SPORTS MED • REHAB • SPINE • PRIMARY CARE

INVICTUS

FITNESS • PERFORMANCE • NUTRITION

**Patient Information**

Full Name: _____ Date of Birth_____

Gender: ◯ Male ◉ Female

SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: home_____ cell_____

Email: _____

Ethnicity: ◯ Hispanic or Latino ◯ Not Hispanic or Latino

Race: ◯ Native American ◯ Alaskan Native ◯ Asian ◯ Black/African American

◯ Native Hawaiian/Pacific Islander ◯ White ◯ Other

Preferred Language: ◯ English ◯ Spanish ◯ Chinese ◯ French ◯ German

◯ Italian ◯ Japanese ◯ Portuguese ◯ Russian

**Pharmacy Information**

Pharmacy Name_____ Phone_____

Pharmacy Address: _____

**Emergency Contacts Information and Relationship to Patient**

Name _____ Relationship _____

Phone_____

**Insurance Information**

Primary Insurance_____

Policy Holder Name _____

Relationship to Patient _____

**Employer** _____ **Address**_____

Patient/Guarantor Signature _____Date _____

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Name: _____ Today's Date _____

Date of Birth: _____

## Medical History

| Condition | Year | Condition | Year | Other Conditions | Year |
|---|---|---|---|---|---|
| ☐ Congestive Heart Failure | | ☐ Cancer | | 1. | |
| ☐ Heart Attack | | ☐ Diabetes | | 2. | |
| ☐ Stroke | | ☐ Thyroid Problem | | 3. | |
| ☐ High Blood Pressure | | ☐ COPD | | 4. | |
| ☐ Depression | | ☐ High Cholesterol | | 5. | |
| ☐ Chronic Kidney Disease | | ☐ Arthritis | | 6. | |

## Social History

1. Do you exercise regularly (Yes/No)? _____ If Yes:

   What type of exercise?_____

   What type of exercise? _____

2. Do you depend on a spouse/family member for assistance (Yes/No)? _____

3. Do you smoke (Yes/No)_____ If so, how many packs/days? _____ How many years? _____

4. Do you drink alcoholic beverages(Yes/No)? _____ If so, how many drinks in a sitting? _____

5. Do you take recreational drugs(Yes/No)? ____ If so, how often? _____ Type: _____

6. Do you eat a balanced diet (Yes/No)? ____

7. How would you describe your general health (please select one)? ◯ Great ◯ Average ◯ Okay ◯ Poor

## Family History

| Condition | Relationship | Condition | Relationship | Other/Relationship: |
|---|---|---|---|---|
| ☐ Heart Disease | | ☐ Cancer | | 1. |
| ☐ Stroke | | ☐ Diabetes | | 2. |
| ☐ High Cholesterol | | ☐ Glaucoma | | 3. |
| ☐ High Blood Pressure | | ☐ Alcoholism | | 4. |
| ☐ Depression/suicide | | ☐ Asthma/COPD | | 5. |

## Medication

| Name | Date last filled | Name | Date last filled |
|---|---|---|---|
| 1. | | 6. | |
| 2. | | 7. | |
| 3. | | 8. | |
| 4. | | 9 | |
| 5. | | 10. | |

**Medication allergies:**

**Allergies:**

### Day to Day Functions

1. Do you feel unsteady when you walk? ◯ Yes ◯ No
2. Do you need help with eating, getting dressed, grooming, bathing, walking or using the toilet? ◯ Yes ◯ No
3. Do you need help with transportation, shopping, preparing meals, housework? ◯ Yes ◯ No
4. Do you have trouble falling/staying asleep or sleeping too much? ◯ Yes ◯ No
5. Do you feel tired or have little energy? ◯ Yes ◯ No
6. Have you felt depressed or hopeless recently? ◯ Yes ◯ No
7. Have you felt bad about yourself or that you are a failure? ◯ Yes ◯ No
8. Have you experienced trouble focusing on a task? ◯ Yes ◯ No

Name_____ Date_____

**Current Complaints**

Progression of your current condition since it started ◯ **Same** ◯ **Improved** ◯ **Worse** ◯ **Other**

Describe Other:

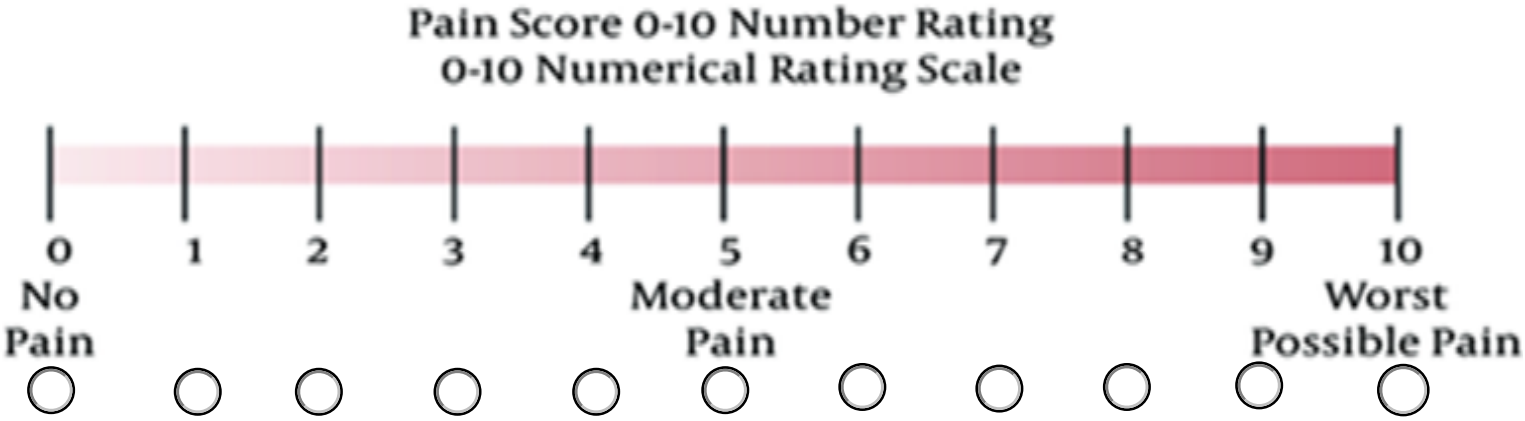
Does your present condition affect your daily activities at home or in the office? Describe:

Describe the type of pain you are experiencing (select all that apply):

☐ Sharp ☐ Tingling ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Dull ☐ Burning ☐ Cramping
☐ Other (Describe below)

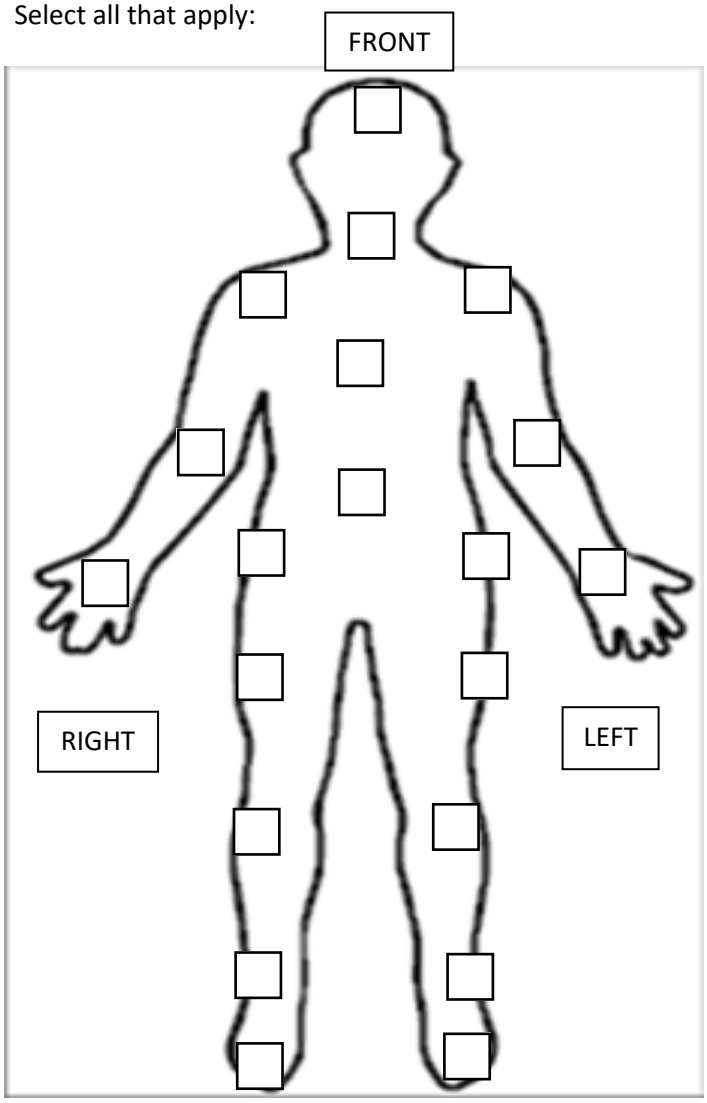
Describe the areas where you feel pain and provide as much detail as possible. Mark the body outline to indicate the location of pain.

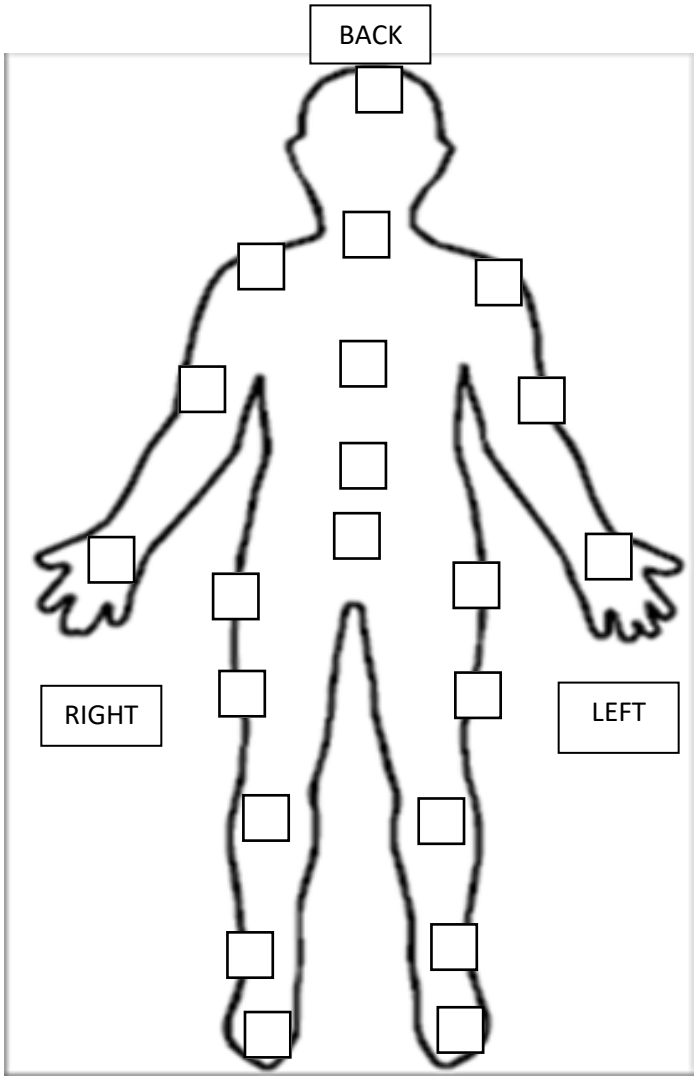
Please select your pain scale below:




PAIN ASSESSMENT

Select all that apply:




Additional Description of Pain and Location(s)

PAIN ASSESSMENT

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739 Thimble Shoals Blvd
BLDG 1000, Ste 1008
Newport News, VA 23606
(757) 310-6413

I have been advised of and agree to the following with regards to receiving opioid medications as part of my treatment for chronic pain.

1. I understand that controlled substance medications (i.e. narcotics, opioids, tranquilizers, and barbiturates) are useful, but have a high potential for misuse and are, therefore closely controlled by local, state, and federal government.

2. I understand the potential side effects include nausea, vomiting, drowsiness, and constipation. Less common effects are mental slowing, impaired ability to concentrate, slowed reaction time, low blood pressure, low heart rate, depression, flushing, urinary difficulty, itching and rash. If these side effects occur, it is my responsibility to notify my physicians. I will develop a physical dependency with increasing tolerance to their pain relieving effects. I will develop withdrawal symptoms if medications are stopped suddenly. I may develop a psychological dependency (addiction) to them. I understand the above and consent to treatment with these medications.

3. I am responsible for my pain medications. I agree to take this medication only as prescribed.
    a. I understand that increasing my dose without the close supervision of my physician could lead to drug overdose causing severe sedation, respiratory depression and death.
    b. I understand that decreasing or stopping my medication without the close supervision of my physician can lead to withdrawal. Withdrawal symptoms may include yawning, watery eyes, runny nose, anxiety, tremors, aching muscles, how and cold flashes, “goose flesh,” abdominal cramps, insomnia, and diarrhea. These symptoms can occur 24 to 48 hours after the last dose and can last for weeks.
    c. I will not alter the medication in any way. (crush, cut,etc.)

4. Except for emergencies, I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from an Invictus Health provider. If I do, I will inform the office and forward documentations of my emergency medical care of scheduled outpatient procedure care to Invictus Health. **Running out of medication early is not an emergency.**

5. I understand that opioid medication is strictly for my use. The opioid should never be given to others.

6. I will not abuse my opiod medication or other drugs, inclusive of illicit drugs, marijuana or alcohol. I will agree not to consume alcoholic beverages in any quantity while I am a patient of an Invictus Health chronic pain management program. Use of alcohol with opioid medications may procedure profound sedation, respiratory depression, and even death. I agree to submit to urine, oral fluids and blood screens at any time as determined by my physician to detect the use of both prescribed and non-prescribed medications. I also agree to submit it to my medication for random count, by the end of the business day, if so requested by my physician. I also authorize my doctor to request and my pharmacy to disclose pharmacy profiles for monitoring.

_____ **(Initial Here)**

7. If other treatments are indicated, such as physical therapy or psychology services, I agree to follow through with the entire program, and may not continue to receive opioids unless therapy appointments are kept.

8. During the time that my opioids dose is being adjusted, I will return to the clinic at least one time per month or whenever instructed by my physician. After I have been placed on a stable dose, I will return to the clinic for medical evaluation at regular intervals as determined by my physician.

9. I am responsible for my opioid prescription, I understand that refill prescriptions:
    a. Can only be written for one month's supply and will be filled at the same pharmacy.
    b. Will be made during regular office hours, Monday through Friday and shall be sent to pharmacy on file.
    c. Will not be made if "run out early" or "lose a prescription" or "spilled or misplace my medication." I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. If the medication is stolen I will report this to the local police and obtain a stolen item report.
    d. Will not be made as an "emergency," such as Friday afternoon because I suddenly realize I will "run out tomorrow." I will call 5 business days before my medications are due.
    e. Can only be filled by one pharmacy.
    f. Will not be mailed.

10. If it appears to the physician that there is no improvement to my daily function or quality of life from the controlled substance, my opioids may be discontinued after a gradual taper as prescribed by my physician.

11. I understand that the main treatment goal is to increase my ability to function and/or work an/or reduce pain. In consideration to the goal, I agree to help myself by following better health habits: exercise, weight control, avoidance of tobacco and alcohol.

12. I understand that the long term advantages and disadvantages of chronic opioid use have yet to be scientifically determined, I understand, accept, and agree that there may be unknown risks associated with the long term use of controlled substances and that my physician will advise me as knowledge advances and will make the appropriate treatment changes.

13. I am responsible to notify my physician should I become pregnant, children born to mothers on opioids will be physically dependent on them at birth.

14. I understand that if I do ot follow all of the above conditions, my physician may determine that opioid therapy is no longer appropriate for my care. I will then be gradually tapered off this medication and other therapies will be used or I may be discharged from the clinic. Pain medicines will not be prescribed for the sole purpose of withdrawal prevention.

15. Taking opioids may impair my ability to drive/operate heavy equipment.

16. I will continue to be under the care of a primary care physician for all of my medical needs. If I am not under the care of a primary care physician, I will obtain one prior to my next appointment with this office

_____ **(Initial Here)**

17. By signing below, I authorize the release of all my medical records in regard to my pain diagnosis from other physicians that have treated me in the past for this, to Invictus Health. I authorize these physicians to communicate in the future with a physician in this department. I authorize the review of any report generated under my name in Virginia by a physician in this department. I authorize the review of any report generated under my name in the Virginia Prescription Monitoring Program.

_____ **(Initial Here)**

18. I understand that it is a felony to forge, tamper or change in any way physician's prescription for controlled medications punishable by law.

_____ **(Initial Here)**

19. I understand that inappropriate behavior toward the physician, in clinic personnel and/or office staff will not be tolerated and will lead to immediate dismissal from the clinic.

20. If I am discharged from an Invictus Health chronic pain management program, I will receive a certified letter stating why I am discharged, a list of doctors in the area that practice pain management, information on withdrawal symptoms, a copy of your last UDS if applicable and a medical release form. All appointments will be cancelled for chronic pain management. You may continue treatment for primary care.

21. It may become necessary for physicians/providers to modify parts of the contract based on presenting medical information or special circumstances.

22. I _____ have read the above information, or it has been read to me by _____ and all my questions regarding the treatment of pain with opioids have been answered to my satisfaction. In addition, I fully understand the consequences of violating this agreement. I hereby give my consent to participate in opioid therapy.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

_____ _____

Physician Pharmacy

_____

Phone Number


# Financial Policy

**PLEASE READ CAREFULLY**

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

Co-payments, deductibles and non-covered fees are the responsibility of the patient. They are due at the time of service. Please understand that your insurance policy is a contract between you and your insurance company. We cannot assume that any specific charge will be covered. Your involvement in knowing what your plan covers is important and we encourage you to become familiar with your plan. This information is best obtained by contacting your insurance company. Please bring your active insurance card to each visit.

Co-payments, deductibles and coinsurance are part of the contractual agreement between you and your insurance company. Your insurance company requires us to collect your co-payment in full at the time of service. If your plan also has a deductible and/or coinsurance that hasn't been met, we will collect a deposit of $45.00, as we can only estimate the future amount due, at the time of service. Initial _____

If Invictus Health is not part of your health insurance company's network, then some health care services you receive from Invictus Health may not be provided by an in-network provider. We recommend that you contact your health insurance company to determine if Invictus Health is an in-network provider. If not, you may be billed and financially responsible for health care services performed by us as an out-of-network provider, in addition to any cost-sharing requirements that you may have.

We file primary and secondary insurance claims for our patients. In the event of a third insurance, claims are expected to be filed by the patient. If a service is considered "not covered" by your insurance company, the patient will be responsible for the uncovered balance. If you do not agree with the denial, you must resolve the matter with your insurance company. Payment is due upon receipt of a statement from our billing office. Failure to do so may result in any balance being forwarded to a contracted collection agency and potential dismissal from the practice.

If, for any reason, you are unable to keep your appointment, please contact our office to reschedule or cancel at least 24 hours in advance. Failure to call to cancel an appointment without sufficient notice may result in a $50 charge to your account. This fee is not covered by any medical insurance. If you miss one appointment without calling to reschedule or cancel, you may be dismissed from the practice. Initial _____ I have read and understand the Financial Policy and I agree to be bound by its terms.

Printed Patient Name_____

Signature of Patient_____ Date _____

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# HIPAA Privacy Authorization Form

Effective Date: October 19, 2020

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164).

Please initial next to each line to acknowledge your understanding and sign below

**Authorization.** I authorize (Invictus Health) to use and disclose the protected health information described below:

**Effective Period**. This authorization for release of information covers all past, present, and future periods of health care.

**Extent of Authorization.** I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

**Use.** This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

**Termination.** This authorization shall be in force and effect until the death of Patient, at which time this authorization form expires.

**Revocation Rights.** I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

**Benefits.** I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

**Disclosure.** I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

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Patients Signature or Representative

Printed Name of Patient

_____

Date