Benjamin Ladner, M.D.
Jimmy Dunn, M.D.
Taylor Pool, D.O.
Jennifer Christopher, CRNP

- Welcome to Athens Limestone Pain Center. We are honored that you have chosen us as your pain care provider. Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner.
- You will need to bring your insurance card and a photo ID with you for each appointment. Please let our staff know if you have had any information changes since your last appointment. If you are unable to provide us with your insurance card, your appointment will need to be rescheduled.
- All co-pays and past due balances are expected at time of service, unless a prior agreement has been made with our billing department.
- We ask that you allow plenty of time to get to the office for your appointment. You will be asked to reschedule your appointment if you are more than 15 minutes late. We will strive to stay on time. From time to time, a patient emergency arises and we may be running late for your visit. You will have the option to re-schedule or stay to be seen and we will keep you informed of how long of a delay you may experience.
- Please bring all of your prescription and over-the-counter medications with you at each visit.
- Our office policy for a missed appointment is:
  We understand that appointments sometime need to be changed, so we ask that you call in advance if you cannot keep your scheduled appointment (256-262-2190). Otherwise, you are subject to a $25.00 “no-show” fee.
- Providing the highest quality of professional care to our patients is very important to us. Therefore, the following guidelines for dispensing medications in our office have been established:
  1. If you are on a medication that requires refills, you will be given ample refills for 30 or 90 days at a time during your office visit.
  2. For the safety and well-being of our patients:
  a. Requests for new medications and medication refills will not be taken over the phone during office hours without an appointment and evaluation by the provider.
  b. No new medications will be called in over the phone after office hours.

Athens Limestone Pain Center is affiliated with Athens Limestone Hospital. I am on the medical staff at Athens Limestone Hospital and work with the many specialty physicians there. I will be directing our patients to use Athens Limestone Hospital’s laboratory services and imaging resources. Our electronic medical record allows us to receive patient results quickly and efficiently through our direct link. This is an important resource in meeting our goal of providing high quality care in a timely manner.

Welcome to our practice and thank you for choosing Athens Limestone Pain Center.

Sincerely,

Athens Limestone Pain Center Physicians

209 Fitness Way
Athens, AL 35611
Phone: 256-262-2190 Fax: 256-262-2196

PATIENT INFORMATION:

Last Name_______________________ First Name__________________________ Middle________________

Male/Female_______ SS#__________________ Marital Status_________________ Date of Birth________

Race______________ Ethnic Group________________ Primary Language Spoken ____________________

Street Address_________________________________ City/State____________________ Zip____________

Home Phone__________________ Cell Phone____________________ Work Phone___________________

Email Address_________________________________ Preferred Reminder Method___________________

Employer______________________ Retired_____ Homemaker____ Disabled____ Unemployed____

Preferred Pharmacy_______________________________

INSURANCE: _________________________ Contract # ____________________ Group # ______________

Secondary Insurance __________________ Contract # ____________________ Group # ______________

EMERGENCY CONTACT:

Name___________________________ Phone_____________________ Relationship__________________

RESPONSIBLE PARTY INFORMATION (If Not Self)

Full Name____

Street Address_________________________________ City/State____________________ Zip____________

Home Phone__________________ Cell Phone____________________ Work Phone____________________

Date of Birth__________ Marital Status ___________SS#_________________ Relationship_____________

***How did you hear about us? ___Source Magazine ___Facebook ___Friend/Family ___Billboard**

___Internet search ___Hospital Inpatient ___Other, Please specify_____________________________

I hereby authorize and direct payment to Valley Internal Medicine for medical benefits, if any, otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for the charges not covered by this authorization. I understand that checks returned for non-payment will incur a $30.00 fee. I hereby authorize Valley Internal Medicine to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of processing claims for medical services. I understand that regardless of my insurance status, I am solely responsible for payment of any services rendered to me, or on my behalf, whether or not paid by my insurance company.

Patient/Responsible Party Signature_________________________________ Date______________

Due to the Privacy Confidential Act, please list the following people that you approve to have access to your information as stated below:

Billing Information: ________________________ **Relationship**: ________________________________

________________________ **Relationship**: ________________________________

Medical Information: ______________________ **Relationship**: ________________________________

________________________ **Relationship**:________________________________

Authorization to Leave Messages:
I hearby authorize Athens-Limestone Pain Center staff to leave messages regarding my medical condition, such as lab results, imaging results, other test results, medications, and appointment reminders on my home/cell answering machine/voicemail. This authorization will be in effective until I have given written notice to Athens-Limestone Pain Center.

Check one of the following:

Agree: ___________ **Disagree**: __________

We are required by law to maintain the privacy of, and provide individuals with a notice of our legal duties and privacy practices with respect to protected health information (PHI). If you have any objections to this form, please ask to speak to the HIPAA Compliance Officer in person or by phone at Athens-Limestone Hospital.

Signature below is acknowledgement that you have received this Notice of our Privacy Practices and agree to all information listed above. Signature below also indicates that you have received a copy of the Patient Rights and Responsibilities for Athens-Limestone Health Services Clinics.

Patient's Printed Name: _______________________________

Patient's Date of Birth: ________________________________

Signature of patient/patient's representative: ____

Date: _______________________________

Name: ____

Date of Birth: ____________________________________

Patient Health Assessment

Please use ink pen and fill in all applicable areas. If you have any questions, please discuss with doctor or nurse at your initial visit.

Indicate special communication needs of which we should be aware

□ Vision □ Speech □ Learning Disability □ Hearing □ Language

Recent Immunizations Indicate whether or not you have received the following immunizations. If yes, indicate approximate year received.

Yes	No		Yes	No	
□	□	Flu ________________			
□	□	Hepatitis B ___________	□	□	Chicken Pox ____________
□	□	Pneumovax 23 ________	□	□	TB Skin Testing__________
□	□	Prevnar 13____________	□	□	T DAP_________________
□	□	Tetanus (TD) __________	□	□	Meningitis_______________

Nutrition

Yes	No	
□	□	Do you follow any special diet (diabetic, low protein, low sodium, low fat)? If yes, specify: ____________________
□	□	Do you have any other nutrition needs (food preferences, food intolerance, texture modification)? If yes, explain: ____________________

Life Habits

Yes	No	
□	□	Do you live alone? If no, with whom do you live?____________________
□	□	Have you ever used nicotine? (Circle Cigarettes, pipe, cigar) How much per day?________ How many years? ___________
□	□	Do you currently use nicotine? If yes, what do you use? (Circle Cigarettes, pipe, cigar, smokeless tobacco, nicotine gum/patch?) How much per day?___________ For how many years?_________________
□	□	Are you regularly exposed to secondhand smoke?
□	□	Do you currently use alcohol? If yes, how much per day?_________ How often?____________ Past use?__________
□	□	Do you currently use any illicit drugs? If yes, what? _____________ How often?____________ Past use?__________
□	□	Are you currently exposed to occupational hazards? If yes, what kind?____________________
□	□	Do you have problems sleeping? If yes, explain____________________
□	□	Will you need help in planning for your care?____________________
□	□	Do you walk independently? If not, explain____________________
□	□	Do you need help with feeding □ dressing □ bathing □ toileting □ If yes, explain____________________

Domestic Violence

Yes	No	
□	□	Are you being abused, injured or frightened by anyone at home or in another area of your life?

Beliefs, Rights, and Values

Yes	No	
□	□	Do you have ethnic, religious, spiritual or cultural practices that need to be part of your care? ____________________
□	□	Do you have financial concerns related to your medical care? Circle those that apply: job insurance other
□	□	Do you have children? How many? Adult____________ Minor___________
□	□	Do you have a guardian? If yes,_________ whom?______________________________
□	□	Do you have an Advance Directive (e.g. living will or durable medical power of attorney)? If yes, bring a copy with you to the office upon your admission. If not, information is available upon request.
□	□	Are you an organ/tissue donor?

PAST MEDICAL HISTORY FORM **Name**: ________________________ **Date of Birth**: __________

Check the box if the condition pertains to you and write comments if necessary.

Cardiovascular Comment
- ☐ Arrhythmia ________________
- ☐ Angina ________________
- ☐ Atrial Fibrillation ________________
- ☐ CHF ________________
- ☐ Heart Disease ________________
- ☐ Heart Attack ________________
- ☐ High Blood Pressure ________________
- ☐ High Cholesterol ________________
- ☐ Pacemaker/Defibulator ________________
- ☐ Vascular Disease ________________
- ☐ Other ________________

Respiratory Comment
- ☐ Asthma ________________
- ☐ COPD ________________
- ☐ Emphysema ________________
- ☐ Sleep Apnea ________________
- ☐ TB ________________
- ☐ Other ________________

Gastrointestinal Comment
- ☐ Celiac Disease ________________
- ☐ Constipation ________________
- ☐ Diarrhea ________________
- ☐ Diverticulitis ________________
- ☐ Diverticulosis ________________
- ☐ GERD ________________
- ☐ Heartburn ________________
- ☐ Hepatitis ________________
- ☐ Hiatal Hernia ________________
- ☐ IBS ________________
- ☐ Other ________________

Renal/Genitourinary Comment
- ☐ BPH ________________
- ☐ Endometriosis ________________
- ☐ Erectile Dysfunction ________________
- ☐ Kidney Stones ________________
- ☐ Polycystic Kidney Disease ________________
- ☐ Renal Failure ________________
- ☐ Urinary Incontinence ________________
- ☐ UTI, Recurrent ________________
- ☐ Other ________________

Musculoskeletal Comment
- ☐ Arthritis ________________
- ☐ Chronic Pain ________________
- ☐ Fibromyalgia ________________
- ☐ Gout ________________
- ☐ Numbness/Weakness ________________
- ☐ Osteoarthritis ________________
- ☐ Osteoporosis ________________
- ☐ RA ________________
- ☐ Other ________________

Endocrine Comment
- ☐ Addison Disease ________________
- ☐ Cushing Disease ________________
- ☐ Type I Diabetes ________________
- ☐ Type II Diabetes ________________
- ☐ Hyperthyroidism ________________
- ☐ Hypothyroidism ________________
- ☐ Other ________________

Neurological Comment
- ☐ Alzheimer's Disease ________________
- ☐ ADD/ADHD ________________
- ☐ Dementia ________________
- ☐ Faint/Dizziness ________________
- ☐ Headache-Migraine ________________
- ☐ Headache-Tension ________________
- ☐ MS ________________
- ☐ Neuropathy ________________

Neurological (Continued) Comment
- ☐ Stroke ________________
- ☐ Cognitive Impairment ________________
- ☐ Other ________________

Hematologic
- ☐ Anemia ________________
- ☐ Hepatitis B ________________
- ☐ Hepatitis C ________________

PAST MEDICAL HISTORY FORM Cont.….

- ☐ Seizures ________________
- ☐ Iron Deficiency ________________
- ☐ Other ________________

Allergy/Immunology/Dermatology Comment

- ☐ Allergies ________________
- ☐ Chicken Pox ________________
- ☐ Eczema ________________
- ☐ Sinus, frequent ________________
- ☐ Other ________________

Ears/Nose/Throat

- ☐ Vertigo/Dizziness ________________
- ☐ Hearing Loss ________________
- ☐ Otitis ________________
- ☐ Tinnitus ________________
- ☐ Other ________________

Psychiatric Comment

- ☐ Anxiety ________________
- ☐ Depression ________________
- ☐ Bipolar Disorder ________________
- ☐ Schizophrenia ________________
- ☐ Personality Disorder ________________
- ☐ Substance Abuse ________________
- ☐ Panic Attacks ________________
- ☐ PTSD ________________
- ☐ Eating Disorder ________________

Other Conditions Comment

- ☐ Insomnia ________________
- ☐ AIDS/HIV ________________
- ☐ Cancer ________________
- ☐ Cataracts ________________
- ☐ Glaucoma ________________
- ☐ Other ________________

ALLERGIES

Check Appropriate Allergy, Then Write Specific Allergy / Reaction

- ☐ **NO KNOWN DRUG ALLERGIES**
- ☐ **FOOD:** ________________
- ☐ **MEDICATIONS:** ________________
- ☐ **OTHER:** ________________

Previous Surgeries

Date: ________ Surgery________________ Date: ________ Surgery________________
Date: ________ Surgery________________ Date: ________ Surgery________________
Date: ________ Surgery________________ Date: ________ Surgery________________

Last:

Colonoscopy Date: _______ Mammogram Date: _______ Bone Density Date: ________
Pap Smear Date: _______ Eye Exam Date: _______ Dental Exam Date: ________

Please list all other Healthcare Providers you see:

Doctor: ________________________ Specialty: ________________
Doctor: ________________________ Specialty: ________________
Doctor: ________________________ Specialty: ________________
Doctor: ________________________ Specialty: ________________
Doctor: ________________________ Specialty: ________________
Doctor: ________________________ Specialty: ________________

Patient's Name: ________________________________Date of Birth:________________________

Family History (Complete Health Information about your family)

Disease	Family Member (Circle one)
Alzheimer's / Dementia	Father Mother Sibling Grandparent Other: _____________
Asthma, Hay Fever	Father Mother Sibling Grandparent Other: _____________
Cancer, Type: __________________	Father Mother Sibling Grandparent Other: _____________
Cataracts	Father Mother Sibling Grandparent Other: _____________
CHF	Father Mother Sibling Grandparent Other: _____________
CVA / Stroke	Father Mother Sibling Grandparent Other: _____________
COPD	Father Mother Sibling Grandparent Other: _____________
Diabetes	Father Mother Sibling Grandparent Other: _____________
GI Problems	Father Mother Sibling Grandparent Other: _____________
Glaucoma	Father Mother Sibling Grandparent Other: _____________
Heart Attack	Father Mother Sibling Grandparent Other: _____________
Heart Bypass	Father Mother Sibling Grandparent Other: _____________
Heart Disease	Father Mother Sibling Grandparent Other: _____________
Heart Stent	Father Mother Sibling Grandparent Other: _____________
Hyperlipidemia	Father Mother Sibling Grandparent Other: _____________
Hypertension	Father Mother Sibling Grandparent Other: _____________
Kidney Problems	Father Mother Sibling Grandparent Other: _____________
Seizures	Father Mother Sibling Grandparent Other: _____________
Thyroid Disease	Father Mother Sibling Grandparent Other: _____________
Other: ________________________	Father Mother Sibling Grandparent Other: _____________
Other: ________________________	Father Mother Sibling Grandparent Other: _____________

List any other family history on back of this form.

MEDICATIONS CURRENTLY IN USE ***NO APPOINTMENT WILL BE MADE WITHOUT A COMPLETE LIST OF MEDS***

Medication Name	Dose	Frequency	Check here if NO MEDS ____

List any additional medications on back of this form.

Authorization to Disclose and/or Obtain Protected Health Information

Patient Name: _________________ Date of Birth: ____________ SSN: XXX-XX-________ Phone: ____________
Address: _____________________________________

I hereby authorize Athens Limestone Pain Center to use, disclose, and/or obtain my health information as follows: (please check all that apply)

Disclose health information to: Athens-Limestone Pain Center
209 Fitness Way Athens, AL 35611
Phone: 256-262-2190 Fax: 256-262-2196

______Obtain health information from: ____
(Name of Physician or Facility)

______ Send health information to:

____
(City/State)

____
(Fax Number)

Requesting: ____

____

1. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

2. For the purpose of to Obtain or Disclose and treat the patient.

3. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the clinic _________________________________. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

4. Unless otherwise revoked, the authorization will expire on the following date, event, or condition:
   ____
   If I fail to specify an expiration date, event or condition, this authorization will expire in six months from the date of signing.

5. I understand that once the information is obtained pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

6. I understand that as the recipient, I am responsible for the security of these medical record copies and the health information contained therein, whether in paper format or on CD/DVD.

7. I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits. or
   I understand that if I refuse to sign this form, under specific conditions the organization can refuse:
   Treatment , Enrollment in the health plan Eligibility for benefits

______________________________ SIGNATURE	______________ DATE	________ TIME
______________________________ IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	______________ SIGNATURE OF WITNESS	______ DATE ____ TIME

Questions?

What is a Patient Portal?
A patient portal is a secure online website that gives you convenient 24-hour access to your personal health information and medical records—called an Electronic Health Record or EHR—from anywhere with an Internet connection.

Why is a Patient Portal Important?
Accessing your personal medical records through a patient portal can help you be more actively involved in your own health care. Accessing your family members' health information can help you take care of them more easily. Also, patient portals offer self-service options that can eliminate phone tag with your doctor and sometimes even save a trip to the doctor's office.

Can my family access my Portal?
You may choose to give family members, such as parents or healthcare proxies, access to your Portal.

Is my information safe?
Yes. Patient portals have privacy and security safeguards in place to protect your health information.

Always remember to protect your user name and password from others and make sure to only log on to the patient portal from a personal or secure computer.

Athens Limestone

Health Services

https://www.healthportalsite.com/

Athens Limestone Health Services

Invites you to join our

Patient Portal

Access to YOUR health information...

Anytime
Anywhere

Registration is Easy!

Provide us with your preferred e-mail address so we can give you access to the Patient Portal

A Portal Registration e-mail is automatically sent to you containing a registration link

Click on the registration link

Enter the requested personal information to verify your identity

Follow the instructions for creating a user name and password

Confirm your personal and insurance information on the next screen

EXPLORE!

Patient Portal Website:

https://www.healthportalsite.com/

Online Help!

There is an online help system that will explain how to use each feature in the Patient Portal.

Look for the question mark button in the upper right hand of the Patient Portal.

See all of your health information in one place!

Lab Results
Radiology Reports
Allergies & Medications
Vital Signs
Past Medical History
Upcoming & Past Appointments

What Do I Do If...

...I don't receive a registration email?
Be patient. The e-mails may take a few minutes to deliver. You may also check your junk mail or spam folders to see if the email was routed there by mistake. If necessary, you can call the office to re-send the registration e-mail.

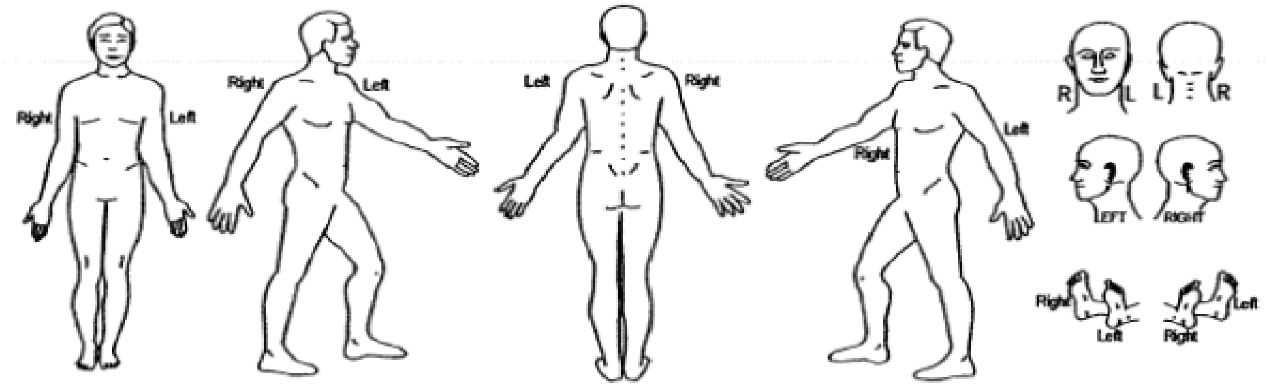
Also, failure to register your portal account within thirty days will inactivate your registration. If this happens, please contact the office to send you a new registration.

...I forget my password?
After you attempt to login with a username and password, click on the link that says, "Forgot Password," and follow the additional instructions. If you still need help, contact the office to reset your account.

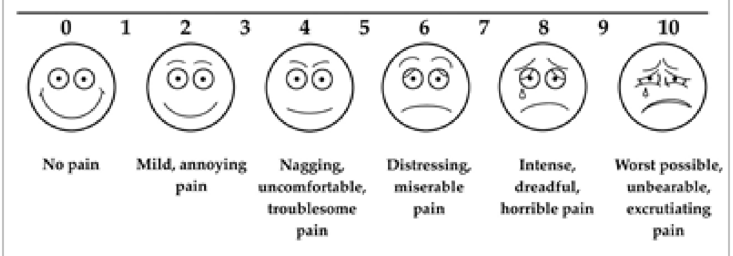
...I have an urgent issue or an emergency?
Do NOT use the Patient Portal. Call the office if you need to speak with a staff member immediately. If you are experiencing an emergency, call 911 or go to the nearest emergency room.

ALPC New Patient Pain Evaluation

1) Please circle the areas where your **WORST** pain is located.



2) **Please circle your pain level on an AVERAGE day (not your worst day).**



3) **When was the last time you went to Physical Therapy (PT)?** ______________________________
Was Physical Therapy helpful? ____

4) **Which of the following medications have you tried and what were the results?**

Acetaminophen (Tylenol) ____

NSAIDS (i.e. Ibuprofen, Aleve, Celebrex, Mobic) ____

Neurontin (gabapentin) or Lyrica ____

Muscle Relaxers (Flexeril, Robaxin, etc.) ____

Tramadol (Ultram) ____

Other Opioids (i.e. Percocet/oxycodone, morphine, Dilaudid/hydromorphone, buprenorphine)
____

5) **Have you ever had injections (i.e. epidural steroid injections, facet injections, ablations, etc.) for the area of your chronic pain?** Yes or No
If yes, what kind and did they help? ____

6) **Have you ever had surgery in the area of your chronic pain? Yes or No**
If yes, when and what kind of surgery? ____

Patient Name: ____

Date of Birth: ____

DUE TO THE PRIVACY CONFIDENTIAL ACT, please list the people that you approve to have access to your information as stated below:

BILLING INFORM: (Insert Name, Relationship, and Phone #)

____

____

____

MEDICAL INFORM:

____

____

____

AUTHORIZATION TO FILE INSURANCE

I authorize the release of medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I hereby authorize Athens Limestone Health Services to apply benefits on my behalf for the covered services rendered by the office, or by the office's order. I request that payment from my insurance company be made directly to Athens Limestone Health Services or to the party who accepts assignment. I certify that the information I have reported with regard to my insurance coverage is correct. I also acknowledge that I am responsible for payment of any services not covered by my insurance and that it is my responsibility to know what services may not be covered by my insurance policy.

Agree: ☐ Disagree: ☐

AUTHORIZATION FOR PHONE CONTACT

I hereby authorize clinic staff to leave messages regarding my medical condition, such as lab reports, other test results, medications, and appointment reminders on my home answering machine or cell phone. By providing us with your landline and/or cell phone numbers, you give express authorization to be contacted at those numbers, as well as authorize such contact by our agents and assigns. This authorization applies to any landline or cell number you may acquire in the future. We may also contact you by sending text message or emails, using any email address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable. This authorization will be in effect until I have given written notice to the clinic.

Agree: ☐ Disagree: ☐

AUTHORIZATION TO OBTAIN PRESCRIPTION HISTORY

I hereby authorize the clinic staff to electronically obtain my prescription history via SureScripts. This authorization will be in effect until I have given written notice to the clinic.

Agree: ☐ Disagree: ☐

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES AND PATIENT RIGHTS

We are required by law to maintain the privacy of, and provide individuals with a notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone.

Signature below is acknowledgement that you have received this Notice of our Privacy Practices and agree to all information listed above. Signature below also indicates that you have received a copy of the Patient Rights & Responsibilities for Athens-Limestone Health Services Clinics.

Signature of patient or patient's representative **Date:**

____