Dear Patient,

Welcome to Willow Pain and Wellness.

Attached is your New Patient Paperwork. Please complete the enclosed packet and **BRING** it with you to your scheduled appointment. All information requested is vital to your plan of care on your first visit with us. Please **DO NOT** mail the packet back. If you are unsure about certain sections/questions, simply leave blank and we will assist you.

It is very important to provide us a copy of any imaging results (MRI/CT/X-Ray), physical therapy notes, previous nerve blocks records or pain clinic records related to your pain complaint(s). This information should be faxed to us ahead of time.

Arrive 15 minutes early for you 1st appointment, and if you are going to be late or need to reschedule call our office 662-638-0462.

We look forward to meeting you!

Thank you,
Willow Pain and Wellness

Your appointment is scheduled with:

Kirk L. Kinard, DO Mamie Kosko, FNP-C

Teresa Hewlett, ANP Christianne Curbow, FNP

2215 Jefferson Davis Dr.
Oxford, MS 38655

Appointment Date: _____ Appointment Time: _____

PLEASE BRING TO YOUR APPOINTMENT

- ○ **Completed Paperwork**
- ○ **Driver's License/Photo ID**
- ○ **All Insurance Cards**
- ○ **ALL medications in their original bottles with dosing information**

!ATTENTION!

You must complete this paperwork BEFORE you come to your appointment.

FAILURE TO COMPLETE THIS PAPERWORK MAY RESULT IN BEING RESCHEDULED FOR A LATER DATE

Please arrive to your appointment 15 minutes early

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Patient Intake Form

Your completed intake paperwork helps our providers to get to know you and your medical history. We will rely on the accuracy and your attention to detail to supply us with all pertinent information so that we can provide you with the best care possible. Please take your time to complete each question thoroughly and we can help you with certain sections/questions during your appointment if needed.

Patient Information

Name: _____ Gender: ☐ Male ☐ Female

Street Address: _____

City/State/Zip: _____

Physical Address Same as Mailing? ☐Yes ☐No/ If not: _____

Social Security Number: _____(This is necessary for some insurance filing)

Date of Birth: _____ Age: _____

Email: _____

Preferred Phone: _____ ☐ Home ☐ Mobile ☐ Work

Secondary Phone: _____ ☐ Home ☐ Mobile ☐ Work

Driver's License #: _____ State Issued: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other _____

Primary Care Doctor: _____

Race: (Question required by Affordable Care Act): ☐ American Indian or Alaskan Native

☐ Asian or Pacific Islander ☐ African American ☐ Caucasian ☐ Refuse to Report

Ethnicity (Question required by Affordable Care Act): ☐ Hispanic ☐ Non-Hispanic ☐ Refuse to Report

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Have you **ever** had a Worker's Compensation Claim? (If yes, please contact our staff) ☐Yes ☐No

Referral

Who can we thank for referring you to our clinic? _____

Authorization to Leave Messages Concerning Your Care

You may leave messages for the following: (Please check all that apply)
☐ Confirming appointments ☐ Scheduling procedure information ☐ Message to return call
Please list persons you authorize to take a message from our staff regarding your care:
Name: _____ Phone: _____
Name: _____ Phone: _____

Medical History, Consent for Treatment and Assignment of Benefits

I certify that the information I provided in this document is accurate, complete and true.

I authorize Willow Pain and Wellness and any associates, assistants and other healthcare providers it may deem necessary to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness. I give my consent for Willow Pain and Wellness to retrieve and review my medication history. I understand this will become part of my medical record.
I acknowledge that I have had the opportunity to review Willow Pain and Wellness's Notice of Privacy Practices. This describes how my protected health information may be used and disclosed and how I may access my health records.
I authorize Willow Pain and Wellness to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, physicians and healthcare practitioners involved in my care, and any physician, therapist or healthcare practitioner to whom I may be referred. I also authorize Willow Pain and Wellness to release any information required in obtaining procedure authorization or the processing of any payment claims. Willow Pain and Wellness will not release my Protected Health Information to any other (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" form.

I hereby assign any/all medical and/or surgical benefits to which I am entitled through Medicare, Medicaid, Worker's Compensation, Letter of Protection or any other governmental or private insurance or health plans to Willow Pain and Wellness. This assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as the original. I understand that I am solely responsible for obtaining any/all referrals required by my insurance carrier(s) in order to see Dr. Kirk Kinard D.O and/or his associates at Willow Pain and Wellness under the coverage of my insurance carrier. I also understand if I fail to obtain the proper referral and my insurance declines to cover any date of service, if my insurance declines to cover any date of service for any reason, and/or if I fail to provide complete and accurate insurance information on this form, I am financially responsible for all affected date(s) of service and agree to promptly pay any fees due for those dates of service.

Signed: _____ Date: _____

Patient Contract

I understand that payments made to Willow Pain and Wellness are for my medical evaluation and care. I have not been promised any particular medication or treatment by any provider or associate in exchange for payment. Additionally, no other doctor has represented to me that such medications would be prescribed for me in exchange for these payments. I further understand that if any provider or associate of Willow Pain and Wellness deems that I am not currently a candidate for certain pain medications, no such medications will be provided.
In addition, a urine specimen will be collected today as is standard for every new patient consultation. Urine drug screens will be conducted randomly throughout my course of treatment and we will periodically check the Prescription Monitoring database to review your controlled substance prescription history.

Signed: _____ Date: _____

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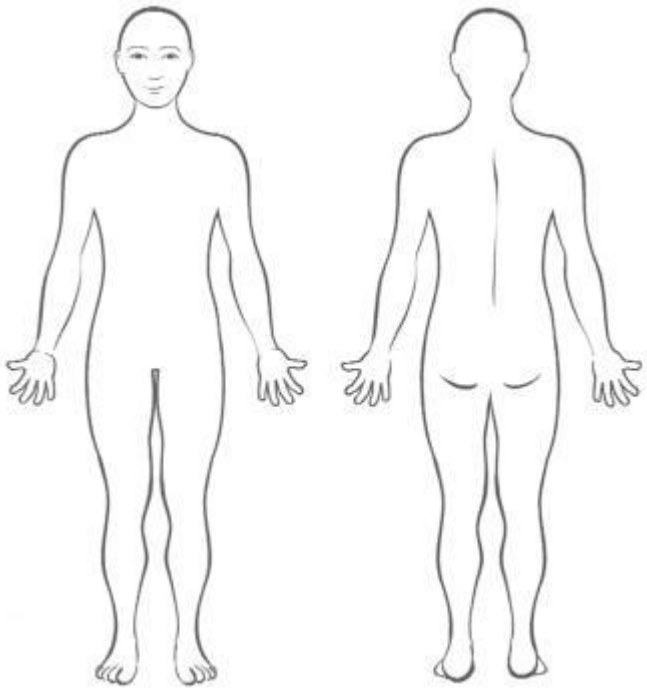
Pain Symptoms

Circle the location of your WORST pain:



Onset of Symptoms

Approximately when did this pain begin? _____

What caused your current pain episode? _____

Is your pain related to surgery or an accident? _____

Did your current pain begin gradually or suddenly? _____

Since your pain began has it: increase / decreased / stayed the same?

Has your pain had an impact on

- ☐ Your General Lifestyle
- ☐ Social Life
- ☐ Sexual Life
- ☐ Ability to work
- ☐ Ability to sleep
- ☐ Exercise

Mark all the following tests you have had that are related to your MAIN pain complaint:

Diagnostic Tests and Imaging

☐ MRI of the _____ Date: _____ Facility/Where: _____

☐ XRAY of the _____ Date: _____ Facility/Where: _____

☐ CT Scan of the _____ Date: _____ Facility/Where: _____

☐ EMG/NCV study of the _____ Date: _____ Facility/Where: _____

☐ Other test: _____ Date: _____ Facility/Where: _____

☐ I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINT(S)

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Patient Comfort Assessment

Circle the words that describe your pain.

aching	sharp	penetrating
throbbing	tender	nagging
shooting	burning	numb
stabbing	exhausting	miserable
gnawing	tiring	unbearable

Circle one: occasional continuous

What time of day is your pain the worst? Circle one.

morning afternoon evening nighttime varies

Rate your pain by circling the number that best describes your pain at its worst in the last month

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

Rate your pain by circling the number that best describes your pain at its least in the last month

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

Pain score without medication

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

Pain score with medication

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

Pain score with activity

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

What makes your pain better? _____

What makes your pain worse? _____

Treatments

Which of the following treatments have you had for your **PRIMARY PAIN COMPLAINT** (**In the last year**) and how did it work?

TREATMENT	No Relief	Temporary Relief	Excellent Relief	Year
Acupuncture				
Botox Injections				
Chiropractic				
Epidural Steroid Injections **Circle: Cervical / Thoracic/ Lumbar**				
Facet Joint Injections **Circle: Cervical/ Thoracic/ Lumbar**				
Heat (Heating Pad; Hot Bath)				
Ice Packs				
Joint Injections **Which Joint(s)_____**				
Massage				
Nerve Blocks **Which Nerve? _____**				
Physical Therapy				
Vertebroplasty/ Kyphoplasty				
Psychotherapy				
Radiofrequency Ablation (AKA "nerve burning) **Location: _____**				
Spinal Cord Stimulator **Circle: Trial/ Permanent Implant**				
Stretching				
Surgery **Details: _____**				
TENS Unit				
Traction				
Trigger Point Injection **Where? _____**				

____I have not had any prior treatments for my current pain complaints

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Current Medications

Medication	Dosage (mg)	Frequency (how often)	Prescribing Doctor

Preferred Pharmacy

Pharmacy Name: _____

City/State: _____

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Medical History

Check all that apply

General Medical

- ☐ Cancer Type _____
- ☐ Diabetes /Type _____
- ☐ HIV/AIDS
- ☐ RA
- ☐ Lupus
- ☐ Kidney Failure

Head/Eyes/Ears/Nose/Throat

- ☐ Other
- ☐ Migraines
- ☐ Head Injury
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Glaucoma

Gastrointestinal

- ☐ Bowel Incontinence
- ☐ Gerd (Acid Reflux)
- ☐ GI Bleeding
- ☐ Constipation
- ☐ Stomach Ulcers

Hepatic

- ☐ Hepatitis A (active/inactive/unsure)
- ☐ Hepatitis B (active/inactive/unsure)
- ☐ Hepatitis C (active/inactive/unsure)
- ☐ Liver Failure

Cardiovascular/Hematologic

- ☐ Anemia
- ☐ Bleeding Disorder Type: _____
- ☐ Heart Attack Date: _____
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Artificial Heart Valve
- ☐ Blood clot
- ☐ Poor Circulation
- ☐ Stroke Date:
- ☐ Coronary Artery Dis.
- ☐ Cong.Heart Failure

Musculoskeletal

- ☐ Amputation
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Chronic Back Pain
- ☐ Fibromyalgia
- ☐ Joint Pain/Injury
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Phantom Limb Pain
- ☐ Rheumatoid Arthritis
- ☐ Tendonitis
- ☐ Vertebral Compression Fracture
- ☐ Scoliosis

Neuropsychological

- ☐ Alcohol Abuse Past____ Present: _____
- ☐ Prescription Drug Abuse Other Drug Abuse:_____
- ☐ Bipolar Disorder
- ☐ Schizophrenia
- ☐ Alzheimers/Dementia
- ☐ Multiple Sclerosis
- ☐ Paralysis
- ☐ Peripheral Neuropathy
- ☐ Depression
- ☐ Anxiety
- ☐ Seizure Disorder
- ☐ Reflex Sympathetic Dystrophy/CRPS

Respiratory

☐ Asthma ☐ CPAP ☐ Emphysema/COPD ☐ Obstructive Sleep Apnea ☐ Home Oxygen

ALLERGIES

YES OR NO

If yes, please list the allergen & the **REACTION** to it. Include any topical allergies

_____

_____

_____

Drug: _____ Reaction: _____
Drug: _____ Reaction: _____
Drug: _____ Reaction: _____
Drug: _____ Reaction: _____

Surgical History

Spine/Surgery

- ☐ Discectomy (Levels?)_____
- ☐ Laminectomy (Levels?) _____
- ☐ Spinal Fusion (Levels?) _____
- ☐ Spinal Cord Stimulator _____

Heart/Lung Surgery

- ☐ CABG (heart bypass) Year: _____
- ☐ Stent (heart) Year: _____
- ☐ Pacemaker / defibrillator Year: _____
- ☐ Valve Replacement
- ☐ Lung Surgery

Family History

Alcoholism	_____ Father	_____ Mother	_____ Brother	_____ Sister
Illicit Drug Use	_____ Father	_____ Mother	_____ Brother	_____ Sister
Prescription Drug Abuse	_____ Father	_____ Mother	_____ Brother	_____ Sister

Social History

- ☐ Married ____ Yrs.?
- ☐ Divorced
- ☐ Single
- ☐ Separated
- ☐ Widowed

Number of children _____

Number of grandchildren ____

Alcohol Yes No

Drinks per Week _____

Cigarettes Yes No

Packs per day? _____

Disabled? ☐ Yes ☐ No

Review Of Systems

Check if you CURRENTLY have any of the following?

General/Constitutional:

____ Insomnia ____Fatigue _____ Fever

Allergy/Immunology:

Ophthalmologic:

____ Double/blurred vision

____ Discharge ____ Recent Visual Changes ____ Diminished visual activity

____Eye Pain ____ Itching and redness

Respiratory:

_____ Breathing problems _____ Cough _____ Shortness of Breath _____ wheezing

Cardiovascular:

____ Chest pain ____ Fluid accumulation in the legs

____ Irregular heartbeat ____Palpitations

Gastrointestinal:

____ Abdominal pain _____ Change in bowel habits _____ Constipation ____ Diarrhea

____ Acid reflux _____ Heartburn _____ Hernia ____

____ Vomiting Nausea _____Sudden weight loss

Musculoskeletal:

____ Back pain ____ Joint pain ____ Leg cramps ____ Muscle spasms

____ Neck Pain ____ Joint stiffness ____ Muscle weakness

Skin:

_____ Easy bruisability _____ Blistering of skin _____ Dry Skin _____ Hives

_____ Itching _____ Rash

Neurological:

____ Headaches _____ Difficulty Speaking ____ Dizziness ____ Fainting

____ Paralysis _____ Numbness ____ Loss of Strength ____ Memory Loss

_____ Fall frequently

Psychiatric:

_____ Anxiety ____ Auditory/visual Hallucinations _____ Suicidal plans _____ Depressed mood

_____ Mental or physical abuse _____ Suicidal thoughts

Wellness Screenings

Any falls within the past year? YES/NO
Were you injured? Describe below.

_____
_____
_____

Pneumonia Vaccination?	YES/NO	Year? _____
Mammogram?	YES/NO	Year? _____
Colonoscopy?	YES/NO	Year? _____
Prostate Screening?	YES/NO	Year? _____
Influenza Vaccination?	YES/NO	Year? _____

Willow Pain and Wellness, LLC

Patient/Responsible Party Financial Policy

Patient Name: _____DOB: _____Date: _____

In order to establish a complete understanding of the financial responsibilities associated with the care provided, these financial policies are provided for your review. If you have any questions, please feel free to ask our staff.

We would like to assist you in receiving the maximum allowable benefit from your health insurance. In order to do this, we need you to provide complete and accurate personal and insurance information on our registration form. Please complete this information completely and provide your insurance card to be copied.

We will verify your insurance as a courtesy to you. We will also submit any claims to your insurance company. When coming in for an office visit or procedure, your co-payment/co-insurance is due at the time of service. Insurance companies will not tell us exactly what your portion will be until they receive the claim and review it; therefore, the payment you make will apply to your balance for that specific date of service. Then you will be responsible for only the remaining balance. We accept cash, Visa, MasterCard, Discover and American Express or care credit. **NO CHECKS.** Payment for all services rendered are the responsibility of the patient or guarantor regardless of insurance. In some situations, your insurance company may mail a payment to you directly instead of to our billing agency. If you receive a payment from your insurance company please contact our billing agency for instructions 855-303-2212. _____ Initials

Your insurance company may consider our Providers out-of-network. Most insurance carriers have out of network coverage. Out-of-network benefits may mean payments made are done so in a different ratio than in-network and may have a separate deductible. You may owe additional money if your insurance doesn't cover the entire cost of your visit. _____ Initials

Our clinic uses an independent lab for monitoring our medication compliance. You may receive a separate bill from them for processing your sample. Our office provides the drug screening company with the insurance information you provide. All charges incurred monitoring compliance are the patient's responsibility. _____Initials

In the event that a patient's account is turned over to a collection agency for further collection actions, the patient will be responsible for all collection, legal, and court costs related to the patient's account and unpaid balances. _____ Initials

Willow Pain and Wellness, LLC
Patient Policies

- Cancelled Appointments: Cancellation of an *office visit* must be made 24 hours in advance or a ***$50 cancellation fee*** will be charged to the patient. Cancellation of a *procedure* must be made 48 hours in advance or a ***$125 cancellation fee*** will be charged to the patient. Three consecutive cancelled or rescheduled appointments may result in being marked as "**ineligible for reschedule**". _____ Initials

- Worker's Comp.: All workman's compensation cases must be approved by the workman's compensation carrier. If your workman's compensation case closes/settles during your treatment at our facility, you must notify our office immediately. _____ Initials

- Motor Vehicle Accident: We do not file any MVA cases to your health insurance. We do not file Liability Claims. If you are in a lawsuit or become involved in a lawsuit, please notify our office immediately with your attorney's information. _____ Initials.

- Phone Calls: If our staff is unavailable to take your call, please leave a detailed message with a working phone number. Your call will be returned as a staff member becomes available. Please refrain from multiple calls in one day. We do not have "after hours". If you are having urgent problems when our office is closed, you should go to the nearest Emergency Room or walk-in clinic for evaluation. _____ Initials

- Medication Calls: Your call will be returned by a nurse the same day if received before 4pm. You must leave a working number and be available to answer when the nurse returns your call. There is no after-hours number. If you are having urgent problems when our office is closed, you should go to the nearest Emergency Room or walk-in clinic for evaluation. _____ Initials

- Appointments: There are no walk-in appointments. Please contact us for our earliest available appointment. We will not be able to see you without an appointment. _____ Initials

- Primary Care Doctor: You are required to have a primary care doctor that takes care of all your non-pain problems. If you have an accident, a fall or other injury, you must be evaluated by your primary care doctor or go to the ER for evaluation. We do not treat new injuries or acute pain. Your pain provider does not admit people to the hospital. Chronic pain is treated on an outpatient basis. _____ Initials

- Patient Behavior: Patients/Patient representatives cannot bring firearms in the clinic. We are unable to see armed patients. We expect our patients to be cooperative and pleasant. Inappropriate or abusive behavior toward our staff or other patients may result in our inability to care for you. _____ Initials

- Minority Ownership Disclosure Statement: Your WPW provider might have an ownership interest in BMH North Mississippi Imaging Services, LLC, d/b/a/ Oxford Diagnostic Center. You have the freedom to choose any facility available for the purpose of obtaining the procedure or test being performed. _____ Initials

- Right to Refuse: Providers have a right to refuse treatment or to give prescriptions if a patient is non-compliant with their personally prescribed treatment. _____ Initials

I have read, understand and have been given a copy of the patient policies. I agree to follow them.

_____ _____

Signature Date

_____ _____

Printed Name Date of Birth

Willow Pain and Wellness
Authorization of Use or Disclosure of Protected Health Information

Patient's Full Name	**Patient's Social Security Number/Medical Record Number**
Address	**Patient's Date of Birth**
City, State Zip Code	**Patient's Telephone Number**

I hereby authorize use or disclosure of protected health information about me as described below.

Initial

1. I authorize Dr. Kirk Kinard and associates to receive all health information about appointments, treatments and/or other information pertinent to my healthcare and/or payment for my healthcare provided at Willow Pain and Wellness and I authorize Dr. Kinard and associates to communicate (verbally/written) and /or to send records to my treating physician(s) to coordinate my care to ensure that all of my providers are aware of my health care needs. This information may include details about alcohol/substance abuse, HIV/AIDS or mental health.
2. I acknowledge that Dr. Kirk Kinard and associates will access my prescription monitoring report on a regular basis, which will become part of my medical record. This may include access via RxHub service, other medical providers, pharmacy benefit managers or insurance companies.
3. The following person (or class of persons) may receive disclosure of protected health information about me:

Name

Address

Phone Number

I agree that Willow Pain and Wellness may appropriately disclose my Protected Health Information including information about alcohol/substance abuse, HIV/AIDS or mental health:

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying Willow Pain and Wellness in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. Disclosure of your health information or its use for any purpose other than those listed in the "Notice of Privacy Practices" and/or consent require your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke authorization will not affect or undo any use or disclosure of information that occurred before you gave notification of your decision. You have the right to request restrictions on use and disclosure of your health information.

I would like the following restrictions regarding the use and disclosure of my health information:

By signing below, I am acknowledging that I have read, understand and agree to the above terms.

Signature of Individual* (The person about whom the information relates)	**Date of Individual's Signature**	**Date of Birth or Social Security Number**

OR, if applicable –

Signature of Guardian* or Personal Representative of Patient's Estate	**Date of Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**

A copy of this completed, signed and dated form must be given to the Individual or other signatory.

Official Use Only

Received/Witnessed	**Printed Name**	**Date**