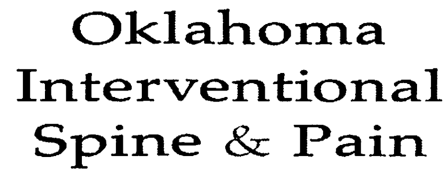
Brandon Claflin, DO
Board Certified, Physical
Medicine & Rehabilitation
Pain Medicine



Okspinepain.com

Interventional Pain Management, Spine Pain, Musculoskeletal Medicine, Electrodiagnosis (EMG/NCS), Botox

OFFICE POLICIES

- New patients will need to arrive to our office at least 15 minutes prior to your appointment. This allows time for paperwork and insurance updates.
- If you are **more than 5 minutes late** for your appointment, YOU MAY BE RESCHEDULED to the next available appointment and may be charged a **$125.00 late fee.**
- If you are unable to keep your appointment for any reason, please call our office **24 hours in advance** to avoid a rescheduling fee. If you do not show up to or you fail to cancel your appointment 24 hours in advance, you will be charged a **$150.00 "no-show" fee.** This will be billed to the patient, not your insurance company and you will not be rescheduled until this fee is paid.
- Please note **2 appointments** missed without cancelling (these do not need to be consecutive) will result in discharge from our care.
- It is the **patient's responsibility** to verify that we are a participating provider with his/her insurance plan and to understand his/her benefits.
- You will need to present your insurance card/s and photo ID at your initial visit (failure to have either will result in rescheduling once you have those documents available) and at the beginning of each new year and at each renewal or change of insurance. NO balances will be carried.
- **INSURANCE COPAYS MUST BE PAID AT THE TIME SERVICES ARE RENDERED.**

IF YOU ARE PRESCRIBED NARCOTICS:

- You must be seen monthly for refills. You must bring those medications to each office visit in the most recent pill bottle prescribed. Only bring medications prescribed by Dr. Claflin.
- Refill requests must be made **at least 72 hours** prior to running out of medication. This gives us enough time to refill your medication in a timely manner.
- We **DO NOT** replace lost or stolen meds for any reason, even with a police report.
- You will need to sign a medication contract with our office.

I have read and understand the policies listed above.

Patient Signature ____

PATIENT INFORMATION

Name____________________________ Date of Birth__________

Address________________________________

City______________ State________ Zip Code__________ Home phone__________

Work phone__________ Cell/other____________ Email______________

Social Security Number:__________________

What is your preferred method of contact? Home phone Work phone Cell phone Email

Marital status (circle one) Single Married Separated Divorced Widowed

Race (circle one) American Indian Alaskan Native Asian Black Caucasian Other

Ethnicity (circle one) Hispanic Non-Hispanic Primary language:______________

Current employer__________________________ Phone #______________

Preferred pharmacy (Name/Address/Phone #)______________________________

Responsible Party (If other than above) ______________________________

Address____

City__________________________ State________ Zip Code__________

Home phone____________________ Work phone____________________

INSURANCE INFORMATION (If this is a WORKERS COMPENSATION Injury, please see the next page)

Do you have medical insurance? Yes / No Is this a workers compensation injury? Yes / No

Insurance (1)____

Policy #______________________ Group #______________________

Name on policy____________________ DOB__________ SSN__________

Insurance (2)____

Policy #______________________ Group #______________________

Name on policy____________________ DOB__________ SSN__________

SPOUSE INFORMATION (for emergency contact)

Spouses Name____________________ DOB__________ SSN__________

Work phone __________________ Cell phone__________________

Who would we contact in case of an emergency *other* than your spouse?

Name______________________________

Work phone__________________ Cell phone__________________

This is an authorization of release of medical information and payment of medical benefits. I authorize the release of any medical information necessary to process this claim. Also, I request payment of medical benefits to the physician for service. I understand and agree that charges by Oklahoma Interventional Spine & Pain are to be paid in full, and I am responsible for the service and/or items not covered by my insurance company.

Signed____________________ Date__________________

WORKERS COMPENSATION INFORMATION

Is the reason for the visit a work-related injury? Yes_____(answer questions below) No________(go to page 4)

Date of Injury__________________

Body part injured:____

Workers Compensation Insurance____

Employer______________________________Contact__________________________

Address______________________________City____________State_____Zip________

Name of adjuster or case manager (If known)________________________________

Adjuster or case manager phone____

Claim Number____

HEALTH HISTORY

Name:______________________________ DOB:______________

Age:________ Height:________ Weight:________ Sex: Male / Female

MEDICATIONS:

Please list all ***current*** medications, dose, and how often you take each medicine (if you need more space please write on the back of this paper)

Medication	Dose	How often?

ALLERGIES:

Have you ever had an allergic reaction to:

- Xray dye? Yes / No
- Morphine, Demerol or other narcotics? Yes / No
- Novocain or other anesthetics? Yes / No
- Aspirin or other pain remedies? Yes / No

Please list all allergies, including allergies to medicines.

Medication/Allergy	Type of reaction

SURGERIES:

Do you have any metal in your body from any previous surgeries? Yes / No

Please list previous surgeries

Surgery	Date	Details

SOCIAL HISTORY:

a. Use of alcohol? Never Rarely Moderate Daily
b. Use of tobacco? Never Previously, but quit (When?______) Active (___packs/day x ___years)
c. Use of recreational drugs (ie Marijuana)? None Some (Type/Frequency________________)
d. Have you ever had a problem with dependency or abuse of prescription or non-prescription drugs? Y / N
   If yes, please explain________________________________
e. Have you ever been physically abused? Yes / No
f. Have you ever been sexually abused? Yes / No

PAST MEDICAL HISTORY:

Please list ALL conditions you have had in the past

Condition	Age Diagnosed	Details

FAMILY MEDICAL HISTORY:

Please indicate blood relative with any illnesses or pain problems

Family Member	Age	Diseases/pain problems

DIAGNOSTIC STUDIES:

Please list all diagnostic studies you have had done. These can include x-rays, CT scans, MRIs, discograms, EMG/nerve conduction studies, etc.

Study (ex: MRI)	Body part	Date	Location (ex: St Francis)

REVIEW OF SYSTEMS:

Please mark the box next to the u have a history of or currently have:

Constitutional Symptoms:

- [ ] Unexplained weight loss
- [ ] Fever
- [ ] Night sweats

Integumentary:

- [ ] Change in skin color, hair, or nails
- [ ] Change in temperature of extremities
- [ ] Itching

Eyes:

- [ ] Eye disease or injury
- [ ] Wear glasses/contact lenses
- [ ] Blurred vision
- [ ] Glaucoma

Ear/Nose/Mouth/Throat:

- [ ] Hearing loss
- [ ] Ringing in ears
- [ ] Dry mouth
- [ ] Chronic sinus problem or rhinitis

Cardiovascular:

- [ ] Heart trouble
- [ ] Chest pain or angina pectoris
- [ ] Palpitations/murmurs
- [ ] Fainting
- [ ] Swelling of feet, ankles, or hands

Respiratory:

- [ ] Chronic or frequent coughs
- [ ] Shortness of breath

Gastrointestinal:

- [ ] Nausea or vomiting
- [ ] Frequent diarrhea
- [ ] Constipation
- [ ] Rectal bleeding or blood in stool
- [ ] Abdominal pain
- [ ] Peptic ulcer (stomach or duodenal)

Hematologic/Lymphatic:

- [ ] Slow to heal after cuts
- [ ] Bleeding or bruising tendency

Musculoskeletal:

- [ ] Joint pain
- [ ] Joint stiffness and/or swelling
- [ ] Weakness of muscles or joints
- [ ] Muscle pain
- [ ] Difficulty in walking

Genitourinary:

- [ ] Frequent urination
- [ ] Bowel/Bladder incontinence

Neurological:

- [ ] Progressive focal weakness
- [ ] Numbness in groin
- [ ] Numbness and/or tingling sensations

Psychiatric:

- [ ] Memory loss or confusion
- [ ] Anxiety
- [ ] Insomnia
- [ ] Depression

Endocrine:

- [ ] Heat or cold intolerance
- [ ] Kidney stones or disease
- [ ] Osteoporosis or vertebral fracture
- [ ] Long term steroid use
- [ ] History of IV drug use

PAIN HISTORY/INVENTORY

****If you are NOT seeing us today for PAIN, please skip this section*****

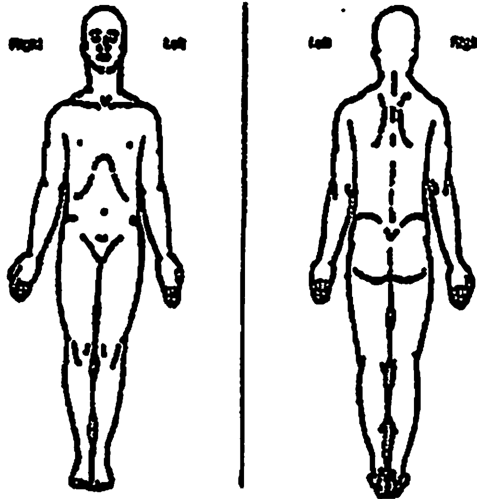
DATE:____________________

PATIENT NAME:______________________________ DOB:____________________

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today? (CIRCLE ONE) Yes No

   A. When did your pain begin?______________________________
   B. What were the circumstances?
      a. Accident (home, work, etc)? Following illness or injury? Pain just began?
         Explain______________________________
         ____

2. On the diagram, shade in areas where you feel pain. Put an X on the area that hurts the most.



A. Do you have any numbness in your arms or legs? Yes No If yes, where?__________
B. Do you have any tingling sensations in your arms or legs? Yes No If yes, where?__________
C. Do you have any weakness in your arms or legs? Yes No If yes, where?__________
D. Do you have incontinence (loss of control) of bowel? Yes No
E. Do you have incontinence of bladder? Yes No

3. How would you describe your pain (burning, aching, sharp, shooting, electrical, tight, "Charlie horse", etc)?
____
____

4. Your pain is (circle one): Constant Constant but intensity varies Intermittent

5. Does the severity of your pain vary according to time of day? Yes No
   If yes, how (worse upon awakening, worse as day goes on, etc)?______________________________
   ____

6. List specific activities or things which *increase* your pain:______________________________
____

7. List specific activities or things which *decrease* your pain:______________________________
____

8. Please rate your pain by circling the number that best describes your pain at its ***worst*** in the last 24 hours?

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

9. Please rate your pain by circling the number that best describes your pain at its ***least*** in the last 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

10. Please rate your pain by circling the number that best describes your pain ***on the average***.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

11. Please rate your pain by circling the number that tells how much pain you have ***right now***.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

12. Circle the number that describes how, ***during the past 24 hours***, pain has interfered with your:

A. General Activity

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

B. Mood

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

C. Walking ability

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

D. Normal Work (includes both work outside the home and housework)

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

E. Relations with other people

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

F. Sleep

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

G. Enjoyment of life

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

14. Have you seen any other physicians for your pain (besides your primary physician)? Yes / No

	Name of Doctor	Treatment Received	Helpful?	Side effects?
Anesthesiologist				
Chiropractor				
Neurologist				
Neurosurgeon				
Pain mgmt. Physician				
Physical Therapist				
Psychologist				
Rheumatologist				
Other				

15. What treatments/therapies have you tried in the ***past*** (that you are ***NOT*** currently using)? These can include heat, TENS unit, physical therapy, massage, injections, etc.

Treatment/Therapy	Helpful? Yes/No	Side effects/why discontinued

16. What treatments/therapies are you ***currently*** using? These can include heat, TENS unit, physical therapy, massage, injections, etc.

Treatment/Therapy	Dose	Frequency

17. Do you or anyone in your family have a history of alcohol or drug addiction? Please explain. ____________________

____

____

____

____

18. Please briefly describe your goals of treatment: ____________________

____

____

____

____

____

____

PRIVACY NOTICE

Dear Patient or Representative:

We are committed to protecting the privacy of your medical information. We are required by law to maintain the confidentiality of information that identifies you and the care you receive. This Notice describes your rights and our legal duties regarding your Protected Health Information (PHI). Protected Health Information means any information about you that identifies you or for which there is a reasonable basis to believe the information can be used to identify you.

HOW OKLAHOMA INTERVENTIONAL SPINE & PAIN MAY USE OR DISCLOSE YOUR MEDICAL INFORMATION:

1. We will use your medical information to treat you. For example, if there is any follow-up care such as home health services, etc. We may also disclose your medical information to people outside our office that are involved in your care such as your family members, referring physicians, pharmacist, etc.
2. We may use and disclose your medical information to receive payment for our services from you, and insurance company or a third party. For example, we may need to give your health plan information about a procedure we perform at our office so your health plan will pay us or reimburse you for the procedure. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether you plan will cover the treatment.
3. We may share your medical information with our business associates. We have a written contract with each business associate that contains terms requiring them to protect the confidentiality of your medical information.
4. Any other uses and/or disclosures of your medical information will be made only with authorization. Your authorization may be revoked, but must be communicated in writing.

DESCRIPTION OF YOUR MEDICAL INFORMATION RIGHTS:

1. You have the right to inspect and copy medical and billing records that we maintain. You must submit your request in writing. By Oklahoma statute, we currently charge $1.00 for the first page and $0.50 each additional page plus postage costs.
2. You have the right to request an amendment to the medical information we have about you if you believe it is incomplete or incorrect. To request an amendment, your request must be made in writing; include a reason for your request, and it will be submitted to the privacy officer. We may deny your request for an amendment for the following reasons: It is not in writing; does not include a reason; the information was not created by us; is not a part of the medical information kept by our practice; is not part of the information which you are permitted to inspect a copy; or in our judgment, the information will be acted on no later than sixty days after its receipt.
3. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, we will only contact you at work, home, by mail, phone, answering machine, etc. Your request must be specific and in writing to the privacy officer in our office.
4. You have the right to request a list of the disclosures we have made of your medical information. To request this list, you must submit your request in writing to this office. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. Your request must state a time period no longer than six years. The first copy of the list is free, but each additional request may invoke a fee.
5. You have the right to request a restriction on the information we use or disclose for treatment, payment, or health care. Information for treatment or health care operations we are not required to agree to the restriction and reserve the right to immediately withdraw our services from you and terminate the relationship.
6. You have the right to receive a paper copy of this Privacy Notice.

For more information or to report a problem you may contact the Oklahoma Interventional Spine & Pain Privacy Office, 9308 S Toledo Avenue, Tulsa, OK 74137. If you believe your privacy rights have been violated, you may file a complaint with the Privacy officer or the Secretary of the Department of Health and Human Services. All complaints must be in writing. There will be no retaliation by Oklahoma Interventional Spine & Pain if you file a complaint.

We reserve the right to change or amend this Privacy Notice at any time in the future. Revised copies will be available to you.

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

Oklahoma Interventional Spine & Pain

9308 S. Toledo Avenue

Tulsa, OK 74137

918-728-8020

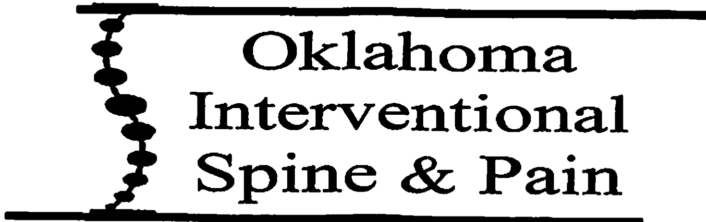
A complete description of how your medical information will be used and disclosed by Oklahoma Interventional Spine & Pain is in our "Privacy Notice", which you should read before signing this acknowledgment.

I hereby certify that I have read the "Privacy Notice" for "Oklahoma Interventional Spine & Pain".

____ ______________________________

Patient or representative Date signed

Brandon Claflin D.O
Board Certified, Physical Medicine & Rehabilitation Medicine



Okspinepain.com

Interventional Spine Pain Management. Electrodiagnosis (EMG, Nerve Conduction Studies), Workers Compensation Injuries

HIPAA RELEASE OF PROTECTED HEALTH INFORMATION

Patient Signature.______________________________Date:__________________________

Please provide us with a list of names of whom you would allow our office to release OR discuss medical information.

Information may be released to the following individuals:

Name:_____________________________ Relationship to patient.________________________

Name:_____________________________ Relationship to patient.________________________

Name:_____________________________ Relationship to patient________________________

Tulsa: 9308 S. Toledo Ave Tulsa, OK 74137 •918.728.8020 • Fax 918.728.8019
Bartlesville: 421 E. 5th St. Bartlesville, OK 74003 • 918.728.8020 • Fax 918.728.8019
Stillwater: 801 S. Walnut St. Stillwater, OK 74074 • 918.728.8020 • Fax 918.728.8019