Todd E. Handel, M.D.
Interventional Physiatrist, Clinical Assistant Professor

BROWN
Alpert Medical School

Handel Center

Spine Sports Pain Intervention

******VERY IMPORTANT*** PLEASE READ********

Dear Patient:

This letter is to confirm your appointment on _____ at _____. (directions on reverse side)

Enclosed you will find forms that MUST be completed PRIOR to your appointment. Please remember to bring completed forms, your insurance card, ID and required co-pay which is required at time of visit. Health plans that require a referral is the sole responsibility of the patient and is expected prior to your scheduled appointment.

Please arrive 20minutes prior to your appointment time, so we may have time to complete all necessary paper work.

Also, please bring your most recent MRI, CT scans or X-Rays films that you may have related to the reason you are coming in. Please request that the report is included with these films.

If you need to reschedule or cancel your appointment, please contact the office at (401)305-5280 at least 24hrs in advance.

PLEASE NOTE IF YOU ARE MORE THAN 15MINUTES LATE FOR YOUR APPOINTMENT YOU WILL NEED TO BE RESCHEDULED.

Thank you for your cooperation. We look forward to meeting you and participating in your healthcare.

Sincerely,
Handel Center

Todd E. Handel MD

100 Highland Street, Suite 102 Providence, RI 02909
401.305.5280 401.305.5285 FAX www.handelcenter.com

HANDEL CENTER FOR SPINE, SPORT, AND PAIN INTERVENTION

ALL INFORMATION MUST BE COMPLETED

FIRST NAME: _____ MI: ____ LAST NAME: _____
TODAY'S DATE: _____ D.O.B.: _____ SEX: ____ SS #: _____-____-_____
ADDRESS: _____ CITY: _____ STATE: ___ ZIP: _____
CELL PHONE: (____) ____-_____ HOME PHONE: (____) ____-_____
WORK PHONE: (____) ____-_____ PREFFERED PHONE: ☐ Cell ☐ Home ☐ Work
EMAIL ADDRESS: _____ RACE: _____
PREFERRED LANGUAGE: _____

PHARMACY NAME: _____ PHARMACY PHONE: (____) ____-_____
PHARMACY ADDRESS: _____

EMPLOYER: _____ EMPLOYER PHONE: (____) ____-_____
EMPLOYER ADDRESS: _____

CONTACT PERSON IN CASE OF EMERGENCY: _____
RELATIONSHIP: _____ EMERGENCY CONTACT #: (____) ____-_____

PRIMARY CARE PHYSICIAN: _____ PHONE: (____) ____-_____
ADDRESS: _____ CITY: _____ STATE: ___ ZIP: _____

REFERRING PHYSICIAN: _____ PHONE: (____) ____-_____
ADDRESS: _____ CITY: _____ STATE: ___ ZIP: _____

INSURANCE NAME (Please be as specific as possible): _____
INSURANCE CO. ADDRESS: _____
NAME OF PERSON HOLDING POLICY: _____ RELATIONSHIP: _____
SUBSCRIBER NUMBER: _____ GROUP NUMBER: _____

IF YOU HAVE TWO INSURANCES, PLEASE COMPLETE THE FOLLOWING:
SECONDARY INSURANCE NAME: _____
INSURANCE CO. ADDRESS: _____
NAME OF PERSON HOLDING POLICY: _____ RELATIONSHIP: _____
SUBSCRIBER NUMBER: _____ GROUP NUMBER: _____

APPOINTMENT NO-SHOW POLICY

Patient Name: _____ Date: _____

I have been notified of the "no-show" policy by The Handel Center as follows:

- It is your responsibility to keep track of your appointments. Our office calls as a courtesy reminder.
- No-Show Office Appointment: $25.00 fee, this fee must be paid prior to next scheduled appointment or your appointment will be rescheduled.
- No-Show Procedure Appointment: $50.00 fee, this fee must be paid prior to next scheduled appointment or your appointment will be rescheduled.

These charges are your responsibility and are NOT covered under your health insurance plan

Patient Signature: _____

PLEASE READ CAREFULLY AND SIGN BELOW:

I authorize that payment be made on my behalf directly to the Handel Center by my health insurance plan or its agents for all covered services rendered by this provider and his employees or contracted agents.

I understand that it is my responsibility to pay the provider directly for services not covered by my health insurance plan and all applicable copays and/or deductibles. I acknowledge and agree that these payments may be due at the time of service is directed by the provider and the terms of my health insurance.

I agree to contact the provider's office at (401) 305-5280 24 hours prior to my appointment to cancel. Otherwise, I acknowledge that I may be billed a no-show fee of $25.00.

I understand that under the Health Insurance Portability and Accountability Act of 1999 (HIPAA) as amended, I have certain rights to privacy regarding my protected health information. I understand that at any time I may request a more detailed PHI Privacy Policy containing a more complete and updated description of the uses and potential disclosures of my health information.

I understand that at any time a PMP (prescription monitoring program) report will be reviewed.

I understand that anytime at doctor/PAC/NP's discretion a random urine drug screening will be obtained.

_____ Date: _____/_____/_____

Signature of patient and/or guardian

STATEMENT OF FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFITS

I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by The Handel Center. I authorize payment to The Handel Center. I understand that my insurance carrier may not approve or reimburse my medical services in full, due to usual and customary rates, benefit exclusions, coverage limits, and lack of authorization or medical necessity. I understand that I am responsible for paying my provider directly for any policy deductibles, co-insurance, or co-payments within thirty (30) days of service. Failure to meet these obligations may affect my credit history. I also understand that I will be responsible for any costs resulting in my failure to pay, such as collection fees by a Handel Center attorney. Presenting an invalid or inactive insurance card will result in full responsibility of payment by me. I understand that if I do not have an authorization for a visit and my insurance requires one that I may be responsible for the full charges for that date of service. If for any reason I cannot make the full required payment, I understand that I may call The Handel Center to make advance arrangements.

MISSED APPOINTMENT/RETURNED CHECK NOTICE

Due to the nature of our practice, we require a 24-hour notification if you're unable to keep your appointment. Patients who no-show three (3) times in a 12-month period may be discharged from the practice, thus they will be denied any future appointments. There is also a fee for any returned checks.

POLICY OF STATEMENT CHARGES

Insurance copayments, coinsurance , and deductibles are due at the time of service. After ninety (90) days your account will be turned over to collections.

_____ _____

Patient's Signature Date

_____ _____

Patient's Name (Printed) Patient's Date of Birth

PATIENT CONFIDENTIALITY FORM

1. Can we call your cell number to:
   a. Confirm appointments ☐ Yes ☐ No
   b. Change appointments ☐ Yes ☐ No

2. Can we call your home number to:
   a. Confirm appointments ☐ Yes ☐ No
   b. Change appointments ☐ Yes ☐ No

3. Can we leave messages on your answering machine about:
   a. Appointment confirmation ☐ Yes ☐ No
   b. Appointment cancellation ☐ Yes ☐ No
   c. Test results ☐ Yes ☐ No
   d. Just to ask you to call the office ☐ Yes ☐ No

4. Can we leave messages with anyone else besides you?
   a. If so, whom:

   _____

5. If applicable, can we call you at your work number?
   a. Leave messages on work voicemail? ☐ Yes ☐ No
   b. Leave messages with co-workers to have you call us? ☐ Yes ☐ No

Patient Signature: _____ D.O.B.: _____
Print Name: _____ Date: _____

PATIENT ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Patient Name: _____ D.O.B.: _____

I hereby acknowledge that I have received an individual copy of the Privacy Practices from The Handel Center.

Signature: _____ Date: _____

Please take a few minutes to complete this form. Your careful answers will help us to understand your problem and design the best treatment program for you. The form also helps keep our office on schedule by minimizing patient wait times. Information on this form is kept confidential and will become part of your medical record.

Are you ☐ Right or ☐ Left-Handed?

What is the **main problem** for which you are seeking treatment at our clinic?

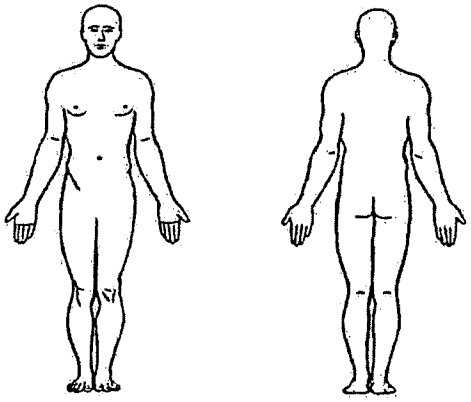
_____

When and **how** did your current pain start?

_____

Please describe the **location(s)** of your pain: _____

Please mark the locations of your pain on the diagrams below by shading painful areas.



Did your pain start ☐ suddenly or ☐ gradually?

Have you ever had similar problems before? ☐ Yes ☐ No

Which of the following best describes the **frequency** of your pain? (please check one)

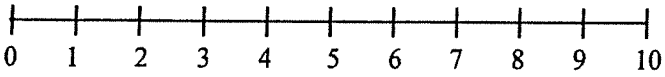
☐ Constant
☐ Intermittent and occurring daily
☐ Infrequent
☐ Intermittent and occurring on most days

How would you describe your pain (choose as many adjectives as are applicable):

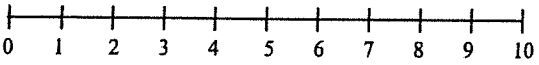
☐ Burning ☐ Sharp ☐ Cutting ☐ Throbbing
☐ Cramping ☐ Numbness ☐ Dull, aching ☐ Pressure
☐ Pins and Needles ☐ Shooting ☐ Electric-like ☐ Other: _____

PAIN SEVERITY

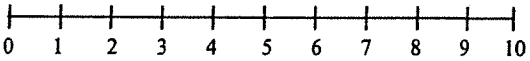
Circle your current pain with "0" representing no pain and "10" the most severe pain imaginable.



Circle your **best** pain over the last 7 days:



Circle your **worst** pain over the last 7 days:



How do the following affect your pain? Please check one for each item.

	Decrease	*No Change*	*Increase*
Lying down	☐	☐	☐
Standing	☐	☐	☐
Sitting	☐	☐	☐
Walking	☐	☐	☐
Driving	☐	☐	☐
Medications	☐	☐	☐
Relaxation/Rest	☐	☐	☐
Coughing/Sneezing	☐	☐	☐
Lifting/Bending	☐	☐	☐
Bowel Movements	☐	☐	☐

TREATMENTS

Please check all previous or current treatments that you have tried for your pain. Include the date and indicate if it provided you with any relief.

	Approx. Date	*No Relief*	*Moderate Relief*	*Excellent Relief*
☐ Physical Therapy		☐	☐	☐
☐ Occupational Therapy		☐	☐	☐
☐ Surgery		☐	☐	☐
☐ Back Corset or Brace		☐	☐	☐
☐ Acupuncture		☐	☐	☐
☐ Injections		☐	☐	☐
☐ TENS		☐	☐	☐
☐ Medication		☐	☐	☐
☐ Exercise		☐	☐	☐
☐ Biofeedback		☐	☐	☐
☐ Psychotherapy		☐	☐	☐
☐ Chiropractic		☐	☐	☐

PREVIOUS DIAGNOSTIC STUDIES

Please check any that have been done and include the approximate date(s).

☐ MRI	☐ Discogram
☐ CT Scan	☐ Myelogram
☐ X-Rays	☐ EMG

PAST SURGICAL HISTORY

Please include approximate date and the type of operation.

Spine Surgery:
Other:

PAST MEDICAL HISTORY

Have you ever had any of the following health problems? Please check all that apply.

☐ High Blood Pressure ☐ Diabetes or high blood sugar ☐ Kidney Disease

☐ Heart Disease ☐ Sleep Apnea ☐ Liver Disease

☐ Asthma or Wheezing ☐ Seizure or epilepsy ☐ Bleeding Problems

☐ Cancer, or any history of cancer; please specify: _____

☐ Other; please specify: _____

ALLERGIES

Please list any allergies: _____

_____

FAMILY MEDICAL HISTORY

What illnesses/diseases run in your family? Please check all that apply.

☐ High Blood Pressure ☐ Diabetes or high blood sugar ☐ Kidney Disease

☐ Heart Disease ☐ Sleep Apnea ☐ Liver Disease

☐ Asthma or Wheezing ☐ Seizure or epilepsy ☐ Bleeding Problems

☐ Cancer, or any history of cancer; please specify: _____

☐ Other; please specify: _____

PSYCHOSOCIAL HISTORY

FUNCTIONAL

Do you currently, or have you ever, engaged in a regular exercise program? ☐ Yes ☐ No

If yes, what type of program? _____

Does your pain limit your ability to participate in:

Daily Activities: ☐ Yes ☐ No Recreational Activities: ☐ Yes ☐ No

EDUCATION AND EMPLOYMENT

What is your highest level of education? _____

What is your current or former occupation? _____

Are you working currently? ☐ Yes ☐ No If so, how many hours per week? _____

Do you have any work restrictions recommended by other doctors? ☐ Yes ☐ No

Is your job ☐ sedentary ☐ light ☐ medium or ☐ heavy?

If you are currently unemployed or employed part-time, is this due to your present pain condition? ☐ Yes ☐ No

If you are unemployed, please indicate how long you have been off work: _____

FAMILY

Are you ☐ single ☐ married ☐ widowed ☐ separated or ☐ divorced?

If you have children, what are their ages? _____

SUBSTANCE ABUSE

Do you have any history of alcoholism? ☐ Yes ☐ No

Have you ever been in a detox program for substance abuse? ☐ Yes ☐ No

Do you or did you ever smoke cigarettes? ☐ Yes ☐ No ☐ Quit ___ years ago.

How many years have you smoked? ___ How much do or did you smoke per day? _____

PSYCHOLOGICAL HISTORY

Have you ever had psychiatric or psychological evaluations or treatments for any problem, including your current pain? ☐ Yes ☐ No

Have you ever experienced physical or emotional injury/abuse from a parent or other primary caregiver? ☐ Yes ☐ No

LEGAL

Please indicate any of the following claims you have filed related to your pain problem:

☐ Worker's Compensation ☐ Personal Injury/Liability (unrelated to work)

☐ Supplemental Security Income (SSI) ☐ Social Security Disability Insurance (SSDI)

REVIEW OF SYSTEMS

Please check all items that you feel are applicable to you.

	Y	N
Have you experienced any unexplained weight loss?		
Do you have any fever or chills?		
Have you had any recent infections?		
Do you have a bleeding problem?		
Do you have a thyroid problem?		
Do you have a rash?		
Do you have shortness of breath?		
Do you have palpitations (awareness of fast heart)?		
Do you have chest pain?		
Do you have nausea?		
Have you had any abdominal pain?		
Have you had any diarrhea?		
Do you have any problems controlling your bowels?		
Do you have any problems controlling your bladder?		
Do you have any pain with urination?		
Does pain limit your current sexual activity?		
Do you have joint pain (knee, elbow, etc.)?		
Have you had any joint swelling?		
Do you have any numbness in your arms or legs?		
Have you experienced any recurrent headache?		
Do you have a problem with dizziness or keeping balance?		
Do you have any numbness in your genital area?		
Do you have trouble walking?		
Do you have paralysis or any muscle weakness?		
Do you frequently feel fatigued?		
Have you had any changes in your appetite?		
Do you feel depressed?		
Do you frequently feel anxious?		
Do you have difficulties with sleep?		
Do you have severe nighttime pain?		

How many hours do you sleep on an average night? _____ hours

PAST MEDICATIONS

Using the list below, please indicate the prescription medications that you have tried in the **PAST** by checking the box(es).

NARCOTICS

- ☐ Tylenol with codeine
- ☐ Darvocet (Propoxyphene)
- ☐ Percocet
- ☐ Oxycodone
- ☐ Morphine
- ☐ Codeine
- ☐ Vicodin
- ☐ Hydrocodone
- ☐ Lortab
- ☐ Dilaudid (Hydromorphone)
- ☐ Demerol (Meperidine)
- ☐ Fentanyl
- ☐ Duragesic Patch
- ☐ Oxycontin
- ☐ Methadone
- ☐ MS Contin
- ☐ Levorphanol

ANTIINFLAMMATORIES (NSAIDS)

- ☐ Ibuprofen (Motrin, Advil)
- ☐ Naprosyn (Naproxen)
- ☐ Aleve (Naproxen)
- ☐ Aspirin
- ☐ Lodine (Etodolac)
- ☐ Relafen (Nabumetone)
- ☐ Celebrex
- ☐ Indomethacin (Indocin)
- ☐ Toradol (Ketorolac)
- ☐ Vioxx
- ☐ Mobic

ANTI-DEPRESSANTS

- ☐ Elavil (Amitriptyline)
- ☐ Pamelor (Nortriptyline)
- ☐ Norpramin (Desipramine)
- ☐ Sinequan (Doxepin)
- ☐ Desyrel (Trazodone)
- ☐ Zoloft (Sertraline)
- ☐ Prozac (Fluoxetine)
- ☐ Paxil (Paroxetine)
- ☐ Wellbutrin (Bupropion)
- ☐ Effexor (Venlafaxine)
- ☐ Serzone (Nefazodone)

ANTISPASMODICS

- ☐ Flexeril (Cyclobenzaprine)
- ☐ Soma (Carisoprodol)
- ☐ Baclofen (Lioresal)
- ☐ Zanaflex (Tizanidine)
- ☐ Norflex (Orphenadrine)
- ☐ Robaxin (Methocarbamol)

ANTI-ANXIETY

- ☐ Ativan (Lorazepam)
- ☐ Klonopin (Clonazepam)
- ☐ Valium (Diazepam)
- ☐ Xanax (Alprazolam)
- ☐ Serax (Oxazepam)
- ☐ Halcion (Triazolam)
- ☐ Buspar (Buspirone)

OTHERS

- ☐ Neurontin (Gabapentin)
- ☐ Ultram (Tramadol)
- ☐ Ambien (Zolpidem)
- ☐ Topamax (Topiramate)
- ☐ Tegretol (Carbamazepine)
- ☐ Dilantin (Phenytoin)
- ☐ Phenobarbital
- ☐ Lamictal (Lamotrigine)
- ☐ Depakote (Valproic Acid)

CURRENT MEDICATIONS

Please list all medications that you are taking **currently**, including both the ***dose*** and ***frequency***.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____