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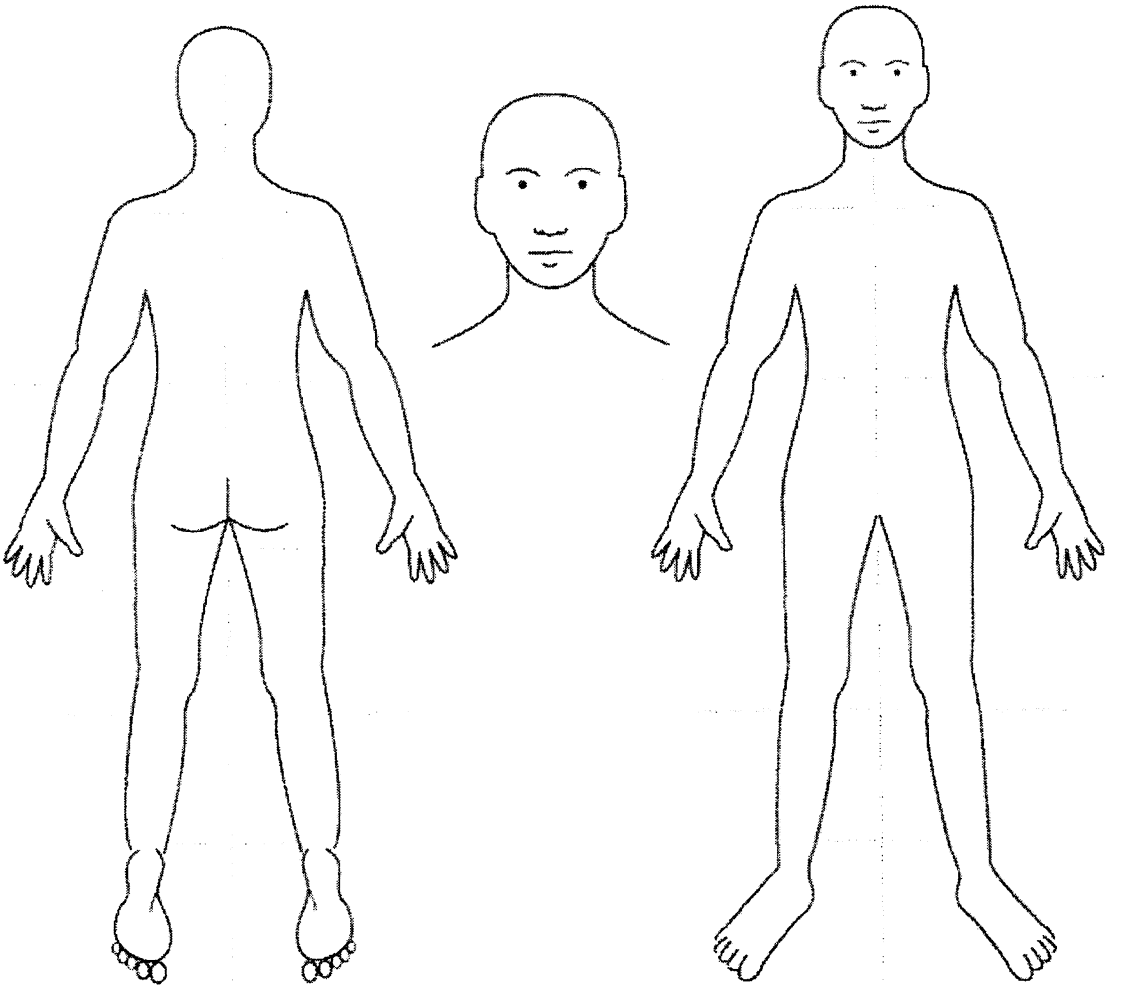
Name: _____
Date: _____
Chart: _____

Pain & Body Chart

Please use the body chart below to help us understand the pain areas

- Please draw on the picture where you feel pain or any other sensations, for example, pins and needles
- **Using the scale of 1-10**, please tell us how intense your pain is **now** for each location.

L R R L



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Name: _____ Date: _____ Chart: _____

Medication & Medical History

ALLERGIES Please list all allergies to medications, **contrast dyes** used in diagnostic tests, or **Latex**, and include what type of reaction you have had to these medications: _____

List ALL CURRENT MEDICATIONS. Please be sure to include any blood thinners (Coumadin, Plavix, Pradaxa, Aggrenox, love NOx etc....) that you are taking. If more room is needed, please use the back of this sheet or attach a separate list.

Medication	Dose	Frequency	Start Date/Duration

PAST MEDICAL HISTORY				
□ Yes □ No	*Do you have a bleeding disorder?*			
□ Yes □ No	*Are you currently pregnant or believe that you may be pregnant?*			
□ Yes □ No	*Have you been diagnosed with any of the following?*			
	□ *Stomach Ulcer or GI Bleed*	□ *Thyroid disorder*	□ *HIV or AIDS*	□ *Psoriasis*
	□ *Reflux/Heartburn*	□ *Pneumonia*	□ *Hepatitis*	□ *Ankylosing Spondylitis*
	□ *Kidney Disease*	□ *Glaucoma*	□ *Asthma*	□ *Crohn's disease*
	□ *Kidney Stones*	□ *Headaches*	□ *COPD*	□ *Ulcerative colitis*
	□*Heart Disease*	□ *Seizure/Epilepsy*	□ *Osteoarthritis*	□ *Reiter's Syndrome*
	□ *High blood pressure*	□ *Peripheral Neuropathy*	□ *Rheumatoid Arthritis*	□ *Liver Disease*
	□ *Circulation problems*	□ *Stroke*	□ *Gout*	□ *Fibromyalgia*
	□ *Aneurysm*	□ *Head injury*	□ *Depression*	□ *Anxiety/Depression*
	□ *Diabetes*	□ *Nerve or muscle disease or injury (including carpal tunnel syndrome)*	□ *Any infection in the last year*	□ *Bone, joint, tendon, or ligament injury*
	□ ***Other*** (including orthopedic injuries):			
□ Yes □ No	Have you ever been diagnosed with tumors or cancer? If yes what type?			

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Genesis Analgesia Center
1408 Currier Lane
Knoxville, Tennessee 37919-8821
PATIENT REGISTRATION
Please Fill Out Both Sides

Patient Name: _____ Chart: _____
Social Security Number: _____ Date of Birth: _____
Address: _____ DL ____ID#: _____
City: _____ State: _____ Zip: _____ * _____
Home Phone: _____ Cell: _____
Which number do you want us to call first when we make our reminder calls? _____

E-Mail Address: _____
**Required if you want access to records on patient portal*

o Invitation Sent

(Circle one for each category) **Gender:** M F ~ **Marital Status:** S M D W
Emergency Contact: _____ Relation: _____
(Social Security Number: _____ Date of Birth: _____)
(***Only needed if they carry your insurance***)

Address: _____
City, State, Zip: _____
Phone: _____ Cell: _____

Physician Information

PCP: _____ Phone: _____
Referring Phys: _____ Phone: _____
Preferred Pharmacy: _____
How did you hear about Genesis Analgesia Center, PLLC? _____

Please Note: Our office makes appointment reminder calls. Would you like to receive appointment reminder notifications via text as well?

☐ Yes, Please send me notifications VIA text messaging to my personal cell number listed above.

☐ No, Not at this time.

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

Parent/Guardian: _____
Signature: _____ Date: _____

If you need to cancel or reschedule appointment please call 865-692-4141 48 hours in advance – Thank you!

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INFORMATION REGARDING ADVANCE DIRECTIVES

Federal law requires that we give you information about your right to make advance health care decisions. Right now, you may be able to make your own health care decisions. You may not always be able to make such Decisions, however. By giving advance directions, you can tell your health care provider and family about the medical care you would like to receive and whether you want another person to be able to accept or refuse treatment for you.

You can name a person to make medical treatment decisions for you by appointing someone to have a "Durable Power of Attorney for Health Care" for you. This person is allowed to make health care decisions for you, including life support decisions, but only after your health care provider certifies that you are no longer able to make your own health care decisions.

You can also leave advance direction about life support by executing a "Living Will". A Living Will tells your health care provider and family about the types of life support that you want to be provided or withheld in case you are ever kept alive by artificial means and are no longer able to make decisions for yourself.

If you already have a Living Will or Durable Power of Attorney for Health Care, please tell your health care provider. We need to put a copy of the document in your medical chart in order to be sure that your wishes are honored. If you want more information on how to name a Durable Power of Attorney for Health Care or how to make a Living Will, please feel free to ask your health provider, hospital, social worker or attorney.

It is our policy to honor our patient's health care decisions to the full extent required or allowed by law. You are NOT required to give advance health care decisions in order to receive care at this facility.

DO YOU HAVE A LIVING WILL? YES____NO____
IF "YES", WILL YOU PROVIDE US WITH A COPY? YES____NO____
DO YOU HAVE A DURABLE POWER OF ATTORNEY? YES____NO____
IF "YES", WILL YOU PROVIDE US WITH A COPY? YES____NO____

_____ _____
Patient Signature Date

Consent to Treat Patient

I, _____ am presenting myself for diagnosis and treatment at Genesis Analgesia Center. I voluntarily consent to the rendering of such care including diagnostic procedures and medical treatment by authorized agents and employees of the facilities, their medical staff, or designees as may in their professional judgment be deemed necessary or beneficial. I acknowledge that no guarantees have been made to me as to the effect of any such examinations or treatment, and I understand any special procedure or treatment involving appreciable risk will be explained to me by a provider and that I may at any time refuse such treatment.
My signature below constitutes:

1. I acknowledge, that I have read, and understood with and agree to the foregoing.
2. I hereby give authorization and consent.

_____ _____
Signature of Patient or Representative Relationship to patient (if other than self)

_____ _____
Witness to Signature (if other than self) Date

If you need to cancel or reschedule appointment please call 865-692-4141 48 hours in advance – Thank you!

Genesis Analgesia Center
1408 Currier Lane
Knoxville, Tennessee 37919-8821
Please Fill Out Both Sides

Privacy Policy

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. Protected health information is health information, including personal demographic information, collected from a patient and created or received by the physician, another healthcare provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to a patient's past, present or future physical or mental health condition. There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your information within our practice for quality control or other operational purposes.
- We may need to use your name, address, telephone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health-related information that may be of interest to you.

You may restrict the individuals or organizations to which your health care information is released or revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address (see above). We will not be able to honor your revocation request if we have already released your health Information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Authorization for Disclosure of Protected Health Information

1. I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Genesis Analgesia Center in writing.
2. I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
3. I may inspect or copy any information used or disclosed under this agreement.
4. I understand that if the person or organization that receives the information is not a health care provider or plan covered by Federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by these regulations.

NOTE
You have the right to know specifically what information you are authorizing for release (i.e., "results of a lab test performed on 1/4/03" or, if your entire medical record is included, "all health information").
You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information (i.e., the names of your health care provider(s).
You have the right to know who is going to use it and what it is going to be used for. (e.g., John Smith, Ph.D. / Research).

If you need to cancel or reschedule appointment please call 865-692-4141 48 hours in advance – Thank you!

***Please note that patients may receive telephone calls regarding confidential healthcare information such as lab test results and upcoming appointments. Please indicate who may receive such information on your behalf and how you would like to receive that information. If you would like to receive lab results or reminders for upcoming appointments via e-mail, please provide us with your current e-mail address.**

Please Check All Preferable Options:

- ❑ Please leave information on my home answering machine.
- ❑ Please leave information on my personal cell phone voicemail.
- ❑ E-mail address: _____

I authorize Genesis Analgesia to provide information regarding my personal healthcare to the following individual(s)

_____ _____
(Name) (Relationship)

_____
(Indicate allowable information type)

_____ _____
(Name) (Relationship)

_____
(Indicate allowable information type)

❑ No one is allowed to have my Medical Information

I, _____ authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____ _____
Patient's Signature or Patient's Representative Date

_____ _____
Printed name of Patient's Representative Relationship to Patient

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

HIPAA Authorization for Release of Information- This form does not constitute legal advice and covers only Federal Not State laws.

This authorization will expire in seven years after the date on which you last received services from us.

If you need to cancel or reschedule appointment please call 865-692-4141 48 hours in advance – Thank you!

Genesis Analgesia Center Office Policies

Payment Policy

1.) **Insurance:** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are not insured by a plan we do business with, but don't have an up to date insurance card, payment in full for each visit is required until we can verify your coverage.

2.) **Co-Payments and deductibles:** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying those at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any question you may have regarding your coverage.

3.) **Non-covered services:** Please be aware that some and perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of the visit.

4.) **Claims:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

5.) **Coverage Changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

6.) **Nonpayment:** Finance charges may be added to outstanding balances. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. If Genesis Analgesia Center, PLLC takes legal action to collect any unpaid balance. The patient agrees to pay reasonable court cost and attorney fees.

Hours and Operations Policies

1.) **Missed Appointments:** ***Our Policy is to charge for missed appointments not canceled within 24 hours.*** These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment. **Initial here:** _____ **Thank you.**

2.) **Pricing:** Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

3.) **Hours of Operation:** We will be open Monday, Tuesday and Thursday from 8 am till 4:30 pm. ***Wednesday & Friday we are closed***. We will be closed on holidays.

4.) **Refills: It is our policy to NOT refill prescriptions over the phone.** Please ensure that you make all scheduled appointments and bring your medications to every appointment. Please make follow-up appointments with holidays and weekends in mind so as to NOT run out of your meds. **Initial here:** _____ **Thank you.**

5.) **Dismissal from Genesis Analgesia Center:** We hope to be your healthcare provider for many years. There are certain instances that will force our providers to dismiss you from our practice. They are listed below:

- **a.** Three (3) appointments that are missed without the patient notifying the office in advance.
- **b.** Balances that are left unpaid for ninety (90) days unless prior arrangements have been made.
- **c.** Any act of dishonesty
- **d.** Any act of violence toward our staff or property.

I have read and understand the policies above and agree to abide by these guidelines:

_____ _____

Signature of Patient or Patient Representative **Date**

If you need to cancel or reschedule appointment please call 865-692-4141 48 hours in advance – Thank you!

Consent for Patient Testing After Healthcare Worker Exposure

Genesis Analgesia Center, PLLC healthcare workers handle blood and other body fluids for many reasons such as when performing lab tests, cleaning equipment, and performing procedures. It is the policy of Genesis Analgesia Center, PLLC to test a patient for Hepatitis B, Hepatitis C and HIV (the virus that causes AIDS) if any employee or healthcare worker is exposed to a patient's blood or other body fluid in such a way that transmission of these infections could occur; Should an accidental exposure occur the tests would be conducted at our cost. We are requesting that you consent to these tests prior to treatment. My signature below indicates my consent to testing my blood or body fluid for Hepatitis B, Hepatitis C, or HIV.

_____ _____

Signature of Patient or Representative Date

I decline to authorize the above testing, and upon doing so, I understand that Genesis Analgesia Center, PLLC will not treat me as a patient.

_____ _____

Signature of Patient or Representative Date

If you need to cancel or reschedule appointment please call 865-692-4141 48 hours in advance – Thank you!

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Do not fill out this page. Just Sign. Thank you!

David Newman, M.D. – 1408 Currier Lane Knoxville, TN 37919-8821 – Office: (865)692-4141 Fax: (865)692-1224

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

Previous Name(s): _____

I request and authorize _____
to release my healthcare information to

Dr. David Newman – Genesis Analgesia Center, PLLC – 1408 Currier Lane Knoxville, TN 37919

*****PLEASE FAX ALL DOCUMENTS TO 865-692-1224*****

This request and authorization applies to:

- o Healthcare information relating to the following treatment, condition and dates:
  _____
  _____
  _____
  _____
  _____
  _____
  _____
  _____
- o All Healthcare Information
- o Other: _____

Patient Signature: _____ Date: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

If you need to cancel or reschedule appointment please call 865-692-4141 48 hours in advance – Thank you!

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Watermark Medical ARES Questionnaire

PRINT IN CAPITAL LETTERS – STAY WITHIN THE BOX

First Name		Middle Initial	Last Name		Tally ARES Risk Points
Weight	Pounds	**Age**	Years	Gender: Male ○ Female ○	Neck Size +2 Male ≥16.5 +2 Female≥15.0
Height	Feet / Inches		**Neck Size**	Inches	
Date of Birth	Month / Day / Year		**ID Number**	Optional	Score

COMPLETELY FILL IN ONE CIRCLE FOR EACH QUESTION – ANSWER ALL QUESTIONS

Have you been diagnosed or treated for any of the following conditions?

Co-morbidities +1 for each Yes response — Score

High blood pressure	Yes ○	No ○	Stroke	Yes ○	No ○
Heart disease	Yes ○	No ○	Depression	Yes ○	No ○
Diabetes	Yes ○	No ○	Sleep apnea	Yes ○	No ○
Lung disease	Yes ○	No ○	Nasal oxygen use	Yes ○	No ○
Insomnia	Yes ○	No ○	Restless leg syndrome	Yes ○	No ○
Narcolepsy	Yes ○	No ○	Morning Headaches	Yes ○	No ○
Sleeping Medication	Yes ○	No ○	Pain Medication e.g., vicodin, oxycontin	Yes ○	No ○

Do not assign any points for these eight responses

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

0 = would never doze; 1 = slight chance of dozing; 2 = moderate chance of dozing; 3 = high chance of dozing

Epworth Score **TOTAL** the values from all 8 questions. If 11 or less **Score = 0** If 12 or more **Score = 2**

	0	1	2	3
Sitting and reading	○	○	○	○
Watching TV	○	○	○	○
Sitting, inactive, in a public place (theater, meeting, etc)	○	○	○	○
As a passenger in a car for an hour without a break	○	○	○	○
Lying down to rest in the afternoon when circumstances permit	○	○	○	○
Sitting and talking to someone	○	○	○	○
Sitting quietly after lunch without alcohol	○	○	○	○
In a car, while stopped for a few minutes in traffic	○	○	○	○

Score

Assign points for each of the first three responses

Frequency 0 - 1 times/week 1 - 2 times/week 3 - 4 times/week 5 - 7 times/week

On average in the past month, how often have you snored or been told that you snored?

Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Do you wake up choking or gasping?

Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Have you been told that you stop breathing in your sleep or wake up choking or gasping?

Never ○ Rarely ○ +1 Sometimes ○ +2 Frequently ○ +3 Almost always ○ +4

Do you have problems keeping your legs still at night or need to move them to feel comfortable?

Never ○ Rarely ○ Sometimes ○ Frequently ○ Almost always ○

Signature	Area Code / Phone Number	**Total all 6 boxes from above** If point total = 4 or 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)	**Point Total**