Winke Orthopedic
Pain Management Center

Appointment Date & Time: _____ Arrival Time: _____

PLEASE REVIEW, COMPLETE AND SIGN ALL FORMS PRIOR TO YOUR SCHEDULED APPOINTMENT
THINGS TO BRING WITH YOU TO YOUR APPOINTMENT

Insurance card/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 PACET BACK TO THE OFFICE. Please bring this COMPLETED packet in with you to your appointment. If these items are not present at 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 Email: info@winkeorthopain.com

Locations:
Virginia Beach (Behind Tread Quarters & Merchants Tire)
5226 Indian River Road, Suite 102, Virginia Beach, VA 23464

Carrollton (Sentara St. Lukes Urgent Care)
20209 Sentara Way, Suite 104, Carrollton, VA 23314

Suffolk (Medical Office Building connected to Obici Hospital)
2800 Godwin Boulevard, Suite 320, Suffolk, VA 23434

Your appointment is scheduled with: *Dr. Beth Winke*_____ *Dr. James Sanderlin* _____

Directions

SUFFOLK LOCATION

Sentara Obici Hosptial is located at the intersection of Godwin Boulevard and Rt. 10 near US 58.
From Petersburg/Richmond:
Take Route 460 East to exit Route 10 turn left. Proceed to third traffic light and Obici Hospital campus is on the right.

From Hampton/Newport News:
Take 664 S to Ex 13 A toward Suffolk to 58 West. Stay in the middle lane on 50 West. (Do not take Downtown Suffolk Exit) Take Petersburg-Emporia staying straight on 58 West. Take Smithfield Newport News exit to route 10. Turn right at the light onto route 10. 2nd light Hospital is on the Right.

From Norfolk/Virginia Beach:
Take I-64 to I-264 toward Suffolk. At Bowers Hill exchange, take Suffolk exit onto Route 58/460. Proceed approximately 12 miles to exit Route 10 (Newport News/Smithfield). At the traffic light turn right. Hospital campus is on the right at the 2nd light.

From Franklin:
Take Route 58 Bypass to Suffolk to Route 10 (Newport News/Smithfield) exit. Turn left at traffic light. Proceed the third traffic light. Hospital campus is on the right.

From North Carolina:
Take Route 13/32 into Suffolk. Proceed through downtown to intersection of Route 460/10. Turn right onto Route 10 hospital is located at the third traffic light on the right.

From Smithfield:
Sentara Obici Hospital is located approximately 10 miles from the Benns Church intersection. Proceed on Route 10 the hospital will be on your left across from the YMCA.

CARROLLTON LOCATION

Sentara St. Lukes Urgent Care is located off of Brewer's Neck Boulevard (Route 258) near the intersection with Route 10, just adjacent to the former location of Smithfield Downs Golf Course.

Nearby Street Address for use in Map Lookup:
20279 Brewer's Neck Boulevard
Carrollton, Virginia 23314

If you have any questions please call 757-216-4030

Located on the First Floor in the Sentara St. Lukes Urgent Care in Suite 104
INDIAN RIVER ROAD LOCATION

5226 Indian River Road, Suite 102, Virginia Beach, VA 23464

Location near the intersection of Kempsville Road & Indian River Road.

We are located on the same side as Acredale Saddlery (Store with white horse on top). You will see Firehouse Subs then Tread Quarters & Merchants. We are directly behind Tread Quarters & Merchants Tire in a white brick building. It is beside Calvary Chapel Church and The Glass Doctor.

****IF YOU HAVE GONE TO FERRELL PKWY YOU HAVE GONE TOO FAR****

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Winke Orthopedic
Pain Management Center

TO: Patients receiving opioid category drugs (narcotics)

For chronic pain management

FROM: Dr. Beth M. Winke

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 by made available, including past medical records, past pain treatment, and any alcohol or other drug addiction of 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, 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 prescriptive 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 (of course)sell medication.
4. Narcotic medications will only be available by written prescription during normal office hours.

5. 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.

6. 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.
7. The patient has been advised that random urine analysis and random pill counts could be done at anytime. New Patients if you are unable to provide urine sample within 15 minutes of your scheduled appointment you will not be able to reschedule. Established patients if you are unable to provide a urine sample within 15 minutes of your appointments you will be asked to reschedule your appointment.
8. To ensure a smoothly operating clinic schedule we ask guests and family members to remain seated in the waiting room. Any issues or questions can be discussed after the patient's appointment.
9. Clinic policy dictates that arrival for a scheduled appointment 15 minutes or more 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.

10. 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.
11. Any use of illegal substances is an AUTOMATIC DISCHARGE.
12. 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).
13. 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.

14. 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.
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 maybe 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 request a copy of their medical record personally, or for non-medial 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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Winke Orthopedic Pain Management Center

PATIENT INFORMATION SHEET

PATIENT NAME: _____ **DOB:** _____ **Age:** _____
Last **First** **MI**

GENDER: ☐ F ☐ M **SSN:**_____ **MARITAL STATUS:** ☐Single ☐Married ☐Sep. ☐Div. ☐Wid.

RACE:_____ **LANGUAGE:** ☐English ☐Spanish ☐ Other:_____ **ETHNICITY:**_____

ADDRESS:_____ **APT/UNIT #**_____

CITY:_____ **STATE:**_____ **ZIP:**_____

HOME PHONE:_____ **CELL PHONE:**_____ **WORK PHONE:**_____

EMAIL:_____ **PERFERRED CONTACT METHOD:** ☐Home ☐Cell ☐Work ☐Email

++

EMPLOYER:_____ **OCCUPATION:**_____

ADDRESS_____ **CITY:**_____ **STATE:**_____ **ZIP:**_____

SPOUSE/PARENT NAME:_____ **DOB:**_____ **SSN:**_____

Last First MI

++

EMERGENCY NOTIFICATION:_____ **RELATIONSHIP:**_____

Last First MI

HOME PHONE:_____ **CELL PHONE:**_____

++

PRIMARY INSURANCE

NAME:_____ **POL #:**_____ **GROUP#:**_____ **COPAY:$**_____

POLICY HOLDER'S NAME:_____ **DOB:**_____ **RELATIONSHIP TO PATIENT:**_____

SECONDARY INSURNACE

NAME:_____ **POL #:**_____ **GROUP#:**_____ **COPAY:$**_____

POLICY HOLDER'S NAME:_____ **DOB:**_____ **RELATIONSHIP TO PATIENT:**_____

OTHER INSURANCE

NAME:_____ **POL #:**_____ **GROUP#:**_____ **COPAY:$**_____

POLICY HOLDER'S NAME:_____ **DOB:**_____ **RELATIONSHIP TO PATIENT:**_____

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REFERRING PHYSICIAN:_____ **OFFICE PHONE:**_____

***** The provider who sent you to us – we need a doctor's name, not where you were seen *****

ADDRESS:_____

Street City State Zip

++

REFERRING PHYSICIAN:_____ **OFFICE PHONE:**_____

***** The doctor you see regularly / write SAME if the doctor referred you to us*****

ADDRESS:_____

Street City State Zip

PHARMACY/ADDRESS/PHONE:_____

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WORKER'S COMPENSATION INJURIES(*For Workman's Compensation-Injured while on the job-Your employer will have given you paperwork for us)*

DATE / TIME OF INJURY:_____ / _____ **WORK CASE MANAGER:**_____

CAUSE:_____ **REFERRED BY:**_____

NAME OF EMPLOYER:_____

WORKMAN'S COMP CARRIER:_____ ☐**ACCIDENT** / ☐**INJURY**

ATTORNEY CO/NAME AND PHONE #:_____

DATE / TIME OF INJURY:_____ / _____ **DATE FIRST TREATED BY PHYSICIAN:**_____

Winke Orthopedic
Pain Management Center

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.

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

Name:_____

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:

_____

_____

_____

Winke Orthopedic
Pain Management Center

Notice of Privacy Practices (3/03)

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.
(2) We are required to abide by the terms of this Notice currently in effect.
(3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign and acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for your services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization.** Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted disease or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and low-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. [Delete if inapplicable:] You should be aware that we utilize an “open adjusting room” in which several people may be adjusted at the same time and in close proximity. We will try to speak quietly to you in a manner reasonable calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be adjusted in a private room, please let us know and we will do our best to accommodate your wishes.

Others involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person’s involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as

necessary if we determine that it is in your best interest based on our professional judgement. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general conditions or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgement, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonable practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality or the information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

You have certain **rights regarding your health record information**, as follows:

1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure without restriction.
2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodating and will be required to specify the alternative address or method or contact and how payment will be handled.
3) You have the right to inspect, copy and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or proceeding to which your access is restricted by law. We will charge a reasonable free for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.
4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.
5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.
6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy right with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

All questions concerning this Notice or requests made pursuant to it should be addressed to PRIVACY OFFICER, WOPMC 808 Eden Way North, Suite 102, Chesapeake, VA 23320.

WINKE ORTHOPEDIC PAIN MANAGEMENT CENTER, PLC

I. 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 TO BE RESCHEDULED AT THE DISCRETION OF THE PRACTICE.

II. 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 teating may have been performed.

III. 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.

IV. 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.

Date Authorized Signature (Parent if minor)

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

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20209 Sentara Way, Suite 104, Carrollton, VA 23314
2800 Godwin Blvd, Suite 320, Suffolk, VA 23434
757-216-4030| 757-216-4029 fax| info@winkeorthopain.com

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 care at each visit. All co-payments and patient balances are due at the time of service unless arrangement's 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.

No-Fault
Office visits for patients with No-Fault insurance are paid at time of service. Patients submit their receipt to their NF carrier for reimbursement.

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

_____ Date:_____/_____/_____
Signature of patient (or responsible party, if minor)

Winke Orthopedic
Pain Management Center

PRESCRIPTION MEDICATION POLICY

The doctor on call cannot fill prescription medications after regular working hours Monday through Friday and on weekends. The doctor on call does not have access to patients' medical records, so we cannot medically or legally provide medications accurately over the phone. While this is an unfortunate situation, we have no choice in this matter and must adhere to this policy.

If medications or refills are needed, you must call the office during regular business hours (Monday through Friday 9:00am-5:00pm). 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 the relationship to drug prescriptions.

Thank you,

_____

Patient's Signature

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2800 Godwin Blvd, Suite 320, Suffolk, VA 23434
757-216-4030| 757-216-4029 fax| info@winkeorthopain.com

Winke Orthopedic Pain Management Center

808 Eden Way North, Suite 102

Chesapeake, VA 23320

Phone: 757.216.4030 Fax: 757.216.4029

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

_____ _____

Signature Date

Acknowledgement of Receipt of Notice of Privacy Practice / HIPPA

I certify that:

I hereby acknowledge receipt of a Notice of Privacy Practices from Winke Orthopedic Pain Management Center.

Print Name:_____

Signature:_____ Date:_____

Witness:_____ Date:_____

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Winke Orthopedic Pain Management Center

Medical Information Release Form

Phone: 757.216.4030 Fax: 757.216.4029

To authorize medical release:

I, x_____ 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 Signature:_____ Date:_____/_____/_____

If you're declining any medical release of information:

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

Employee Signature:_____ Date:_____/_____/_____

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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?	○	○	○	○	○

 The SOAPP®-R was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

PainEDU.org
IMPROVING PAIN TREATMENT THROUGH EDUCATION

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
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?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
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.

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Winke Orthopedic Pain Management Center

SHORT PATIENT HISTORY FORM

Name:_____ Date:_____

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 or drink alcohol? yes no If yes, how much?_____

Do you use illegal substances or have a history of substance abuse? yes no

Do any of your relatives have a history of substance abuse?_____

_____

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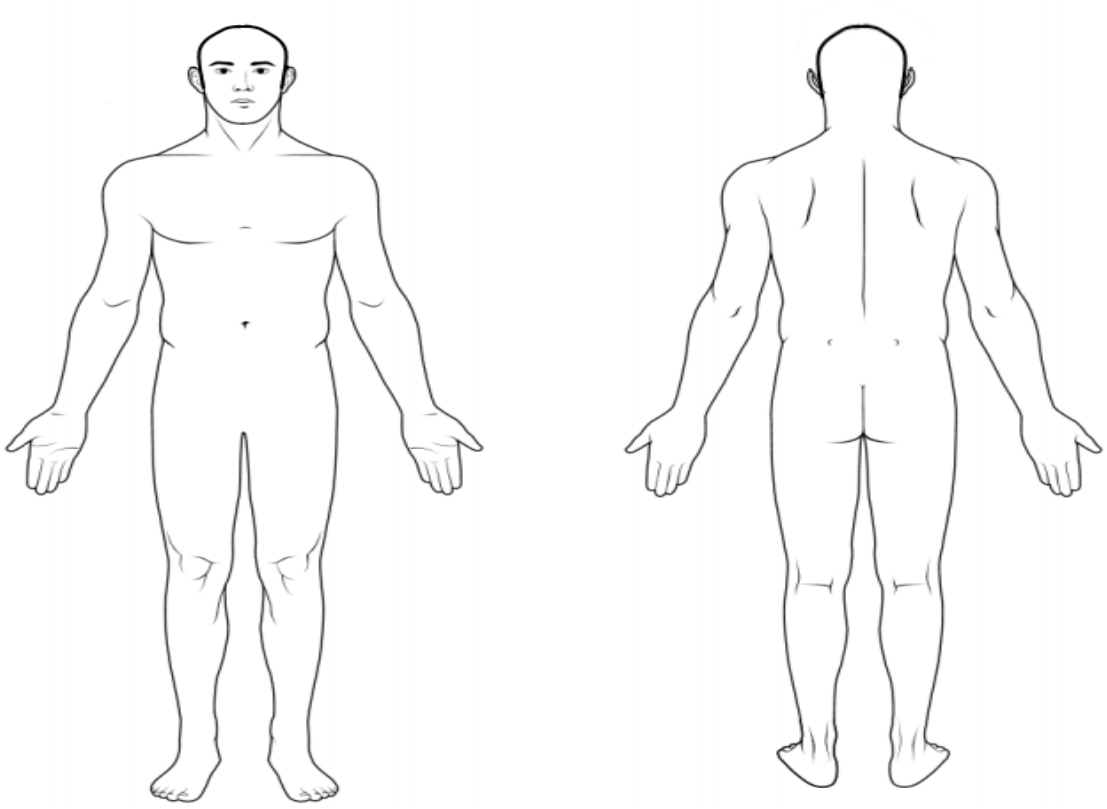
Winke Orthopedic
Pain Management Center

COMPREHENSIVE REHABILITATION PAIN QUESTIONNAIRE

Please complete and bring to 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 ///
>>>	===	…	XXX	///
>>>	===	…	XXX	///



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" on the line below to indicate the level of your pain.

Today: None_____0_____1_____2_____3_____4_____5_____6_____7_____8_____9_____10 severe / worst imaginable

Least: None_____0_____1_____2_____3_____4_____5_____6_____7_____8_____9_____10 severe / worse imaginable

Worst: None_____0_____1_____2_____3_____4_____5_____6_____7_____8_____9_____10 severe / worse imaginable

_____

_____

_____

_____

_____

Please circle all of the previous medications that you have tried:

Medication	Discontinued Reason	Medication	Discontinued Reason
Diclofenac/Voltaren	_____		
Ibuprofen	_____	Cymbalta	_____
Naprosyn	_____	Effexor	_____
Aspirin	_____	Lexapro	_____
Tylenol	_____	Zoloft	_____
Celebrex	_____	Paxil	_____
Mobic	_____	Prozac	_____
Arthrotec	_____	Ultram/Ultracet/Ultram ER/tramadol	_____
Relafen	_____	Tylenol #3 / Tylenol #4	_____
Baclofen	_____	Percocet	_____
Skelaxin	_____	Lortab/Lorcet/Vicodin/Vicoprofen/Norco	_____
Flexeril	_____	Morphine	_____
Soma	_____	Dilaudid/hydromorphone	_____
Zanaflex	_____	Duragesic patch/Fentanyl	_____
Robaxin	_____	Oxycontin	_____
Lorzone	_____	Demerol/Meperidine	_____
Valium	_____	Actiq	_____
Xanax	_____	Fentora	_____
Neurontin	_____	Opana	_____
Tegretol	_____	MS Contin	_____
Zonegran	_____	Kadian	_____
Lyrica	_____	MSIR	_____
Elavil/Amitriptyline	_____	Hydrocodone	_____
Pamelor/Nortriptyline	_____	Oxycodone	_____
Topamax/Topiramate	_____	Nucynta	_____
Wellbutrin	_____	Exalgo	_____
Flector patches	_____	Embeda	_____
Voltaren gel	_____	Avinza	_____
Lidoderm patches	_____	Butrans	_____
Compound cream	_____	Suboxone	_____
Pennsaid	_____	Methadone	_____

Please circle all of the previous treatments:

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?_____

Are you: Single Married Separated Divorced Widowed

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

What is your occupation?_____ Employer:_____

Please circle the appropriate diseases with regards to your family history:

Mother High Blood Pressure Diabetes Heart Disease Cancer Arthritis Stroke Heart Attack

Father High Blood Pressure Diabetes Heart Disease Cancer Arthritis Stroke Heart Attack

Siblings High Blood Pressure Diabetes Heart Disease Cancer Arthritis Stroke Heart Attack

Sons/Daughters High Blood Pressure Diabetes Heart Disease Cancer Arthritis Stroke Heart Attack

Aunts/Uncles High Blood Pressure Diabetes Heart Disease Cancer Arthritis Stroke Heart Attack

Grandparents High Blood Pressure Diabetes Heart Disease Cancer Arthritis Stroke Heart Attack

Please circle any problems that you have from the list below:

Constitutional
Fever
Night sweats
Weight gain (_____ lbs)
Weight loss (_____ lbs)
Exercise intolerance

Eyes
Dry eyes
Irritation
Vision change

Ears/Nose/Mouth/Throat
Difficulty hearing
Ear pain
Frequent nosebleeds
Nose/sinus problems
Sore throat
Snoring
Dry mouth
Oral abnormalities
Mouth ulcer
Teeth abnormalities

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

Genitourinary
Urinary loss of control
Difficulty urinating
Increased urinary frequency
Blood in urine
Incomplete emptying

Musculoskeletal
Muscle aches
Muscle weakness
Arthralgas/joint pain
Back pain
Swelling in the extremities

Integumentary
Abnormal mole
Jaundice
Rash
Itching
Dry skin
Growths/lesions

Neurologic
Tingling/paresthesias of the limbs
Loss of consciousness
Weakness
Numbness
Seizures
Dizziness
Frequent or severe headaches
Migraines
Restless legs

Psychiatric
Anxiety
Depression
Sleep disturbances
Restless sleep

Allergic/Immunologic
Runny nose
Sinus pressure
Itching
Hives

Respiratory
Cough
Wheezing
Shortness of breath
Coughing up blood
Sleep apnea

Endocrine
Fatigue
Increased thirst
Hair loss
Cold intolerance

Gastrointestinal
Constipation
Heartburn
Abdominal pain
Vomiting
Change in appetite
Black or tarry stools
Frequent diarrhea
Vomiting blood

Hematologic/Lymphatic
Swollen glands
Easy bruising
Excessive bleeding