



PAIN CARE ASSOCIATES OF OKLAHOMA
6585 S. Yale, Suite 1110 Tulsa, OK 74136
1705 E. 19th St., Suite 706 Tulsa, OK 74104
www.PCAOklahoma.com

Telephone: (918) 502-PAIN (7246)
Facsimile: (918) 502-7250

PATIENT INFORMATION

Patient Name: \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_ DOB \_\_\_\_\_
Address: \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ SS#: \_\_\_\_\_
Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: \_\_\_\_\_
Marital Status: \_\_\_ Occupation: \_\_\_\_\_
Employer's Name: \_\_\_\_\_
Employer's Address: \_\_\_\_\_ Phone: \_\_\_\_\_
Spouse's Name: \_\_\_\_\_ DOB: \_\_\_\_\_
SS#: \_\_\_\_\_ Employer: \_\_\_\_\_
Employer's Address: \_\_\_\_\_ Phone: \_\_\_\_\_
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_
Relationship to Patient: \_\_\_\_\_
We accept Visa, Mastercard, Checks and Cash. How will your bill be paid today? \_\_\_\_\_

Please note: our office does not accept Third Party Liability

WORKERS COMP INFORMATION:

Date of Injury: \_\_\_\_\_ Adjusters Name: \_\_\_\_\_
Insurance Company Name: \_\_\_\_\_
Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_
Policy Number: \_\_\_\_\_ Claim #: \_\_\_\_\_
Attorney: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_
Address: \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

ACKNOWLEDEEMENT OF NOTICE OF PRIVACY PRACTICES - A detail of your rights and how your medical information will be used and disclosed by PCAO is set forth in the NOTICE OF PRIVACY PRACTICES. A copy has been furnished to me and is posted in the clinic. I authorize the release of medical information to the health plan indicated for information requested by the health plan to determine the payment of medical benefits. The information authorized for release may include information about communicable or noncommunicable disease, mental health, and substance or alcohol abuse. I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES.

Signature \_\_\_\_\_ Date \_\_\_\_\_

***Pain Care Associates of Oklahoma***

***Stephen T. Lester M.D., DABA, ABAPMC***

***Karen Morgan, M.D., DABA, ABAPMC***

***Chad Owens, D.O., DABA, ABAPMC***

***Michael G. Jenson, MS, PA-C, CPP***

***6585 S Yale, Suite 1110***

***Tulsa, Ok 74136***

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***918-502-7246***

***FINANCIAL POLICY***

Thank you for choosing Pain Care Associates as your pain care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete our information and insurance form before seeing the doctor.

***FULL PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.***

***OUR TERMS ARE NET 30. YOUR BALANCE IS CONSIDERED PAST DUE ON DAY 31. PAST DUE ACCOUNTS MAY ACCRUE INTEREST AT 1.5% PER MONTH.***

***WE ACCEPT CASH, CHECKS, MASTERCARD AND VISA.***

***IF YOUR ACCOUNT BECOMES PAST DUE, NO APPOINTMENTS OR PRESCRIPTION REFILLS WILL BE GIVEN TO YOU UNTIL YOUR ACCOUNT HAS BEEN CLEARED BY THE BUSINESS OFFICE.***

***Regarding Insurance***

Our office files your insurance as a courtesy to you. The balance of your account is your responsibility regardless of insurance. We will not bill your insurance company unless you give us your correct insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract, unless you belong to a managed care plan that we are providers for. If your insurance company has not paid your account within 45 days of service, the balance will be automatically transferred to patient responsibility. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the managed care, Medicare program and/or other medical insurance.

Regarding Insurance Plans where we are a participating provider, all co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to above paragraph.

***Usual and Customary Rates***

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

***Adult Patients***

Adult patients are responsible for full payment at time of service unless you are a member of a managed care organization that we participate in. Your provider handbook will provide the names of the physicians contracted with your organization.

***Minor Patients***

Minors must be accompanied by an adult parent or guardian. The parents and/or guardian of the minor are responsible for payment of services rendered.

***Missed appointments***

Unless canceled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of \$28.00 per visit. Please help us serve you better by keeping scheduled appointments.

Please let us know if you have questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

X \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Patient or Responsible Party

**PCA: Pain Care Associates of Oklahoma**

Name: \_\_\_\_\_ Date:   /  /    
 Date of Birth:   /  /   Age:    Sex:  M  F

To help us establish you with our practice, please provide us with your complete health history

**Main Problems or Reasons for Appointment:**  
 (Please rank in terms of importance to you)

1. \_\_\_\_\_  
 2. \_\_\_\_\_  
 3. \_\_\_\_\_

\*Note: we may not be able to address every problem during this visit

When did these problems begin?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Since these problems began, have they:  
 Worsened  Improved  Stayed the same

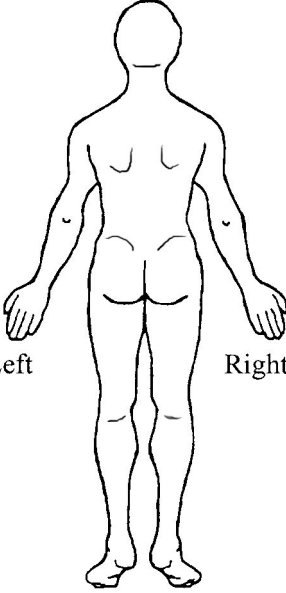
Is there anything that improves the problem or pain?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Is there anything that worsens the problem or pain?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

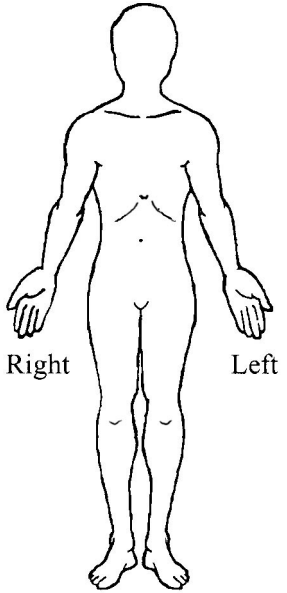
Are there other symptoms you experience with these problems? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Locate your pain on the figures below, using the symbols given below.

Ache    Numbness    Pins/Needles    Burning    Stabbing    Other  
 ▲▲    =====    ○○○    xxxx    ////    ●●●



Back View



Front View

Left                      Right                      Right                      Left

Please rate your pain on the scale below with  
**W**=Worst pain level, **B**=Best pain level, **C**=Current pain level  
 "0" = No Pain and "10" = Worst possible pain

□

□

□

□

□

□

□

□

□

□

□

0    1    2    3    4    5    6    7    8    9    10

**Past & Current Medical Problems:**

Diagnosis

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Past Surgeries, Procedures & Hospitalizations:**

Month/Year

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



Patient Name: \_\_\_\_\_

Review of Systems			
Please mark any symptoms you have experienced in the <b>last month</b> . If not marked it is considered negative or non-pertinent.			
<p><b>Constitutional</b></p> <input type="checkbox"/> Appetite, excessive <input type="checkbox"/> Appetite, poor <input type="checkbox"/> Chills <input type="checkbox"/> Fatigue <input type="checkbox"/> Fevers <input type="checkbox"/> Insomnia <p><b>Head</b></p> <input type="checkbox"/> Dizziness <input type="checkbox"/> Grinding Teeth <input type="checkbox"/> Headache <input type="checkbox"/> Jaw Pain or Click <input type="checkbox"/> Tooth Pain <p><b>Eyes</b></p> <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Floaters or Spots <input type="checkbox"/> Vision Change <input type="checkbox"/> Vision Loss <p><b>ENT</b></p> <input type="checkbox"/> Ear Pain <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Ringing or Buzzing <input type="checkbox"/> Nosebleed <input type="checkbox"/> Sinus Pain <input type="checkbox"/> Sinus Congestion <input type="checkbox"/> Sinus Infection <input type="checkbox"/> Change in Taste <input type="checkbox"/> Dry Mouth <input type="checkbox"/> Sore Throat <input type="checkbox"/> Trouble Swallowing	<p><b>Cardiovascular</b></p> <input type="checkbox"/> Blood Clots <input type="checkbox"/> Chest Pain <input type="checkbox"/> Short of Breath with Activities <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Lightheaded <input type="checkbox"/> Swelling Feet <p><b>Respiratory</b></p> <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Cough <input type="checkbox"/> Frequent Colds <input type="checkbox"/> Pneumonia <input type="checkbox"/> Short of Breath <input type="checkbox"/> Wheezing <p><b>Gastrointestinal</b></p> <input type="checkbox"/> Bleeding <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Heartburn/Reflux <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Ulcer <input type="checkbox"/> Vomiting <input type="checkbox"/> Bloody or Dark Stools <input type="checkbox"/> Loss of Bowel Control	<p><b>Musculoskeletal</b></p> <input type="checkbox"/> Broken Bones <input type="checkbox"/> Difficulty Standing <input type="checkbox"/> Difficulty Sitting <input type="checkbox"/> Difficulty Walking <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Morning Stiffness <input type="checkbox"/> Muscle Cramps <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Numb Hands/Fingers <input type="checkbox"/> Numb Feet/Toes <p><b>Neuro/Psych</b></p> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Difficulty Falling Asleep <input type="checkbox"/> Difficulty Staying Asleep <input type="checkbox"/> Fainting <input type="checkbox"/> Head Injury <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Loss of Sensation <input type="checkbox"/> Poor Balance <input type="checkbox"/> Poor Coordination <input type="checkbox"/> Seizures <input type="checkbox"/> Tingling Sensation <input type="checkbox"/> Tremor or Shakes <p><b>Skin</b></p> <input type="checkbox"/> Dry <input type="checkbox"/> Itchy <input type="checkbox"/> Rashes	<p><b>Genitourinary</b></p> <p>-Urination that is:</p> <input type="checkbox"/> Bloody <input type="checkbox"/> Burning <input type="checkbox"/> Frequent <input type="checkbox"/> Painful <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Loss of Urinary Control <input type="checkbox"/> Wake Up to Urinate <p><b>Reproductive</b></p> <input type="checkbox"/> Infertility <input type="checkbox"/> Pain with Sex <input type="checkbox"/> Erection Problems <input type="checkbox"/> Pelvic Pain <input type="checkbox"/> Painful Periods <input type="checkbox"/> Hot Flashes ___ # of Pregnancies ___ # of Live Births ___ Age Periods Began ___ Age Menopause Began <p><b>Immune/Endocrine</b></p> <input type="checkbox"/> Anemia <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Frequent Infections <input type="checkbox"/> High / Low Blood Sugar <input type="checkbox"/> Low thyroid <input type="checkbox"/> High thyroid <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Swollen Lymph Nodes <input type="checkbox"/> Weight Gain or Loss

Tests/Studies						
Please indicate where and when (month/year) you had any of the following tests done for the appropriate region.						
Anatomy	Procedure	X-ray	MRI	CT Scan	Bone Scan	EMG
Head/Brain						
Cervical						
Thoracic (Mid Back)						
Lumbar (Low Back)						
Chest						
Upper Extremity						
Lower Extremity						
Abdomen						
Pelvis						
Other						

**YOUR PRIMARY CARE DOCTOR'S NAME:** \_\_\_\_\_

**DR's PHONE #** \_\_\_\_\_

**YOUR PRIMARY CARE DOCTOR'S ADDRESS:**

\_\_\_\_\_

**MAY WE CONTACT YOUR REGULAR OR REFERRING DOCTOR?**  Yes  No

**This history record has been designed to facilitate our patient's continuity of care**

**This is a confidential record and will be kept in this facility.**

**Information contained here will not be released to anyone without your authorization to do so.**

\_\_\_\_\_  
**Patient/Guardian signature who filled out the history**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Physician Signature**

\_\_\_\_\_  
**Date**

Patient Name: \_\_\_\_\_



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## **BEHAVIOR AGREEMENT FOR THE USE OF CONTROLLED DRUGS**

**By signing below I agree to the following when the Doctor and I decide on using controlled drugs as a part of my treatment for chronic pain. These medications are considered controlled substance medications because their use is closely controlled and monitored by the local, state and federal agencies. Narcotics, tranquilizers and/or barbiturates are examples of controlled drugs.**

**SIGNING THIS AGREEMENT DOES NOT INFER OR GUARANTEE THAT ANY NARCOTICS WILL BE PRESCRIBED. THIS PRACTICE SPECIALIZES IN INTERVENTIONAL PAIN MEDICINE. THE DECISION TO PRESCRIBE NARCOTIC MEDICATIONS IS DETERMINED BY THE PHYSICIAN ON A CASE-BY-CASE BASIS AND IS NOT NECESSARY FOR MANY PATIENTS.**

**OBTAINING NARCOTIC MEDICATIONS FROM ANOTHER SOURCE WHILE ALSO BEING PRESCRIBED NARCOTICS BY OUR OFFICE IS A BREACH OF THIS AGREEMENT AND MAY RESULT IN DISMISSAL FROM THIS PRACTICE.**

**I consent to their usage and understand the risks and possibility of addiction, dependency, and tolerance to these medications with their continued use. I will follow the rules set forth below:**

*\* Initial by each line*

- 1) **While being treated by a physician of Pain Care Associates of Oklahoma I will not obtain controlled drugs (for example Xanax, Vicodin, Percocet, Tylenol #3, etc.) from any other doctor without first notifying my doctor. \_\_\_\_\_\***
  
- 2) **I am aware that these medications may cause sleepiness, dizziness, and occasional euphoria (an overly happy feeling) and that I have been advised not to drive cars, operate machinery, or unnecessarily expose myself to hazards while on these medications. If sedation (sleepiness) occurs, decrease your dose and notify the doctor's office at (918)502-7246 during business hours. \_\_\_\_\_\***
  
- 3) **While physical dependence and tolerance may be expected after long-term use of opioid pain medications, signs of addiction shall be interpreted as a need to slowly decrease the dose and then stop the drug. The difference between physical dependence, tolerance, and addiction are:**

Patient Name: \_\_\_\_\_

- a. **Physical Dependence:** A patient with drug dependence may experience withdrawal symptoms if they suddenly stop using the medication. This is not a sign of addiction and occurs with a number of different medications including blood pressure pills and anti-seizure drugs.
  - b. **Tolerance** is the need for higher doses to continue to achieve the same amount of pain control. It is not necessarily a sign of addiction.
  - c. **Addiction** is a psychological and behavioral syndrome that is recognized when the patient abuses the drug to:
    - i. Obtain mental numbness or euphoria (“get high”);
    - ii. When the patient shows a drug craving behavior;
    - iii. When the patient shows a manipulative attitude toward the physician in order to obtain the drug.
- 4) **Withdraw symptoms** may occur if opioids are stopped abruptly. They include yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot and cold flashes, “gooseflesh”, abdominal cramps and diarrhea. \_\_\_\_\_ \*
- 5) I do hereby acknowledge that I am not now or ever was addicted to any medications, “street drugs” or alcohol. If I have a chemical abuse history or criminal history of narcotic use, I have divulged this to the doctor. **I understand that my criminal history may be screened for drug related offenses.** \_\_\_\_\_ \*
- 6) I will **not** combine these drugs with alcohol or recreational drugs (this includes marijuana). \_\_\_\_\_ \*
- 7) I must contact the doctor before taking other sedating drugs such as Valium, Ativan, seizure medication or psychiatric drugs. \_\_\_\_\_ \*
- 8) I realize that upon the medical judgment of the doctor. I may be asked to submit to drug testing to monitor for inappropriate drug use. If positive for inappropriate drugs, absence of prescribed medications, or I refuse testing, continued care by Pain Care Associates of Oklahoma may be terminated, and a chemical dependency treatment program advised. \_\_\_\_\_ \*
- 9) I will have my pain medicine filled at only one pharmacy which is \_\_\_\_\_ in the city of \_\_\_\_\_.  
Phone# \_\_\_\_\_. I hereby authorize you to fax or send this information to my pharmacy. If I go to another pharmacy, I will notify the office of this. If my medication is not available at that pharmacy, I will inform the office of which pharmacy I have used to fill the prescription. \_\_\_\_\_ \*
- 10) I will notify the office immediately if I become pregnant. \_\_\_\_\_ \*
- 11) I hereby release/allow you to discuss any suspected prescription drug abuse/misuses with law enforcement authorities, any other treating physicians or potentially treating physicians, and/or pharmacists. I authorize the release of any information and hospital records by the doctor or his/her designee to other health care providers, my family, my employer, my insurance company or other reimbursing agencies. I also authorize any pharmacy to release information regarding my prescriptions. \_\_\_\_\_ \*
- 12) I am responsible for my old prescriptions. I understand that refill prescriptions;
  - a. Can only be written for a one-month supply and will be filled at the same pharmacy unless my pharmacy doesn’t carry my medication and make the office aware of the change of pharmacy. \_\_\_\_\_ \*

Patient Name: \_\_\_\_\_

- b. **I will call the office at least 48 hours in advance to request a refill prescription.** Calls should be made during regular business hours, Monday through Friday to (918) 502-7246 and prescriptions shall be picked up in person. Refill prescriptions will not be written at night, on holidays, or on weekends. If my pain is significantly worsened, I will go to the emergency room. \_\_\_\_\_\*
- c. **Will not be made if I “run out early”, “lose a prescription”, “spill” or “misplace my medication.” I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. If my medication is stolen, I will report this to my local police department and obtain a stolen items report. Replacement prescriptions will be given at the discretion of the doctor.** \_\_\_\_\_\*
- d. **I will take the medications as directed. If I use up my medications sooner than prescribed, I understand that they will not be replaced.** \_\_\_\_\_\*
- 13) **I realize that any time the discretion of my physician of my pain medications can be tapered or discontinued.** \_\_\_\_\_\*
- 14) **The dosage must not be increased without first checking with the doctor’s office.** \_\_\_\_\_\*
- 15) **Write down all instructions received from the doctor’s office and the medication dosage agreed upon. Phone calls regarding medications are to be made to the doctor’s office only during business hours (8:30 a.m. – 4:30 p.m. Monday through Friday) at (918) 502-7246. If it is an emergency, go to the emergency room. If your problems can wait until morning leave a message on our voice mail and we will get back to you the next business day.** \_\_\_\_\_\*

*\* Initial by each line*

I understand that if I fail to abide to the above, or if I show signs suspicious for narcotic overuse or abuse, I may be discharged and narcotic prescriptions will be discontinued. I will be instructed to slowly decrease my narcotic dose. If I do not slowly decrease my dose I will put myself at risk for withdrawal. I assume to risk of drug withdraw symptoms if I break any of the above rules and narcotics are discontinued.

**I DO HEREBY AGGREE TO AND UNDERSTAND ALL OF THE ABOVE. I HAVE RECEIVED A COPY OF THIS ABOVE AGREEMENT. SIGNING THIS DOES NOT GUARANTEE THE ISSUANCE OF PARTICULAR MEDICATIONS.**

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

\_\_\_\_\_  
Date

*\*Please return this to the desk. We will scan it to your records and return the original to you.*