Beacon Pain Clinic
Patient Registration Form

Patient Name_____
First Middle Last

Phone (home)_____(cell)_____(work)_____

Email_____

Social Security #_____ DOB_____

Address_____

City_____ State_____ Zip_____

Emergency Contact_____ Phone_____

Emergency Contact Relation_____

Insurance Information

Guarantor (person who holds insurance policy) ____self ____parent ____spouse

Guarantor name_____ DOB_____

Employer_____ SSN_____

Patient Employer_____

Primary Insurance_____ Policy#_____

Group#_____

Secondary Insurance_____ Policy#_____

Group#_____

I authorize payment directly to Rebekah Guy, MD, doing business as Beacon Pain Clinic, for all charges for medical products and services. I understand that I am financially responsible to Dr. Guy for all charges that are billed to the insurance company. I further understand that medical decisions are made between the doctor and the patient. Some insurance companies might call some treatments “medically unnecessary” without regard for what the doctor and patient have decided upon. Some procedures we perform, while proven to be safe and effective and considered “experimental” by insurance companies are not covered. I authorize Dr. Guy to provide information, including my medical information, to the insurance company and to discuss our treatment plan. I understand that I am responsible for these charges if the insurance company denies my claim for any reason. I understand that it is my responsibility to verify if my insurance will cover my procedures or services rendered. If I am a Medicare patient, I will be told in advance if a service or procedure is known not to be covered and will submit payment at the time of service or procedure. I hereby request that the payment of authorized benefits for services rendered or in my behalf by Dr. Guy, be made to the provider. I authorize any holder of medical information about me to release it to the healthcare financing administration, my insurance carrier or its agents, any information (in compliance with HIPAA and other regulations) a required to determine these benefits or the benefits payable for related services.

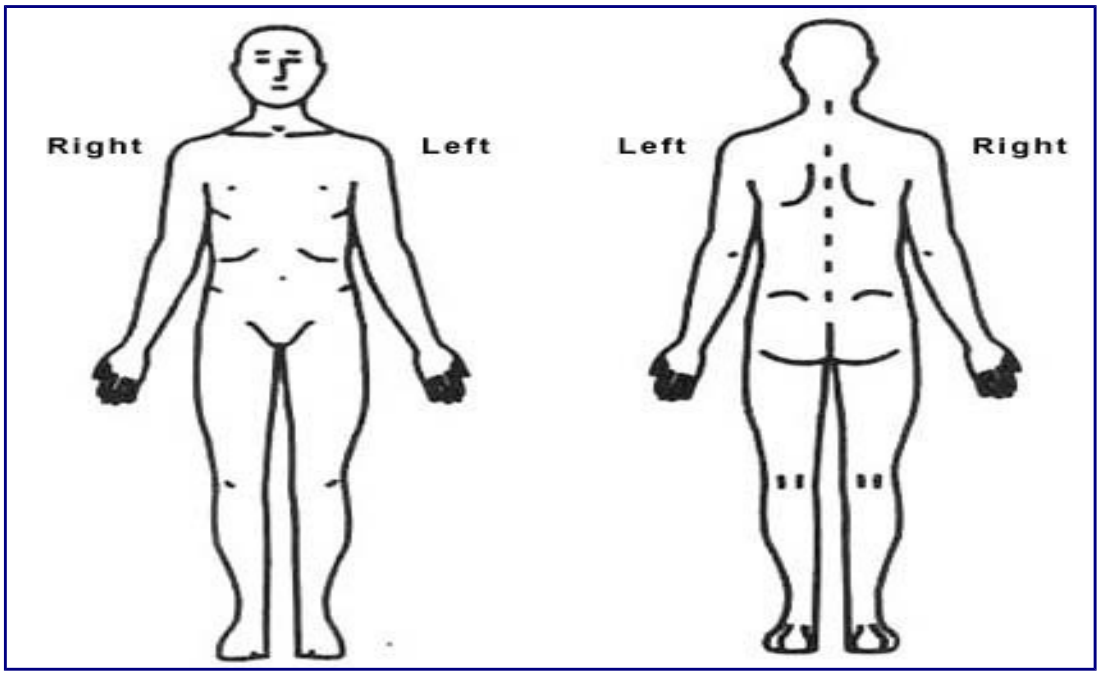
Patient Signature_____ Date_____

Guarantor Signature_____ Date_____

Beacon Pain Clinic
Pain Diagram/Scale

Patient Name:_____ Date:_____

DOB:_____ Height:_____ Weight:_____



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

Check all of the following that describe your pain:

Dull/aching	Hot/burning	Shooting	Throbbing
Cramping	Numbness	Spasming	Tightness
Squeezing	Tingling/pins and needles	Stabbing/sharp	

When is your pain at its worst?

Morning Daytime Evening Middle of the night Always the same

How often does the pain occur?

Constant Changes in severity but always present Intermittent (comes and goes)

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right now_____ The best it gets _____ The worst it gets _____

Do you have any of the following associated symptoms?

Weakness in the arm/leg	Bladder incontinence	Balance problems
Joint swelling/stiffness	Bowel incontinence	Fevers/chills

Name_____ DOB_____

Please mark any current or previous medical conditions:

Cancer – type_____
Diabetes – type_____
Anemia
Heart attack
Coronary artery disease
High blood pressure
Peripheral vascular disease
Stroke/TIA
Heart valve disorders
GERD (acid reflux)
Gastrointestinal bleeding
Stomach ulcers
Constipation
Chronic kidney disease
Kidney stones
Urinary incontinence
Dialysis
Multiple sclerosis

Peripheral neuropathy
Seizures
Depression
Anxiety
Schizophrenia
Bipolar disorder
Headaches
Migraines
Head injury
Hyperthyroidism
Hypothyroidism
Glaucoma
Asthma
Bronchitis/pneumonia
Emphysema/COPD
Bursitis
Carpel tunnel syndrome
Fibromyalgia

Osteoarthritis
Osteoporosis
Rheumatoid arthritis
Chronic joint pains
Other diagnosed conditions:

_____

_____

_____

_____

_____

_____

Surgical History

Approximate date	Surgeon	Procedure
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

Name_____ DOB_____

Family History

Mark all appropriate diagnoses as they pertain to your first degree relatives (mother, father, siblings)

Arthritis
Alzheimer/Dementia
Cancer
Depression
Diabetes
Epilepsy/seizures
Headaches/migraines
Heart trouble
High blood pressure
High cholesterol
Kidney problems
Liver problems
Osteoporosis
Rheumatoid arthritis
Stroke
Trouble with blood clotting
No significant family medical history

Social History

Are you: single____ married____ widowed____ divorced____ separated____ significant other____

What kind of work do you do?_____

What types of recreational activity/relaxation do you partake in? How often?_____

_____

Do you Drink? No____ Yes____ Drinks per day____ Socially____ Rarely____ Moderately____

Do you Smoke? No____ Yes____ How many a day?_____ Less than a pack a week?_____

Does anyone in your family have a substance abuse history? No____ Yes____ Whom?_____

Do you have a history of street drug abuse? No____ Yes____ Drug?_____

Do you have a history of prescription drug abuse? No____ Yes____ Drug?_____

Have you ever been hospitalized for a psychiatric condition? No____ Yes____

When?_____ Where?_____

Have you used or are you using any illegal substances? No____ Yes____ Which ones?_____

Is there any substance abuse in your household? No____ Yes____ Which kind?_____

Have you ever been treated for, or do you feel you have problems with alcoholism or any type of substance abuse? No____ Yes____ Details_____

Name_____ DOB_____

Please list all current medications you are taking, including vitamins and over the counter medications:

Medication	Dose	#per day	Physician	Medication	Dose	#per day	Physician

Please list any blood thinners or anti-coagulants you are currently taking, including who prescribes them:

- ▫ Aspirin _____
- ▫ Coumadin _____
- ▫ Eliquis _____
- ▫ Plavix _____
- ▫ Xarelto _____
- ▫ None

List your allergies and the reaction:

_____

_____

_____

_____

Name_____ DOB_____

Review of Symptoms

Please circle any of the following problems or symptoms which you may have:

General Health: weakness, fatigue, body aches, headaches, poor appetite, excessive appetite
Other:_____

Skin: hives, eczema, dryness, itching, rash, changes in moles or skin color, changes in nails
Other:_____

Head: headaches, migraines, fainting/loss of consciousness, dizziness, passing out
Other:_____

Eyes: blurred vision, double vision, change in vision, pain
Other:_____

Ears: changes in hearing, pain, ringing, drainage, vertigo
Other:_____

Nose: congestion, runny nose, bloody nose, sinus problems, snoring
Other:_____

Throat and Mouth: difficulty swallowing, hoarseness, dry mouth, sores in mouth
Other:_____

Respiratory: shortness of breath, asthma, wheezing, sleep apnea, cough, pneumonia
Other:_____

Gastrointestinal: abdominal pain, heartburn, nausea/vomiting, blood in stool, IBS, diarrhea, hernia, constipation, ulcer, jaundice, excessive gas, bloating, colitis
Other:_____

Muscles, Bones and Joints: arthritis, muscle/joint pain, cramps, joint swelling, fractures, gout, osteoporosis, fibromyalgia, polio (Specific joint areas: shoulder, elbow, wrist, hand, fingers, hip, knee, ankle, foot, toes)
Other:_____

Back and Neck: Back pain or stiffness, neck pain or stiffness, restricted motion, disc problems, sciatica, fracture
Other:_____

Psychiatric and Mood: depression, anxiousness, poor energy or motivation, short temper, compulsive behavior, change in mood, problems sleeping, poor concentration
Other:_____

Cardiovascular: pacemaker, chest pain, high blood pressure, blood clots, murmur, heart attack, high cholesterol, leg edema/swelling, rheumatic fever
Other:_____

Other conditions or problems not listed:_____

_____

Name_____ DOB_____

Diagnostic Tests and Imaging

Mark all of the following tests that you have related to your current pain and complaints:

MRI of the: _____ Date: _____

Xray of the: _____ Date: _____

CT scan of the: _____ Date: _____

EMG/NCS of the: _____ Date: _____

Other diagnostic testing: _____ Date: _____

I have not had ANY diagnostic tests for my current pain complaint

Physical Therapy & Chiropractic Care

Mark all of the following you have completed related to your current pain and complaints:

Physical therapy: _____ Date: _____

Where completed?_____ # of visits: _____

Chiropractor: _____ Date: _____

Where completed? _____ # of visits: _____

Other : _____ Date: _____

Where complete? _____ # of visits: _____

Beacon Pain Clinic Controlled Substance Agreement

The purpose of this agreement is to protect your access to controlled substances and protect our ability to prescribe to you. Please check the line below or initial by each line 1-13.

____If this line is checked, I do not want controlled prescriptions. However, if I ever get controlled medications I agree to these provisions.

____1. I understand that my provider and I will work together to find the best treatment for my pain. To achieve this goal this office is willing to prescribe controlled substances. The goals of this treatment is to reduce my pain in order to improve my ability to function, but may not completely eliminate my pain.
____2. I understand that I am responsible for my medications. I will take measures to secure them to prevent possible theft. If the medications are lost, stolen, or misplaced, **regardless of the reason.** I understand that my medications will **NOT** be replaced or refilled and I risk being discharged from Beacon Pain Clinic.
____3. I **will not** request or accept pain medications from any other physician or individual while receiving medications from Beacon Pain Clinic. I understand by doing so I could be endangering my health and it is illegal. Exceptions will be made if I have DISCUSSED THEM WITH DR. GUY or while I am admitted to the hospital.
____4. Use of prohibited substances can interfere with my opioid therapy and cause adverse effects. Therefore, I agree to notify my provider of the use of all substances: to include marijuana, alcohol, and illicit drugs. I understand that I should not be using these substances while on opioid therapy and by doing so I risk being discharged.
____5. Medication changes will **NOT** be made over the phone. Changes in my medication will require a doctors visit so I can be re-evaluated. **I will not dispose of unused medications. I will bring in all medications in their original containers to every appointment.**
____6. I will take the medication at the dose and frequency prescribed by my provider. **I understand that I am NOT to increase the dose of my medication.** By doing so I may no longer receive controlled substances from my physician.
____7. I understand that prescriptions may take up to 72 hours to refill. I will be responsible and plan accordingly in order to get my refills on time and will also plan for weekends and holidays so as I will not run out of my medication. Same day requests or walk in requests will NOT be honored or filled.
____8. I understand that opioids have common potential side effects that include: constipation, sweating itching/rash, and allergic reactions. Drowsiness may occur when starting or increasing the dosage. I understand this and agree to refrain from driving a motor vehicle or operating machinery until drowsiness subsides.
____9. I agree to random drug testing by my physician to monitor my compliance with proper medication use. I waive certain privacy rights so that my physician may talk to other healthcare providers, family members, and even law enforcement officials. I also agree to come into the office when asked to and submit to a drug screen or produce unused portions of medications to verify they are being taken correctly.
____10. I understand that I can become dependent on opioid medications, which in a small number can lead to addiction. If addiction occurs my physician will discontinue the medication and I will be referred to a drug treatment program.
____11. I understand that some persons develop tolerance, which is the need to increase the dose of the medication to achieve the same level of pain control. I also understand that I may become physically dependent on the medication and stopping the medication suddenly my cause serious withdrawal symptoms.
____12. I understand that all controlled substances are my responsibility and I am not to give them to any other persons for any reason. If I do my physician may no longer prescribe controlled substances to me and may also lead to discharge from the clinic.
____13. I fully understand that if I violate any of the above conditions that my controlled substance prescriptions and/or the treatment with Beacon Pain Clinic may be immediately terminated and I risk being discharged from the clinic. I also understand that this may result in withdrawal symptoms.

Patient Name:_____ Date:_____

Signature:_____ Reviewed by Physician:_____

Name & location of pharmacy_____ Witness Initials:_____

Opioid Risk Tool (ORT)

Patient Form

Name _____ **Date** _____

Mark each box that applies		Female	Male
1. Family history of substance abuse	▪ Alcohol ▪ Illegal drugs ▪ Prescription drugs	[ ] [ ] [ ]	[ ] [ ] [ ]
2. Personal history of substance abuse	▪ Alcohol ▪ Illegal drugs ▪ Prescription drugs	[ ] [ ] [ ]	[ ] [ ] [ ]
3. Age (mark box if 16-45 years)		[ ]	[ ]
4. History of preadolescent sexual abuse		[ ]	[ ]
5. Psychological disease	▪ Attention-deficit/ hyperactivity disorder, obsessive-compulsive disorder, bipolar disorder, schizophrenia ▪ Depression	[ ] [ ]	[ ] [ ]

Beacon Pain Clinic Important Information

____1. I understand that prior authorization for my imaging will be done once, and I need to schedule and complete the imaging appointment within my insurance's approved authorization time-frame. I understand that the authorization process can take several days to several weeks or more.

____2. I understand that I must give 48 business hours notice to cancel/reschedule a follow-up appointment, and 72 business hours notice to cancel/reschedule a procedure. Failure to do so will result in a $75 rescheduling fee for follow-up appointments and $150 rescheduling fee for procedures. I understand that insurance will not cover this fee and I will not be allowed to schedule until that fee is paid.

____3. I understand that I will need to make my medication follow-up appointments 10 days prior to my medication fill date.

____4. I understand that my copay, coinsurance and deductible payments must be made in a timely manner. If I fail to make regular payments, I risk having my bill sent to collections. If my bill is sent to collections, I understand that I will not be able to remain a patient of Beacon Pain Clinic.

____5. I understand that I may need to leave a urine sample at my appointment, and I will always arrive prepared to do so. I further understand that if I do not leave a sufficient sample and/or do not tighten the lid properly and there is a spill, I may have to repeat the sample and could potentially be charged a cleanup fee. I understand I need to fill the cup ¼ to ½ full.

____6. I understand that my medication may require prior authorization from my insurance company, and that process may take up to two weeks.

____7. I understand that it is my responsibility to make sure I have a current referral from my primary care provider if my insurance requires that for a specialist.

____8. I understand that it is my responsibility to inform Beacon Pain Clinic of any insurance, address or phone number changes.

____9. I understand that Beacon Pain Clinic has a small staff and I may need to leave a message if they do not answer the phone. I understand that they will get back to me as soon as possible and I only need to leave one message. I further understand that I should not call the on call doctor for refills, appointment changes/cancellations, prior authorizations, etc, as the on call doctor can not help me with these issues.

___10. I understand that if my medications are lost, stolen, or misplaced, <u>regardless of the reason,</u> they will <u>NOT</u> be replaced or refilled.

___11. I <u>will not</u> request or accept pain medications from any other physician or individual while receiving medications from Beacon Pain Clinic. I understand by doing so I could be endangering my health and it is illegal. Exceptions will be made if I have DISCUSSED THEM WITH DR. GUY or while I am admitted to the hospital.

___12. I understand that the use of prohibited substances can interfere with my opioid therapy and cause adverse effects. Therefore, I agree to notify my provider of the use of all substances: to include marijuana, alcohol, and illicit drugs. I understand that I should not be using these substances while on opioid therapy.

___13. I understand that medication changes will NOT be made over the phone and will require an appointment. I will not dispose of unused medications. I will bring in all medications in their original containers to every appointment.

___14. I will take medication at the dose and frequency prescribed by my provider. I understand that I am NOT to increase the dose of my medication.

___15. I understand that prescriptions may take up to 72 hours to refill. I will be responsible and plan accordingly in order to get my refills on time and will also plan for weekends and holidays so that I will not run out of my medication. Same day requests or walk in requests will NOT be honored or filled.

___16. I agree to random drug testing by my physician to monitor my compliance with proper medication use. I also agree to come into the office when asked to and submit to a drug screen or produce unused portions of medications to verify they are being taken correctly.

____17. I understand that all controlled substances are my responsibility and I am not to give them to any other persons for any reason.

THANK YOU FOR YOUR PATIENCE WHILE WE PRIORITIZE PATIENT NEEDS AND TAKE CARE OF URGENT NEEDS BEFORE ALL ELSE.

Patient Name:_____ Date:_____

Signature:_____ Witness Initials:_____

Please click ‘Sign’ at the Left top corner. DO NOT click ‘Save and Send’.