Comprehensive Pain Management and Rehab
Dr. Chayapathy Jollu MD
Board Certified in Physical Medicine Rehabilitation
New Patient Pain Questionnaire

Date:_____

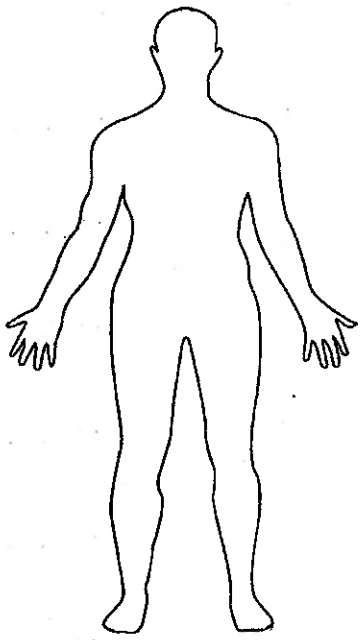
First Name:_____ Middle Name:_____

Last Name:_____ Age:_____ Gender:_____

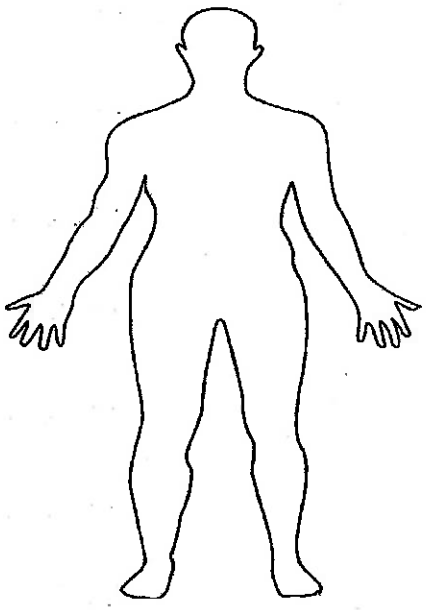
Referring Physician:_____ Primary Care Physician:_____
Phone Number_____ Phone number:_____

Main Reason for your visit:_____

FRONT



BACK



1.When did your pain start_____
2.Please describe how your pain started:
a. Did you fall? Yes or No if yes how did you fall_____
b. Did you lift/ push any thing heavy? Yes or No if yes what was it ? _____
c. Was this a work related injury? Yes or No
d. Did your pain start slowly without any injury? Yes or No
e. Where is your MAIN pain now? _____

3. **Have you ever been to any other pain clinic?** Yes or No

Name of clinic	Dr.'s name

4. **Have you had any previous treatment for your current pain?** Yes or No

Have you had physical therapy for your pain? Yes or No Where_____ How long_____

Have you had occupational therapy for your pain? Yes or No Where_____ How long_____

Have you tried acupuncture for pain relief for pain relief? Was it helpful? Yes or No

Have you ever seen a chiropractor for pain relief ? Was it helpful? Yes or No

Name of facility_____ Dr.'s name_____

Have you ever had previous injections for your pain? Yes or No

What kind of injection _____

Did it help? Yes or No

Have you had previous surgery for your pain? Yes or No How many _____

Who was the doctor?_____

Name of the surgery?_____

When was it done?_____

Did the surgery help? Yes or No

How much pain relief did you have from the surgery? _____(0 to 100%)

5. **Current pain level:** (no pain: 0 ~ 10 worst pain) _____

Pain level with medication: _____

Level without medication:_____ Average pain score over the last 24 hours_____

6. **Pain quality circle the ones that apply to your pain**: Throbbing shooting stabbing sharp cramping burning tingling aching

7. **Pain pattern:** Continuous- Rhythmic - Comes and goes

8. **What makes your pain worse?** Sitting standing walking lifting cough/sneeze laying flat on back bending twisting other

9. **What makes your pain better?** Sitting laying on your back medications resting other

10. **Do you have any of the following symptoms when you have pain?** Nausea, vomiting weakness, shortness of breathe, incontinence: bladder/ bowel other_____

11. **Do you have difficulty sleeping because of pain?** Yes or No

12. **Have you ever been treated for a different pain condition?** Yes or No
Where:_____When_____

13. **Past medical history** please circle any of the following problems:
High blood pressure Diabetes Heart murmur Arrhythmia Heart attack
Chest pain Asthma Tuberculosis Stomach ulcers Hepatitis HIV infection
Seizure Stroke Cancer Kidney -infection/ stones Thyroid disease Bleeding disorders
Depression Psychosis Others_____

14. **Past Surgical History** please list all previous surgeries

Date (Mo/Yr)	Name of surgery

15. **Current pain medications/ other/ over the counter**

Name	Dose	How do you take it	is it effective

16. List ALL Medication allergies

17. **List any MRI's/ XRAY's / CT's / other imaging that** you may have had done

18. **Social History**

Are you currently: Single Married Widowed Divorced Separated
Do you smoke cigarettes? Yes or no packs per day _____ for _____ years? Quit_____
Do you drink alcohol beverages? Yes or no how much per day _____
Have you ever used Marijuana, methamphetamine's or cocaine? Yes or no
Are you currently working ? Yes or no
how many hours per day ?_____
Is this a workers compensation case? _____
Are you involved in a lawsuit related to your pain condition?_____
Are you interested to return to work soon, if you are not working currently?_____

19. **Family History**

Do you have a family history of
1. Diabetes 2. Tuberculosis 3. Heart attacks 4. Rheumatoid arthritis
5. Back problems 6. Others:_____

20. **Review of Systems:**

Have you had any of the following symptoms **recently?**
Constitutional : fever weight loss sleep difficulty
Cardiovascular: chest pain shortness of breath
Respiratory: cough wheezing asthma breathing difficulty
Gastrointestinal: nausea vomiting abdominal pain constipation
Genitourinary: urine incontinence pain on urination impotence
Female reproduction: pregnant abnormal bleeding
Skeletal muscle: back pain arm weakness leg weakness gait unsteadiness
Vision: visual difficulty glaucoma eye pain
ENT: ear infection ear pain
Skin: rash ulcer skin cancer infection hypersensitivity color change temperature change
Immunology: Rheumatoid arthritis SLE
Psychological: depression anxiety panic attacks suicidal ideation
Hematology: Melena Hematemesis anemia
Psychology : anxiety depression PTSD BPD
Neurology: tremors weakness shakes seizures

Comprehensive Pain Management and Rehab
Controlled Substance Maintenance Agreement

I _____ understand and voluntarily agree that
(Initial each statement after reviewing)

_____I will keep (and be on time for) all my scheduled appointments with the doctor and other members of the treatment team.

_____I will participate in all other types of treatment that I am asked to participate in.

_____I will keep the medicine safe, secure and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment, and may not be replaced at all.

_____I will take my medication as instructed and not change the way I take it without first talking to the doctor or other member of the treatment team.

_____I will not call between appointments, or at night or on the weekends looking for refills. I understand that prescriptions will be filled only during scheduled office visits with the treatment team.

_____I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.

_____I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

_____I will not sell this medicine or share it with others. I understand that if I do my treatment will be stopped.

_____I will sign a release form to let the doctor speak to all other doctors or providers that I see.

_____I will tell the doctor all other medicines that I take, and let him/her know right away if I have a prescription for a new medicine.

_____I will use only one pharmacy to get all on my medicines:
Pharmacy name/phone#

_____I will not get any opioid pain medicines or other medicines that can be addictive such as Benzodiazepines (klonopin, xanax and valium) or stimulants (Ritalin, amphetamine) without telling a member of the treatment team **before I fill that prescription**. I understand that the only exception to this is if I need pain medicine for an emergency at night or on the weekends.

_____I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment may be stopped.
_____I will come in for drug testing and counting of my pills within 24 hours of being called. I understand that I must make sure the office has current contact information in order to reach me, and that any missed tests will be considered positive for drugs.
_____I will keep up to date with any bills from the office and tell the doctor or member of the treatment team immediately if I lose my insurance or can't pay for treatment anymore.
_____I understand that I may lose my right to treatment in this office if I break any part of this agreement.

Pain Treatment Program Statement

We here at are making a commitment to work with you in your efforts to get better. To help you in this work, we agree that: We will help you schedule regular appointments for medicine refills. If we have to cancel or change your appointment for any reason, we will make sure you have enough medication to last until your next appointment. We will make sure that this treatment is as safe as possible. We will keep track of your prescriptions and have RANDOM DRUG TESTING, that may be at the patients expense, as some insurance companies so not provide this benefit (If a positive for illegal drugs or other opiates not prescribed by this practice, the patient will be discharged from the practice.(Patients CAN NOT use THC (marijuana) in any form, this includes (ie tablets, cookies, oils, brownies, honey, or any other items containing illegal substances).
We will help connect you with other forms of treatment to help you with your condition. We will help set treatment goals and monitor your progress in achieving those goals. We will work with any other doctors or providers you are seeing so that they can treat you safely and effectively. We will work with your medical insurance providers to make sure you do not go without medicine because of paperwork or other things they may ask for. If you become addicted to these medications, we will help you get treatment and get off of the medications that are causing you problems safely, without getting sick.

I have been told that:

_____ 1.If I drink alcohol or use street drugs, I may not be able to think clearly and I could become sleepy and risk personal injury.
_____ 2.I may get addicted to this medicine.
_____ 3.If I or anyone in my family has a history of drug or alcohol problems, there is a higher chance of addiction.
_____ 4.If I need to stop this medicine, I must do it slowly or I may get very sick.

I agree to the following:

_____I am responsible for my medicines. I will not share, sell, or trade my medicine. I will not take anyone else's medicine.
_____I will not increase my medicine until I speak with my doctor or nurse. My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.
_____I will keep all appointments set up by my doctor (e.g., primary care, physical therapy, mental health, substance abuse treatment, pain management)
_____I will bring the pill bottles with any remaining pills of this medicine to each clinic visit.
_____I agree to give a urine sample, if asked, to test for drug use.

Refills:
Refills will be made only during regular office hours—Monday through Friday, 9:30AM-5:00 PM. **No** refills will be done on **nights, holidays**, or **weekends**. I must call 5 DAYS (5) working days ahead (M-F) to ask for a refill of my medicine. **No exceptions will be made**. I must keep track of my medications. **No** early or emergency refills may be made.

Pharmacy:
_____I will only use **one** (1) pharmacy to get my medicine. My doctor may talk with the pharmacist about my medicines.
The name of my pharmacy is_____ Address_____

Store #_____ Phone#_____

Prescriptions from Other Doctors:

_____**If I see another doctor who gives me a controlled substance medicine (for example, a dentist, a doctor from the Emergency Room or another hospital, etc.) I must bring this medicine to this clinic in the original bottle, even if there are no pills left.**

Privacy:

While I am taking this medicine, my doctor may need to contact other doctors or family members to get information about my care and/or use of this medicine. I will be asked to sign a release at that time.

Termination of Agreement:

_____If I break **any** of the rules, or if my doctor decides that this medicine is hurting me more than helping me, this medicine may be stopped by my doctor in a safe way.
I have talked about this agreement with my doctor and I understand the above rules.
Provider Responsibilities

As your doctor, I agree to perform regular checks to see how well the medicine is working.

Patient's signature_____ Date_____

Physician's signature_____

CHAYAPATHY JOLLU, MD
Diplomate of the American Board of Pain Medicine
Diplomate of the American Board of Physical Medicine and Rehabilitation
10238 SW 86th Circle, Suite 300
Ocala, Florida 34481
Telephone: (352) 873-1011 Fax: (352) 873-1017

To ALL new patients:

This letter is to inform you that on your first visit Dr. Jollu will be performing an initial assessment for your plan of treatment and based on his findings, he may or may NOT continue your current medications, dosage or the amount you are taking daily. He will determine the plan of action that he feels will work best for you.

_____ _____

Patient signature Date

_____

Chayapathy Jollu M.D.

Chayapathy Jollu, M.D.

10238 SW 86th Circle
Suite 300
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Phone (352) 873-1011
Fax (352) 873-1017

Insurance Information

Date_____ Home Phone:_____

Patient Name_____

Responsible Party (if a minor)_____

Street Address_____

City_____State_____Zip Code_____

Sex _____Male_____Female_____Age _____DOB: _____

Race __ American Indian or Alaska Native __ Asian __ Black or African American __ Native Hawaiian or other Pacific Islander __ White __ Patient Refusal

Ethnicity __ Hispanic or Latino __ Not Hispanic or Latino **Preferred Language** _____

Marital Status ____ Single _____Married _____Widowed _____Separated _____Divorced

Patient Employer _____

Business Address _____

Occupation _____Business Phone_____

Spouse (or responsible party) _____

Spouse Employer _____

Business Address _____

Occupation _____Business Phone _____

Who is responsible for this account? _____Relationship to Patient _____

Patient Social Security # _____Spouse Social Security #_____

Do you have Medical Insurance? ___ No ___Yes Name of Primary Insurer_____

Contract # _____Group # _____ Subscriber# _____

Name of Secondary Insurer (If any) _____

Contract # _____ Group # _____Subscriber# _____

_____Medicare _____Medicaid Claim ID# _____

Emergency Contact _____Phone _____

How did you learn of our practice? _____

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Insurance Authorization

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
Name of Insurance Company

And assign directly to Chayapathy Jollu, M.D., all medical benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Chyapathy Jollu, M.D., for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date

Chayapathy Jollu, M.D.

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Notification of Privacy Practices and Authorization Form

Date:_____

I, (please print)_____, acknowledge that I have received a copy of Medical Associates Notice of Privacy Practices.

In the event that a copy of my personal health information is needed for reasons other than the immediate treatment, I hereby authorize the following family members or friends, acting on my behalf, the release of personal health information to them.

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I understand that I may amend this authorization at any time.

I also understand that any other requests for personal health information by anyone other than those listed above will require additional authorization by me in writing

Patient's Signature:_____

Witness:_____

Chayapathy Jollu, M.D.

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Lifetime Authorization

Insurance Assignments and Authorization to Release Information

I **Release of Information** – I the below named patient, do hereby authorize any physician examining and/or treating me to release any third party (such as an insurance company or governmental agency, example Florida Blue or Medicare) any medical, psychiatric condition, alcohol or drug related condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

II **Physician Insurance Assignment** – I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

III **Medicare/Medicaid** – Patient's certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration Division of Family Services or its intermediaries or carries any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

IV **I Permit a copy of these authorization and assignments to be used in place of the original which is on file at the physician's office.** The assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. I understand it's my responsibility to pay any deductible amounts, co-insurance, or other balance not paid for by my insurance or third party payor within a reasonable period of time not to exceed 60 days.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collection.

_____ _____

Patient Signature Date

Subscriber (if different from patient)_____

Original Signature On File At Physician's Office

Medigap (Secondary Insurance Signature

_____ _____

Name of Beneficiary Health Insurance Company

_____

Medigap Policy Number

I request that payment of authorized MEDIGAP benefits be made on my behalf to _____ for any services furnished me by a physician/supplier. I authorize any holder of medical information about me to release to _____ any information needed to determine these benefits or the benefits payable for related services.

(Insurance Company)

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Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within the reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/ co-insurance/deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurances changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due to this office.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/ Responsible Party_____

Printed Name of Patient/ Responsible Party_____

_____Patient initials to indicate copy received

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Authorization To Release Health Information

Patient Name_____ Medical Record Number (HUN)_____

Date of Birth_____

1. I authorize the use or release of the above named individual's health information as described below

2. The fallowing individual or organization is authorized to release information

_____

_____

3. The type and amount of information to be used or released is as follows (include dates where appropriate)

Date(s) of Service_____

_____Emergency Dept Records _____Discharge Summary _____History & Physical _____Consultations

_____Laboratory Reports _____Radiology Reports _____Operative Reports _____Pathology Reports

_____Billing Information _____Home Health Records _____Rehab Records _____Speech & Hearing Records

_____Entire Record _____Other_____

4. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired Immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. This Information may be released to and used for the fallowing individual or organization

Chayapathy Jollu, MD
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Fax Records To (352) 873-1017
For the purpose of continuation of care.

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records Department. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in 60 days.

I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or released, as provided in 45CFR 164.542. I understand and release of information carrier with it the potential for re-release by the recipient and once authorized to be released, the information may not be protected by the privacy rules of the Health Insurance Portability and Accountability Act of 1996. If I have questions about the release of my health information, I may contact Chayapathy Jollu, MD Office (352) 873-1010.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness

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Optum Patient Portal

If you are interested in being able to obtain your medical records, request appointments, or request prescription refills online. Please provide us with a valid e-mail address that we can send you a link to sign up for an account with our EMR service **Optum Patient Portal.**

E-mail Address: _____

Patient's Name: _____