

You can download this form at  
[www.gapaincare.com/new](http://www.gapaincare.com/new)



## **NEW PATIENT PACKET**

Please fill out the following  
pages completely before  
coming in for your appointment

*If you have any questions, please call our office*

### **GEORGIA PAIN AND SPINE CARE**

1665 Hwy 34 East, Suite 100

Newnan, GA 30265

T (770) 252-7557

F (770) 252-7513

[www.gapaincare.com](http://www.gapaincare.com)

#### *Directions to our office*

From I-85, take Exit 47 (Newnan/ Shenandoah/ Hwy 34)  
Turn East towards Peachtree City on GA Hwy 34 (Bullsboro Drive)  
(Left from I-85 South and Right from I-85 North)

Our building is located on the Right

Just past White Oak Drive

We are located in Suite 100

**GEORGIA PAIN AND SPINE CARE**

**PERSONAL INFORMATION**

Today's Date: \_\_\_\_\_ Account #: \_\_\_\_\_ SSN: \_\_\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

Marital Status:  Single  Married  Divorced  Legally Separated  Widowed

May we leave information on your answering machine or voicemail?  Yes  No

Primary Phone (where you wish to be reached): \_\_\_\_\_ Mobile: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Work No: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Full Time Student:  Yes  No

In the event of an emergency please contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone No: \_\_\_\_\_

Minor Patients: Name of Parent/Guardian: \_\_\_\_\_

Who referred you? (How did you hear about us?)  Physician  Family  Friend  Phone Book  Insurance Co.

Other: \_\_\_\_\_

Referring Physician's Name: \_\_\_\_\_ Phone No: \_\_\_\_\_

Primary Physician's Name: \_\_\_\_\_ Phone No: \_\_\_\_\_

**INSURANCE INFORMATION - Please present your insurance card(s) to the receptionist. Please give complete information**

Primary Insurance: \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Patient's Relationship to Insured:  Self  Spouse  Child  Other: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Employer: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Patient's Relationship to Insured:  Self  Spouse  Child  Other: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Employer: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

**NOTICE REGARDING INSURANCE CLAIMS/PAYMENTS**

If we are filing insurance for your visit, we must have complete information and any required referral at the time of the visit. If you cannot provide this information we will be unable to file your insurance and payment in full will be required.

Payment of your charges cannot be determined until the claim is submitted to your insurance company. Payment will be based on your individual health plan, and the amount applied to your plan deductible and/or coinsurance will be your responsibility. Procedures which are excluded from coverage, based on your plan's determination of medical necessity will also be your responsibility. Your office visit co-pay is due at the time of the visit and, in many cases, covers only the office visit charge. Any procedures performed will be considered surgery by your insurance company, and deductibles and coinsurance may apply.

For all other patients, payment is required at the time of service. We will provide you with the necessary documentation to file for reimbursement upon your request.

I have read the above information and understand that I am responsible for payment for services I receive.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# MEDICATION AGREEMENT PLEASE READ!

As part of your treatment, our medical staff may prescribe medications for you. As you know, medications can have serious side effects if they are not managed properly. Your health and safety are very important to us, and we need your help to make sure your treatment follows the prescribed guidelines. No prescriptions will be written unless you accept the following agreement.

1. I agree to follow the dosing schedule prescribed by my doctor.
2. I will never share, sell or exchange my medications with anyone for any reason.
3. I understand that I am solely responsible for the safekeeping of my medications. I will treat my medications as I would any valuable possession. I know that Georgia Pain and Spine Care does not replace LOST OR STOLEN prescriptions or controlled medications.
4. I understand that I should not drive or operate heavy machinery while I am taking medications that may cause drowsiness or impaired cognitive functions.
5. I agree to notify Georgia Pain and Spine Care if I experience any adverse effects or dosage problems with my prescribed medications. I may be asked to bring any unused medication to Georgia Pain and Spine Care for Disposal.
6. I agree that if I receive a controlled substance prescription from Georgia Pain and Spine Care, I am not allowed to accept controlled substance prescriptions (any pain medication(s)) from any other physician without my doctor's consent.
7. I agree to use only one pharmacy for my pain-related medications. In the event, that circumstances require the use of another pharmacy, I will notify Georgia Pain and Spine Care of this immediately and provide them with all pertinent contact information.
8. I understand that prescriptions involving narcotics require a scheduled appointment in the office. **Narcotic refills will not be called into a pharmacy. Narcotic dosages will not be increased by phone.**
9. **I agree to keep all scheduled appointments. I understand that no medications will be given for cancelled or no-show appointments.** I understand that if I am more than 15 minutes late to my scheduled appointment time, I will have to reschedule for another time. There is a \$25.00 "No Show" fee.
10. I know that I cannot be seen at the office without a scheduled appointment for ANY reason.
11. The Georgia Pain and Spine Care phone triage hours are 8:30 am to 4:00 pm, Monday through Friday for Non-Emergency medication questions. I know that I cannot call this line more than two times in any day.
12. I know that I can be asked to bring any or all of my prescribed medications to my office appointment or at a random time for a prescription compliance check (Pill Count).
13. I understand that Georgia Pain and Spine Care will write and dispense medication prescriptions on a 30 day basis. In order to receive another narcotic medication prescription I must schedule another office visit within 30 days of the date on my current prescription so my doctor can properly evaluate my progress.
14. I understand that abusive behavior or harassment toward any Georgia Pain and Spine Care Staff cannot be tolerated. The doctor will determine what actions can be considered harassment on a case-by-case basis and, if warranted, I can be dismissed from the practice.
15. I understand that dealing with a forged, falsified or altered prescription will result in my immediate dismissal from the Georgia Pain and Spine Care and may be reported to the local police.
16. I understand that Georgia Pain and Spine Care reserves the right to PERFORM A URINE DRUG SCREEN AT ANY TIME WHILE I AM BEING TREATED WITH PRESCRIBED CONTROLLED SUBSTANCES. If the results of the urine drug screen do not reflect medicine prescribed by my doctor or test positive for illegal drugs, I understand that I can be dismissed immediately from the practice. I also agree to pay any cost not covered by my insurance.
17. I understand that if I have a problem or need to change my medication(s), I will need to make an appointment and bring in **ALL THE MEDICATION(S) PRESCRIBED BY Dr. Brownlow**. If I fail to bring them, Dr. Brownlow will not issue a new prescription.

By signing this agreement, you affirm that you have the full right and power to be bound by this agreement and that you have read, understood and accepted these terms. Non-compliance with this agreement will be terms for dismissal from the practice.

PHARMACY NAME PHARMACY NUMBER \_\_\_\_\_

PATIENT NAME (PRINT) \_\_\_\_\_

PATIENT SIGNATURE DATE Rev 01/20/2010 \_\_\_\_\_



## NO-SHOW POLICY

PLEASE READ CAREFULLY!

- You must provide at least **24** hours prior notice if you need to cancel a scheduled office visit, otherwise your account will be charge a **\$25** “no-show” fee.
- You must provide at least **48** hours prior notice if you need to cancel a scheduled office procedure, otherwise your account will be charge a **\$50** “no-show” fee.
- Prior notice is defined as telephoning our office during regular business hours (8:30 am to 4:00 pm, Monday through Friday, except holidays) to inform us of your inability to make your scheduled appointment. You can leave a message on the company voice mail.
- If you “no-show” to your appointment, you will be expected to pay the fee at your next appointment. Failure to do so will result in cancellation of your appointment. No prescriptions will be given or called-in until your “no show” fee is paid.
- If you “no show” for an appointment more than two consecutive times in a calendar year, we reserve the right to consider dismissing you from the practice.

**\*\*Confirmation calls are courtesy calls. All policies regarding no-shows apply whether a confirmation call was or was not received.**

I have read the above policy and understand that I will be responsible for payment of a “No Show” fee if I do not cancel my appointment in a timely manner. I also understand that if I incur a “No Show” fee, this fee must be paid before the physician can see me again.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Rev 01/20/2010



## AUTHORIZATION

### TO DISCUSS OR DISCLOSE HEALTH INFORMATION

I authorize Georgia Pain and Spine Care to discuss and/or disclose my health information with the following person/persons listed below:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

I understand that this information may include any and all treatment plans, medication issues, history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care and evaluations; treatment for alcohol and/or drug abuse; or similar conditions.

The following information should not be released: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

SSN#: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

This form is valid for one year from patient's signature date.



## URINE DRUG SCREEN POLICY

**Prescription pain medications are potentially addictive.**

The number of deaths in the US from prescription drug overdoses has doubled in the past 10 years to more than 30,000 per year. Prescription medications are the number one abused drugs in our country. At Georgia Pain and Spine Care we're committed to helping our patients have the best quality of life possible and that includes responsible prescribing of pain medications. Part of this responsibility includes random drug screens at a minimum of two times per year. In Florida, state law requires that you be checked three times a year; in Louisiana state law requires you be checked four times per year.

Please be prepared to offer a urine sample at every visit. If you are unable to provide a urine sample when asked we will not be able to prescribe pain medication(s).

**Please understand that our patient's health and safety is our number one priority and we are committed to providing excellent patient healthcare at Georgia Pain and Spine Care.**

Sincerely,

A handwritten signature in black ink, appearing to read "R. Charles Brownlow".

R. Charles Brownlow MD, FIPP

By signing below I understand that urine drug screens are a part of the medication agreement I have signed and I agree to do my part as a patient to ensure compliance with all my pain medications.

\_\_\_\_\_  
Patient Name (PRINT)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Rev 02/09/2010

## DESCRIPTION OF YOUR PAIN

Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_

PCP: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Please fill out the following form to help us learn more about your condition so that we can better assist your needs.

1. When did your pain begin? \_\_\_\_\_

What caused your pain to begin? \_\_\_\_\_

Was your injury work related?  Yes  No

If so, what date? \_\_\_\_\_

Have you pursued legal action for an injury?

Yes  No

Who diagnosed the problem?

\_\_\_\_\_

2. Where is your worst pain located?

\_\_\_\_\_

3. Check all that describe your pain quality:

Aching  Burning  Gnawing  Sharp Shooting

Other: \_\_\_\_\_

4a. Severity of Pain Scale:

Score the intensity of your pain (0 is no pain and 10 is the worst pain ever)

Circle the level of your pain: 0 1 2 3 4 5 6 7 8 9 10

Check how your pain affects your activity:  Mild  Moderate  Severe  Very Severe

4b. Does pain affect your sleep?  Yes  No

5. Your pain:  Is Constant  Comes and Goes

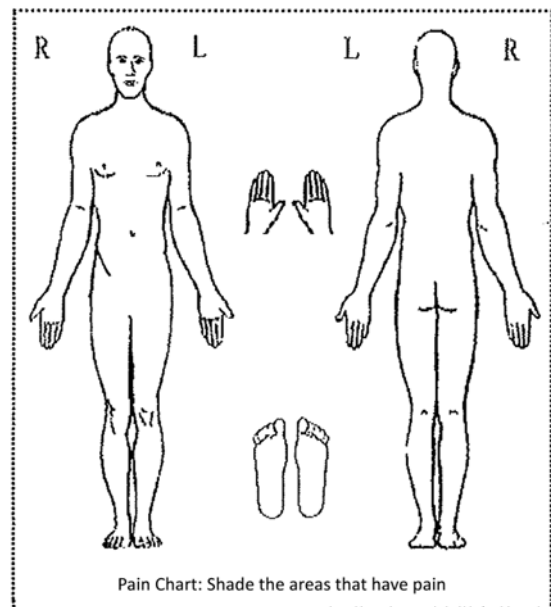
6. When is your pain worst?  Morning  Afternoon  Night

7. The following activities aggravate or worsen your pain:

Sitting  Standing  Walking  Bending  Lying Down  Other: \_\_\_\_\_

8. The following activities relieve or lessen your pain:

Sitting  Standing  Walking  Bending  Lying Down  Other: \_\_\_\_\_



s

- Weakness      Where? \_\_\_\_\_
- Numbness      Where? \_\_\_\_\_
- Tingling      Where? \_\_\_\_\_
- Skin color or temperature change    Where? \_\_\_\_\_
- Incontinence (loss of control):     Bowel     Bladder
- Hypersensitivity:     Touch     Clothes     Cold     Weather Changes

10. What tests have you had done? (Check if yes)

- X-Ray      Date: \_\_\_\_\_ Results: \_\_\_\_\_
- MRI      Date: \_\_\_\_\_ Results: \_\_\_\_\_
- Cat Scan      Date: \_\_\_\_\_ Results: \_\_\_\_\_
- Myleogram      Date: \_\_\_\_\_ Results: \_\_\_\_\_
- EMG/NCS      Date: \_\_\_\_\_ Results: \_\_\_\_\_

Treatments

11. Previous treatments you have tried: (Check if yes)

- Doctor      Doctor(s) Name: \_\_\_\_\_
- Pain Specialist    Specialist(s) Name: \_\_\_\_\_
- Epidural/ Injection      Date: \_\_\_\_\_ Did it help?     Yes     No
- Physical Therapy      Date: \_\_\_\_\_ Did it help?     Yes     No
- Chiropractor      Date: \_\_\_\_\_ Did it help?     Yes     No
- Anti-inflammatory      Check the ones you've tried:
  - Motrin       Ibuprofen       Naproxen       Naprosyn       Aleve
  - Celebrex       Mobic       Voltaren       Aspirin       Tylenol

Medications

12. List all the medications you are currently prescribed for pain, and all other prescription and non-prescription medications that you also take. Please list WHY you are taking the medications.

Example: "Celebrex – Arthritis". (Please use the back side of this paper if you need additional space)

---



---



---



---

13. Do you have medication allergies?  Yes  No If yes, please list: \_\_\_\_\_

\_\_\_\_\_

14. Are you taking any blood thinners?  Yes  No If yes, please list: \_\_\_\_\_

\_\_\_\_\_

Surgery

15. Previous surgeries and year performed:

Heart surgery Year: \_\_\_\_\_  Appendectomy Year: \_\_\_\_\_

Neck surgery Year: \_\_\_\_\_  Chest/Lung Year: \_\_\_\_\_

Hernia surgery Year: \_\_\_\_\_  Back surgery Year: \_\_\_\_\_

Gallbladder Year: \_\_\_\_\_  Hysterectomy Year: \_\_\_\_\_

Joint/bone Year: \_\_\_\_\_  No surgeries

List any additional surgeries: \_\_\_\_\_

Past Medical History

16. Are you currently, or have you in the past, been treated for any medical conditions? Please Explain:

(You may use the back of this page if you need additional space) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Social History

17. Check the correct answer:

Current employment status:  Full-time  Part-time  Retired  Disabled

Marital Status:  Single  Married  Divorced  Legally Separated  Widowed

Children living at home?  Yes  No If yes, what ages? \_\_\_\_\_

Do you live alone?  Yes  No