Center for Interventional
PAIN & SPINE

PHONE: 844-365-7246
FAX: 844-518-0080

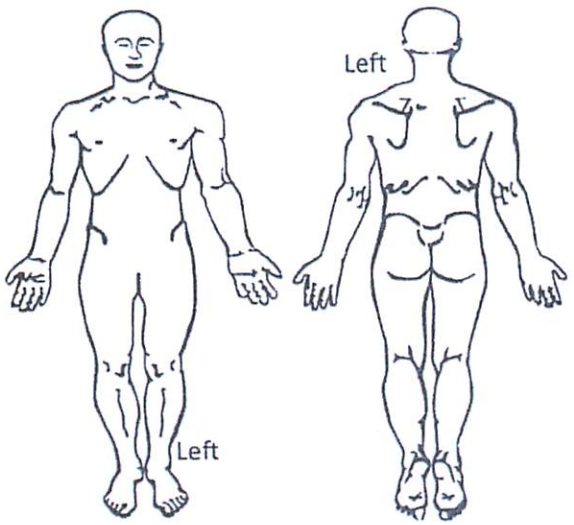
INITIAL ASSESSMENT FORM

Name: _____

Date: _____

BP: _____/_____ HR: _____
Wt: _____ Ht: _____
Temp: _____

Location of pain: Please **shade** your area of pain



Please check what describes your pain:

☐ aching ☐ throbbing ☐ dull ☐ sharp ☐ stabbing
☐ shooting ☐ burning ☐ other:_____

Please check if you have associated symptoms:
☐ numbness ☐ tingling ☐ muscle spasm ☐ weakness
☐ bowel or bladder incontinence ☐ pins and needles

What worsens your pain? ☐ coughing ☐ straining ☐ standing
☐ bending ☐walking ☐ sitting ☐ driving ☐ touch
☐ cold ☐ Other: _____

What makes your pain better? ☐ rest ☐ cold ☐ warmth
☐sitting ☐ standing ☐ medication
☐ Other:_____

Indicate the one NUMBER between 0-10 that best describes your pain:

No pain *moderate pain* *severe pain* *unbearable*
0 1 2 3 4 5 6 7 8 9 10

_____ Pain at its worst _____ Pain at its least
_____ Average pain _____ Pain now

History of present illness: Is your injury ☐ work related or ☐ auto accident? Date of injury _____ State injury occurred _____

Describe the incident: _____

_____

_____

Review of systems

General
- ☐ fatigue
- ☐ fever
- ☐ weight loss/gain

Eyes
- ☐ vision loss

Head/Ears/Nose/Throat
- ☐ hearing loss
- ☐ nose bleed
- ☐ sore throat

Cardiovascular
- ☐ chest pain
- ☐ palpitations

Respiratory
- ☐ cough
- ☐ shortness of breath

Gastrointestinal
- ☐ vomiting blood

Genitourinary
- ☐ loss of bladder control

Musculoskeletal
- ☐ joint pain/swelling
- ☐ spasms
- ☐ weakness

Skin
- ☐ color changes

Neurological
- ☐ paralysis
- ☐ seizures

Psychiatric
- ☐ depressed mood
- ☐ hallucination

Endocrine
- ☐ elevated blood sugar

Hematology/Lymphatic
- ☐ bleeding
- ☐ bruising

Previous treatment

Did you have previous pain management? With who? _____ Treatments: _____

Did you have injections? ☐ No ☐ Yes, if so any relief? _____

Did you have any alternative therapies: ☐ chiropractor ☐ acupuncture ☐ physical therapy ☐ Other_____
If so any relief? _____

Relative surgical history

☐ Back surgery ☐ Neck surgery ☐ Spinal cord stimulator ☐ IT Pain pump ☐ Defibrillator/Pacemaker

☐ Other: _____

Current medications _____

_____

Blood thinners ☐Aspirin ☐Plavix ☐Warfarin ☐Lovenox ☐Pradaxa ☐Ticlid ☐Pletal

Previous pain medication

☐ Vicodin ☐ Percocet ☐ Dilaudid ☐ Oxycontin ☐ Oxycodone ☐ Fentanyl

☐ Suboxone ☐ Methadone ☐ MS Contin ☐ Other: _____

Medication allergies

☐ No known drug allergies ☐ Betadine/Iodine ☐ Contrast dye ☐ Latex ☐ Medication allergies: _____

Past medical history (please check all that apply)

☐ AIDS/HIV	☐ Diabetes	☐ Cancer: _____	☐ Hepatitis B / C	☐ Heart Disease
☐ Bleeding Disorder	☐ Stroke/Mini-Stroke	☐ Multiple Sclerosis	☐ Liver Disease	☐ Kidney Disease
☐ COPD	☐ Stomach/Intestinal Ulcers	☐ High Blood Pressure	☐ Obstructive Sleep Apnea	☐ Other: _____
☐ Alcoholism	☐ Previous Addiction	☐ Drug Abuse	☐ Bipolar Disorder	☐ Generalized Anxiety Disorder

Family history

Is your Mother living? ☐Yes ☐ No If no, age deceased_____cause of death_____

Is your Father living? ☐Yes ☐ No If no, age deceased_____cause of death_____

Family history related conditions

☐ arthritis ☐ cancer ☐ ankloysis spondylosis ☐ other_____

☐ back pain ☐ Multiple Sclerosis ☐ osteoporosis

Occupation

☐ employed ☐ currently unemployed ☐ disabled ☐ retired Position (former/current):_____

Physician Notes Only:

ALLERGY INFORMATION

INITIAL ASSESSMENT FORM - REQUIRED

Do you have any known allergies or bad reactions?

Examples: medications, foods, latex, contrast dye, vaccines, or anything else.

☐ No known allergies ☐ Yes ☐ Not sure

If YES or NOT SURE, complete each allergy below. Use one section per allergy.

Allergy #1

What are you allergic to? _____

Reaction - check all that apply:

☐ Rash ☐ Hives ☐ Itching
☐ Swelling ☐ Trouble breathing/wheezing ☐ Anaphylaxis
☐ Nausea/vomiting ☐ Diarrhea/stomach upset ☐ Unsure/do not remember
☐ Other: _____

Severity: ☐ Mild ☐ Moderate ☐ Severe ☐ Unsure

Allergy #2

What are you allergic to? _____

Reaction - check all that apply:

☐ Rash ☐ Hives ☐ Itching
☐ Swelling ☐ Trouble breathing/wheezing ☐ Anaphylaxis
☐ Nausea/vomiting ☐ Diarrhea/stomach upset ☐ Unsure/do not remember
☐ Other: _____

Severity: ☐ Mild ☐ Moderate ☐ Severe ☐ Unsure

Allergy #3

What are you allergic to? _____

Reaction - check all that apply:

☐ Rash ☐ Hives ☐ Itching
☐ Swelling ☐ Trouble breathing/wheezing ☐ Anaphylaxis
☐ Nausea/vomiting ☐ Diarrhea/stomach upset ☐ Unsure/do not remember
☐ Other: _____

Severity: ☐ Mild ☐ Moderate ☐ Severe ☐ Unsure

Allergy #4

What are you allergic to? _____

Reaction - check all that apply:

☐ Rash ☐ Hives ☐ Itching
☐ Swelling ☐ Trouble breathing/wheezing ☐ Anaphylaxis
☐ Nausea/vomiting ☐ Diarrhea/stomach upset ☐ Unsure/do not remember
☐ Other: _____

Severity: ☐ Mild ☐ Moderate ☐ Severe ☐ Unsure

Severity guide: Mild = small rash, itching, upset stomach Moderate = hives, swelling, worse rash, vomiting, needed medication
Severe = trouble breathing, throat/tongue swelling, anaphylaxis Unsure = patient does not remember

If more than 4 allergies, please ask staff for an additional allergy page.

Center for Interventional
PAIN & SPINE

NAME: _____
Last *First* *Middle initial*

Birthdate_____ SSN _____ Sex: □Male □Female

Address: _____

City: _____ State: _____ Zip _____

Home Phone (_____) _____ Cell (_____) _____ Work (_____) _____

Emergency Contact: _____ Phone number: (_____) _____

Relationship: _____

Pharmacy: _____ Phone (_____) _____

Address _____ City _____ State _____ Zip _____

Email: _____

Marital Status: □ Single □ Married □ Widowed □ Partnered □ Divorced □ Separated

Tobacco Use: □ Former □ Never □ Current _____pack(s)/day How many years? _____

Alcohol use: □ No □ Yes Illicit drug use: □ No □ Yes

Race: □ Caucasian □ African American □ Asian □ Hispanic □ Mixed race
□ Indian □ Other_____

Ethnicity: □ Hispanic □ Non-Hispanic □ Caucasian □ African American

Preferred Language: □ English □ Spanish

PHYSICIAN INFORMATION

Primary Care Physician: _____ Phone (_____) _____

Address _____ City _____ State _____ Zip _____

Referring Physician: _____ Phone (_____) _____

Address _____ City _____ State _____ Zip _____

INSURANCE INFORMATION:

Primary Insurance Carrier: _____ Secondary Insurance Carrier: _____

Policy/ID #: _____ Policy/ID #:_____

Center for Interventional
PAIN & SPINE

Patient Responsibility

Demographic Information
We rely on our patients to keep us up-to-date with your personal information. It is your responsibility to contact our office should any of the following change: Home address, phone number or emergency contact.

Insurance Information
We understand insurance information may change from time to time, however it is your responsibility to notify us immediately should any changes occur.

Insurance Co-Payments
In accordance with my insurance contract, I understand that co-payments are due at time of service.

Deductible
If my insurance deductible has not been met, I understand that outstanding deductible amounts will be collected at the time of service unless other payment arrangements have been made.

Co-insurance
I understand that co - insurance amounts may be collected at time of service, and at the time interventional procedures are scheduled.

Self- Pay Patients/Non-Covered Services
Insurance companies do not pay for all medical services, even those that might be beneficial to the patient. When a service is not covered by your insurance policy, you are responsible for paying the bill. Patients who so not have insurance will be required to make payment at time of services rendered.

Medical Records
We are happy to provide you with copies of your medical records upon request. However, because of time restrictions, please allow up to 7 business days to fulfill this request. Please note there is a charge for personal use per the state medical

record fee, however, medical records sent to another medical provider will be done free of charge.

Other Forms
We will respond (at the provider's discretion) to requests for the completion of certain medical forms (FMLA, Short Term Disability & Long-Term Disability) Other forms not listed may be considered for completion. Please allow up to 14 business days to fulfill this request. Form fees must be paid prior to the form being completed.

After Hours Phone Calls
Center for Interventional Pain & Spine strives to provide comprehensive care to all of our patients even after the office is closed. We have our on call 24/7 when the office is closed. Please keep in mind after hours calls are for emergencies only. If you need to contact our after-hours service should an urgent matter arise, please call 844-365-7245 and allow for a call back within the hour. If you are suffering from a medical emergency, please go to your nearest emergency room.

Notice of Privacy Practices I have been given the option to review Center for Interventional Pain & Spine, LLC "Notice of Privacy Practices" that explains how my personal health information will be used. I am also aware that I may request a copy of the "Notice of Privacy Practices" at any time.

I HAVE READ AND AGREE TO ABIDE BY THIS FINANCIAL AGREEMENT, AND NOTICE OF PRIVACY PRACTICES. By signing this, you are indicating that you understand and agree to the terms of service explained above.

Name: _____

Signature: _____ Date: _____

LIVING WILL / ADVANCED CARE DIRECTIVE

An **Advanced Directive** is a witnessed statement made by a competent member regarding his/her wishes or desires in regards to future health care, (for example-provide artificial life support).
A **Living Will** is a formalized version of an Advanced Directive
Please take this information home and carefully review it. If you wish to execute an Advanced Directive or a Living Will, please notify this office on your next visit.

PLEASE CHECK ONE:

_____ I DO NOT HAVE a Living Will/Advanced Care Directive
_____ I HAVE a Living Will/Advanced Care Directive and will provide a copy to this office.

Center for Interventional
PAIN & SPINE

Notice of Privacy Practices

Effective 2/16/26

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Commitment to your Privacy

- We understand that information about you and your health is personal.
- We are committed to protecting information about you.
- We create a record of care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all records of your care generated by us, whether made by our staff or your provider. Your provider may have different policies or notices regarding the use and disclosure of your information created in the provider's office or clinic.

  This notice will describe your rights, and certain responsibilities we have regarding the use and disclosure of your information. This notice will also tell you about the ways in which we may use and disclose information about you.

Your Rights

When it comes to your health information, you have certain rights. You have the right to:

Inspect or receive an electronic or paper copy of your medical record.	• You can ask to see or get a copy of your medical records and other health information we have about you. This request may require a written authorization by you. Contact us using the information on the back page to make this request. • We will provide a copy usually within 30 days of your request. There may be a reasonable, cost-based fee to provide the requested information.

Request an update to your medical record.	• If you feel the information, we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by us. To request an amendment, your request must be submitted to us in writing. Contact us using the information on the back page to make this request. • We may deny your request. We will let you know in writing the reason why within 30 days.
Request an accounting of disclosures we have made to share your information.	• You can request a list (accounting) of disclosures where we have shared your health information, to include who we shared it with, and why. The list will include all disclosures except for our own uses for treatment, payment and health care operations, and certain other disclosures (such as any you requested us to make, or exceptions required by law). • To request this list, you must submit your request in writing. Your request must state a time period which may not be longer than six years prior to the date of the request. Contact us using the information on the back page to make this request. • The first list you request within a 12-month period will be free. Additional lists may be charged for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
Request confidential communications.	• You can request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. • To request confidential communications, you must make a written request. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. Contact us using the information on the back page to make this request.
Receive a paper copy of this notice.	• You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. Contact us using the information on the back page to promptly receive a copy of this notice. • You may also obtain a copy of this notice at our website: Centerpain.com
Choose someone to act for you.	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights have been violated.	• You may file a complaint with us if you believe your privacy rights have been violated. You may contact us by using the information on the back page. Complaints may be submitted by email or mail. • You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting http://www.hhs.gov/ocr/privacy/hipaa/complaints/. • You will not be penalized or retaliated against for filing a complaint.

Your Choices

For certain situations, you can tell us about your preference on what health information we can share. Talk to us, let us know what you would like for us to do, and we will follow your instructions.

Disclose information when requested by you.	The following disclosures may require a written authorization by you. *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.* • Sharing information with family, close friends or others involved in your care. • Sharing information in a disaster relief situation.
We do not use or share your information for marketing, fundraising, or the sale of your information without your written authorization, except as permitted or required by law.	• Marketing purposes. • Fundraising. • Sale of your information.
Ask us to limit what we use or share.	• You may request to restrict or limit the information we use or disclose about you for treatment, payment or our health care operations. • You may request a limit on the information we disclose about you to someone who is involved in your care or the payment for your care. • If you, or someone else on your behalf (other than a health plan or insurer), has paid for the item or service full, you may ask us to not disclose that information for the purpose of payment or our operations with your health plan or insurer. Even if you request this special

	restriction, we can disclose the information to a health plan or insurer for purposes of treating you. We will say "yes" unless the disclosure is required by law. • To request these limitations and restrictions, you must make your request in writing. In your request, you must tell us what information you want to limit; whether you want to limit our use, disclosure or both; and to whom you want the limits to apply. • We are not required to agree to the above requests and may say "no" if it would affect your care.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and provide you with a copy.
- We will not use or share your information other than as described in this notice unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. This will stop any further use or disclosure of your information for the purposes covered by your written authorization.

Our Uses and Disclosures of your Health Information

We typically share your health information in the following ways.

Provide treatment for you.	We can use information about you to provide you with medical treatment or services. We may disclose information about you to doctors, nurses, technicians, health care students, or other personnel who are involved in taking care of you.	For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process.
Payment for services provided to you.	We can use and disclose information about you so that the treatment and services you receive may be billed to and payment may be collected from health plans or other entities.	For example, we may need to give information about treatment you received to your health plan so it will pay for services.
Operate our organization.	We can use and disclose information about you for our health care operations. These uses and disclosures are necessary to run our organization and make sure that all of our patients receive quality care.	For example, we may use information to review our treatment and/or services to evaluate the performance of our staff and improve our services for you.

We are also allowed, or required, to share your health information in other ways. Usually in ways that contribute to the public good, such as public health and safety, or research. The following categories describe the different ways we may share your health information. We must meet conditions in the law before we can share your information for the purposes described. For each category of uses or disclosures, we will explain what we mean and give examples, as appropriate.

Public health and safety activities	We can disclose information about you for public health and safety situations such as to: • Prevent or reduce a serious threat to anyone's health or safety, • Prevent or control disease, injury, or disability, • Report births and deaths, • Report suspected abuse or neglect of children, elders and dependent adults, or domestic violence, • Report adverse reactions to medications or problems with products.
Required by law.	We will disclose information about you when required to do so by federal, state, or local law, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy laws.
Health Information Exchange.	We may disclose your health information electronically with other groups through a Health Information Exchange network. These other groups may include hospitals, laboratories, doctors, public health departments, and health plans. For example, if you travel and need treatment, it allows other doctors that participate to electronically access your information to help care for you.
Research.	We can use or share information about you for health research.
Address workers' compensation, law enforcement and other government requests.	We can use or disclose health information about you: • For workers' compensation claims. • For law enforcement purposes such as to report certain threats to third parties, about a death that may be the result of criminal conduct, criminal conduct at one or our facilities. • With health oversight agencies for activities authorized by law.
Organ and tissue donation.	We can disclose information about you with organ or tissue procurement organization.

Respond to lawsuits and legal actions.	We can disclose information about you in response to a court or administrative order, or in response to a subpoena. We can disclose health information to courts, attorneys, and court employees in the course of conservatorship, and certain other judicial or administrative proceedings. NOTE: If you have questions about disclosures related to reproductive health care, please contact our Privacy Officer. We will use or disclose information only as permitted or required by law.
Work with coroners and medical examiners.	We can release information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.
Psychotherapy notes.	We do not create or maintain psychotherapy notes as defined by HIPAA in this practice. If psychotherapy notes are created, they are protected and generally require your written authorization for disclosure, except as permitted by law.
Special considerations and/or disclaimers.	If we receive or maintain substance use disorder (SUD) treatment records that are protected by federal confidentiality rules (42 CFR Part 2), we will not re-disclose them without your written consent, except as otherwise permitted or required by law. A general authorization for release of medical information may not be sufficient for Part 2-protected records. *We do not create or manage a hospital directory.*

Who Will Follow this Notice

This notice describes Center for Interventional Pain & Spine practices and that of:

- Any health care professional authorized to enter information into your health record.
- All departments, units, clinics, facilities, and offices.
- Any member of a volunteer group we allow to help you while you are in our care.
- All employees, staff, and other personnel.
- Any business associates we contract to conduct services on our behalf.

All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites, and locations may share your information with each other for treatment, payment or health care operations purposes described in this notice.

Changes in the Terms of this Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for information we already have about you as well as any information we receive in the future. The new notice will be available on request, on our website and in all of our office locations. The updated notice will contain the effective date with the revisions.

Contact Information

For questions regarding this notice, additional information, or requests, contact

Privacy Officer: Jen Colonna
291 Carter Dr. Middletown, DE 19709
(P) 844-365-7246
jennac@centerisp.com

Acknowledgment of Receipt of Notice of Privacy Practices (NPP)

I acknowledge that I was offered/received a copy of the Notice of Privacy Practices for Center for Interventional Pain & Spine.

Patient Name (print): _____

Patient Signature: _____ Date: //_____

If signed by representative: Name/Relationship: _____

Office Use Only (if not signed):

☐ Patient declined to sign

☐ Unable to obtain signature (reason): _____

Staff initials: _____ Date: _____

Center for Interventional Pain & Spine
AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

Patient Name: _____

Account Number: _____ Date of Birth: ____/____/_____

1. Center for Interventional Pain & Spine is authorized to disclose the health information of the above-named individual as described in this authorization:

2. The Center for Interventional Pain & Spine may discuss and/or release protected health information with the following individuals (User/Recipient):
   Name _____Phone: _____

   Name _____Phone: _____

   May we leave telephone messages at the telephone number provided? ____yes ____no

3. The following health information can be discussed and/or released by this authorization to the individuals listed above:
   ❒Complete medical record
   ❒Appointment information including reason for appointment and times
   ❒Results of diagnostic testing and other information related to your health
   ❒Exceptions (Please List):
   _____

   Psychotherapy notes will not be covered unless specifically covered in a separate authorization. Please note that other mental health and behavioral information included in any checked category will be covered by this authorization unless excluded below.

4. The following information is specially protected by state and/or federal law. Please indicate below whether you would like the following information to be released

				Initials
Substance use disorder (SUD) treatment records (42 CFR Part 2, if applicable)	Yes ❑	No ❑	NA❑	_____
Mental health records protected by the Mental Health Procedures Act	Yes ❑	No ❑	NA❑	_____
HIV/AIDS related information	Yes ❑	No ❑	NA❑	_____

5. Please specify any other restrictions on the covered information: _____

6. I am requesting use or disclosure of the covered health information for the following purpose:
   ❒My personal use ❒Further medical treatment
   ❒ Insurance eligibility or benefits ❒School
   ❒Legal investigation or action ❒Other (please describe) _____

7. I understand that I have the following rights:

   - **Right not to sign.** You may refuse to sign this authorization. Refusal to sign will not affect your ability to obtain treatment by the Center for Interventional Pain & Spine except when health services are solely for the purpose of reporting to a third party. An example is a pre-employment physical.
   - Right to revoke. You may revoke this authorization at any time. Your revocation will not apply to any actions that we have already taken in reliance on this authorization. To revoke this authorization, you must submit a written revocation to our privacy officer at the following address:
     Center for Interventional Pain & Spine
     Attention: Jennifer Colonna SA-C, CHCO /Privacy/Security Officer
     291 Carter Dr.
     Middletown, DE 19709
     Phone: 844-365-7246
     Email: jennac@centerisp.com
   - Re-disclosure. I understand that once the covered health information has been disclosed, it may no longer be protected by privacy laws and may be re-disclosed by the recipient. If the information disclosed includes substance use disorder (SUD) treatment records protected by 42 CFR Part 2, federal law generally prohibits the recipient from re-disclosing that information unless further disclosure is expressly permitted by the patient's written consent or as otherwise permitted by 42 CFR Part 2.

NOTICE TO RECIPIENT (only applies if you receive 42 CFR Part 2–protected SUD records): This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

8. **Expiration.** This authorization expires as of the following date or event_____

I have read and understand this authorization, and authorize the use or disclosure of the covered health information as described in this authorization.

_____ _____
Signature of patient (or personal representative/surrogate) Date

Personal Representative/Surrogate Information (as applicable):

_____ _____
Name of personal representative Relationship to patient