Randy E. Durbin, D.O., P.C.
5400 Laurel Springs Pkwy, Suite 1404
Suwannee, GA 30024
PHONE: 706-216-7188 FAX: 855-884-2774

Musculoskeletal Dysfunction/Pain Patient Information Sheet

Today's Date: _____/_____/_____ Patient Name (print): _____

Date of Birth: _____/_____/_____ Sex: □ Male □ Female Social Security: _____/_____/_____

Address: _____ City, State, Zip:_____

E-mail: _____ Permission to contact via email? □ Yes □ No

Home Phone (_____)_____ Permission to leave a message? □ Yes □ No

Cell Phone (_____)_____ Permission to leave a message? □ Yes □ No

Work Phone (_____)_____ Ext: _____ Permission to leave a message? □ Yes □ No

Patient Security Word* for Phone Calls: _____ (e.g. favorite car, pet's name, etc.)

Primary Care Doctor/Clinic: _____ Phone: _____

Address: _____ City, State, Zip:_____

Emergency Contact:

Last Name: _____ First Name: _____ MI: _____

Relationship to Patient: _____

Address: _____ City, State, Zip:_____

Home Phone: (_____)_____ Work Phone: (_____)_____ Ext: _____

Permission to Leave Message with Emergency Contact: Home: □ Yes □ No Work: □ Yes □ No

Social History:

Race: □ White □ Black or African American □ American Indian or Alaska Native □ Asian □ Other □ Declined

Ethnicity: □ Non-Hispanic or Latino □ Hispanic or Latino □ Declined

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

Number of Children: _____ Their Year(s) of Birth: _____

Religious Affiliation: _____

Current Employment Status: □ Employed □ Unemployed □ Disabled □ Retired □ Student

**Patient Security Word is used to verify identity when there is a verbal release of patient's Protected Health Information over the phone.*

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Occupation and Responsibilities: _____

Place of Employment: _____

Hours Per Week: □ 0-10 □ 10-20 □ 20-30 □ 30-40 □ 40+

Hobbies/Recreation (Sports, Music/Arts, Crafts):_____

Please select smoking status: □ Current (daily) □ Current (some days) □ Former □ Never

□ Smoker, current status unknown □ Unknown if ever smoked

If you are a current smoker, are you interested in a cessation program? □ Yes □ No

Do you drink alcohol? □ Yes □ No If so, how many drinks per week? □ 0 □ 1-6 □ 7-13 □14+

Have you ever been treated for substance abuse or illegal drug use? □ Yes □ No

If so, for what drugs/alcohol _____

If so, what type of treatment and where? (e.g. “counseling: NA meetings”)

_____

Are you interested in nutritional counseling and discussing your daily diet? □ Yes □ No

Do you have concerns about your weight? □ Yes □ No

If so, are you interested in physician supervised weight loss? □ Yes □ No

Allergies:

Are you allergic to tape or adhesives? □ Yes □ No Are you allergic to latex? □ Yes □ No

Do you have an allergy to medications? □ Yes □ No

If so, what drug(s) and what type of reactions (e.g. “throat closing” or “rash”)?

_____

Are you allergic to any food items? □ Yes □ No

If yes, please list food and reaction: _____

Do you suffer from seasonal/environmental allergies? □ Yes □ No

Please list: _____

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Why are you here today? Please list problem(s):

_____

_____

Review of Symptoms: Indicate any of the following symptoms you have had in the past 6 months:

Constitutional: □ None □ Fatigue □ Fever □ Night sweats □ Weight gain □ Weight loss

Cardiovascular: □ None □ Chest Pain/Pressure □ Heart Palpitations (Skipped Beats)

Skin: □ None □ Cellulitis □ Keloid □ Psoriasis □ Rash □ Redness □ Sores □ Warmth

Gastrointestinal: □ None □ Abdominal Pain □ Constipation □ Diarrhea □ Heartburn □ Nausea □ Vomiting

Genito-urinary: □ None □ Kidney Failure □ Pregnancy (if applicable)

Hematology: □ None □ Bleeding □ Blood Clots □ Bruising

Musculoskeletal: □ None □ Back Pain □ Bone Pain □ Decreased Range of Motion □ Joint Locking □ Joint Pain(s) □ Muscle Pain(s) □ Muscle Weakness □ Neck Pain □ Osteoporosis □ Shooting Pain □ Swelling

Neurology: □ None □ Gait Abnormality □ Numbness and Tingling

Psychiatric: □ None □ Alcohol Abuse □ Anxiety □ Depression □ Drug Abuse □ Stress

Respiratory: □ None □ Emphysema □ Shortness of Breath □ Wheezing

Other Medical Problems for which you are being/have been treated:

□ Alcoholism	□ Cardiovascular Disease	□ Gastro Reflux	□ Kidney Disease	□ Pulmonary Embolism
□ Alzheimer	□ Cellulitis	□ Heart Disease	□ Liver Disease	□ Rheumatoid Arthritis
□ Anemia	□ Cirrhosis	□ Hepatitis	□ Lupus	□ Seizures
□ Arrhythmia	□ Deep Vein Thrombosis	□ High Cholesterol	□ Mental Illness	□ Stroke
□ Arthritis	□ Depression	□ High Blood Pressure	□ MS	□ Ulcers
□ Asthma	□ Diabetes	□ Hyperthyroidism	□ Osteoporosis	□ Other
□ Bleeding Disorders	□ Fibromyalgia	□ Hypothyroidism	□ Parkinson	□ Other
□ Cancer	□ Gastritis	□ Keloid	□ Psoriasis	□ Other

If other, please list: _____

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List any previous surgeries and note the year they were performed to the right:

□ None	□ Breast	□ Foot	□ Knee	□ Tonsillectomy
□ Abdominal	□ Cardiac	□ Gall Bladder	□ Nasal	□ Vascular
□ Ankle	□ Ear	□ Hand	□ Ovary	□ Wrist
□ Appendectomy	□ Elbow	□ Hip	□ Prostate	□ Bladder
□ Back	□ Eye	□ Hysterectomy	□ Shoulder	□ Facial

Indicate any other tests or treatments that you have had (include location and year):

□ Injection _____ □ X-rays _____

□ MRI _____ □ CT/CAT Scans _____

□ EMG _____ □ Physical Therapy _____

□ Other _____

Family History: Please check all that apply and indicate family relationship (parent, brother, sister or child) with any of the following conditions:

Condition	List Relative	Condition	List Relative
□ Alcoholism		□ Hearing Loss	
□ Allergies		□ Heart Disease	
□ Alzheimer Disease		□ High Cholesterol	
□ Anemia		□ Hypertension	
□ Arthritis		□ Hyperthyroidism	
□ Asthma		□ Hypothyroidism	
□ Bleeding Disorders		□ Kidney Disease	
□ Breast Cancer		□ Lupus	
□ Cancer		□ Mental Illness	
□ Cardiovascular Disease		□ Multiple Sclerosis	
□ Cerebrovascular Disease		□ Osteoporosis	
□ Crohn Disease		□ Parkinson Disease	
□ Degenerative Joint Disease		□ Prostate Cancer	
□ Depression		□ Rheumatoid Arthritis	
□ Diabetes		□ Seizures	
□ Eczema		□ Skin Cancer	
□ Epilepsy		□ Stroke	
□ Gastro Reflux (GERD)		□ Ulcerative Colitis	
□ Other (please describe usi line)			

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List any current medications you are taking:

Anti-Depressant:
□ Effexor (venlafaxine)
□ Cymbalta (duloxetine)
□ Prozac (fluoxetine)
□ Paxil (paroxetine)
□ Wellbutrin (bupropion)
□ Zoloft (sertraline)

Anti-Ulcer:
□ Prilosec (omeprazole)
□ Prevacid (lansoprazole)
□ Nexium (esomeprazole)
□ Protonix (pantoprazole)
□ Tagamet (cimetidine)
□ Zantac (ranitidine)

Allergy/Asthma:
□ Allegra (fexofenadine)
□ Claritin (loratadine)
□ Singulair (montelukast)
□ Zyrtec (cetirizine)
□ Albuterol Inhaler
□ Asthma-Steroid Inhaler
□ Nasal Steroids

Blood Thinners:
□ Aspirin
□ Coumadin (warfarin)
□ Refludan (lepirudin)
□ Ticlid (ticlopidine)
□ Plavix (clopidogrel)
□ Aggrastat (tirofiban)

Cholesterol Lowering:
□ Lipitor (atorvastatin)
□ Zocor (simvastatin)
□ Crestor (rosuvastatin)
□ Mevacor (lovastatin)
□ Niaspan (niacin)
□ Gemfibrozil
□ Zetia

Diabetes:
□ Insulin Injections
□ Glucophage (metformin)
□ Glucotrol (glipizide)
□ Glucagon
□ Avandia (rosiglitazone)
□ Precose (acarbose)

Cardiac/Hypertension:
□ Capoten (captopril)
□ Lisinopril
□ Cozaar (losartan)
□ Diovan (valsartan)
□ Dyazide
□ Nifedipine
□ Verapamil
□ Diltiazem
□ Norvasc (amlodipine)
□ Inderal (propranolol)
□ Tenormin (atenolol)
□ Lopressor (metoprolol)
□ Coreg (carvedilol)
□ Toprol

Pain Medications:
□ Darvocet
□ Fentanyl
□ Hydrocodone
□ Lyrica
□ MS Contin
□ Neurontin
□ Oxycodone
□ OxyContin
□ Percocet
□ Tylenol #3
□ Vicodin
□ Vistaril
□ Zanaflex

Antibiotics:
□ Amoxicillin
□ Augmentin
□ Bactrim (trimethoprim)
□ Biaxin (clarithromycin)
□ Cipro
□ Cleocin (clindamycin)
□ Doxycycline
□ Erythromycin
□ Keflex (cephalexin)
□ Levaquin (levofloxacin)
□ Lamisil
□ Sporanox (itraconazole)
□ Zithromax (azithromycin)

Anti Inflammatory
□ Acetaminophen
□ Celebrex
□ Naproxen (Aleve)
□ Ibuprofen
□ Prednisone

Osteoporosis Treatment:
□ Actonel
□ Fosamax
□ Boniva

Reproductive:
□ Birth Control Pills
□ Depo-Provera Injections
□ Hormone Replacement

Other (including vitamins/supplements):

□ _____ □ _____ □ _____

□ _____ □ _____ □ _____

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Psychiatric History

Have you ever been diagnosed with depression? □ Yes □ No

If so, at what age? _____

What medications were you prescribed?

_____

Did they work? □ Yes □ No

Have you ever been diagnosed with Bipolar Depression? □ Yes □ No

If so, at what age? _____

What medications were you prescribed?

_____

Did they work? □ Yes □ No

Have you ever been diagnosed with Schizophrenia? □ Yes □ No

If so, at what age? _____

What medications were you prescribed?

_____

Did they work? □ Yes □ No

Have you ever been diagnosed with any other mental health disease? □ Yes □ No

If so, at what age? _____

What medications were you prescribed?

_____

Did they work? □ Yes □ No

Patient Name (print): _____

Patient Signature: _____ Date: _____

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Criminal History

1) Have you ever been arrested for any type of drug related crime (possession, distribution, sales, etc)? □ Yes □ No

2) Have you ever been arrested for DUI? □ Yes □ No

PER APPLICABLE LAWS, THIS CLINIC REPORTS CRIMINAL ACTIVITY DIRECTLY TO THE PROPER AUTHORITIES.

Past Substance Abuse History

1) Have you ever been in an alcohol or drug rehabilitation program ("rehab")? □ Yes □ No

If yes, how many times? _____ What year(s)? _____

What drug(s) were you in rehab for? _____

2) Have you ever been involved in Alcoholics Anonymous (AA) OR Narcotics Anonymous (NA)?

□ Yes □ No If yes, please describe:

_____

_____

_____

_____

I RELEASE THE ABOVE INFORMATION TO DR. DURBIN FOR USE IN MY TREATMENT AND ATTEST THAT THE INFORMATION CONTAINED IN THIS INTAKE FORM IS TRUE AND CURRENT TO THE EXTENT OF MY KNOWLEDGE.

Patient Signature: _____ Date: _____

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Notice of Privacy Practices for Protected Health Information

This notice describes how health information about you may be shared and how you can get access to this information. Please review it carefully.

EFFECTIVE DATE: 07/17/2014

If you consent, the medical provider is permitted by Federal Law to make use and disclosure of your health information for the purpose of treatment, payment and health care operations. Protected health information is the information we create and obtain in providing our service to you. Such information may include documenting your symptoms, examination, test results, diagnosis, treatment and applying for future treatment. It also includes billing documents for those services if applicable.

An example of using your health information by a nurse is:

An employee of the provider's office obtains treatment information about you and records it in a health record.

During the course of your treatment, the provider determines that he/she will need consult with another specialist in the area. She/he will share the information with that specialist.

An example of using your health information for payment purposes:

We provide you with a receipt for payment, which you then submit for reimbursement to your insurance company. The insurance company requests information from us regarding the services that were rendered. We will provide that information to them about you and the care that you received.

An example of using this information for health care operations:

The state licensing authority wants to review records to assure that we have acted consistently with state laws regarding your care. At the licensing authority request, we will provide a copy of your chart.

Your health information rights:

The health and billing records we collect during your visits are considered physical property of this office. The information in it however, belongs to you.

You have the right to:

Request a restriction on certain uses and disclosures of your protected health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted. You may obtain a paper copy of the Notice of Privacy Practices for Protected Health Information by making a request at our office that you are allowed to inspect and receive a copy of your health and billing records. You may exercise this right by delivering the request in writing to our office using the form we provide to you. You may appeal or deny access to your protected health information except in certain circumstances. You may request that your health care records be amended or corrected for incomplete or incorrect information. You may file a statement of disagreement if your amendment is denied and request that the request for amendment and any denial be attached in all future disclosure s of your protected health information.

You may obtain an accounting of disclosures of your health information as required to be maintained by law by delivering written request to our office using the form we provide to you. The accounting will not include internal uses of information for treatment, payment or operations. Request that the communication of your health information be made by alternative means should be made by delivering the request in writing to our office using the form we provide. You may revoke any authorizations that you made previously to use or disclose information, except to the extent information or actions have already been taken by delivering a written revocation to our office.

YOU HAVE THE RIGHT TO REVIEW THIS NOTICE BEFORE SIGNING THE CONSENT AUTHORIZING USE OF DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION.

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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided with a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the notice of privacy practices.

I understand that this form will be placed in my patient chart and maintained for at least six years.

_____ _____

Patient Name (Printed) Date

_____

Patient Signature

THIS FORM WILL BE PLACED IN THE YOUR CHART AND MAINTAINED FOR AT LEAST SIX YEARS.

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Acknowledgement of Medication Risks/Release of Fault

I have chosen to enter into pain management for reasons that are important to me. I understand that the medications being prescribed to me are very strong and powerful medications. I understand that there are risks to taking these medications but I am willing to accept those risks to improve my quality of life.

Besides the tolerance and dependency that may occur with these medications there is also a risk of death by overdose.

My doctor has explained to me that an overdose is likely if I were to do any of the following:

a. Take more than my prescribed dosage
b. Combine my medication with street drugs or alcohol
c. Crush, chew, inhale, smoke, or inject my medication.

If an overdose does occur and I die from these medications, I acknowledge I was warned by my physician not to combine my medications with street drugs or alcohol, to only take the dosage that was prescribed to me, and to only take my medications in the way they were prescribed.

If an overdose does occur, I accept the responsibility as my own and release my physician and this clinic from all responsibility from an action that I took despite all of warnings.

Furthermore, I do not want my family, an attorney they may hire, or any government agency to pursue action against my physician or this clinic. I was warned and I agreed not to overdose in this contract. I accept the risk of pain management, and I accept all the responsibilities of my actions.

Patient Name (Printed)_____

Patient Signature: _____ Date: _____

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Pain Management Agreement

The purpose of this agreement is to prevent misunderstanding about certain medications you will be taking for pain management. This is so both you and your physician comply with the law regarding controlled pharmaceuticals.

1. I agree that I am not, have not and will not seek pain medication from any other source. I also understand that going to more than one doctor for pain medication is a felony punishable by law, and the appropriate authorities will be contacted and charges may be brought against me. This subjects me to immediate discharge from Dr. Durbin's practice facilities or a change in my treatment.
2. I understand that this agreement is essential to the clinic, and confidence is necessary in a physician and patient relationship; and that my physician undertakes to treat me based on this agreement.
3. I understand that if I break this agreement, my physician will stop prescribing these pain-control medications.
4. I will communicate fully with my physician about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medication is helping to relieve the pain.
5. I will not use any illegal controlled substances, including marijuana, cocaine, etc.
6. I will not share, sell, or trade these medications with anyone.
7. I will safeguard my pain medication from loss or theft; lost or stolen medications will not be replaced. I understand that a fire-safe bolted to a wall or floor is ideal.
8. I agree that refills of my prescriptions for pain medicine will only be made at the time of an office visit or during regular office hours. No refills will be available during the evenings or on weekends.

Patient Name (Printed) _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date:_____

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Diversion Policy

1. I authorize my physician and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this state board of Pharmacy, in the investigation of my possible misuse, sale, or other diversion of pain medicine.
2. I authorize my physician to provide a copy of this agreement to my pharmacy.
3. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
4. I agree that I will submit to a blood or urine test if required by my physician to determine my compliance with my program of pain control medication.
5. I agree that I will use my medication at a rate no greater than the prescribed rate, and that the use of my medication at a greater rate will result in my being without medication for a period of time.
6. I will bring all unused pain medication to every office visit.
7. I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered.
8. A copy of this document has been given to me.

Patient Name (Printed) _____

Patient Signature: _____ Date: _____

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Informed Consent to Take Opiate/Narcotic Medication

Your physician has determined that opiate pain medication is indicated for treatment of your pain. Opiate pain medications include: **(Percodan, Percocet, Oxycontin, and Roxycodone (Schedule II) Lorocet, Lortab, Suboxone, Subutex, Vicodin (Schedule III)** General schedule II medications have a greater potential for abuse and addiction, but are indicated if other medications have failed to control you.

As with any medical treatment, there are risks and benefits to treatment with opiate drugs.

BENEFITS

Reduced pain, increased sleep, and decreased fatigue, improved function at work, and increased mood, and enjoyment of life.

RISKS

Side effects such as constipation, sedation, nausea, vomiting and itching are the most common side effects. A serious potentially fatal side effect is respiratory depression. This usually only occurs at very high doses and in patients that also use drugs with an additive effects such as tranquilizers, muscle relaxers or sleeping medicine. You are also at increased risk for respiratory depression if you have respiratory conditions such as asthma, chronic obstructive pulmonary disease (COPD), or emphysema. It is important to tell your physician if you are taking any other medications and if you have any other medical conditions when he takes your medical history. You must not use alcohol or any recreational drugs if you are taking opiate pain medication as this can cause potentially fatal respiratory depression. You must also inform your physician if you have liver, kidney, or gastrointestinal problems. Opiate medications can be dangerous or even fatal in some of these conditions.

TOLERANCE

You may develop a tolerance to opiate medications. This means that you will need to increase the dose in order to continue to get pain relief. You should never do this on your own. If the medication is not working, you must inform your physician and he will adjust the dose. During the course of your treatment, your physician will attempt to lower the dose of medication and wean you slowly from the medication. You should never stop medication suddenly as this may precipitate a syndrome know as withdrawal. This can be uncomfortable with rapid heartbeat, shaking, sweating, or more serious symptoms. If you experience withdrawal symptoms, call your physician, proceed to the emergency room, or call 911 immediately.

ADDICTION

Certain patients are psychologically prone to addiction, which is not the same as tolerance. Addiction is psychosocial dependence on the medication for reason other than pain management. If you have ever has a substance abuse problem, or been treated for a psychiatric condition, it is important to tell your physician this when he takes your history. You will be referred to the appropriate specialist in this case.

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Treatment Plan

Each treatment plan is individually discussed with the patient. But there are some basics that do apply to almost everyone. Those basics would include the following:

1. A measurable decrease in your pain.
2. An understanding of the risks and side effects associated with taking pain medications.
3. An understanding to always use the minimum amount of medication possible.
4. To improve the quality of life.
5. To help improve the quality and duration of your sleep.
6. To help you complete your work requirements.
7. To improve the quality of your relationships with others.
8. To help improve your daily vitality (overall strength, energy, and endurance).
9. To help you begin, continue and increase a physical exercise program

   My exercises will be_____

10. To evaluate the role of other therapies (injections, etc.) for your care.
11. To evaluate the role of possible surgery for your care.
12. To always be evaluating strategies which could one day help you manage your condition without the use of opioids.

Other_____

Patient Name (Printed)_____

Patient Signature: _____ Date: _____

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Payment and Refund Policy

1. Payment is required in full at the time of service—we cannot process credit/debit cards at a date after service.
2. We require 12 hour notice to reschedule appointments. No-shows will result in a $25 appointment cancellation fee.
3. We are unable to accept checks.

NO REFUNDS WILL BE GRANTED FOR:

1. Failing a urine analysis (testing positive for illegal drugs in your system)
2. Any unlawful activity
3. Counterfeit or modified MRI report or any other documentation.
4. Failure to provide required medical records including, but not limited to the following:
    a. MRI
    b. Medical History
    c. Referral/Documents from previous physician
    d. Previous pharmacy records

Any refund requested for any reason other than those listed will be on considered on an individual basis.

If you have any questions you may speak to the office manager.

I UNDERSTAND THAT IT IS MY SOLE RESPONSIBILITY TO SEEK THIRD PARTY REIMBURESEMENT (e.g. submitting to Blue Cross Blue Shield or Humana), IF APPLICABLE.

Patient Name (Printed)_____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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Drug Screen/Criminal Consent Form with Authorization and Acknowledgement

I hereby authorize Randy E. Durbin, D.O., P.C., or his agents to obtain my urine sample for the purpose of conducting drug screening test.

I fully understand that my urine drug test will be used to determine if I have taken any illicit substances.

I fully understand that my urine drug test is a mandatory procedure as required by the Drug Enforcing Agency (DEA), and I must fully comply with this policy in order to receive pain care and treatment.

I fully understand that a positive finding of any illicit substance in my urine drug test is a violation of Randy E. Durbin, D.O., P.C. Policy, and this will be ground for disqualification and termination of my treatment.

I hereby certify that my urine specimen is my own and has not been substituted or adulterated.

I furthermore agree and grant permission to test my urine specimen for drug metabolites and alcohol.

I hereby authorize Randy E. Durbin, D.O., P.C., to receive any criminal history record information pertaining to me which may be in the files of any state or local criminal justice agency in the United States.

Patient Name (Printed)_____

Patient Signature: _____ Date: _____

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Authorization for Release of Protected Health Information

Patients full name at the time of treatment: _____

Date of Birth: _____/_____/_____ Social Security number: _____-_____-_____

I authorize_____ (or other physician or health facility) to release my Medical Records to:

Randy E. Durbin, D.O., P.C. 5400 Laurel Springs Pkwy, Suite 1404 Suwannee, GA 30024

Information to be released (Please check all that apply):

□ Initial medical examination □ Progress notes from _____ to _____

□ X-Ray/CRCT/MRI Scan Reports □ Pharmacy Records

□ Lab Results □ Discharge Summary

□ Other_____

1) I understand that if my records contain documentation of alcohol abuse, psychiatric condition, drug abuse, or communicable diseases, that this information will be released as part of my record.

2) I understand that if the person or entity receiving this information is not covered by federal privacy regulations, this information will no longer be protected and may be re-disclosed.

3) I understand that I may revoke this authorization at any time, but revocation will not apply to information that has already been released.

4) I understand that a copy or FAX of this document is just as valid as the original document.

5) I understand that this notice will stay in my chart and be considered valid until I revoke this consent in writing, or until my patient-physician relationship with Dr. Durbin is dissolved.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date:_____