NAPA PAIN INSTITUTE

The best care for every patient, *every day*.

New Patient Information Packet

Please complete all of the forms in this packet, and bring them to your first appointment. If you have questions or are unable to fill out any of the forms, please arrive one hour before your first appointment, so we can assist you.

NAPA PAIN INSTITUTE

Phone (707) 252-9660
Fax (707) 258-2780
www.NapaPainInstitute.com

Office Address
3434 Villa Lane, Suite 150
Napa, CA 94558

Mailing Address
P.O. Box 5510
Napa, CA 94581

WELCOME TO NAPA PAIN INSTITUTE

Eric J. Grigsby, MD
CEO and Medical Director

David C. Miller, MD, MA *Physician*

Gail McGlothlen, DNP RN-BC CNS

Kathleen Kinda, MSN, AGNP-BC, RN

Kristine Fields
Manager, Clinical Operations

Dear Sir or Madam,

Welcome to Napa Pain Institute and thank you for choosing us for your care.

Enclosed you will find several forms. Please complete each form and bring them to your appointment. Please also bring any records, imaging on discs or CDs, and imaging reports pertaining to your condition.

We ask that you arrive to your first appointment at least 30 minutes early so we have the opportunity to collect and organize your records.

Bring all your insurance information to each visit. We will bill your insurance company but please remember that ultimately, you are financially responsible for services provided in our office.

Again, thank you for choosing Napa Pain Institute for your health care needs. We look forward to meeting you.

Please do not hesitate to contact me directly with questions.

Sincerely,

Kimberly DeStefano
New Patient Relationship Coordinator
Direct Line: 707-252-9675
Clinic: 707-252-9660

PERSONAL INFORMATION

			DATE
LAST NAME		FIRST NAME	MIDDLE NAME
MAILING ADDRESS		CITY & STATE	ZIP CODE
DATE OF BIRTH		SOCIAL SECURITY #	SEX (CHECK ONE) ☐ Male ☐ Female
HOME PHONE #	CELLPHONE #	EMAIL ADDRESS	
CAREGIVER NAME		CAREGIVER PHONE #	
MARITAL STATUS (CHECK) ☐ Single ☐ Married ☐ Widowed ☐ Divorced	ETHNICITY (CHECK ONE) ☐ Hispanic/Latino ☐ Non Hispanic/Lat. ☐ Decline	RACE (CHECK ONE) ☐ American Indian or Alaska Native Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Decline ☐ Other:	
EMPLOYED? (CHECK ONE) ☐ Yes ☐ No	IF YES, BY WHOM?		WORK PHONE #
WORK ADDRESS	CITY & STATE		ZIP CODE
REFERRING PHYSICIAN NAME			PHYSICIAN'S PHONE #
PHYSICIAN'S ADDRESS	CITY & STATE		ZIP CODE
EMERGENCY CONTACT		RELATIONSHIP	PHONE #

INSURANCE INFORMATION

PATIENT NAME	DATE

PRIMARY INSURANCE COMPANY NAME		PHONE #
BILLING ADDRESS	CITY & STATE	ZIP CODE
INSURANCE ID #	GROUP #	
SUBSCRIBER	ADDRESS	
DATE OF BIRTH	PATIENT RELATIONSHIP	

SECONDARY INSURANCE COMPANY NAME		PHONE #
BILLING ADDRESS	CITY & STATE	ZIP CODE
INSURANCE ID #	GROUP #	
SUBSCRIBER	ADDRESS	
DATE OF BIRTH	PATIENT RELATIONSHIP	

WORKERS' COMPENSATION INFORMATION

WORKER'S COMPENSATION CARRIER			PHONE #
BILLING ADDRESS	CITY & STATE		ZIP CODE
CLAIM #	DATE OF INJURY	ADJUSTER	
EMPLOYER AT TIME OF INJURY			PHONE #
STREET ADDRESS	CITY & STATE		ZIP CODE
YOUR WORKER'S COMPENSATION ATTORNEY			

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ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign all medical and /or surgical benefits to include major medical benefits, to which I am entitled, private insurance and other health plans to Napa Pain Institute / Eric J. Grigsby, MD / David C Miller, MD.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

This serves as our patient notification that Eric Grigsby, MD is the owner of Napa Surgery Center.

Napa Pain Institute participates in developments of pain treatments by participating in research studies. I give permission to Napa Pain Institute to contact me about research studies relating to my condition.

NAME	
SIGNATURE	DATE

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CANCELLATION REQUIREMENT

REQUIREMENT

Appointment cancellation requires 24 hour advance notice. Napa Pain Institute will charge a $75.00 cancellation fee which will be the responsibility of the patient regardless of insurance coverage.

My signature below serves as acceptance of responsibility for billed charges each time I do not meet the cancellation requirement.

NAME	
SIGNATURE	DATE

CREDIT CARD AUTHORIZATION

CARD TYPE (CIRCLE ONE)

ACCOUNT # (16-DIGIT)	
EXPIRATION DATE (MONTH/YEAR)	SECURITY CODE (3-DIGIT)

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RECORDS RELEASE AUTHORIZATION

AUTHORIZATION

I hereby authorize this person/organization:

NAME		
STREET ADDRESS		CITY & STATE
ZIP CODE	PHONE	FAX

To release my medical records that are currently in his/her posession to:

NAME Napa Pain Institute		
STREET ADDRESS 3434 Villa Lane, Suite 150		CITY & STATE Napa, CA
ZIP CODE 94558	PHONE (707) 252-9660	FAX (707) 258-2780

PATIENT'S SIGNATURE

NAME	DATE OF BIRTH
SIGNATURE	DATE
WITNESS	

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CONSENT AGREEMENT FOR PROVISION OF CHRONIC CARE MANAGEMENT

PATIENT NAME	DATE

GENERAL INFORMATION

By signing this Agreement, you consent to Napa Pain Institute (referred to as "Provider"), providing chronic care management services (referred to as "CCM Services") to you as more fully described below.

CCM Services are available to you because you have been diagnosed with two (2) or more chronic conditions which are expected to last at least twelve (12) months and which place you at significant risk of further decline.

CCM Services include 24-hours-a-day, 7-days-a-week access to a health care provider in Provider's practice to address acute chronic care needs; systematic assessment of your health care needs; processes to assure that you receive timely preventative care services; medication reviews and oversight; a plan of care covering your health issues; and management of care transitions among health care providers and settings. The Provider will discuss with you the specific services that will be available to you and how to access those services.

PROVIDER'S OBLIGATIONS

When providing CCM Services, the Provider must:

- Explain to you (and your caregiver, if applicable), and offer to you, all the CCM Services that are applicable to your conditions.
- Provide to you a written or electronic copy of your care plan.
- If you revoke this Agreement, provide you with a written confirmation of the revocation, stating the effective date of the revocation.

CONSENT AGREEMENT FOR PROVISION OF CHRONIC CARE MANAGEMENT

BENEFICIARY ACKNOWLEDGEMENT & AUTHORIZATION

By signing this Agreement, you agree to the following:

- You consent to the Provider providing CCM Services to you.
- You authorize electronic communication of your medical information with other treating providers as part of coordination of your care.
- You acknowledge that only one practitioner can furnish CCM Services to you during a thirty (30)-day period.
- You understand that cost sharing will apply to CCM Services, so you may be billed for a portion of CCM Services even though CCM Services will not involve a face-to-face meeting with the Provider.

BENEFICIARY RIGHTS

You have the following rights with respect to CCM Services:

- The Provider will provide you with a written or electronic copy of your care plan.
- You have the right to stop CCM Services at any time by revoking this Agreement effective at the end of the then-current thirty (30)-day period of services. You may revoke this agreement verbally (by calling (707) 252-9660) or in writing (to Napa Pain Institute, 3434 Villa Lane, Suite 150, Napa, CA 94558). Upon receipt of your revocation, Napa Pain Institute will give you written confirmation (including the effective date) of revocation.

NAME	
SIGNATURE	DATE

MEDICATION REFILL PROCESS

Current practice and regulatory requirements require frequent office visits for medication management. Therefore, medication refills can be provided at office visits only. New prescriptions and changes to existing prescriptions also require an office visit. Thank you for your understanding of the process.

My signature below acknowledges that I understand medication refills and medication changes both require and can only be completed at an appointment.

NAME	
SIGNATURE	DATE

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PATIENT MEDICATION LIST

NAME	DOB	DATE

For your safety, the following list must be completed prior to each appointment. If you have an up-to-date copy of your Medication List already, please bring that with you to your appointment, so we can make a copy of it. Please check the box below if you are planning to bring your own list, or fill out the form below.

☐ **My Medication List is Attached**

PAIN OR ROUTINE MEDICINE

PAIN MEDICINE NAME	DOSE	# PER DAY

OVER THE COUNTER & PRESCRIPTION MEDICATION

CHECK AND LIST ALL THAT YOU TAKE

- ☐ Aggrenox®
- ☐ Aspirin®
- ☐ Coumadin®
- ☐ Excedrin®
- ☐ Eliquis®
- ☐ Fish Oil
- ☐ Heparin®
- ☐ Ibuprofen®
- ☐ Lovenox®
- ☐ Motrin®
- ☐ Plavix®
- ☐ Pradaxa®
- ☐ Xarelto®

DRUG ALLERGIES

LIST ALL/ANY DRUG ALLERGIES HERE OR USE THE BACK SIDE OF THE PAGE
PREFERRED PHARMACY

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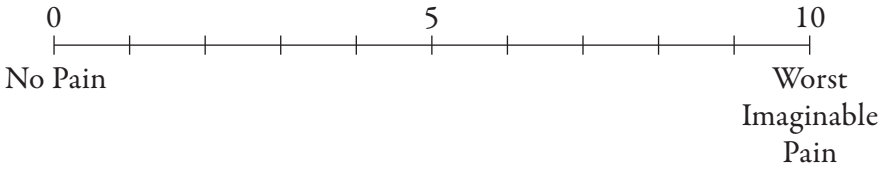
IDENTIFYING PAIN

NAME	DATE

VISUAL ANALOG SCALE (VAS)*

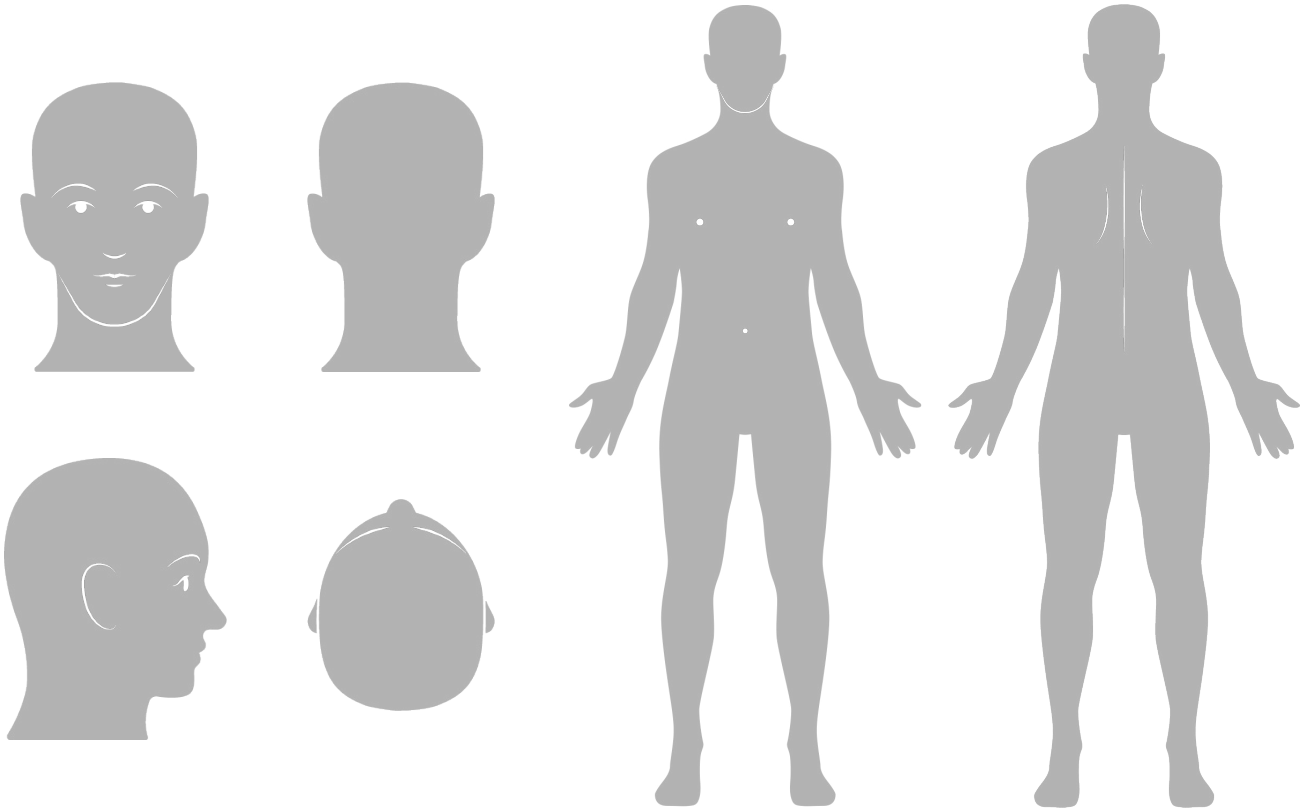
Draw a vertical line (|) to describe your pain over the past 24 hours using the visual analog scale.



*A 10-cm baseline is recommended for VAS scales. From: Acute Pain Management: Operative or Medical Procedures and Trauma, Clinical Practice Guideline No. 1. AHCPR Publication No. 92-0032; February 1992. Agency for Healthcare Research & Quality, Rockville, MD; pages 116-117.

BODY & HEAD DIAGRAM

Please draw, mark or color the area of your pain.



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SCREENER AND OPIOID ASSESSMENT FOR PATIENTS WITH PAIN (SOAPP-R)

NAME	DATE

The following are some questions given to all patients at the Napa Pain Institute who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Please answer the questions below using the following scale:

0 = Never
1 = Seldom
2 = Sometimes
3 = Often
4 = Very Often

	Never Seldom Sometimes Often Very Often 0 1 2 3 4
1. How often do you have mood swings?	0 1 2 3 4
2. How often have you felt a need for higher doses of medication to treat your pain?	0 1 2 3 4
3. How often have you felt impatient with your doctors?	0 1 2 3 4
4. How often have you felt that things are just too overwhelming, that you can't handle them?	0 1 2 3 4
	0 1 2 3 4
5. How often is there tension in the home?	0 1 2 3 4
6. How often have you counted pain pills to see how many are remaining?	0 1 2 3 4
7. How often have you been concerned the people will judge you for taking pain medication?	0 1 2 3 4
8. How often do you feel bored?	0 1 2 3 4
9. How often have you taken more pain medication than you were supposed to?	0 1 2 3 4
10. How often have you worried about being left alone?	0 1 2 3 4

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SCREENER AND OPIOID ASSESSMENT FOR PATIENTS WITH PAIN (VERSION 1.0)

NAME	DATE

	Never 0	Seldom 1	Sometimes 2	Often 3	Very Often 4
11. How often have you felt a craving for medication?	0	1	2	3	4
12. How often have others expressed concern over your use of medication?	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	0	1	2	3	4
14. How often have others told you that you had a bad temper?	0	1	2	3	4
15. How often have you felt consumed by the need to get pain medication?	0	1	2	3	4
16. How often have you run out of pain medication early?	0	1	2	3	4
17. How often have others kept you from getting what you deserve?	0	1	2	3	4
18. How often, in your lifetime, have you had legal problems or been arrested?	0	1	2	3	4
19. How often have you attended an AA or NA meeting?	0	1	2	3	4
20. How often have you been in an argument that was so out of control that someone got hurt?	0	1	2	3	4
21. How often have you been sexually abused?	0	1	2	3	4
22. How often have others suggested that you have a drug or alcohol problem?	0	1	2	3	4
23. How often have you had to borrow pain medications from your family or friends?	0	1	2	3	4
24. How often have you been treated for an alcohol or drug problem?	0	1	2	3	4

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EPWORTH SLEEPINESS SCALE

NAME	DATE
AGE	SEX ☐ Male ☐ Female

How likely are you to doze off or fall asleep in the situations described below, 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.

Please choose an appropriate number for each situation using the following scale:

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

1. Sitting and reading	0 1 2 3
2. Watching TV	0 1 2 3
3. Sitting, inactive in a public place (e.g. a theatre or a meeting)	0 1 2 3
4. As a passenger in a car for an hour without a break	0 1 2 3
5. Lying down to rest in the afternoon (when circumstances permit)	0 1 2 3
6. Sitting and talking to someone	0 1 2 3
7. Sitting quietly after a lunch without alcohol	0 1 2 3
8. In a car, while stopped for a few minutes in the traffic	0 1 2 3
Total	

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Thank you!

Dear patient,

Thank you for taking time to fill out the forms in this packet. Please, make sure to bring it to your first appointment. If you have questions or were unable to fill out any of the forms, please arrive one hour before your first appointment, so we can assist you.

A urinalysis test may be required during your visit.

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