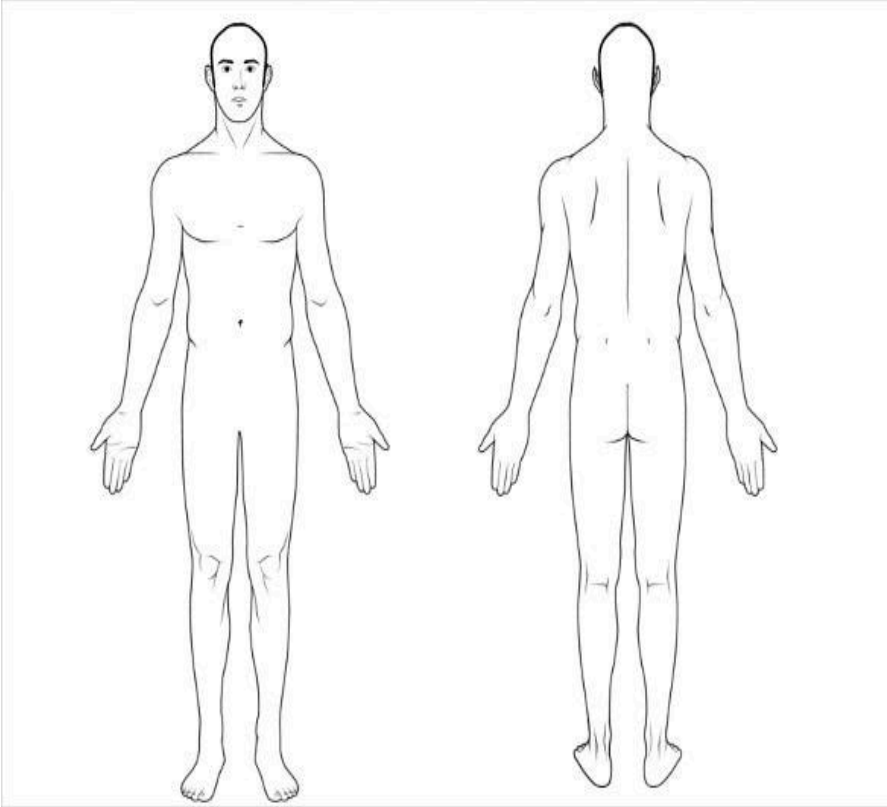
THE ORTHOPAEDIC INSTITUTE OF WESTERN KENTUCKY

100 Clint Hill Blvd.
Paducah, Kentucky 42001
270-450-7229

MRN:_____

Patient Name: _____ Date of Birth:_____ Date Today:_____

Please circle <u>all</u> terms that describe your pain:

1 FLICKERING QUIVERING THROBBING BEATING POUNDING 2 JUMPING FLASHING SHOOTING 3 PRICKING BORING DRILLING STABBING LANCINATING 4 SHARP CUTTING LACERATING 5 PINCHING PRESSING GNAWING CRAMPING CRUSHING 6 TUGGING PULLING WRENCHING 7 HOT BURNING SCALDING SEARING 8 TINGLING ITCHY SMARTING STINGING 9 DULL SORE HURTING ACHING HEAVY 10 TENDER TAUT RASPING SPLITTING	11 TIRING EXHAUSTING 12 SICKENING SUFFOCATING 13 FEARFUL FRIGHTFUL TERRIFYING 14 PUNISHING GRUELING CRUEL VICIOUS KILLING 15 WRETCHED BLINDING 16 ANNOYING TROUBLESOME MISERABLE INTENSE UNBEARABLE 17 SPREADING RADIATING PENETRATING PIERCING 18 TIGHT NUMB DRAWING SQUEEZING TEARING 19 COOL COLD FREEZING 20 NAGGING NAUSEATING AGONIZING DREADFUL TORTURING **PATIENT PAIN INDEX:** NO PAIN MILD DISCOMFORTING DISTRESSING	EXCRUCIATING BRIEF MOMENTARY TRANSIENT RHYTHMIC PERIODIC	INTERMITTENT CONTINUOUS STEADY CONSTANT HORRIBLE
		FRONT BACK 	
		COMMENTS:	

For office use only:

PRI: S_____ A_____E_____M_____PRI(T)_____PPI_____
(1-10) (11-15) (16) (17-20) (1-20)

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MRN:_____

PAIN ASSESSMENT

Referring Physician: _____ Primary Care Physician: _____

DIRECTIONS: Patient must complete **ALL** items below.

Current Medications:

Blood Thinners:	**Other Medications:**	**Allergies:**
_____	_____	_____
_____	_____	_____
Pain Medications:	_____	_____
_____	_____	_____
_____	_____	
Herbal Supplements:	_____	
_____	_____	
_____	_____	
_____	_____	

Are you currently working? Yes___ No___

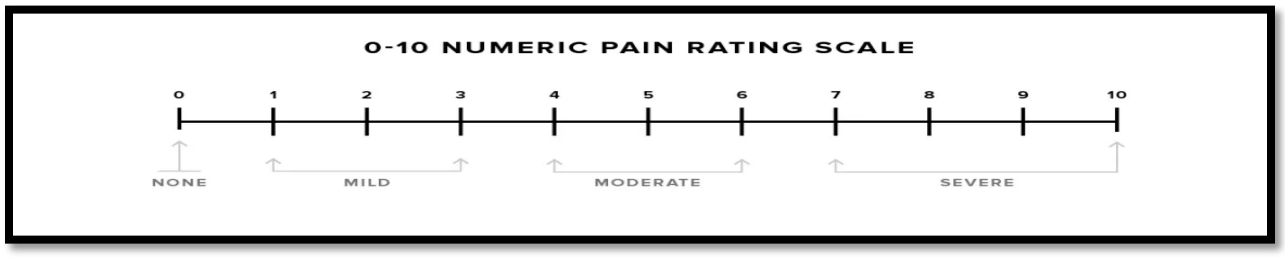
If no, please indicate why: _____

Are you currently in Physical Therapy? Yes___ No___

Location: _____

Are you currently undergoing biofeedback/relaxation therapy? Yes___ No___

INDICATE A NUMBER THAT BEST RATES YOUR PAIN:



DO NOT WRITE BELOW THIS LINE

B/P:_____ Temp:_____ P:_____ Provider Notes:

HT:_____ WT:_____

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MRN: _____

SOCIAL HISTORY		
Alcohol Use	○ None	○ Yes Number of drinks: _____per day Frequency: _____
Tobacco Use	○ None	○ Yes Smoke, or Other: _____ # of packs per day_____
Other Drug Use (Recreational/illicit)	○ None	○ Yes What drugs: _____ Frequency: daily weekly monthly rarely

SURGICAL HISTORY		
1._____	4. _____	7. _____
2._____	5. _____	8. _____
3. _____	6. _____	9. _____

MEDICAL HISTORY (circle all that apply)		
AIDS/HIV	Diabetes	Migraines
Alcohol Abuse	Drug Abuse	Obesity
Alzheimer's Disease	High Cholesterol	Osteopenia/Osteoporosis
Anxiety	Fibromyalgia	Parkinson's Disease
Asthma	GERD	Psoriasis
Arthritis: (Rheumatoid or Psoriatic)	Gout	Schizophrenia
Bipolar Disorder	Heart Attack	Seizure Disorder
Cancer, Type_____	Heart Disease	Sleep Apnea
Congestive Heart Failure	Hepatitis, Type_____	Stroke
Deep Vein Thrombosis (DVT)	Hypertension	Systemic Lupus Erythematosus
Depression	Kidney Disease	Thyroid Disease
	Liver Disease	Other: _____

FAMILY HISTORY (Immediate Family Only)		
Alcoholism	Heart Disease	Parkinson's Disease
Alzheimer's Disease	High Cholesterol	Stroke
Cancer, Type: _____	Hypertension	Thyroid Disease
Depression	Kidney Disease	Other: _____
Diabetes	Liver Disease	
Drug Abuse	Osteopenia/Osteoporosis	

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MRN: _____

REVIEW OF SYSTEMS

Circle any symptoms/conditions which apply or that you are currently experiencing:
General o Chills o Fever o Night Sweats o Weight Gain o Weight Loss o Fatigue o Weakness o Malaise (discomfort)
HEENT o Blurred Vision o Fascial Pain o Nasal Congestion o Double Vision o Headache o Ringing Ears o Dysphagia (difficulty swallowing) o Hearing Loss o Vertigo o Ear Drainage o Hoarseness o Vision Loss
Respiratory O Chest Pain o Dyspnea (shortness of breath) o Known TB Exposure o Cough o Wheezing O Recent Infections
Cardiovascular o Chest Pain o Heart Murmur o Syncope o Cyanosis (Bluish) o Leg Swelling o Irregular Heartbeat/Palpitations
Gastrointestinal o Abdominal Pain o Diarrhea o Loss of Appetite o Constipation o Heartburn o Nausea o Black Tarry Stools o Jaundice o Vomiting
Genitourinary o Dysuria (Painful Urination) o Urge Incontinence o Frequent Urination 0 Urinary Incontinence o Hematuria (Blood in Urine)
Metabolic/Endocrine o Cold Intolerant o Hair Loss o Heat Intolerant
Neurological o Difficulty Walking o Memory Loss o Seizures o Dizziness o Muscle Weakness o Tremors o Poor Coordination o Paresthesia (Pins & Needles Feeling)
Psychiatric o Anxiety o Depression o Insomnia
Integumentary o Contact Allergy o Rash o Skin Lesion o Itchy Skin o Skin Infections
Hematologic o Bleeding o Bruising
Immunological o Asthma o Contact Dermatitis o Food Allergies o Bee Sting Allergies o Environmental Allergies o Seasonal Allergies

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MRN:_____

Date _____

Patient Name _____

OPIOID RISK TOOL©

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 – 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder Obsessive Compulsive Disorder Bipolar Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
TOTAL		**[ ]**		

Total Score Risk Category Low Risk 0 – 3 Moderate Risk 4 – 7 High Risk ≥ 8

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MRN:_____

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?					
2. In the past 30 days, how often do people complain that you are not completing necessary tasks?(work, appointments etc.)					
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? (ER, streets etc.)					
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?					
5. In the past 30 days, how often have you seriously thought about hurting yourself?					
6. In the past 30 days, how much of your time was spent thinking about opioid medications? (having enough, taking them, dosing schedule etc.)					
7. In the past 30 days, how often have you been in an argument?					
8. In the past 30 days, how often have you had trouble controlling your anger?					
9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?					
10. In the past 30 days, how often have you been worried about how you're handling your medications?					
11. In the past 30 days, how often have others been worried about how you're handling your medications?					
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?					
13. In the past 30 days, how often have you gotten angry with people?					
14. In the past 30 days, how often have you had to take more of your medication than prescribed?					
15. In the past 30 days, how often have you borrowed pain medication from someone else?					
16. In the past 30 days, how often have you used your pain medicine for symptoms other than pain? (e.g to help you sleep, improve mood or relieve stress)					
17. In the past 30 days, how often have you visited the emergent room?					

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PEG Score

1. What number best describes your pain on average in the past week?

0 1 2 3 4 5 6 7 8 9 10

No pain — Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

PN: _____

Billing Information, Financial Policy, Information Release

Billing Information

An insurance claim for fracture care will typically appear as follow, as it is considered surgery:

1. Exam at the documented level for diagnosis/decisions about the best treatment options.
2. An x-ray is often used to diagnose the fracture and/or a post fracture treatment x-ray to ensure proper alignment.
3. A Fracture Code will be assigned based on the site, type of fracture, and whether the treatment is *closed* or *open*. Open treatment is most often performed in an operating room at a surgery center or hospital. Closed treatment is often done at the emergency room of in the office. However, all fracture treatment is considered "Major Surgery" and will often be reported as surgery on your insurance company's Explanation of Benefits (EOB).
4. The Cast Application for the initial work of applying the cast is included in the above Fracture Code at no charge. Subsequent applications are separately reported and billable.
5. Cast Supplies are reported separately and billable.
6. Subsequent Fracture Care: Most "routine" fractures will require several post operative visits which are included in the fracture fee. There are special rules our office requires to use to report those services.

This office is required by Federal Compliance Law to report the services provided based on the documentation in the medical record. As a matter of policy, we cannot improperly alter a claim with the purpose of obtaining payment. If you discover a bone fide billing error, duplicate charge, or other posting error, we would greatly appreciate you bringing the matter to the attention of our business office staff for further investigation, upon which further, corrective action may be taken. If you receive a questionnaire from your insurance asking how your injury occurred, please complete the form, and return to them promptly. Your insurance company will not pay until the form is returned to them.

Insurance coverage and payment amounts vary greatly by payer. If you have any questions about your coverage, it is best to inquire with your insurance company's representative. Our business office staff is happy to assist in the claims filing process for prompt adjudication and payment of your insurance claim.

Financial Policy

No Surprises Act: The Orthopaedic Institute of Western Kentucky follows the guidelines put in place by the Centers for Medicare and Medicaid Services (CMS) and the State of Kentucky for "out of network" and "self-pay" patients. You will receive a notice explaining your rights as a patient and a "Good Faith Estimate" (GFE).

Contracted Insurances: The Orthopaedic Institute of Western Kentucky is contracted with all major insurance companies. Any co-pays assigned by your specific insurance company is due at the time of service. We accept payment via cash, check, VISA, Mastercard, or Discover.

Workers' Compensation: Charges will be submitted for you **IF** all information has been fully furnished and agreed to by your employer. You are required to provide us the claim number, name, address, and contact information of your compensation carrier. **IF** all information is not provided, we assume and expect payment from you.

"I authorize any treating physician or provider to communicate orally, or in writing, with my employer or its insurance company, claims administrator, medical management consultant, case manager, field nurse case manager, and/or attorneys as to the treatment provided associated with my assumed work-related injury, and do hereby waive my physician-patient privilege."

Authorization: "I authorize Drs. T. DeWeese, S. Patel, B. Kern, B. Strenge, W. Adams, S. Romine, R. Beck, and/or J. Patton to release records pertaining to my health to insurance companies, referring physicians, attorneys, employer, employer's insurance company, case manager, field nurse case manager, claims administrator, and/or my other responsible party. I authorize release of my x-rays to above said persons. I request payment under the medical insurance program to be made directly to the appropriate above said physicians. Should my account become delinquent and referred to collection, I shall pay all reasonable collection expenses, court costs, and attorney fees associated."

"I have read and understand the billing information, financial policy, and information release, and agree to the contents."

Patient Signature: _____ Date: _____

Signature of other Responsible Party: _____ Date: _____

Notice of Privacy Practices

I, _____, have read the notice of privacy practices, and authorize The Orthopaedic Institute of Western Kentucky to disclose the identified information to the persons and for the purpose described herein. I understand that by signing this document, I release The Orthopaedic Institute of Western Kentucky harmless of any release made pursuant to this authorization.

_____ Date: _____

Signature of Patient or Legal Representative

_____

Description of Legal Representative's Authority