohol
- ☐ Socially use alcohol
- ☐ Daily use alcohol

Details: _____

- ☐ I do not use recreational drugs
- ☐ I use marijuana
- ☐ I use cocaine
- ☐ I use heroin
- ☐ I use morphine
- ☐ I use methamphetamines
- ☐ I use LSD
- ☐ I use mushrooms
- ☐ I use ecstasy
- ☐ I use _____

- ☐ I never exercise
- ☐ I exercise 1-2 times per week
- ☐ I exercise 3-5 times per week
- ☐ I exercise 6-7 times per week
- ☐ Aerobics
- ☐ Biking
- ☐ Running
- ☐ Hiking
- ☐ Swimming
- ☐ Climbing
- ☐ Treadmill/Elliptical
- ☐ Walking
- ☐ Weight lifting
- ☐ _____
- ☐ _____

Family History—Check the box that best answers questions about your family.

☐ Unknown, adopted ☐ Unknown

Condition	Father	Mother	Brother	Sister	Other
Arthritis					
Asthma					
Bleeding disorder					
Coronary artery disease					
Cancer					
Congestive heart failure					
COPD					
Diabetes					
High blood pressure					
Irritable bowel syndrome					
Kidney disease					
Heart attack (MI)					
Peripheral artery disease					
Stroke					
Thyroid disease					

History - Check box if you have been diagnosed with the any of the following:

☐ Depression Describe: _____

☐ Anxiety Describe: _____

☐ Psychosis Describe: _____

Check which applies

☐ I am currently not in treatment ☐ I am currently seeing a psychiatrist ☐ I am currently seeing a psychologist

Check which applies

☐ I have had thoughts of suicide ☐ I have not had thoughts of suicide

Check which applies

☐ I am coping with my chronic pain ☐ I am frustrated with my chronic pain