WELCOME TO OMAHA PAIN PHYSICIANS

YOUR JOURNEY TO PAIN RELIEF BEGINS HERE.

Omaha Pain Physicians is proud to offer the best pain management care in the region. We are happy to schedule new patient appointments with you but prior to making your first appointment we will need the following information faxed to our office at 402-934-8119.

- Any past treatment records (including all MRI's, CT's, radiology reports or other imaging records & reports) that pertain to your pain.
- If you have never seen anyone for your pain, contact your primary care doctor and request that they send us your medical records.

Upon receiving these records we will contact you to schedule a new patient appointment. We ask that you fill out the enclosed documents prior to your appointment and consult the first appointment checklist on the next page. If you have any questions or concerns feel free to call our staff anytime at 402-614-1999.

We look forward to caring for you.
FIRST APPOINTMENT CHECKLIST

- It is best if your medical records, imaging (such as MRI’s & CT’s), radiology reports and any other past treatments pertaining to your pain are here as soon as possible.

- Please bring all medication bottles with you for your physician to review. Bring all medication bottles to every appointment.

- Many insurance companies today require a referral from your primary care doctor and some also require a copay. Please check with your primary doctor and/or insurance company before your appointment and bring payment in the event a copay or appointment fee is due.

- Write down your questions and bring them to your appointment. We have a notes page at the end of this document. There are a lot of things to understand and we want to make sure that you are well informed. Remember, there are no foolish questions with regard to your health.

- When checking in, our staff will take a photocopy of your ID and insurance card before notifying the physician of your arrival. Please arrive 20 minutes prior to your appointment.

- Your first appointment may take two hours.

Thank you for choosing Omaha Pain Physicians, we look forward to meeting you.
MEET OUR PRACTITIONERS

MATTHEW STOTTLE MD

Dr. Matthew Stottle is a fellowship trained, double Board-Certified, Interventional Pain Medicine Physician serving the Omaha Metro area.

Dr. Stottle attended the University of Nebraska Medical Center where he received his Medical Doctorate. After completing residency in Anesthesiology at the University of Nebraska Medical Center he went on to study Pain Management at one of the country’s top ACGME-accredited Pain Management fellowship programs at John H. Stroger Hospital in Chicago, IL. Dr. Stottle was involved in many clinical trials, which concentrated on treating chronic pain with a multimodal approach.

WESLEY PRICKETT MD

Dr. Wesley Prickett is a fellowship trained, double Board-Certified, Interventional Pain Medicine Physician serving the Omaha Metro area.

Dr. Prickett attended the University of Nebraska Medical Center where he received his Medical Doctorate. After completing his residency in Anesthesiology at the University of Nebraska Medical Center he went on to study Pain Management at one of the country’s top ACGME-accredited Pain Management fellowship programs at the University of California, Davis. Dr. Prickett was mentored by Dr. Scott Fishman, an internationally recognized author and leader in pain management.

R.L. FOWLER PA-C

R.L. ‘Lee’ Fowler is a Physician Assistant who has 10 years experience in Chronic Pain Management. Lee has worked as an Licensed Practical Nurse for 20 years prior to receiving her Masters Degree in Physician Assistant Studies at Union College in 2009.

Lee then went to work at Midwest Anesthesia and Pain Management Group for 5 years prior to working at Urgent Care.

KRISTINA MCCUTCHEON PA-C

Kristina McCutchen attended Creighton University, where she received a Bachelor of Arts degree in psychology. She earned her Masters of Medical Science in Physician Assistant Studies at Midwestern University in Downer’s Grove, Illinois.

Kristina has over a decade of experience in treating patients with acute and chronic pain. Kristina specializes in health and diet’s role in pain management.

STACIE JOHNSON APRN

Stacie Johnson is a Board Certified nurse practitioner and has been practicing since 2015. Stacie received both her nursing degree and Master’s of Science in Nursing from Clarkson College in Omaha. Stacie has been married to her husband, Jake, for 11 years and they have four children.
New Patient Intake Paperwork

Your completed intake paperwork helps our providers get to know you and your medical history better. We rely on its accuracy and completeness to provide you with the best care possible. Please take your time and inquire at our front desk or call (402) 614-1999 if you have any questions or are unsure how to complete any section of this form.

Today’s Date __________________________

<table>
<thead>
<tr>
<th>Patient Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Your Name:</strong> ________________</td>
</tr>
<tr>
<td>Gender: [ ] Male [ ] Female</td>
</tr>
<tr>
<td>Date of Birth: ________________ Age: ______</td>
</tr>
<tr>
<td>Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Other ____________________________</td>
</tr>
<tr>
<td>Race: [ ] American Indian or Alaskan Native [ ] Asian or Pacific Islander [ ] Black [ ] White [ ] Refuse to Report</td>
</tr>
<tr>
<td>Ethnicity: [ ] Hispanic [ ] Non-Hispanic [ ] Refuse to Report</td>
</tr>
<tr>
<td>Primary Language: [ ] English [ ] Spanish [ ] Other ____________________________</td>
</tr>
<tr>
<td>Social Security Number: _______ - _______ - _______ Mother’s Maiden Name: ________________</td>
</tr>
<tr>
<td>Mailing Address: ____________________________ City/State/Zip: ____________________________</td>
</tr>
<tr>
<td>Preferred Pharmacy: ____________________________ Physical address same as Mailing? [ ] Yes [ ] No If not, ____________________________</td>
</tr>
<tr>
<td>Secondary Phone: (______) - _______ [ ] Home [ ] Mobile [ ] Work</td>
</tr>
<tr>
<td>Preferred Phone: (______) - _______ [ ] Home [ ] Mobile [ ] Work</td>
</tr>
<tr>
<td>Email: ____________________________ Driver’s License # /State: ____________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Referral and Physician Relationships</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who is your primary care physician? ____________________________</td>
</tr>
<tr>
<td>Were you referred to Omaha Pain Physicians by another physician? [ ] Yes [ ] No</td>
</tr>
<tr>
<td>[ ] If so, whom? ____________________________</td>
</tr>
<tr>
<td>[ ] If not, how did you hear about us? [ ] TV [ ] Radio [ ] Insurance Company [ ] Family [ ] Friend [ ] PCP [ ] omahapainphysicians.com [ ] Facebook [ ] Twitter [ ] YouTube [ ] Other Website ____________________________</td>
</tr>
<tr>
<td>Who is your surgeon? ____________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Care Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mark the following sources of medical coverage that apply to you for this current pain complaint(s)</td>
</tr>
<tr>
<td>[ ] Private Insurance [ ] State Medicaid [ ] Worker’s Compensation</td>
</tr>
<tr>
<td>[ ] Medicare [ ] Self-Pay [ ] Automobile Insurance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preferred Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy Name: ____________________________ Phone Number: ____________________________</td>
</tr>
<tr>
<td>Street Address: ____________________________ City/State/Zip: ____________________________</td>
</tr>
</tbody>
</table>

Arizona Pain Specialists, PLLC  Page 1 New Patient Intake Form – Revised March 28, 2011

Preferred Pharmacy

Pharmacy

Name: ____________________________ Phone Number: ____________________________

Street Address: ____________________________ City/State/Zip: ____________________________
**Primary Insurance Plan**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payer (e.g. BC/BS):</td>
<td>____________</td>
</tr>
<tr>
<td>Plan:</td>
<td>____________</td>
</tr>
<tr>
<td>Group Number:</td>
<td>____________</td>
</tr>
<tr>
<td>Policy/I.D. Number:</td>
<td>____________</td>
</tr>
<tr>
<td>Insurance policy holder:</td>
<td>Self</td>
</tr>
<tr>
<td></td>
<td>Spouse</td>
</tr>
<tr>
<td></td>
<td>Child</td>
</tr>
<tr>
<td></td>
<td>Other</td>
</tr>
</tbody>
</table>

Complete this box if you are not the policy holder for your primary insurance

**Policy Holder**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>____________</td>
</tr>
<tr>
<td>Policy Holder Gender:</td>
<td>Female</td>
</tr>
<tr>
<td></td>
<td>Male</td>
</tr>
<tr>
<td>Street Address:</td>
<td>____________</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td>____________</td>
</tr>
<tr>
<td>City/State/Zip:</td>
<td>____________</td>
</tr>
<tr>
<td>Social Security Number:</td>
<td>____________</td>
</tr>
<tr>
<td>Primary telephone number:</td>
<td>____________</td>
</tr>
<tr>
<td>Employer:</td>
<td>____________</td>
</tr>
</tbody>
</table>

**Secondary Insurance Plan (if any)**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payer (e.g. BC/BS):</td>
<td>____________</td>
</tr>
<tr>
<td>Plan:</td>
<td>____________</td>
</tr>
<tr>
<td>Group Number:</td>
<td>____________</td>
</tr>
<tr>
<td>Policy/I.D. Number:</td>
<td>____________</td>
</tr>
<tr>
<td>Insurance policy holder:</td>
<td>Self</td>
</tr>
<tr>
<td></td>
<td>Spouse</td>
</tr>
<tr>
<td></td>
<td>Child</td>
</tr>
<tr>
<td></td>
<td>Other</td>
</tr>
</tbody>
</table>

Complete this box if you are not the policy holder for your secondary insurance

**Policy Holder**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>____________</td>
</tr>
<tr>
<td>Policy Holder Gender:</td>
<td>Female</td>
</tr>
<tr>
<td></td>
<td>Male</td>
</tr>
<tr>
<td>Street Address:</td>
<td>____________</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td>____________</td>
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<td>City/State/Zip:</td>
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</tr>
<tr>
<td>Social Security Number:</td>
<td>____________</td>
</tr>
<tr>
<td>Primary telephone number:</td>
<td>____________</td>
</tr>
<tr>
<td>Employer:</td>
<td>____________</td>
</tr>
</tbody>
</table>

**Workers Compensation Claim Information**

Complete this section only if your visit today is related to a Workers Compensation claim

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workers Comp Company:</td>
<td>____________</td>
</tr>
<tr>
<td>Agent Name:</td>
<td>____________</td>
</tr>
<tr>
<td>Phone number:</td>
<td>____________</td>
</tr>
<tr>
<td>Fax number:</td>
<td>____________</td>
</tr>
<tr>
<td>Claim Number:</td>
<td>____________</td>
</tr>
<tr>
<td>Date of initial injury:</td>
<td>____________</td>
</tr>
</tbody>
</table>

**Emergency Contact**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>____________</td>
</tr>
<tr>
<td>Phone:</td>
<td>____________</td>
</tr>
<tr>
<td>Relationship:</td>
<td>____________</td>
</tr>
</tbody>
</table>

**Employment Status**

- Employed
- Retired
- Unemployed
- Disabled

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer:</td>
<td>____________</td>
</tr>
<tr>
<td>Occupation:</td>
<td>____________</td>
</tr>
</tbody>
</table>
Medical History

Your Name: ____________________________ Date of Birth: ______________________

Today’s Date: ________________________ Height: _______ Weight: _______ lbs

Pain Location

Use this diagram to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms:

“N” = numbness
“S” = stabbing
“B” = burning
“P” = pins and needles
“A” = aching

Where is your worst area of pain located? ______________________________________

Does this pain radiate? If so, where? ___________________________________________

Please list any additional areas of pain: __________________________________________

Onset of Symptoms

Approximately when did this pain begin? _______________________________________

What caused your current pain episode? ☐ Motor Vehicle Accident ☐ Other _________________

☐ Personal Injury (legal term describing injury sustained to your person by negligence of another)

How did your current pain episode begin? ☐ Gradually ☐ Suddenly

Since your pain began, how has it changed? ☐ Decreased ☐ Increased ☐ Stayed the same

Pain Description

Check all of the following that describe of your pain:

☐ Aching ☐ Hot/Burning ☐ Shooting ☐ Stabbing/Sharp
☐ Cramping ☐ Numbness ☐ Spasming ☐ Throbbing
☐ Dull ☐ Shock-like ☐ Squeezing ☐ Tiring/Exhausting
☐ Tingling/Pins and Needles
### Pain Description

Use the pain scale described below to rate your pain for the questions below:

- **0 – Pain-free**
- **1 – Very minor annoyance, occasional minor twinges**
- **2 – Minor annoyance, occasional strong twinges**
- **3 – Annoying enough to be distracting**
- **4 – Can be ignored if you are really involved in your work/task, but still distracting**
- **5 – Cannot be ignored for more than 30 minutes**
- **6 – Cannot be ignored for any length of time, but you can still go to work and participate in social activities**
- **7 – Makes it difficult to concentrate, interferes with sleep, but you can still function with effort**
- **8 – Physical activity is severely limited. You can read and talk with effort. Nausea and dizziness caused by pain.**
- **9 – Unable to speak, crying out or moaning uncontrollably, near delirium**
- **10 – Unconscious, pain makes you pass out**

<table>
<thead>
<tr>
<th>Increases my pain</th>
<th>Decreases my pain</th>
<th>No change in my pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bending Backward</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bending Forward</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Changes in the Weather</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Climbing Stairs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coughing/Sneezing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Driving</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifting Objects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lying on Your Back</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lying on Your Stomach</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rising from a Sitting Position</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sitting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Other activities:

- Balance Problems
- Bladder incontinence
- Bowel incontinence
- Chills
- Difficulty Walking
- Fevers
- Nausea
- Vomiting
- Numbness/Tingling – Where?
- Weakness – Where?

If you have not recently developed any of the above conditions, please mark the following physicians or specialists you have consulted for treatment of your current pain problem(s):

- Acupuncturist
- ENT Physician
- Neurosurgeon
- Plastic Surgeon
- Anesthesiologist
- General Physician
- Ophthalmologist
- Podiatrist
- Chiropractor
- Hypnotist
- Orthopedic Surgeon
- Psychiatrist/Psychologist
- Dentist
- Internist
- Pain Physician
- Rheumatologist
- Endocrinologist
- Neurologist
- Physical Therapist
- Other: _______________________

Mark the effect of each of the following on your pain

Increase your pain
Decreases your pain
No change in your pain

In the past three months have you developed any new:

- Balance Problems
- Bladder incontinence
- Bowel incontinence
- Chills
- Difficulty Walking
- Fevers
- Nausea
- Vomiting
- Numbness/Tingling – Where?
- Weakness – Where?

I have not recently developed any of the above conditions.

Does your pain interfere with any of the following:

- Sleep
- Ability to perform daily activities
- Other: _______________________

---

**Arizona Pain Specialists, PLLC**

**New Patient Intake Form**

**Revised March 28, 2011**
Diagnostic Tests and Imaging
Mark all of the following tests you have had that are related to your current pain complaints:

- MRI of the __________________________ Date: ___________ Facility: ______________
- X-ray of the __________________________ Date: ___________ Facility: ______________
- CT scan of the __________________________ Date: ___________ Facility: ______________
- EMG/NCV study of the __________________________ Date: ___________ Facility: ______________
- Other diagnostic testing: ___________________________________________________________

☐ I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS.

Interventional Pain Treatment History
Mark all of the following interventional pain treatments you have undergone prior to today’s visit:

- Discogram – (circle all levels that apply) Cervical / Thoracic / Lumbar
- Epidural Steroid Injection – (circle all levels that apply) Cervical / Thoracic / Lumbar
- Joint Injection – Joint(s) _________________________________________________________
- Medial Branch Blocks or Facet Injections – (circle all levels that apply) Cervical / Thoracic / Lumbar
- Nerve Blocks – Area/Nerve(s) ____________________________________________________
- Radiofrequency Ablation - (circle all levels that apply) Cervical / Thoracic / Lumbar
- Spinal Column Stimulator – (circle one) Trial Only / Permanent Implant
- Trigger Point Injection – Where ______________________________ _______________________
- Vertebroplasty / Kyphoplasty – Level(s) ____________________________________________
- Other: _______________________________________________________________________

☐ I HAVE NOT HAD ANY INTERVENTIONAL PROCEDURES PERFORMED FOR MY CURRENT PAIN COMPLAINTS.

Please mark all of the following treatments you have used for pain relief

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Helped pain</th>
<th>Worsened pain</th>
<th>No change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biofeedback</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brace Support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic Treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hot/Cold Packs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injection Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Massage Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TENS Unit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Traction</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Then, add up the totals and divide by two for each section.

Add up the scores for each section. The maximum score is 100

Section I Subtotal _______ ÷ 2 = _______

Section II Subtotal _______ ÷ 2 = _______

Section III Subtotal _______ ÷ 2 = _______

Total Score: _______
Have you ever had anesthesia (sedation for a surgical procedure)? □ Yes □ No
If so, have you ever had any adverse reaction to anesthesia? □ Yes □ No
From what type of anesthesia did you react adversely to? Please check all that apply.
- Local anesthesia
- Epidural
- General anesthesia
- IV Sedation
Please explain:

Do you have a family history of adverse reactions to anesthesia? If so, to which of the following?
- Local anesthesia
- Epidural
- General anesthesia
- IV Sedation

Please list the names of other Pain Physicians you have seen in the past:
______________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Mark the following conditions/diseases that you have been treated for in the past:

**General Medical**
- □ Cancer – Type __________________
- □ Diabetes – Type________________

**Cardiovascular/Hematologic**
- □ Anemia
- □ Heart Attack
- □ Coronary Artery Disease
- □ High Blood Pressure
- □ Peripheral Vascular Disease
- □ Stroke/TIA
- □ Heart Valve Disorders

**Gastrointestinal**
- □ GERD (Acid Reflux)
- □ Gastrointestinal Bleeding
- □ Stomach Ulcers
- □ Constipation

**Urological**
- □ Chronic Kidney Disease
- □ Kidney Stones
- □ Urinary Incontinence
- □ Dialysis

**Neuropsychological**
- □ Multiple Sclerosis
- □ Peripheral Neuropathy
- □ Seizures
- □ Depression
- □ Anxiety
- □ Schizophrenia
- □ Bipolar Disorder

**Head/Ears/Eyes/Nose/Throat**
- □ Headaches
- □ Migraines
- □ Head Injury
- □ Hyperthyroidism
- □ Hypothyroidism
- □ Glaucoma

**Respiratory**
- □ Asthma
- □ Bronchitis/Pneumonia
- □ Emphysema/COPD

**Musculoskeletal/Rheumatologic**
- □ Bursitis
- □ Carpal Tunnel Syndrome
- □ Fibromyalgia
- □ Osteoarthritis
- □ Osteoporosis
- □ Rheumatoid Arthritis
- □ Chronic Joint Pains

**Other Diagnosed Conditions**
- □ ____________________________
- □ ____________________________
- □ ____________________________
- □ ____________________________
- □ ____________________________
- □ ____________________________
- □ ____________________________
## Past Surgical History

Please list any surgical procedures you have had done in the past including date:

1) ________________________________ Date? ________________
2) ________________________________ Date? ________________
3) ________________________________ Date? ________________
4) ________________________________ Date? ________________
5) ________________________________ Date? ________________

☐ I have NEVER had any surgical procedures performed.

## Current Medications

Are you currently taking any blood thinners or anti-coagulants?   ☐ YES   ☐ No

If YES, which ones?   ☐ Aspirin   ☐ Plavix   ☐ Coumadin   ☐ Lovenox   ☐ Other ________________

Please list all medications you are currently taking including vitamins. Attach additional sheet if required:

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) ____________________________</td>
<td>______</td>
<td>__________</td>
</tr>
<tr>
<td>2) ____________________________</td>
<td>______</td>
<td>__________</td>
</tr>
<tr>
<td>3) ____________________________</td>
<td>______</td>
<td>__________</td>
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<tr>
<td>4) ____________________________</td>
<td>______</td>
<td>__________</td>
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<tr>
<td>5) ____________________________</td>
<td>______</td>
<td>__________</td>
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<tr>
<td>6) ____________________________</td>
<td>______</td>
<td>__________</td>
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<tr>
<td>7) ____________________________</td>
<td>______</td>
<td>__________</td>
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<tr>
<td>8) ____________________________</td>
<td>______</td>
<td>__________</td>
</tr>
<tr>
<td>9) ____________________________</td>
<td>______</td>
<td>__________</td>
</tr>
<tr>
<td>10) __________________________</td>
<td>______</td>
<td>__________</td>
</tr>
</tbody>
</table>

Please list all past pain medications that you have been on at any point for your current pain complaints:

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) ____________________________</td>
<td>______</td>
<td>__________</td>
</tr>
<tr>
<td>2) ____________________________</td>
<td>______</td>
<td>__________</td>
</tr>
<tr>
<td>3) ____________________________</td>
<td>______</td>
<td>__________</td>
</tr>
<tr>
<td>4) ____________________________</td>
<td>______</td>
<td>__________</td>
</tr>
<tr>
<td>5) ____________________________</td>
<td>______</td>
<td>__________</td>
</tr>
</tbody>
</table>
Allergies

Do you have any drug/medication allergies? □ Yes □ No

If so, please list all medications you are allergic to:

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Allergic Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) ________________</td>
<td>___________________</td>
</tr>
<tr>
<td>2) ________________</td>
<td>___________________</td>
</tr>
<tr>
<td>3) ________________</td>
<td>___________________</td>
</tr>
<tr>
<td>4) ________________</td>
<td>___________________</td>
</tr>
<tr>
<td>5) ________________</td>
<td>___________________</td>
</tr>
</tbody>
</table>

Topical Allergies: □ Latex □ Iodine □ Tape □ IV Contrast

Family History

Mark all appropriate diagnoses as they pertain to your first degree relatives:

If checked, please write which relative had condition: Father, Mother, Sibling, Child

□ Arthritis ____________________ □ Cancer ____________________ □ Diabetes _____________
□ Headaches/Migraines __________ □ High Blood Pressure __________ □ Kidney Problems _______
□ Liver Problems ______________ □ Osteoporosis ______________ □ Rheumatoid arthritis ___
□ Seizures ____________________ □ Stroke ____________________ ________________
□ Other Medical Problems: ___________________________________________________________

Social History

Occupation: ____________________ When was the last time you worked? ____________________

Who is in your current household? ____________________________________________________________________________________

Are there any stairs in your current home? ____________________ If so how many? ____________________

□ Temporary Disability □ Permanent Disability □ Retired □ Unemployed

Are you currently under worker’s compensation? □ No □ Yes

Is there an ongoing lawsuit related to your visit today? □ No □ Yes

Alcohol Use:

□ Social Use □ History of alcoholism □ Current alcoholism □ Never

□ Daily use of alcohol

Tobacco Use:

□ Current user □ Former user □ Never used

□ Packs per day? ______ □ How many years? ______ □ Quit Date: ______

Illegal Drug Use:

□ Denies any illegal drug use □ Currently uses illegal drugs

□ Formerly used illegal drugs (not currently using)

Have you ever abused narcotic or prescription medications? □ Yes □ No
### Review of Systems

Please check any of the following symptoms that you are experiencing currently.

<table>
<thead>
<tr>
<th>CONSTITUTIONAL:</th>
<th>□ Fever</th>
<th>□ Chills</th>
<th>□ Night sweats</th>
<th>□ Weight loss</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Weight Gain</td>
<td>□ Decreased energy</td>
<td>□ Loss of appetite</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HEENT:</th>
<th>□ Runny Nose</th>
<th>□ Nose bleeds</th>
<th>□ Sinus Congestion</th>
<th>□ Hearing loss</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Vision changes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| SKIN:            | □ Rash      | □ Non healing skin lesions |              |              |

| NEUROLOGIC:      | □ Seizure disorder | □ Tremors | □ Dizziness/Fainting | □ Weakness in extremity |

<table>
<thead>
<tr>
<th>CARDIAC:</th>
<th>□ Chest pain/Angina</th>
<th>□ Heart Palpitations</th>
<th>□ Rapid Heart Rate</th>
<th>□ Swelling in extremity</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>RESPIRATORY:</th>
<th>□ Wheezing</th>
<th>□ Cough</th>
<th>□ Sleep apnea</th>
<th>□ Blood stained sputum</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Dyspnea</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GASTROINTESTINAL:</th>
<th>□ Abdominal pain</th>
<th>□ Vomiting</th>
<th>□ Heartburn</th>
<th>□ Constipation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Diarrhea</td>
<td>□ Bloody Stools</td>
<td>□ Hepatitis</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GU/NEPHRO:</th>
<th>□ Dysuria</th>
<th>□ Hematuria</th>
<th>□ Chronic renal failure</th>
<th></th>
</tr>
</thead>
</table>

| ENDOCRINE:       | □ Diabetes         | □ Heat intolerance   | □ Cold intolerance    | □ Thyroid problems |              |

| HEMATOLOGIC:     | □ Abnormal bruising/bleeding | □ Swollen lymphnodes |              |              |

<table>
<thead>
<tr>
<th>MUSCULOSKELETAL:</th>
<th>□ Joint pain</th>
<th>□ Back pain</th>
<th>□ Neck pain</th>
<th>□ Muscle pain</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Joint restrictions</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| PSYCHIATRIC:     | □ Depression        | □ Anxiety             | □ Drug abuse        |              |

| IMMUNOLOGIC:     | □ HIV/AIDS          |                      |                    |              |
CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, Nebraska Occupational Health Center, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:
- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent, and the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations. I understand that Omaha Pain Physicians is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance upon this consent.

Please list any family members or other persons, if any, whom we may inform of your general medical condition and your diagnosis (including treatment, payments, and healthcare options):
______________________________________
______________________________________
______________________________________

Home/Cell Phone Number: __________________________
☐ May only leave providers name and number
☐ May leave detailed information (lab results, appointment reminders)
☐ May NOT leave message

Work Phone Number: __________________________
☐ May only leave providers name and number
☐ May leave detailed information (lab results, appointment reminders)
☐ May NOT leave message

Signature of Patient or Legal Representative
______________________________________
Witness
______________________________________
Date
Notice Effective Date or Version
OMAHA PAIN PHYSICIANS FINANCIAL POLICY

All patients must accept our FINANCIAL POLICY before receiving treatment. Full payment of your bill is considered part of your treatment. We accept cash, check, Visa, Mastercard, and Discover.

APPOINTMENTS
Copayments: Copayments for clinic visits are due at the time of service. If you are unable to make your copayment at the time of service, Omaha Pain Physicians reserves the right to reschedule your appointment until a time that you are able to make your copayment. Payment for any outstanding balance is due at your appointment.

Procedure Prepayment: Omaha Pain Physicians collects your payment for a procedure at the time when the procedure is scheduled. Your prepayment is based on an estimate of your expected financial responsibility. This is an estimate only. You are responsible for any unpaid balance after your insurance (if applicable) has been billed. In the event of overpayment, you may request a refund according to our refund policy, below. We reserve the right to reschedule your procedure until prepayment has been made.

Missed Appointments and Late Arrivals: If you are late to an appointment, we may reschedule your appointment. If you do not show up to your appointment, you will be responsible for a missed appointment fee. Missed office visit appointments are subject to a $75 charge. Missed procedure appointments are subject to a $100 charge. These charges are your responsibility and will not be billed to any insurance carrier.

INSURANCE
The patient is required to present an insurance card(s) at each visit. If you have a change to your insurance you need to arrive 15 minutes prior to your appointment. Failure to provide this information may result as a “self-pay” patient. If you are a new patient copays may be due at the time of your visit. If you are an ESTABLISHED patient, a copay may be due at every visit and one third of your current balance will be due at the time you are seen or your appointment will be rescheduled.

Financial Responsibility: Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurer will be your responsibility, except as limited by our contract (if any) with your insurance carrier.

Coverage Changes and Timely Submission: It is your responsibility to inform us in a timely manner of any changes to your billing or insurance information. There is a time limit within which Omaha Pain Physicians must submit a claim on your behalf to your insurer. If Omaha Pain Physicians is unable to submit your claim within this period because we have not been supplied with your correct insurance information, you will be responsible for the charges.

Self-Pay: If you do not have health insurance, or if your health insurance will not pay for services rendered by Omaha Pain Physicians, you are considered a self-pay patient. Self-pay patients are expected to make payment in full at the time of service.

MOTOR VEHICLE INSURANCE
We do not accept motor vehicle insurance at all. If you want to check with your health insurance to see if they will pay for services you must show us proof of insurance coverage from your health insurance company prior to booking your appointment due to the motor vehicle accident. Please note that your health insurance company may not cover so you will want to verify services with your insurance company prior to being seen by our office. If your health insurance refuses to cover it or if you are seen without a letter from your health insurance company verify coverage you are electing self-pay, your charges will be based on our current self-pay fee schedule. Self-pay patients are expected to make payment in full at the time of service.

WORKERS COMPENSATION
We only accept STATE OF NEBRASKA and IOWA. Prior to appointment all workers comp information needs to be submitted and approved.

BENEFITS AND AUTHORIZATION
Insurance Plan Participation: We participate in many but not all insurance plans. It is your responsibility to contact your insurance company to verify that your assigned Practitioner participates in your plan. Out of network charges may have higher deductibles and copayments. Note that when referring to your plan benefits and coverage, the practitioners at our clinic, are categorized as specialists.

Referrals: Referral and prior authorization requirements vary widely among insurance carriers and plans. If your insurance carrier requires a referral for you to be seen by Omaha Pain Physicians, it is your responsibility to be aware of this fact, and to obtain this referral prior to being seen at our clinic. Without this you may be liable for self-payment.

Prior Authorization and Non-Covered Services: Omaha Pain Physicians may provide services that insurance plans exclude or require prior authorization. If insured, it is ultimately your responsibility to ensure that services provided to you are covered benefits and authorized by your insurer. Omaha Pain Physicians, as a courtesy to our patients, makes a good faith effort to determine if services we order are covered by your insurance plan, and, if so, whether or not prior authorization for treatment is required. If determine that a prior authorization is required, we will attempt to obtain such authorization on your behalf.

Out-of-Network Payments: We are not part of your insurance carrier’s network (out-of-network) and your insurance carrier pays you directly, you are solely responsible for payment and agree to forward the payment to Omaha Pain Physicians, immediately.

ACCOUNT BALANCES AND PAYMENTS
Collection of Unpaid Accounts: If you have an outstanding balance over 91 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney, which may result in reporting to credit bureaus and/or legal action. Omaha Pain Physicians reserves the right to refuse treatment to patients with outstanding balances over 91 days old. You agree to pay Omaha Pain Physicians for any expenses we incur to collect on your account, including reasonable attorneys’ fees and collection costs.

Returned Checks: Returned checks will be subject to a $50 returned check fee and you will be unable to pay with check for any following payment.

Refunds: Refunds for overpayment or prepayment on cancelled procedures are made only after there has been full insurance reimbursement for all medical services on your account. Please allow 4-6 weeks for this reimbursement.

I have read and understand the financial policy of Omaha Pain Physicians, and I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to Omaha Pain Physicians. I understand that I am financially responsible for all services I receive from Omaha Pain Physicians. This financial policy is binding upon you and your estate, executors and/or administrators, if applicable.

Signed: ______________________________________  Date: ______________________
NOTICE OF PRIVACY PRACTICES

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.

This Notice of Privacy Practices is provided to you as a requirement of the Health Information Portability and Accountability Act (HIPAA). It describes how National Spine & Pain Centers may use or disclose your protected health information, and with whom that information may be shared. This notice also describes your rights regarding your protected health information.

ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE

Please sign the Acknowledgement of Receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgement.

OUR DUTIES TO YOU REGARDING PROTECTED HEALTH INFORMATION

“Protected health information” is individually identifiable health information that relates to your past, present, or future physical or mental health or condition, the provision of health care to you, or the payment of such health care. It includes certain demographic information, such as your age, address, and e-mail address, which we maintain about you.

We are required by law to (1) maintain the privacy of your protected health information; (2) give you this notice of our legal duties and privacy practices related to the use and disclosure of your protected health information; (3) follow the terms of the notice currently in effect; and (4) communicate any changes in the notice to you. We reserve the right to change this notice. Its effective date is at the top of the first page and at the bottom of the last page. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. If we change this notice, we will make a current copy of the notice available at our office and website treatingpain.com. You may also obtain a copy of this notice by contacting our Privacy Officer to requesting that a copy be mailed to you, or by asking for a copy at your next appointment.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Required Uses and Disclosures - By law, we must disclose your protected health information to you or someone who has the legal right to act on your behalf unless it has been determined by a competent medical authority that it would be harmful to you. We must also disclose health information to the Secretary of the Department of Health and Human Services (HHS) for investigations or determinations of our compliance with laws to protect the privacy of your protected health information.

Treatment, Payment and Health Care Operations

Treatment - We may use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we may disclose your protected health information, as necessary from time-to-time to another physician or health care provider (e.g. a specialist, pharmacist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment. We may also use your protected health information to process on-line prescription refill requests.

Payment - We may use your protected health information, as needed, to obtain payment for your health care services. This may require us to disclose your protected health information to your insurance carrier in order for the carrier to approve or pay for the health care services recommended for you such as determining eligibility or coverage for benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. This may also include disclosing your relevant protected health information in order to obtain approval for a hospital stay.

Health Care Operations - We may use or disclose, as needed, your protected health information to support our daily business activities related to your health care. These activities include, but are not limited to, quality assessment activities, review of our services or staff performance reviews, performing auditing functions, resolving internal grievances, licensing, conducting or arranging for other health care related activities and uses specifically authorized by law.

Appointment Reminders - We may use or disclose your protected health information, as necessary, to contact you or to remind you of your appointment.

Treatment Alternatives and Health-Related Benefits and Services - We may use or disclose your protected health information, as necessary to provide you with information about treatment alternatives or other health-related benefits and services that might interest you subject to limits imposed by law. For example, your name, address and email may be used to send you a newsletter about the services we offer. We may also send you information about practices or ancillary services that we believe might benefit you.

Other Permitted and Required Uses and Disclosures - We may also use or disclose your protected health information for the following purposes in certain circumstances:

Required by Law - We may use or disclose your protected health information if law or regulation requires the use or disclosure.

Business Associates - We may share your protected health information with third-party “business associates” who perform various activities (for example, billing, transcription services) for us if the information is necessary for such functions or services. The business associates will also be required to protect your protected health information.

Individuals Involved in Your Health Care - Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person’s involvement in your health care. We may also give information to someone who helps pay for your care. Additionally, we may use or disclose protected health information to notify or assist in...
YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You may exercise the following rights by submitting a written request or electronic message to our Privacy Officer at the address provided in the “Contact Information” section of this notice. Please be aware that in certain circumstances, when permitted by law, we may deny your request; however you may be able in certain instances to seek a review of any such denial.

Right to Inspect and Copy
You may inspect and obtain a copy of your protected health information that is contained in a “designated record set” for as long as we maintain the protected health information. A designated record set contains medical and billing records and any other records that we use for making decisions about you.

If you request a copy of your designated record set, a fee for the costs of the copying, mailing or other associated supplies may be charged. Under certain circumstances, we may deny your request to inspect or obtain a copy of your protected health information. If we deny your request, we will notify you in writing and may provide you the option to have the denial reviewed.

If we maintain an electronic health record containing your protected health information and we are required to comply with the new federal privacy requirements related to electronic access, you will have the right to request that we send a copy of your protected health information in an electronic format to you or to a third party that you identify. We may charge a reasonable fee for sending the electronic copy of your protected health information.

Right to Request Restrictions
You may ask us to restrict our uses or disclosures of your protected health information for treatment, payment or health care options. You also have the right to ask to restrict disclosures to family members or others who are involved in your health care or payment for your health care. Your request must be made in writing to our Privacy Officer. In your request, you must tell us
(1) what information you want restricted; (2) whether you want to restrict our use, disclosure or both; (3) to whom you want the restriction to apply, for example, disclosures to your spouse; and (4) an expiration date. We are not required to agree to any requested restriction.

Right to Request Confidential Communications
You may request that we communicate with you using alternative means or at an alternative location. We will not ask you the reason for your request. We will accommodate reasonable requests, when possible.

Right to Restrict Certain Disclosures to Health Plans
You may request that in certain circumstances we not send protected health information to health plans if the protected health information concerns a health care item or service you have paid for out-of-pocket.

Right to Request Amendment
If you believe that the information we have about you is incorrect or incomplete, you may request an amendment to your protected health information as long as we maintain this information. While we will accept requests for amendment, we may deny the amendment request in certain circumstances.

Right to Request an Accounting of Disclosures
You have a right to an accounting of certain disclosures of your health information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or your personal representative; (iii) pursuant to your authorization; (iv) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.

Right to Obtain a Copy of this Notice
You may obtain a paper copy of this notice from us upon request at any time, even if you have agreed to receive this Notice electronically. You may also view this notice electronically on our web site, listed in the “Contact Information” section of this Notice.

OTHER APPLICABLE LAWS
This Notice of Privacy Practices is provided to you as a requirement of HIPAA. There are other federal and state privacy laws that may apply and limit our ability to use and disclose your protected health information beyond what we are allowed to do under HIPAA. Below is a list of the categories of protected health information that are subject to these more restrictive laws and a summary of those laws. These laws have been taken into consideration in developing our policies of how we will use and disclose your protected health information.

Alcohol and Drug Abuse
We are allowed to use and disclose alcohol and drug abuse information without your permission under certain limited circumstances, and/or disclose only to specific recipients.

HIV/AIDS
Restrictions apply to the use and/or retention of HIV/AIDS information.

Mental Health
We are allowed to use and disclose mental health information without your permission under certain limited circumstances, and/or disclose only to specific recipients.

Minors
Some state laws concerning minors permit or require disclosure of protected health information to parents, guardians, and persons acting in a similar legal status. We will act consistently with the law of the state where the treatment is provided and will make disclosures following such state laws.

COMPLAINTS
If you believe these privacy rights have been violated, you may file a written complaint with our Privacy Officer at the address provided in the “Contact Information” section of this notice or HHS. No retaliation will occur against you for filing a complaint.

CONTACT INFORMATION
For further information about the complaint process, or for further explanation of this document, contact:

______________________________________
Signature of Patient or Legal Representative

______________________________________
Witness

______________________________________
Date

______________________________________
Notice Effective Date or Version
OMAHA - MAIN OFFICE
13340 CALIFORNIA STREET, SUITE 201
OMAHA, NE 68154
p 402 614 1999 | f 402 934 8119
www.omahapainphysicians.com

PAPILLION OFFICE
1413 SOUTH WASHINGTON ST. SUITE 240
PAPILLION, NE 68046
Located at the Midlands Professional Center, just north of Midlands Hospital (Inside American National Bank building)