PATIENT NAME: _____

DOB: _____

Winke Orthopedic Pain Management Center

Appointment Date:_____Arrival Time:____:_____

PLEASE REVIEW, COMPLETE AND SIGN ALL FORMS BEFORE YOUR SCHEDULED APPOINTMENT.

THINGS TO BRING WITH YOU TO YOUR APPOINTMENT:

- **Insurance card/Valid Picture ID**
- **Insurance Authorization (if needed)**
- **Insurance co-payment (if applicable)**
- **List/Bottle of Current Medications**
- **Any Additional Records/Imaging Pertaining to Your Diagnosis**

****PLEASE DO NOT MAIL THIS PACKET BACK TO THE OFFICE. Please bring this **COMPLETED** packet in with you to your appointment. If these items are not present at the time of check-in your appointment will be rescheduled.***

PLEASE REVIEW THE OPIOID AGREEMENT. A COPY OF THIS AGREEMENT WILL BE GIVEN TO YOU AT YOUR APPOINTMENT.

Contact Phone #: 757-216-4030 Fax #: 757-216-4029

Locations:

_____*Chesapeake (located next to Chartway Federal Credit Union)*
808 Eden Way North, Suite 102, Chesapeake, VA 23320

_____*Suffolk (Drive past the Sports Medicine Building, pass Jonathan's Way, Applewood Office Park on the right, turn here, second tan brick building)*
154 Burnett's Way, Suite 101, Suffolk, VA 23434

☐Beth Winke, MD ☐Hillary Baker, PA ☐Raymond Clifton, PA ☐Brittany Horton, NP ☐LaTara Harris, NP

808 Eden Way N, Suite 102, Chesapeake, VA 23320

154 Burnett's Way, Suite101, Suffolk VA 23434

Phone 757.216.4030 / Fax 757.216.4029

PATIENT NAME: _____

DOB: _____

Winke Orthopedic Pain Management Center

Directions

CHESAPEAKE LOCATION 808 Eden Way North, Suite 102, Chesapeake, VA 23320

Take the Greenbrier Parkway South exit. Go to second stop light (Eden Way North), turn right. Get in your right turn lane, just past 7-11. We are located right after Dominion Eye Care and before Chartway Federal Credit Union. The nearest cross street is Eden Way and Stephanie Way. If you have reached the UPS Store, you have gone too far.

SUFFOLK LOCATION 154 Burnetts Way, Suite 101, Suffolk, VA 23434

From I-664 South
- Take exit 13A (US-13S/US-58W toward US-460W/Suffolk)
- Take the VA-10/VA-32 exit toward Smithfield/Newport News/Downtown Suffolk
- Turn right at the end of the exit onto Godwin Blvd.
- Turn the first right onto Burnett's Way
- Drive past the Sports Medicine Building
- Pass Jonathan's Way
- Applewood Office Park on the right, turn here (right before you enter the neighborhood)
- Second tan brick building

From Franklin
- Take US-58E
- Take the VA-10/VA-32 exit toward Smithfield/Newport News/Downtown Suffolk
- Turn left at the end of the exit onto Godwin Blvd.
- Turn the first right onto Burnett's Way
- Drive past the Sports Medicine Building (really tall)
- Pass Jonathan's Way
- Applewood Office Park on the right, turn here (right before you enter the neighborhood)
- Second tan brick building

From Smithfield
- Take VA-10 (Benn's Church Blvd., which becomes Godwin Blvd.) to Suffolk
- Turn left onto Burnett's Way
- Drive past the Sports Medicine Building (really tall)
- Pass Jonathan's Way
- Applewood Office Park on the right, turn here (right before you enter the neighborhood)
- Second tan brick building

From Ahoskie
- Take N Carolina Hwy 11 North to US-258 N into Virginia
- Make a slight right onto VA-189 (S Quay Road)
- Take US-58E,
- Take the VA-10/VA-32 exit toward Smithfield/Newport News/Downtown Suffolk
- Turn left at the end of the exit onto Godwin Blvd.
- Turn the first right onto Burnett's Way
- Drive past the Sports Medicine Building (really tall bldg.)
- Pass Jonathan's Way
- Applewood Office Park on the right, turn here (right before you enter the neighborhood)
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PATIENT NAME: _____

DOB: _____

Winke Orthopedic Pain Management Center

Please complete and bring to the appointment

SHORT PATIENT HISTORY FORM

Name:_____ Date of Visit:_____

Current symptoms or problem_____

How long have you had the problem? _____

Referring Physician/Primary Care Provider: _____

Previous Pain Management: □ Yes □No: if yes, who, where:_____

Current medications: Please list all medications and prescribing doctor:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies:_____

Medical History: Please list all medical problems

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Surgical History: Please list all surgeries and year

_____ _____ _____

_____ _____ _____

_____ _____ _____

Diseases that run in your family:_____

Do you smoke? □ Yes □No If yes, how much?_____

Do you drink? □ Yes □No If yes, how much?_____

Do you use illegal substances or have a history of substance abuse? □ Yes □No If yes, what substances and how much?_____

Do any of your relatives have a history of substance abuse? ☐Yes ☐No

PATIENT NAME: _____

DOB: _____

Winke Orthopedic Pain Management Center

Please complete and bring to the appointment

COMPREHENSIVE REHABILITATION PAIN QUESTIONNAIRE

Name: _____ Date of Visit: _____

Age: _____ Date of birth: _____ Date of injury/onset of symptoms: _____

Referred by: _____ Statement of Problem: _____

_____

Circumstances of injury/onset: _____

_____

_____

Location at time of injury/onset: _____ Time: _____

What increases your symptoms? (Mark all that apply)

☐Sitting ☐Bending ☐Stooping ☐Reaching ☐Pinching ☐Climbing

☐Standing ☐Lifting ☐Coughing ☐Gripping ☐Reclining ☐Squatting

☐walking ☐Twisting ☐Driving ☐Sneezing ☐Other_____

What time of day is your pain worst? _____

What time of day is your pain least? _____

What percentage of your pain is arm or leg pain? _____

What percentage of your pain is neck or back pain? _____

What decreases your symptoms?

_____ _____

_____ _____

_____ _____

Please list three (3) goals you would like to achieve as a result of medical treatment?

_____

_____

_____

Which daily activities are affected by your current pain condition? _____

_____

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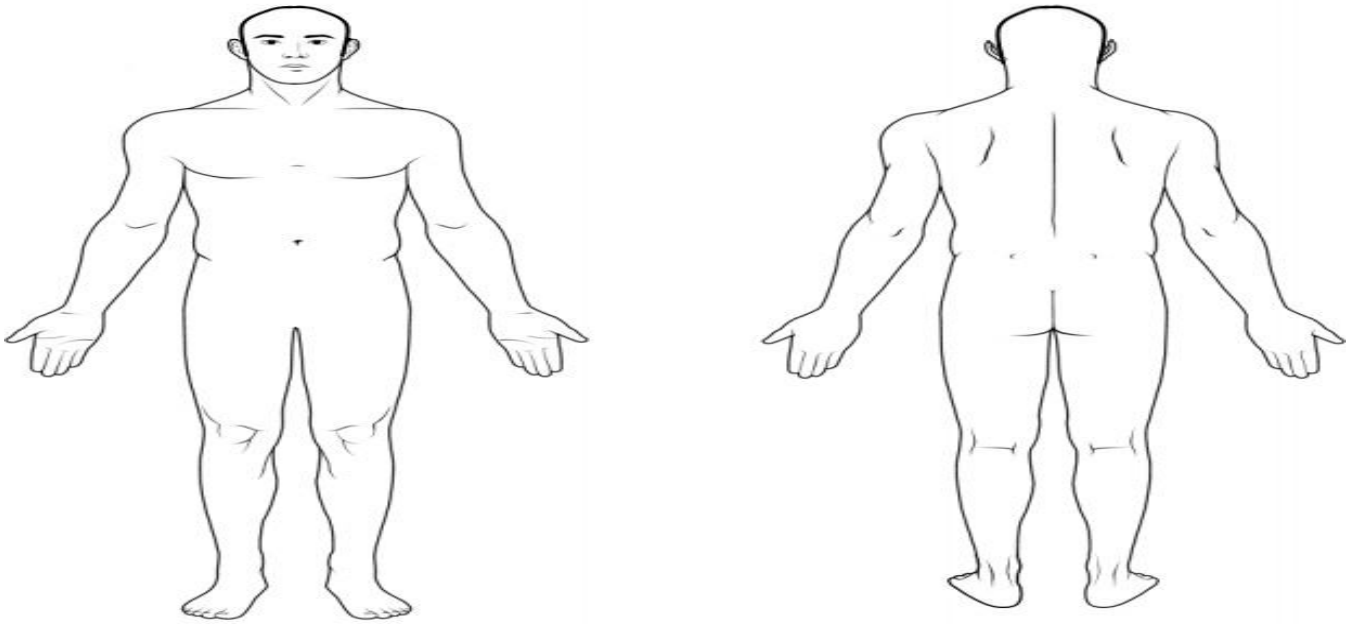
Winke Orthopedic Pain Management Center

Please complete and bring to the appointment

Mark the areas on your body where you feel your pain. Include all affected areas. Use the appropriate symbols indicated below.

Ache>>> Numbness=== Pins & Needles+++ Burning XXX Stabbing ///



Is your pain constant? □Yes □No If yes, has it been constant for the last year? □Yes □No

If no, how many days per week do you have pain?_____How many hours per day?_____

Please place an "X" in the box below to indicate the level of your pain											
	None/0	1	2	3	4	5	6	7	8	9	10
Today											
Least											
Worst											

How would you describe the overall severity of your pain?

_____ Mild, nuisance pain _____Moderate – I am having difficulty dealing with it

_____ Mild to moderate, but I can live with it _____ Severe – it is ruining my quality of life

Please place a checkmark next to your daily activities on a typical day

☐Driving ☐Laundry ☐ Vacuuming, mopping, sweeping
☐Cook/Do dishes ☐Dress self ☐ Walking: Greater or Less than 20 mins
☐Dress children/spouse ☐Bathe unassisted ☐ Grocery shopping/putting away groceries(unassisted)
☐Stairs: Go up/down at least one flight of steps unassisted

PATIENT NAME: _____

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Winke Orthopedic Pain Management Center

Please complete and bring to the appointment

Please place "X" on all of the previous medications that you have tried:

Medication:	Discontinued Reasons	Medication:	Discontinued Reasons
☐Actiq		☐Neurontin	
☐Arhrotec		☐Nucynta	
☐Aspirin		☐Opana/Oxymorphone	
☐Baclofen		☐Oxycodone	
☐Belbuca		☐Oxycontin	
☐Butrans		☐Pamelor/Nortriptyline	
☐Celebrex		☐Paxil	
☐Compound cream		☐Pennsaid	
☐Cymbalta		☐Percocet	
☐Demerol/Meperidine		☐Prozac	
☐Diclofenac/Voltaren		☐Relafen	
☐Dilaudid/Hydromorphone		☐Robaxin/Methocarbamol	
☐Duragesic patch/Fentanyl		☐Skelaxin/Metaxalone	
☐Effexor		☐Soma	
☐Elavil/Amitriptyline		☐Suboxone	
☐Flector patches		☐Tegretol	
☐Flexeril		☐Topamax/Topiramate	
☐Hydrocodone		☐Tramadol	
☐Ibuprofen		☐Tylenol	
☐Lexapro		☐Tylenol #3/Tylenol #4	
☐Lidoderm patches		☐Ultram/Ultracet/Ultram ER	
☐Lorzone		☐Valium	
☐Lyrica		☐Voltaren gel	
☐Methdone		☐Wellbutrin	
☐Mobic		☐Xanax	
☐Morphine		☐Zanaflex/Tizanidine	
☐MS Contin		☐Zoloft	
☐MSIR		☐Zonegran	
☐Naprosyn			

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Please complete and bring to the appointment

Please mark an "X" on all of the previous treatments/Circle Yes/No on each marked:

Treatment / Procedure	Limited Relief	Lasting Relief
☐PT / OT	Yes / No	Yes / No
☐Orthotic Device (Brace)	Yes / No	Yes / No
☐TENS Unit	Yes / No	Yes / No
☐Osteopathic Manipulation	Yes / No	Yes / No
☐Epidural Injection	Yes / No	Yes / No
☐Facet Block	Yes / No	Yes / No
☐Sacroiliac Joint Injection	Yes / No	Yes / No
☐Trigger Point Injection	Yes / No	Yes / No
☐Joint Injection	Yes / No	Yes / No
☐Acupuncture	Yes / No	Yes / No
☐Chiropractor	Yes / No	Yes / No
☐Stimulator/Pump	Yes / No	Yes / No
☐Massage Therapy	Yes / No	Yes / No
☐Botox	Yes / No	Yes / No
☐Dry Needling	Yes / No	Yes / No

Please tell us about yourself

What is your highest level of education completed? _____

Do you have children? ☐ No ☐ Yes If yes, how old are they? _____

What is your occupation? _____Employer:_____

Do you use tobacco? ☐ Yes ☐ No If yes, do you smoke cigarettes?____ How many/day?___How many years?_____

Do you smoke cigars or a pipe? ☐ Yes ☐ No If yes, how many per day? ___ How many years? ____

Do you chew tobacco? ☐ Yes ☐ No If yes, how many cans per week? _____ How many years? ____

Are you a former smoker/tobacco user? ☐ Yes ☐ No If yes, at what age did you quit? _____

Do you use alcohol? ☐ Yes ☐ No If yes, how many/much alcoholic beverages do you drink in a usual week? _____

If no, have you ever used alcohol? ☐ Yes ☐ No Do you use Marijuana/Edibles? ☐Yes ☐No

Do you currently use recreational drugs? ☐ Yes ☐ No If yes, what type and how much? _____

PATIENT NAME: _____

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Winke Orthopedic Pain Management Center

Please complete and bring to the appointment

Have you had abuse problems with recreational drugs in the past? □ Yes □ No If yes, please describe:

_____

Have you had abuse problems with prescription medications in the past? □ Yes □ No If yes, please describe: _____

Are there any recreational drug problems with prescription medications in your household at the present time? If yes, please describe: _____

Please mark an "X" in the appropriate diseases with regards to your family history:							
	High Blood Pressure	Diabetes	Heart Disease	Cancer	Arthritis	Stroke	Heart Attack
Mother							
Father							
Siblings							
Children							
Aunts/Uncles							
Grandparents							

Past Medical History

Depression _____ Skin disease _____

Chicken Pox _____ Polio _____

Arthritis _____ AIDS/HIV _____

Mumps/Measles _____ Epilepsy _____

Cancer _____ Blood transfusion _____

Hepatitis _____ Infectious Mono _____

STD _____

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Please mark an "X" on any problems that you have from the list below:

CONSTITUTIONAL
- ☐Fever
- ☐Night sweats
- ☐Weight gain(___lbs)
- ☐Weight loss(___lbs)
- ☐Exercise intolerance

PSYCHIATRIC
- ☐Anxiety
- ☐Depression
- ☐Sleep disturbances
- ☐Restless sleep

HEMATOLOGIC/LYMPHATIC
- ☐Swollen glands
- ☐Easy bruising
- ☐Excessive bleeding

CARDIOVASCULAR
- ☐Irregular rhythm
- ☐Chest pain on exertion
- ☐Shortness of breath/walking
- ☐Shortness of breath/laying down
- ☐Palpitations
- ☐Known heart murmur
- ☐Light-headed on standing

ENDOCRINE
- ☐Fatigue
- ☐Increased thirst
- ☐Hair loss
- ☐Cold intolerance

EYES
- ☐Dry eyes
- ☐Irritation
- ☐Vision change

GENITOURINARY
- ☐Urinary loss of control
- ☐Difficulty urinating
- ☐Increased urinary frequency
- ☐Blood in urine
- ☐Incomplete emptying

MUSCULOSKELETAL
- ☐Muscle aches
- ☐Muscle weakness
- ☐Arthralgias/joint pain
- ☐Back pain
- ☐Swelling in the extremities

INTEGUMENTARY
- ☐Abnormal mole
- ☐Jaundice
- ☐Rash
- ☐Itching
- ☐Dry skin
- ☐Growth/lesions

NEUROLOGIC
- ☐Tingling/paresthesia of the limbs
- ☐Loss of consciousness
- ☐Weakness
- ☐Numbness
- ☐Seizures
- ☐Dizziness
- ☐Frequent or severe headaches
- ☐Migraines
- ☐Restless legs

EARS/NOSE/MOUTH/THROAT
- ☐Difficulty hearing
- ☐Ear pain
- ☐Frequent nosebleeds
- ☐Nose/sinus problems
- ☐Sore throat
- ☐Snoring
- ☐Dry mouth
- ☐Oral abnormalities
- ☐Mouth ulcer
- ☐Teeth abnormalities

ALLERGIC/IMMUNOLOGIC
- ☐Runny nose
- ☐Sinus pressure
- ☐Itching
- ☐Hives

RESPIRATORY
- ☐Cough
- ☐Wheezing
- ☐Shortness of breath
- ☐Coughing up blood
- ☐Sleep apnea

GASTROINTESTINAL
- ☐Constipation
- ☐Heartburn
- ☐Abdominal pain
- ☐Vomiting
- ☐Change in appetite
- ☐Black or tarry stools
- ☐Frequent diarrhea
- ☐Vomiting blood

PATIENT NAME: _____

DOB: _____

Winke Orthopedic Pain Management Center

Please complete and bring to the appointment

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?					
2. How often have you felt a need for higher doses of medication to treat your pain?					
3. How often have you felt impatient with your doctors?					
4. How often have you felt that things are just too overwhelming that you can't handle them?					
5. How often is there tension in the home?					
6. How often have you counted pain pills to see how many are remaining?					
7. How often have you been concerned that people will judge you for taking pain medication?					
8. How often do you feel bored?					
9. How often have you taken more pain medication than you were supposed to?					
10. How often have you worried about being left alone?					
11. How often have you felt a craving for medication?					
12. How often have others expressed concern over your use of medication?					
13. How often have any of your close friends had a problem with alcohol or drugs?					
14. How often have others told you that you had a bad temper?					
15. How often have you felt consumed by the need to get pain medication?					

PATIENT NAME: _____

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Winke Orthopedic Pain Management Center

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
17. How often have others kept you from getting what you deserve?					
18. How often, in your lifetime, have you had legal problems or been arrested?					
19. How often have you attended an AA or NA meeting?					
20. How often have you been in an argument that was so out of control that someone got hurt?					
21. How often have you been sexually abused?					
22. How often have others suggested that you have a drug or alcohol problem?					
23. How often have you had to borrow pain medications from your family or friends?					
24. How often have you been treated for an alcohol or drug problem?					

TOTAL: _____

Please include any additional information you wish about the above answers. Thank you.

_____

_____

_____

_____

_____

_____

PATIENT NAME: _____

DOB: _____

Winke Orthopedic Pain Management Center

Please complete and bring to the appointment

PATIENT INFORMATION SHEET

Patient Name: _____ DOB: _____ Age: ____
LAST FIRST MI

Gender: ☐ Female ☐ Male SSN: ___/___/___ Ethnicity: _____

Race: ☐African American/Black ☐Caucasian/White ☐Other ☐Am. Indian/Alaskan Native

Marital Status: ☐ Single ☐ Married ☐Separated ☐ Divorced ☐ Widow

Language: ☐ English ☐ Spanish ☐ Other: _____

Address: _____ Apt/unit: _____

City: _____ State: _____ Zip: _____

Phone: Home _____ Cell _____ Work _____

Email: _____

Preferred Contact Method: ☐ Home Phone ☐ Cell ☐ Work ☐ Email

Employer: _____ Occupation: _____

Address: _____ City: _____ State: Zip: _____

Spouse/Parent Name: _____ DOB: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

PRIMARY INSURANCE

Ins. Company: _____ Policy #: _____

Group #: _____ Address: _____

Policy Holders Name: _____ DOB: _____

Rel. To Pt: _____

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SECONDARY INSURANCE

Ins. Company: _____ Policy #: _____

Group #: _____ Address: _____

Policy Holders Name: _____ DOB: _____

Rel. To Pt: _____

TERTIARY/OTHER INSURANCE

Ins. Company: _____ Policy #: _____

Group #: _____ Address: _____

Policy Holders Name: _____ DOB: _____

Rel. To Pt: _____

REFERRING PHYSICIAN: _____ Office Phone: _____
The NAME of the provider who sent you to us, not the Practice Name.

Address: _____ City: _____ State: ____ ZIP: _____

PRIMARY CARE PHYSICIAN: _____ Office Phone: _____
The NAME of the provider who sent you to us, not the Practice Name.

Address: _____ City: _____ State: ____ ZIP: _____

PHARMACY NAME: _____ Pharmacy Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

---

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WORKER'S COMPENSATION INFORMATION

(Documentation from your employer is required to bill W/C)

Date/Time of Injury: _____/_____ ☐ Accident ☐ Injury

Cause Of Injury: _____Date First Treated by A Physician: _____

Referred By: _____

Name Of Employer: _____

Case #: _____Work Case Manager: _____

Work Case Manager Phone #: _____

Workman's Comp Carrier: _____

Attorney Name & Phone Number: _____

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TO: **Patients receiving opioid category drugs (narcotics) for chronic pain management**
FROM: **Dr. Beth M. Winke**
SUBJECT: **Pain Agreement/Opioid Agreement**

When opioid category drugs are prescribed for long-term use as part of a program to control pain, improve quality of life and function, and minimize disability and impairment, the following expectations should be shared by both patient and provider:

1. Candid and accurate treatment history be made available, including past medical records, past pain treatment, and any alcohol, marijuana, or other drug addiction or dependence history.
2. The patient and family members, if available, should inform the prescriber of all medication side effects and concerns regarding use of prescription medications.
3. Any violation of the below issues may lead to dismissal of the patient from this medical practice.
   a) The patient should not use any other psychoactive agents, including alcohol, **MARIJUANA**, naturopathic products or over-the-counter drugs without agreement of the provider before use of these substances.
   b) The patient must follow the provider's instructions precisely, and will not increase or alter the recommended dosages of any prescription drug unless duly authorized by physician or staff, acting on the physician's specific recommendations. Prescriptions will not be refilled early for any reason.
   c) The patient understands that no prescriptions can be taken or sought from any other medical provider that have psychoactive effects, particularly sedative, hypnotic, antidepressant and most certainly opioid agents. If a medical emergency occurs and an alternative provider is involved, all medical information must be communicated as soon as possible, and any treatment be limited only until communication among and between providers is established. The patient agrees that the other medical providers involved in their care may be contacted to discuss the treatment plan.
   d) The patient should not hoard, share, or sell medication.
4. Regularly scheduled appointments must be kept, on a frequency advised and agreed upon by both doctor and patient. Cancellations or delays may interfere with the ability to continue regular prescriptions.
5. The patient understands that the use of these agents has potential complications including the expected developments of tolerance (reduced effect over time), dependency (the potential development of a withdrawal syndrome upon abrupt discontinuation of opioid drugs), and, in susceptible individuals, the possibility of "addiction" (wherein there is loss of control, compulsive use, and continued use, despite adverse social, physical, psychological, or spiritual consequences). Constipation can also be expected as a side effect common to all opioid medications.
6. The patient has been advised that random urine analysis and random pill counts will be done at any time. New patients, if you are unable to provide urine sample within 15 minutes of your scheduled appointment, you will be rescheduled. Established patients, if you are unable to provide a urine sample within 15 minutes of your appointment you will be reschedule.
7. To ensure a smooth operating clinic schedule, we ask guests and family members to remain seated in the waiting room. Any issues or questions can be discussed, with proper written consent of the patient.
8. Clinic policy dictates that arrival for a scheduled appointment 15 minutes late will require rescheduling. Each rescheduled appointment represents a missed appointment without a 24-hour cancellation notice. NO show fees are as follows $25.00 for follow-up visit and $100.00 for missed EMG test.
9. Messages/Nurse Calls will be answered within 48 hours of receiving your message, unless it's an urgent matter. ALL REFILLS will need 48 hours request. Once further instruction has been given from the providers, our office will notify you regarding your messages/refills.
10. Any use of illegal substances is an AUTOMATIC DISCHARGE.
11. Patients should be advised that narcotic medications may impair mental and/or ability required for the performance of potentially hazardous tasks (e.g., driving, operating heavy machinery).

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12. If you ever experience a medical emergency, CALL 911. If you have a non-emergent medical question or prescription refill, kindly call our office, or access the patient portal, and relay your question to the office staff. The question will be directed to the appropriate provider and the office staff will be instructed to return your phone call with an answer prior to the end of the business day. Some questions may require an appointment. If you are unwilling to leave a message, we will happily schedule an appointment for you. Refills on medication require two business days advance notice to process the refill request.
13. Abuse of our staff cannot and will not be tolerated. Physical and/or verbal threats, harassment, or excessive annoyance of our staff (including multiple phone calls, i.e. more than two (2) on the same day), regarding the same question or request, will, unfortunately, necessitate discharging the patient from our practice. If physical threats, verbal threats, or harassment occur, the proper authorities' will be notified and you will be fully prosecuted by the law.
14. I understand that an initial evaluation will be provided by a physician or a physician extender (mid-level provider); and that all follow up appointments will be provided by a physician extender (mid-level provider).
15. The patient also agrees to use only one pharmacy for his/her narcotic medications and will provide my office with the location and telephone number of that pharmacy. If there are problems with your pharmacy filling your medications, you are to notify this office as soon as possible with the filling pharmacy's name, location and telephone number. Your pharmacy or pharmacist may be contacted to review your medications and care plan.
    Pharmacy Name:_____

    Location:_____

    Telephone #:_____
16. It is the position of this office that notes made by a provider in the course of diagnosing and treating patients are primarily for the provider's use and are therefore the property of that provider. As medical specialists, we do provide ongoing copies of office notes to patients' primary care provider to enhance continuity of care. Our office will happily provide any medical facility a copy of our office notes promptly, and at no charge with proper written consent of the patient. If the patient requests a copy of their medical record personally, or for a non-medical designate, a medical release must be personally signed in our office and a $10.00 processing fee and $0.50 per page for the first 50 pages and 0.25 per page thereafter. The notes will then be ready for the patient to personally acquire in the office 72 hours after the request is initiated.
17. If a determination is made to dismiss the patient from the practice, attempts will be made to notify the patient by letter and/or phone call. It is advised the patient then contact their referring doctor or primary care provider for further direction. A list of other pain management practices and addictionologists in the area will be provided upon request.

This memorandum will be kept as part of the treatment file in order to assure that both patient and provider maintain the highest goals and standards for proper treatment of your pain problem.

The above policy has been reviewed with me. I understand and agree with the above.

_____ _____

Patient Signature Date

_____

Witness Signature

Copy sent to primary/referring provider:_____

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Please complete and bring to the appointment

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Winke Orthopedic Pain Management Center is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices, a copy of which is available upon request and is posted in our office lobby.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Winke Orthopedic Pain Management Center.

Name (Please print):_____

Signature:_____

Name of Personal Representative (if appropriate):_____

Signature of Personal Representative (if appropriate):_____

Date:_____

Winke Orthopedic Pain Management Center

Date acknowledgement received: _____

- OR –

Reason acknowledgement was not obtained: _____

_____

PATIENT NAME: _____

DOB: _____

Winke Orthopedic Pain Management Center

Please complete and bring to the appointment

CONSENT FOR TREATMENT AND BILLING

1. PERMISSION FOR TREATMENT: I hereby authorize Winke Orthopedic Pain Management Center, PLC. and its professional staff to treat me for conditions requiring their services. FAILURE TO SIGN THIS DOCUMENT AT THE BOTTOM OF PAGE MAY RESULT IN THE APPOINTMENT BEING RESCHEDULED AT THE DISCRETION OF THE PRACTICE.

2. RELEASE OF MEDICAL INFORMATION: I hereby authorize Winke Orthopedic Pain Management Center, PLC. to release financial, medical and such other information as may be requested by an insurer or other party who may be liable for any part of the charges for my care. I authorize Winke Orthopedic Pain Management Center, PLC. to contact my employer and insurance carrier to verify coverage by my insurance. My signature shall authorize Winke Orthopedic Pain Management Center, PLC. to obtain copies of medical records from previous treating physicians and/or any facilities where diagnostic testing may have been performed.

3. TREATMENT BY PROVIDER: I understand that initial evaluation will be provided by a Physician or a physician extender (mid-level provider); and that all follow up appointments will be provided by a physician extender (mid-level provider).

4. ASSIGNMENT OF BENEFITS: I authorize payment of benefits directly to Winke Orthopedic Pain Management, PLC. for all covered services to be applied against the bill. The undersigned or the patient is responsible for any and all charges not covered under the present insurance policy.

5. I also understand that Winke Orthopedic Pain Management Center, PLC. will consider a bill past due thirty (30) days from the date reflected on the invoice. All past due bills may be subject to a one and one half (1 1/2) percent surcharge per month. It is further agreed that the patient, spouse, or responsible party agrees to pay all costs of collection, including attorney's fees in the amount of 33 1/3% plus court costs and any interest allowable by law, if incurred.

I CERTIFY THAT THE INFORMATION I HAVE PROVIDED REGARDING INSURANCE COVERAGE IS CORRECT AND THAT THE ABOVE RELEASE AND REQUEST FOR ASSIGNMENT WILL BE HONORED.

_____ _____

Authorized Signature (Parent if minor) Date

I permit a copy of this authorization to be used in place of the original, regardless of the date, until cancelled by me.

PATIENT NAME: _____

DOB: _____

Winke Orthopedic Pain Management Center

Please complete and bring to the appointment

PATIENT FINANCIAL POLICY

Winke Orthopedic Pain Management Center is dedicated to providing the best possible care for you. Please understand that payment for services is considered part of your treatment. We ask that you read, agree to and sign this policy prior to any treatment.

Co-pays and Balances

The patient is expected to present a **valid insurance card at each visit**. All co-payments and patient balances are due at the time of service unless arrangements have been made in advance. We accept cash, check and credit card **(Visa and Mastercard).**

Participating Insurance Plans

Your insurance policy is a contract between you and your insurance company. As a service to you, we will file your insurance claims. If your insurance company does not pay the practice within a reasonable period, we will look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you. We will bill your insurance company for all services provided by WOPMC. You are responsible for any balance due. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

Insurance Changes

If you fail to notify us of any insurance changes, you are fully responsible for any amount not paid by your insurance.

Referrals

If your insurance has a designated primary care physician (PCP), you are required to have prior authorization from your PCP prior to your office visit in order to receive maximum benefits. If an authorization/referral is not provided at the time of service, you will be asked to either reschedule your appointment or pay for the visit at the time of service.

Self-pay Accounts

Payment is required at the time of service for all services. Self-pay accounts are:

- Patients without insurance information on file.
- Patients without an insurance card at the time of service.
- Patients who are covered by an insurance plan that the practice does not participate in.

I HAVE READ AND UNDERSTAND THE PRACTICE'S FINANCIAL POLICY AND I AGREE TO BE BOUND BY ITS TERMS.

_____ _____

Patient's Signature Date

808 Eden Way N, Suite 102, Chesapeake, VA 23320
154 Burnett's Way, Suite101, Suffolk VA 23434
Phone 757.216.4030 / Fax 757.216.4029

PATIENT NAME: _____

DOB: _____

Winke Orthopedic Pain Management Center

Please complete and bring to the appointment

PRESCRIPTION MEDICATION POLICY

If medications or refills are needed, you must call the office during regular business hours (Monday through Friday 8:00am-4:00pm) or you may send a request for refill through the patient portal. Please allow the treating provider 48 business hours to process your request. We appreciate your cooperation in this matter. We want to provide the best service available to our patients. We have to be accurate in relation to drug prescriptions.

Thank you for your patience and understanding.

_____ _____

Patient's Signature Date

Phone 757.216.4030 / Fax 757.216.4029

PATIENT NAME: _____

DOB: _____

Winke Orthopedic Pain Management Center

Please complete and bring to the appointment

ACCESS TO EXTERNAL MEDICAL RECORDS

Winke Orthopedic Pain Management Center Staff has access to Sentara / Bon Secours Facilities / Chesapeake General Hospital. With your given permission, we will be able to access additional medical records on your medical condition to help our providers to assist in your treatment.

I_____authorize Winke Orthopedic Pain Management Staff full access to my medical charts from Sentara / Bon Secours Facilities / Chesapeake General Hospital, Virginia and/or North Carolina Prescription Monitoring Program

_____ _____

Patient's Signature Date

Phone 757.216.4030 / Fax 757.216.4029

PATIENT NAME: _____

DOB: _____

Winke Orthopedic Pain Management Center

Please complete and bring to the appointment

Medical Information Release Form

TO AUTHORIZE MEDICAL RELEASE OF OUR INFORMATION TO FAMILY/FRIEND/SPOUSE, ETC.:

I, _____, DOB_____hereby authorize the release of medication information for Winke Orthopedic Pain Management Center regarding my psychiatric care, drug and alcohol abuse, and HIV/AIDS, insurance claims or any other medical information that is needed for utilization review or quality assurance activities to:

(Ex: Spouse, Family Member, Friend)

Name:_____DOB:_____Relationship:_____

Name:_____DOB:_____Relationship:_____

Name:_____DOB:_____Relationship:_____

_____ _____
Patient's Signature Date

_____ _____
Witness Signature Date

IF YOU'RE DECLINING ANY MEDICAL RELEASE OF INFORMATION:

I,_____, DOB_____hereby decline release of my medical information to anyone else but myself.

_____ _____
Patient's Signature Date

_____ _____
Witness Signature

PATIENT NAME: _____

DOB: _____

Winke Orthopedic Pain Management Center

Please complete and bring to the appointment

Fall Risk Efficacy Scale

Please complete for patients 65 years of age and older

Please complete the following scale below. Label each activity using numbers 1 through 10, with 1 being very confident and 10 not confident. Using a scale of 1 through 10, indicate your confidence in completing the following activities without falling.

Activities:	Score: Use numbers 1 through 10 for the following activities.
Take a bath or shower	
Reach into cabinets or closets	
Walk around the house	
Prepare meals not requiring carrying heavy or hot objects	
Get in and out of bed	
Answer the door or telephone	
Get in and out of a chair	
Getting dressed and undressed	
Personal grooming (i.e. washing your face)	
Getting on and off of the toilet	
Total Score:	

PATIENT NAME: _____

DOB: _____

Winke Orthopedic
Pain Management Center