**Victor W. Isaac, MD, FAAPMR**
*Diplomate of the American Board of Physical Medicine & Rehabilitation*
*Diplomate of the American Board of Pain Medicine*
3320 Perimeter Hill Dr. Nashville, TN 37211
**PHONE: (615) 866-904 Fax: (615) 750-5756**

# GUIDELINES & OFFICE POLICIES

1. **Primary Care Referrals:** Please obtain all of the necessary referral forms (if required by your insurance) from your primary care physician in advance of your visit. Unfortunately, patients cannot be seen without the appropriate referral.
2. In order to treat you effectively and efficiently and within HIPAA guidelines, we require Registration Form and several other forms be completed by you.
3. **Co-payments:** Co-payments and deductibles are due upon the patient's arrival. We accept Money order and Visa/MasterCard/Discover/American Express. Returned checks (by mail ONLY) will be subject to an additional **$30.00** service fee.
4. **Tardiness:** Please call if you are running late. New patient may need to reschedule if running late. Follow-up patients arriving late will be seen before the end of the day if possible by a provider. **Cancellations:** We request that patients who are unable to keep an appointment contact our office at least 24-business hours prior to the scheduled appointment time since there are usually other clients we could contact for this time slot. We will charge a **NO SHOW FEE of $ 35.00** if your **follow up** appointment is not kept or cancelled **24 hours** prior to your scheduled time, and a **NO SHOW FEE of $50.00 to $75.00** if your **procedure** appointment is not kept or cancelled **24 hours** prior to your scheduled time.
5. **Repeated Missed Appointments:** We will be unable to schedule future appointments for patients having three (3) missed appointments and/or cancellations without appropriate notice, particularly if we feel that these missed appointments are adversely affecting our intervention/treatment plan.
6. **Medication Refills:** To ensure that your medication needs are met in a timely manner, we request you call our office at least three (3) business days prior to the date your medication is scheduled to run out. It is important to your health that you follow the directions carefully on all medications that we prescribe. In addition we must be informed of all other medications, prescription and over-the-counter. We **WILL NOT** refill controlled medications in advance of their refill date .We **WILL NOT** mail prescriptions. They must be given **IN PERSON** to you at the time of your appointment.
7. **Urine Drug Screen and Pill Count policy:** We pride ourselves in making sure that this office only treats patients who really need and want help from pain management. For this reason it is necessary to perform random Urine Drug Screens and Pill Count. Patients who are non-compliant will be discharged. For Workers Comp and Commercial Insurance Plans: We will do our very best to get authorization for the drug screen prior to your appointment. If for some reason your insurance company does not pay for the screening, you will be held responsible for payment. The cost of the screening is $75.00 for Cash or Credit Cards ONLY. Patients who do not comply with the Urine Drug Screen Policy will be discharged.
8. **Office Hours:** Our hours of operation is **Monday - Thursday 8:00 AM -4:30 PM and Friday from 8:00 AM – 12:00 PM**. The office will be closed on weekends and Holidays.

Appt:_____

Please have paperwork Completed at Arrival-

– Bring Insurance Card(s) - Copayments - Valid TN ID ONLY

FINANCIAL POLICY

**Methods of Payment**

Cash, Personal Check, Visa, or MasterCard are accepted methods of payment by ISAAC SPINE, JOINT & PAIN INSTITUTE, PLLC.
Statements will be mailed monthly and are due for payment within 30 days. If you have not paid your bill, or have not set up a payment plan within 90 days, we will ask for the assistance of a collection agency.
Our billing staff is available to answer questions relating to how your claim was filed or any additional information the carrier may need to process your claim. However, your employer or group plans administrator best addresses coverage issues. Your insurance policy is a contract between you and your insurance carrier. The ISAAC SPINE, JOINT & PAIN INSTITUTE, PLLC is not a party to that contract and cannot act as a mediator with the carrier or your insurance carrier.

**Past Due Accounts**

Returned checks and balances referred to outside collection services are subject to additional fees. In addition, patients whose accounts have been referred to collection agencies must pay any outstanding balance and pay for each visit in full at the time of the appointment before additional services/care will be provided.
Once an account is turned over to the collection agency, the patient or responsible party will have to settle the debt with the agency. Please be aware that if a balance remains unpaid, you may be discharged from ISAAC SPINE, JOINT & PAIN INSTITUTE, PLLC If this is to occur, you will be notified by regular and certified mail. It is your responsibility to inform us of any changes in your insurance, telephone numbers, and address. We ALWAYS need to know insurance changes immediately to avoid a balance that will be the patients' responsibility. Please have your insurance card available at all office visits. We cannot waive co-payment, deductibles, co-insurance or non-covered service amounts defined as patient responsibility under the terms of our contract with the various health plans.
If you have insurance coverage, we are glad to help you receive maximum allowable benefits and will file your claim(s) for you. If your insurance carrier fails to process your claim within 45 days from the date of service, the balance becomes your responsibility. If an insurance problem occurs, you will be asked to assist us in contacting your insurance carrier.
You are responsible for obtaining the necessary referral, if required by your insurance company and bringing the completed form to your appointment. In the event that you are seen without the proper referral/authorization as required by your insurance carrier, you will be responsible for payment of all fees at the time of service.

**MEDICARE PATIENTS:**

Without Supplemental Coverage: Any unpaid deductible, plus the 20% co-pay amount is due at the time of service. The office will file a claim to Medicare for the balance. With Supplemental Coverage: The office will file a claim to both to Medicare and the supplemental carrier for all charges. Any approved amount not paid will become the immediate responsibility of the patient.

**FORMS & MEDICAL RECORDS**

Insurance covers only your medical care. We have a fee for forms that may assist you in collecting disability benefits, maintain employment or handicap permit for parking. Our fee for these services is ($25.00 per page). Medical Records is a $25.00 charge for the first 25 pages & $0.25 each additional page

**I have read the above Financial Policy and agree to its terms and conditions.**

_____
Patient Name (please print)

_____ _____
Signature of Patient or Responsible Party Date

**Patient Name (PRINTED): _____ Date: _____**

**HIPPA PRIVACY PRACTICE ACKNOWLEDGEMENT OF RECEIPT**

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of the Offices of **Isaac, Spine, Joint and Pain Institute, PLLC.** Our Notice of Privacy Practices provides information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at (615) 866-9040.

**Signature X _____**

**Do we have your permission to:**

Send appointment reminders to your home? Y or N

**Do we have permission to leave the following on your home answering/voice mail:**

Appointment information Y or N
Billing information Y or N

I give permission to share appointment, billing and medical information with the person(s) named below:

_____
_____

**Please print (Name): _____ Date: _____**

# PAIN MANAGEMENT AGREEMENT FOR CONTROLLED SUBSTANCES

The purpose of the Agreement is to prevent misunderstandings about certain medicines you will be taking for pain management, while under our care. This is to help both you and your doctor to comply with the law regarding **controlledpharmaceuticals**. By signing this agreement, you indicate your intention to comply with the following: By initialing I acknowledge / accept / agree to follow the agreement & failure to do so can terminate this contract & result in discharge from this medical practice.

- I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is working to relieve my pain symptoms. _____
- Fully participate in all aspects of my care, including all recommended treatments & ONLY take my medications as prescribed. if I run out of medicines, NO early refills will be given. _____
- I will **NOT** use any illegal substances, including marijuana, cocaine, methamphetamines, etc. I will not take other prescription medications that are not prescribed to me. While alcohol is not illegal, it is not allowed as it will interact with any controlled substances and increase the risk of sedation and overdose._____
- I will not share, sell, or trade my medications with anyone. I will bring my pill bottles with all remaining pills to each visit.

I will not attempt to obtain any controlled medicines, including pain medicines, from any other doctor, & I understand that the treatment of pain includes any and ALL pain that I might experience, and is not limited to just the pain that I have been referred for treatment. _____

- I will safeguard my medications from loss or theft, NO lost or stolen medications will be replaced. _____
- Medication refills are made ONLY at regularly scheduled office visits. _____
- Submit to a urine test, if requested, to determine my compliance with my program of pain control medicine. Fees may apply. Ask the receptionist for the complete policy. _____
- **3** No-Shows or Cancellations within 24 hours of scheduled appointments within a 12-month period is unacceptable behavior that will result in discharge from the practice. _____
- I agree to come in to the office, or other specified location, when requested for a pill count. I must comply with the requested pill count by the end of the business day. If I fail to comply with this request, I may be discharged from the practice. _____
- I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicines. I also authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations. _____
- (**FEMALES ONLY**) I certify that I am **not pregnant** If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them-I am aware, that should I carry a baby to delivery while taking these medicines; the baby will become physically dependent upon opioids-I am aware that use of opioids is generally not associated with a risk of birth defects. However, birth defects can occur-whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid. _____
- I understand that if I am a woman of child bearing age (15-44) and capable of becoming pregnant, there are risks associated with taking opioids medications (such as neonatal abstinence syndrome) in the event that I become pregnant. I understand there are different methods of birth control and the availability of free and/or reduced cost of birth control._____
- (**MALES ONLY**) I am **aware** that chronic opioid use has been associated with **low testosterone levels** in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I **understand** that my doctor may check *my* blood to see if my testosterone level is normal. _____
- I agree to follow these guidelines, as have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me. _____

I agree to always use _____ pharmacy, located at _____, telephone number _____, for filling my prescriptions for pain medications, & can **NOT** pay for my prescriptions, they **Must** be paid through insurance & PA done through our office first. Permission is needed from office.
This Agreement is entered into on this _____ day of _____, 20___.

Patient signature: _____

Provider signature: _____

**HEALTH QUESTIONAIRE**

**Personal Data:**

NAME: (FIRST, MIDDLE, LAST)_____ DOB: ___-___-___ AGE: _____
Address: _____
Home Phone: _____Cell Phone: _____
Emergency Contact:_____ Phone:_____
Primary Care Physician: _____Phone:_____
Orthopedic Surgeon: _____Phone:_____
Spine/ Neurosurgeon: _____ Phone: _____
Pharmacy:_____ Phone:_____
Primary Insurance:_____ Policy Number:_____
Policy Holder:_____ Group Number:_____

**For Worker's Compensation**

If you are seeing us due to a work related accident, please answer the following questions:
Date of Injury:_____ Case Number:_____
Assigned Caseworker: _____ Phone: _____

**For Auto Accident**

If you are seeing us due to an auto accident, please answer the following questions:
Date of accident:_____
Auto Insurance:_____ Policy Number:_____ Phone Number:_____
Name of your Attorney:_____Phone:_____

## Chief Complaint

What is the reason for your office visit today? ⑥ Neck pain ⑥ Arm pain ⑥ Back pain ⑥ Leg pain ⑥ Shoulder pain ⑥ Hip pain ⑥ Knee pain ⑥ Ankle pain ⑥ Headaches other reason(s): _____

## REVIEW OF SYSTEM

- Gen ☐ Weight loss ☐ Weight gain ☐ Fever ☐ Fatigue ☐ Loss of appetite ☐ Nausea ☐ Vomiting
- Skin ☐ Skin problem ☐ Rash ☐ Psoriasis ☐ Slow healing ☐ Easy bruising ☐ Itching
- Neuro ☐ Light headed/dizziness ☐ Fainting ☐ Weakness ☐ Stroke ☐ Tremor ☐ Seizure ☐ Memory loss
- Eyes ☐ Vision problem ☐ Glaucoma ☐ Blurred vision ☐ Double vision
- ENT ☐ Ear pain ☐ Hearing loss ☐ Ear noises ☐ Nose bleed ☐ Sore throat ☐ Hoarseness ☐ Dental problems
- Cardiovascular ☐ Chest pain ☐ Chest pressure ☐ Shortness of breath ☐ Irregular heart beat ☐ Murmurs
- Respiratory ☐ Coughing ☐ Difficulty breathing ☐ Asthma/Wheezing ☐ Coughing up blood
- Gastrointestinal ☐ Constipation ☐ Diarrhea ☐ Heartburn ☐ Bloody stool ☐ Pain in stomach ☐ Ulcers ☐ Hepatitis
- Genitourinary ☐ Painful urination ☐ Frequent urination ☐ Bloody urine ☐ Kidney stone ☐ Incontinence ☐ Loss of libido ☐ Sexual difficulty ☐ Infection
- Endocrine ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Diabetes ☐ Parathyroid problems
- Hematology ☐ Anemia ☐ Bleeding disorder ☐ Easy bleeding ☐ Lymphoma/Leukemia ☐ Sickle cell disease
- Immunologic ☐ Catch cold easily ☐ HIV/AIDS ☐ Fever ☐ Hay fever ☐ Frequent sinus problems ☐ Allergies
- Musculoskeletal ☐ Arthritis ☐ Rheumatoid arthritis ☐ Osteoarthritis ☐ Compression fracture ☐ Head injury ☐ Neck injury ☐ Lower back injury ☐ Spinal trauma ☐ Birth trauma ☐ Birth defect ☐ Lupus ☐ Spina bifida ☐ Gout ☐ Osteoporosis ☐ Muscular dystrophy ☐ Muscle pain ☐ Scoliosis
- Women only ☐ Irregular periods ☐ Premenstrual depression ☐ Hot flashes ☐ Menstrual cramps ☐ Vaginal discharge ☐ Hysterectomy ☐ Breast surgery ☐ Nipple discharge ☐ Breast lumps ☐ Last mammogram _____
- Men only ☐ Burning on urination ☐ Dripping after urination ☐ Prostate problems ☐ Difficulty starting urination
- Psychiatric ☐ Depression ☐ Anxiety ☐ Panic attacks ☐ OCD ☐ Manic ☐ Bipolar ☐ Suicidal attempts ☐ Suicidal ideation ☐ Homicidal ☐ Hallucination ☐ Psychosis ☐ Other _____

## HISTORY OF PRESENT INJURY

When did the problem start? (Estimate if no specific date) _____
Was there an inciting event to your symptoms? ◯ Work Injury ◯ Auto Accident ◯ Other _____
Did you have these symptoms in the past? ◯ Yes ◯ No If yes, when? _____
Are you seeing another doctor(s) for this problem? _____ Diagnosis _____
Are you in a legal action regarding this injury? ◯ Yes ◯ No

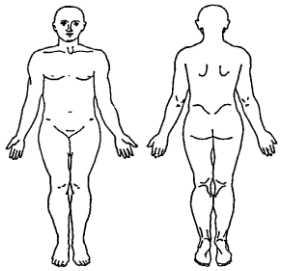
**What test have you had for this problem?(Please give date and results if available)**
◯ X-rays: _____ ◯ MRI: _____ ◯ Bone Scan _____

◯ CAT scan: _____ ◯ EMG: _____ ◯ other: _____

**What treatments have you had? ◯ Physical Therapy ◯ Chiropractic care ◯ Injections:**

**◯ Surgeries: _____ Other: _____**
List the **pain** medications that you have taken, including over-the-counter medications:
_____

**Mark on the picture diagram where the pain is using the following:**
**Please circle:**
-Sharp/stabbing burning /numbness
- dull s /cramping pins & needles



The pain is: ⑥ constant or ⑥ comes and goes
Worse during: ⑥ morning ⑥ noon ⑥ evening ⑥ bedtime
What activities make it worse: _____
What activities make it better: _____
Circle the level of your pain? 0 - 1 – 2 - 3 – 4 - 5 - 6 – 7 – 8 – 9 - 10

## Opioid Assessment - SOAPP-R

Please Answer each question as honestly as possible, There are no right or wrong answers.

| | | |
|---|---|---|
| 1. | How often do you have mood swings | 0-1-2-3-4 |
| 2. | How often have you felt a need for higher doses of medication to treat your pain? | 0-1-2-3-4 |
| 3. | How often have you felt impatient with your doctors? | 0-1-2-3-4 |
| 4. | How often have you felt that things are just too overwhelming that you can't handle them? | 0-1-2-3-4 |
| 5. | How often is there tension in the home? | 0-1-2-3-4 |
| 6. | How often have you counted pain pills to see how many are remaining? | 0-1-2-3-4 |
| 7. | How often have you been concerned that people will judge you for taking pain medication? | 0-1-2-3-4 |
| 8. | How often do you feel bored? | 0-1-2-3-4 |
| 9. | How often have you taken more pain medication than you were supposed to? | 0-1-2-3-4 |
| 10. | How often have you worried about being left alone? | 0-1-2-3-4 |
| 11. | How often have you felt a craving for medication? | 0-1-2-3-4 |
| 12. | How often have others expressed concern over your use of medication? | 0-1-2-3-4 |
| 13. | How often have any of your close friends had a problem with alcohol or drugs? | 0-1-2-3-4 |
| 14. | How often have others told you that you had a bad temper? | 0-1-2-3-4 |
| 15. | How often have you felt consumed by the need to get pain medication? | 0-1-2-3-4 |
| 16. | How often have you run out of pain medication early? | 0-1-2-3-4 |
| 17. | How often have others kept you from getting what you deserve? | 0-1-2-3-4 |
| 18. | How often, in your lifetime, have you had legal problems or been arrested? | 0-1-2-3-4 |
| 19. | How often have you attended an AA or NA meeting? | 0-1-2-3-4 |
| 20. | How often have you been in an argument that was so out of control that someone got hurt? | 0-1-2-3-4 |
| 21. | How often have you been sexually abused? | 0-1-2-3-4 |
| 22. | How often have others suggested that you have a drug or alcohol problem? | 0-1-2-3-4 |
| 23. | How often have you had to borrow pain medications from your family or friends? | 0-1-2-3-4 |
| 24. | How often have you been treated for an alcohol or drug problem? | 0-1-2-3-4 |

Total Score _____

**PAST MEDICAL HISTORY**
Do you have any of the following conditions? (Check all that apply)
◯ Coronary artery disease/ Heart attacks ◯ High blood pressure ◯ Seizures ◯ Diabetes ◯Hepatitis ◯ Stroke(s)
◯ Anemia (low blood count) ◯ Asthma ◯ Thyroid disease ◯ TB ◯ Kidney disease ◯ Peripheral vascular disease ◯ Ulcer
◯ HIV ◯Emphysema ◯ Cancer: _____

**PAST SURGICAL HISTORY**
◯Spine (Cervical, Thoracic, Lumbar)_____
◯ Joint replacement: _____
◯ List other surgeries and dates: _____
◯ List any prior accidents or work injuries:_____

**CURRENT MEDICATIONS:** 1. _____ 2. _____
3. _____ 4. _____ 5. _____

****PLEASE LIST ANY OTHER MEDICATIONS ON A SEPARTE SHEET IF UNABLE TO FIT ALL****
Do you have **Allergies? ◯ Yes ◯ No if yes, list them?** _____

## FAMILY HISTORY

Are there any medical conditions that are common in your family? ◯ Yes ◯ No If yes, list: _____

## SOCIAL HISTORY

Tobacco use: ◯Cigarettes ◯Cigars ◯ others: _____How much per day? _____For how long? _____
Alcohol use: ◯ Beer ◯ other: _____ How often? _____For how long? _____
Illicit drug use: ◯Yes ◯ no if yes, what type(s): _____How often? _____For how long? _____
Do you have a drug or alcohol dependency? ◯ Yes ◯ No If yes, did you have drug rehabilitation?◯Yes◯ No
Occupation: _____◯ Full-time ◯ Part-time Marital Status ◯ S ◯ M ◯ W ◯D
Family Status: Living with_____ Disability: ◯ No ◯ Yes (Type) _____

## DRUG SCREEN CONSENT/VERIFICATION FORM

I,_____ have performed a Urine Screen for Isaac Spin, Joint and Pain institute. It has been explained to me what i am being tested for. I have submitted my sample into the approved container which the have provided. I am aware I will be notified of these results as soon as they are available. If you are taking any other medicine such as Adderall, Xanax, Valium or toher Benzodiazepine please mark below. YES ◯ NO◯ Name of Medicine _____

Patients Signature_____ Collector Signature_____ Provider Signature_____

**For Physician Only**

**HPI:**_____
_____
_____
_____
_____
_____

**Vital:** HR: _____ BP: _____ RR: _____ Height: _____ Weight: _____

**IMPRESSION:**_____
_____
_____

## RECOMMENDATIONS

1. Medicines, PT, Lab/X-Ray/MRI, Procuders, Consults, RTC, PRN_____

_____
_____

**NOTES**_____
_____
_____
_____
_____

**PHYSICIAN NAME:** _____ **DATE:**_____

# ISAAC SPINE, JOINT & PAIN INSTITUTE

MEDICAL RECORDS RELEASE AUTHORIZATION

**Phone:** (615)866-9040 Fax**:** (615)750-5756

Please Print and complete all sections to insure your request is handled in a timely manner

Patients Name: _____ Patients Date of Birth: ___/____/_____

Patients Phone Number: _____ Patients S.S. # _____

Patients Address: _____

City, State, and Zip Code: _____

**FAX RECORDS TO**: _____

Name, Address: _____Isaac Spine Joint & Pain Institute_____

___2004 Hayes St. Suite 655 Nashville TN, 37211

**OFFICE USE ONLY**

**Please specify what records should be released:**

_____

_____

**Purpose of disclosure: _____Continuation of Care_____**

I authorize _____to release or disclose to the above-named facility all of my medical records, including and specially protected records, such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle-cell anemia, or HIV infection for the purpose of medical treatment.

**If you do not want certain portions of your medical records released, identify the information you do not want release. Otherwise, your records will be release as specified above**

This authorization will expire after one year of date of signature

■I understand that I may revoke the authorization at any time prior to the expiration date or event, but that my revocation will not have any effect on actions taken by Isaac Spine, Joint & Pain Institute or its physicians, employees or agents before they received my revocation. Should I desire to revoke this authorization, I must send written notice to Isaac Spine, Joint, & Pain Institute

■I understand that I am not required to sign this authorization. Isaac Spine, Joint & Pain Institute will not condition treatment, payment, enrollment or eligibility for benefits on weather I provide this Authorization

■I understand my records may be subject to disclosure by the recipient & may no longer be protected by federal privacy regulations. I understand that this authorization does not limit Isaac Spine, Joint & Pain specialists' or its physicians', employees' or agents' ability to use or disclose my information for treatment, payment, or health care operations, or as otherwise permitted by law.

_____

Patient or authorized Representative's Signature: Date: