CURIS PAIN AND WELLNESS
6727 Hwy 431 S, Ste L, Owens Cross Roads, AL 35763

REGISTRATION FORM

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div. / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Cell phone no: ( )	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

A secured Patient Portal to access your Personal Medical Records, request appointments, and communicate with us over the internet. (*Your email address will not be shared with anyone outside of Curis Pain and Wellness.*) ___YES ___NO

Email Address:

Primary Pharmacy and Phone:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ BCBS ❑ Humana ❑ United Health Care ❑ Medicaid ❑ Self-Pay
❑ Cigna ❑ Tricare ❑ Aetna ❑ Medicare ❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Curis Pain and Wellness or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Medical History Form

Your answers on this form will help us understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details.

Name________________________________ Date of Birth____________ Today's date__________

1. Personal Medical History

Please indicate if you have had any of the following problems currently or in the past.

Condition	Yes	No	Condition	Yes	No
Anemia	☐ Yes	☐ No	Kidney disease/stones	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Liver disease/Hepatitis	☐ Yes	☐ No
Asthma/Emphysema	☐ Yes	☐ No	Lung disease/pneumonia	☐ Yes	☐ No
Bladder infections	☐ Yes	☐ No	Pancreatitis	☐ Yes	☐ No
Chronic diarrhea	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Diverticulosis	☐ Yes	☐ No	Skin disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Sleep apnea	☐ Yes	☐ No
If yes, what age?_____			Stroke	☐ Yes	☐ No
Emotional problems	☐ Yes	☐ No	Venereal disease/Syphilis	☐ Yes	☐ No
Epilepsy or Seizures	☐ Yes	☐ No	Gonorrhea/Chlamydia	☐ Yes	☐ No
Gallstones	☐ Yes	☐ No	Thyroid disease/Goiter	☐ Yes	☐ No
Gout	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Tumors/Cancer	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No	Ulcers (stomach or intestinal)	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Acid Reflux (Heartburn)	☐ Yes	☐ No

If yes to any of the above, please explain____

____

____

When was your last Tetanus shot given? _____________

2. Family History

☐ **Adopted**, family history unknown.

Has anyone in your family (including grandparents, parents, brothers, sisters, or children) had any of the following conditions?

Condition	Yes	No	Family Relationship:	Living/Deceased:
Alcoholism	☐ Yes	☐ No	________________	________________
Anemia	☐ Yes	☐ No	________________	________________
Arthritis	☐ Yes	☐ No	________________	________________
Bowel/Colon Cancer	☐ Yes	☐ No	________________	________________
Breast Cancer	☐ Yes	☐ No	________________	________________
Depression	☐ Yes	☐ No	________________	________________
Diabetes	☐ Yes	☐ No	________________	________________
Heart Disease/Angina	☐ Yes	☐ No	________________	________________
Hepatitis	☐ Yes	☐ No	________________	________________
High Blood Pressure	☐ Yes	☐ No	________________	________________
High Cholesterol	☐ Yes	☐ No	________________	________________
Kidney Disease	☐ Yes	☐ No	________________	________________
Strokes	☐ Yes	☐ No	________________	________________
Thyroid Disorder	☐ Yes	☐ No	________________	________________
Tuberculosis	☐ Yes	☐ No	________________	________________
Other________________	☐ Yes	☐ No	________________	________________

3. Personal Habits

Tobacco Use

Cigarettes: ☐ Never ☐ Quit-Date______ ☐ Current Smoker-Packs per day___ # of years___

Other tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Are you interested in quitting? ☐ Yes ☐ No

Alcohol Use

Do you drink alcohol? ☐ No ☐ Yes, average # of drinks per week_____

If no, have you in the past? ☐ Yes ☐ No

Drug Use

Do you use any recreational drugs, such as marijuana, cocaine, stimulants, narcotics, diet pills?
☐ Yes ☐ No

Have you ever used needles? ☐ Yes ☐ No.

Sexuality

Are you sexually active? ☐ Yes ☐ No ☐ Not currently

If sexually active, do you practice safe sex? ☐ Yes ☐ No

Birth control method________________

Have you ever had any sexually transmitted diseases (STD's)? ☐ Yes ☐ No

If yes, please include____

Exercise

Do you exercise regularly? ☐ Yes ☐ No

If yes, what type of exercises?______________________________________

Emotions

In the past year, have you had 2 weeks or more during which you felt sad, blue, or depressed; or when you lost interest or pleasure in things that you usually enjoyed? ☐ Yes ☐ No

4. Medications

Please list all your current medications, including medications/supplements not needing a prescription:

Medication	Dose and Directions

5. Allergies

Please list any allergies or reactions to medications:

Medication	Reaction or Side Effect

6. Operations

Have you had any operations? If yes, list:

Type of operation / Reason for operation	Hospital / Facility	Date of operation
______	______	______
______	______	______
______	______	______
______	______	______
______	______	______
______	______	______
______	______	______

7. For Women Only

Total # of pregnancies_____ # of deliveries_____ # of miscarriages_____ # of abortions_____

Age at start of menstrual period _______

Date most recent menstruation began _______

Usual length of menstrual period _______ days

Date of last Pap smear _______

Have you ever had an abnormal Pap smear? ☐ Yes ☐ No

If yes, give date and describe________________________________

Have you stopped having menstrual periods? ☐ Yes ☐ No If yes, when______________

Do you have regular problems with:

Irregular, painful, or heavy menstrual periods ☐ Yes ☐ No

Bleeding between periods or after menopause ☐ Yes ☐ No

Vaginal discharge, pain or itching ☐ Yes ☐ No

Hot flashes ☐ Yes ☐ No

Pain or lumps in breasts ☐ Yes ☐ No

6727 Hwy 431 S, Suite L, Owens Cross Roads AL 35763 *256-489-2870*

AUTHORIZATIONS

A. I hereby authorize release of any medical information necessary to process claims and request payment of insurance benefits either to myself or to the party who accepts assignment.

B. I authorize payment of any medical benefit from third parties for benefits submitted for my claim to e paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter woe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

D. I authorize you to furnish Curis Pain and Wellness, or anyone designated in writing by them, all records, opinions, reports, x-rays, photostatic copies, abstracts of any records or any other information or documents they may request that you may have in your custody or under your control regarding the patient whose name appears below.

Print Name: ____DOB: ____________SS#________________________

Patient Signature: ____Date: ________________________

Guardian Signature: ____Date: _________________________

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I have insurance coverage with the insurance company(s) stated on the information provided to me and I have given it to the receptionist. I also assign directly to "*Curis Pain and Wellness*" all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the release of any medical information necessary to process claims. **I understand that I am financially responsible for all charges whether or not paid by insurance as well as any co-pays, deductibles, or non-covered services that may occur. I also understand that I will be billed to my home/post office address for any balances outstanding. I agree to make full and complete payment within 30 days** of denial of a claim by my insurance company. I also request payment of any government benefits to "*Curis Pain and Wellness*" per their agreement to accept assignments.

I understand all of the above and hereby state that the information is correct to the best of my knowledge.

Date: __________________ Signature of Patient/Guardian: ____

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COLLECTIONS DISCLOSURE

AGREEMENT TO PAY:
I, the undersigned, accept the fee charges as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees, and/or court costs, if such be necessary.

EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE:
You agree, in order for us to service your account or to collect monies you may owe, *Curis Pain and Wellness* and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that *Curis Pain and Wellness*, it's employees, and/or agents may contact me/us as described above.

Responsible Party Signature: ____ Date: _____________

ACKNOWLEDGMENT

I acknowledge that I have received a copy of the "Welcome to Our Practice" letter. I have read and understand the content of the letter. I have had the opportunity to ask questions and agree to comply with the policies set forth in the letter.

Print Name: ____ Date: _________________

Signature: ____

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HIPPA RELEASE FORM

The regulations that apply to the privacy of health information became effective on April 14, 2003. This office is covered by those regulations, which in part, require that we give you a copy of our Notice of Privacy Practices at the time o your first office appointment after that date and that we make a good joint effort to obtain your signed acknowledgment of receiving the copy.

HIPPA Privacy policy 007 states "the patient must be given an opportunity to agree, restrict, or object to providing protected health information to family members, friends, and/or other persons identified by the patient as involved in the patient's care or payment for health care". Please document your decision below:

____YES: The doctor or his designated staff can discuss treatment/care with family members, caretaker, friends, etc., may use any of the phone numbers listed, may leave general messages for me if needed, may send mail to my home address.

____NO: The doctor or his designated staff cannot discuss treatment/care with anyone except as below.

Exceptions/Comments:

A: Other than myself, my health care providers and my insurance company may talk to only the following people about my health care information:

1.___________________________________Relationship: __________________Phone #: _______________________

2.___________________________________Relationship: __________________Phone #: _______________________

B: Please use only the following number(s) to contact me: ____

C: Please do not leave any messages for me except at: ____

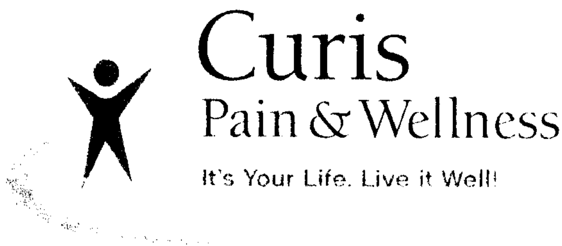
D: Please do not mail anything to my home address. My alternate address is:

____

I acknowledge that I have been given the opportunity to request restrictions on the use and/or disclosure of my protected health information.

Patient/Representative Signature: ____Date: _____________________

Printed Name: ____ Relationship to Patient: ____________________



INTERNAL USE ONLY:
MRN ______
ROI Status: ❑ Processed ❑ Returned to Requester ❑ Encounter
❑ Chart Review ❑ Return Letter Date: ______
❑ Document(s) released in accordance with scope of patient request
Date records were provided ______

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Please read all information and instructions before completing and signing the authorization form.

Patient's Name ______________________ Birth date ______
(Please Print) LAST FIRST MI

Are medical records filed under another name? ______ Phone Number ______

INFORMATION TO BE RELEASED ***BY:***	INFORMATION TO BE RELEASED ***TO:***
REQUEST MUST HAVE COMPLETE ADDRESS OR FAX NUMBER	**REQUEST MUST HAVE COMPLETE ADDRESS OR FAX NUMBER**
______ Organization/Person Name	Curis Pain and Wellness Organization/Person Name
______ Street Address City, State, Zip	6727 Hwy 431 S, Ste L, Owens Cross Roads, AL 35763 Street Address City, State, Zip
______ Phone Fax	256-489-2870 256-489-2878 Phone Fax

TYPE OF MEDICAL INFORMATION REQUESTED:

❑ Complete medical record abstract (includes 3 years of chart notes, most recent labs/pathology & diagnostic imaging reports)
❑ Cancer Partnership records ❑ Radiology/ Diagnostic Imaging (CD/Films) ❑ Mammogram Diagnostic Imaging (CD/Films)
❑ Echocardiograms ❑ Pharmacy ❑ Behavioral Health records only
❑ My health information relating only to the following treatment or condition. ______
❑ My health information only for the following date(s): ______
❑ Other: ______

REASON FOR REQUEST: ❑ Personal ❑ Transfer of Care ❑ Disability ❑ Insurance ❑ Legal Review ❑ Continuing Care
❑ Other (please explain): ______

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse or self-paid services. You are hereby *specifically authorized to release* all information or medical records relating to such diagnosis, testing, or treatment, unless specifically excluded below.

______

MINORS AGE 13-17: A minor patient's signature is required in order to release the following information: (1) conditions relating to the minors reproductive care including, but not limited to: contraception, pregnancy, and pregnancy termination, sterilization, and sexually transmitted diseases (age 14 and older), (2) alcohol and/or drug abuse (age 13 and older), and (3) mental health conditions (age 13 and older).

I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization. You have the right to revoke or cancel this authorization, in writing, at any time. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits).

THERE MAY BE A CHARGE FOR COPIES OF YOUR MEDICAL RECORD UNLESS YOUR COPIES ARE BEING SENT TO ANOTHER PHYSICIAN OR HEALTHCARE FACILITY.

This authorization expires ______ (date or event). Authorization will expire in 90 days if not otherwise specified.

Patient signature ______ **Date** ______

Parent or Legal Guardian ______ **Date** ______

Relationship to patient, if other than patient ______
(You may be required to provide legal documentation as proof for power of attorney or guardianship)

Federal and state laws prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains. A general release is NOT sufficient. 42 CFR Part 2: RCW 70.02.300

Patient Health Questionnaire and General Anxiety Disorder
(PHQ-9 and GAD-7)

Date_______________ Patient Name:________________________________ Date of Birth: ______________

Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems?
Please circle your answers.

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. 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.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): ______________

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems?
Please circle your answers.

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): ______________

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.
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Epworth Sleepiness Scale[11]

How likely are you to nod off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently, try to work out how they would have affected you. It is important that you answer each question as best you can.

Use the following scale to choose the most appropriate number for each situation.

	Would never nod off 0	Slight chance of nodding off 1	Moderate chance of nodding off 2	High chance of nodding off 3
Sitting and reading				
Watching TV				
Sitting, inactive, in a public place (e.g., in a meeting, theater, or dinner event)				
As a passenger in a car for an hour or more without stopping for a break				
Lying down to rest when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a meal without alcohol				
In a car, while stopped for a few minutes in traffic or at a light				

Add up your points to get your total score. A score of 10 or greater raises concern: you may need to get more sleep, improve your sleep practices, or seek medical attention to determine why you are sleepy.

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6727 Hwy 431 S, Suite L, Owens Cross Roads AL 35763 P: 256-489-2870 / F: 256-489-2878
Daniel Burnes, MD – Heather Porch, CRNP

CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribe Program

ePrescribing is a way for doctors to send an accurate, error-free, and understandable prescription electronically from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- **Formulary and benefits transactions** - Gives the health care provider information about which drugs are covered by your drug benefit plan.
- **Fill status notification** - Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.
- **Medication history transactions** - Provides the health care provider with information about your current and past prescriptions. This allows healthcare providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

The medication history information would include medications prescribed by your health care provider at Curis Pain and Wellness as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. ***As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.***

Consent

By signing this consent form, you agree that your provider at Curis Pain and Wellness may request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for medical care, or benefits. Your choice to give or deny consent may not be the basis for the denial of health services. You also have a right to receive a copy of this form after you have signed it.

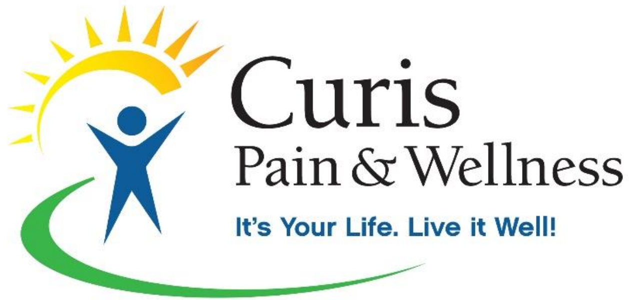
This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to Curis Pain and Wellness to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

________________________________Print Patient Name ______________ Patient DOB

________________________________Signature of Patient or Guardian ______________Today's Date

________________________________Relationship to Patient



NAME: ______________________________

DOB: _____________ **TODAYS DATE:** _______________

HAVE YOU COMPLETED ANY OF THE FOLLOWING:

-Eye Exam? ___ /___ /___
With? _________________________________
Where? _______________________________

-AAA screening? ___ /___ /___
Where? _________________________________

-Mammogram? ___ / ___ / ___
Where? _________________________________

-Pap Smear? ___ / ___ / ___
With? ___________________________________
Where? _________________________________

-DEXA scan **(Osteoporosis Screening)?** ___ / ___ / ___
Where? _________________________________

-Colonoscopy? ___ / ___ / ___
With? ___________________________________
Where? _________________________________

VACCINATIONS:

-Flu vaccine? ___ / ___ / ___
Where? _________________________________

-Pneumonia vaccine? ___ / ___ / ___
Where? _________________________________

-Covid-19 vaccine? Date(s): _______________________
Where? _________________________________

-Shingles vaccine? ___ / ___ / ___
Where? _________________________________

DO YOU SEEN ANY OTHER PROVIDERS?

Cardiology: _____________________________________

Psychology/Psychiatry: ___________________________

Dermatology: __________________________________

Gastroenterology: ______________________________

Hematology/Oncology: __________________________

Eye doctor: ____________________________________

Orthopedic: ____________________________________

Pulmonology: __________________________________

Rheumatology: __________________________________

Urology: _______________________________________

OB/GYN: _______________________________________

ENT: ____

Dentist: _______________________________________

Vascular: ______________________________________

Podiatry: ______________________________________

Endocrinology: __________________________________