



Southern Pain Institute
Pain Management, EMG/NCS and IME
Anna-Louise O. Molette, M.D.
Hannah Jernigan NP-C

Welcome to Southern Pain Institute

Dr. Anna-Louise O. Molette and staff are excited that you have chosen to give our office the opportunity to serve you. Your health is our primary concern. We strive for excellence.

Your appointment is scheduled for _____ at _____. Please arrive 15 minutes before your appointment. An insurance and photo identification card is required at the time services are rendered. If your insurance requires a referral please contact your Primary Care Physician to ensure a referral has been processed. If your services are being paid by a Workers Compensation claim please contact our office three days before your appointment. Contacting our office prior to your visit will allow us time to request approval from your Workers Compensation Administrator.

Co-payments, Co-Insurance, and/or Deductibles are due at the time services are rendered.

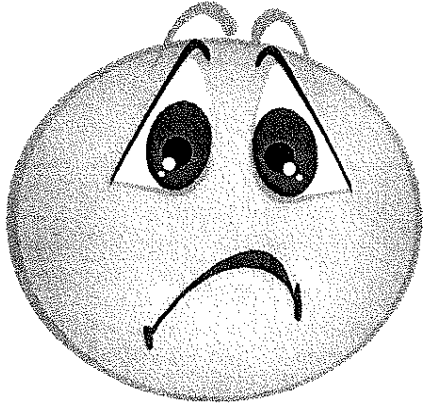
Enclosed is required paperwork for your visit. Please complete the paperwork in its entirety and bring to your appointment. It is not necessary to mail the paperwork prior to your appointment.

Once again thank you for giving our office the opportunity to serve you. If you have any questions please contact the office at the number listed below.

Sincerely

Southern Pain Institute

739 President Place Suite 220, Smyrna, TN 37167
393 Wallace Road, Suite A-204 Nashville, TN 37211
1608 Williams Drive, Suite 300, Murfreesboro, TN 37129
P. 615.459.3244 F.615.459.6525
www.southernpaininstitute.net



There is
a **\$35.00**
charge for same
day cancellations
and/or missed
appointments!!!!!!

Sincerely Management



Southern Pain Institute
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Anna-Louise O. Molette, M.D.

Patient Registration

Name _____ Date of Birth _____ Male Female
 Address _____ Social Security Number ____ - ____ - ____

 Race: Asian African American Caucasian Hispanic

 Native American Language _____

Home Phone () _____ Email _____

Insurance Provider _____ Insurance ID # _____

Insurance Group # _____

Name on Insurance Card _____ If not patient what is relationship _____

Address of Insured if different from patient _____

Insured's place of Employment _____ Work Phone () _____

Are you REGISTERED DISABLED? Yes No

I _____, Authorize the release of any medical or other information necessary to process this case or claim. I request and authorize payment of medical or government benefits to my treating physician here who accepts assignment. I authorize any treatment, procedure, or lab work deemed necessary by the treating physician or staff. I agree to be personally responsible for any and all charges (including, but not limited, no show and same day cancellation fees) regardless of whether they are paid by an insurance company. I also agree to pay any court cost associated with the collection of my account balance.

You were Referred by Dr. _____ Phone () ____ - ____

Your Primary Care Physician (PCP) _____ Phone () ____ - ____

PCP address _____ City/State _____

Emergency Contact Person _____ Phone () ____ - ____

 Signature of Patient

 Date

 Signature of Patient Representative/Guardian

 Date

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Name _____ **Date** _____

List All Current Medications

Name	Strength (mg)	Quantity
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____
9.	_____	_____
10.	_____	_____
11.	_____	_____
12.	_____	_____
13.	_____	_____
14.	_____	_____
15.	_____	_____

Allergies: *(Please list all allergies. If you are not allergic to anything please write that you are not allergic to anything.)*

1. _____
2. _____
3. _____
4. _____

Name _____ Date _____

My complaint today is _____

The problem started _____

How did the problem start? _____

1. What makes the problem worse? Exercise Walking Bending Sitting
 Standing Twisting Lifting Sneezing/Coughing Repetitive use Other

2. What makes the problem better? Lying Sitting Standing Waling
 Manipulation Therapy Pain Pills Muscle Relaxers Injections Anti-inflammatory Other _____

3. Please check the type of pain: Sharp Dull Aching Nagging Boring
 Numb Tingling

4. How long does the pain last? _____ what is the intensity? (0 least- 10 most)

What treatments have you had for this problem? Medication Surgery
Injections Other

5. Surgical History related to your pain _____ (Year) _____ (Year)
did surgery help? _____

6. List other medical problems/surgeries: _____, _____,
_____, _____, _____, _____,

7. Have you had any psychiatric illness? _____ If yes, what is the diagnosis? Are
you seeing a psychologist or psychiatrist? _____ If yes, what is his/her name?

8. Are you working now? ___ What is your occupation? _____ How may
hours per day do you work? _____ Do you plan on changing jobs in the next
5-6 months? _____

9. Are you disabled? _____ Are you able to take care of yourself? ___ If no, what is
the name and relationship of your caregiver? _____ Are you married? ___ How
many children? ___ ages? _____

Name _____ Date _____

10. Are there any substance abuse issues in the household? ___ If yes please explain _____

11. Do you smoke cigarettes or use tobacco of any form now? ___ If no did you ever smoke cigarettes or use tobacco of any form? ___ if yes, when did you stop? How many packs did/do you smoke a day? ___ How many years? _____

12. Which medications have you used? (Check all that apply) Fentanyl patches
 Percocet Hydrocodone Oxycontin Morphine Robaxin Ambien
 Benadryl Ms-contin Elavil Gabapentin Lidoderm patches
 Tramadol Lortab Savella Cymbalta Soma Xanax Motrin
 Other _____

13. Which of the following drugs or substances, if any have you used in the past? (Check all that apply) Next to each drug or substance that you have checked, indicate if you used it occasionally ("O"), frequently ("F"), or continuously ("C")

Alcohol ___ Barbituates ___ Cocaine ___ Heroin ___
 Amphetamines ___ Marijuana ___ Other _____

14. Are you presently using any of the drug or substances below? ? (Check all that apply) Next to each drug or substance that you have checked, indicate if you used it occasionally ("O"), frequently ("F"), or continuously ("C")

Alcohol ___ Barbituates ___ Cocaine ___ Heroin ___
 Amphetamines ___ Marijuana ___ Other _____

15. Have you had any of the following studies? ___ If yes please provide the date of the study.

Diagnostic X-rays ___ Emg(nerve study) ___ MRI/CT ___ other

16. Have you had any physical therapy for the problem? ___ If yes did it help? ___ Are you doing a home exercise program? ___ Have you been hospitalized for the problem? _____

17. What are your treatment goals?

Name: _____

Date: _____

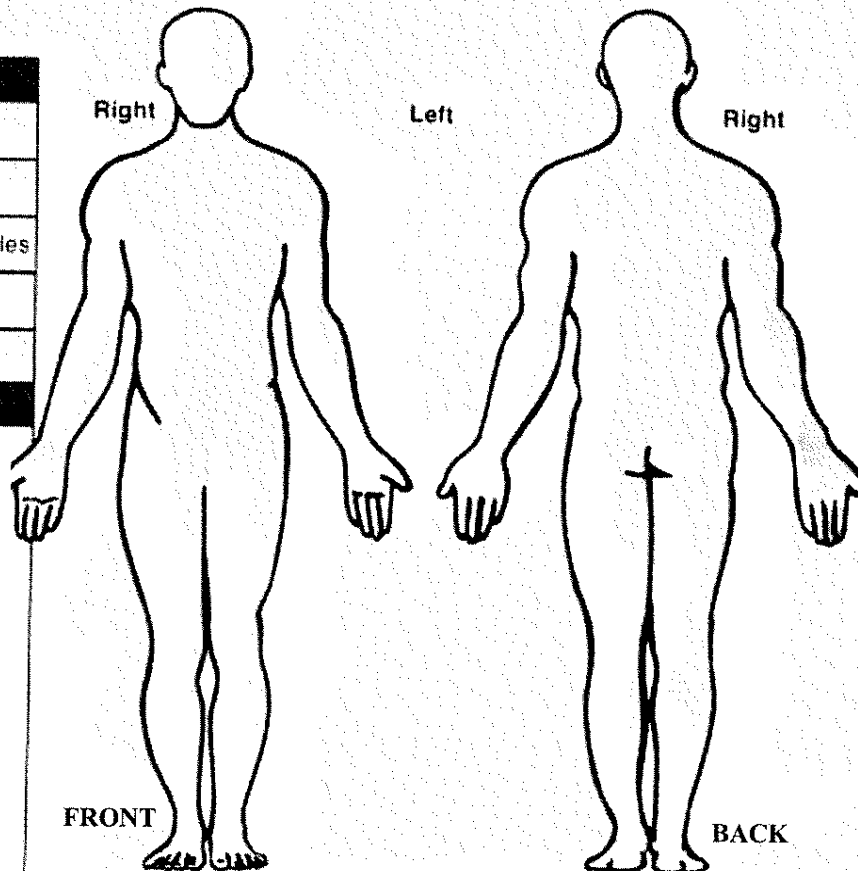
Pain Drawing

SOME PM&R PHYSICIANS HAVE THEIR PATIENTS COMPLETE A PAIN DRAWING SO THEY CAN UNDERSTAND THE LOCATION AND INTENSITY OF THEIR PAIN.

Instructions: Mark these drawings according to where you hurt (if the right side of your neck hurts, mark the drawing on the right side of the neck, etc.). Please indicate which sensations you feel by referring to the key below.

- RIGHT HANDED
- LEFT HANDED

KEY	
	Stabbing
XXXXX	Burning
00000	Pins & Needles
====	Numbness
△△△	Aching
PAIN LEVEL	
0	No Pain at all
1	Mild pain; You are aware of it but it does not bother you.
2	Pain you can tolerate without meds
3	Moderate pain requiring meds to tolerate
4-5	More severe; begin to feel anti social
6	Severe pain
7-9	Intensely severe
10	Most severe pain/ Burning alive/ Contemplating suicide



CIRCLE YOUR CURRENT PAIN LEVEL
 0 1 2 3 4 5 6 7 8 9 10

REVIEW OF SYSTEMS:

Please check any of the following you may be experiencing:

- Fevers or chills
- Night sweats
- Nausea or Vomiting
- Constipation
- Chest Pain
- Shortness of Breath
- Cough
- Headaches
- Changes in Urination
- Blurry Vision
- Weakness

Medication Questionnaire:

Please complete at each visit:

When was the last time you took your pain medication?

Are you taking your pain medication as prescribed? YES/ NO/ SOMETIMES

Is your pain medication helpful? YES / NO / SOMETIMES

Do you exercise on a regular basis? YES / NO

PAIN CONTRACT

The following is an agreement between the Treating Physician prescribing Opioids and/or medications with strong potential for dependence and his/her Patient. Dismissal from the program can be immediate if the contract is broken in any aspect or if the responsible Physician deems it appropriate. Any dismissal from the program will be explained by the treating Physician to the Patient, Referring Provider, Pharmacy, and Sponsoring insurance company as appropriate. Southern Pain Institute & Co. believes the rules and guidelines to be appropriate for the being included in the pain management program. They are intended to help only. They are also believed to be vital, and very much fair. **I may receive Opioids and/or medications with dependence potential while actively participating in this program ONLY if I follow the rules listed below:**

(please initial)

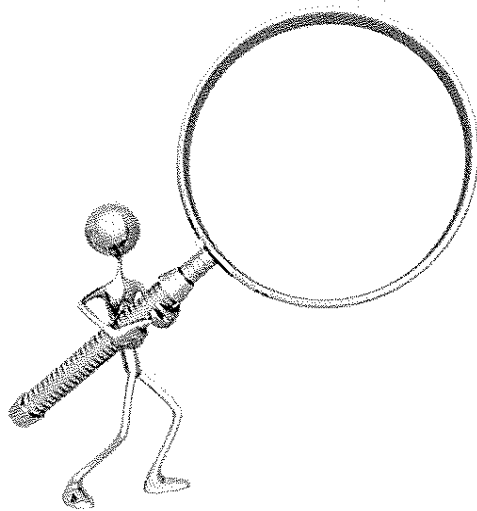
- ___ **01.** I will use the medication only as prescribed by the Southern Pain Institute Physician. **I will not** alter any dosage until I have contacted the prescribing physician and received approval to do so.
- ___ **02.** I will receive my pain medication only from a Southern Pain Institute Physician. If I receive any prescribed medication outside the Southern Pain Institute physician or associate, with respect to pain management, my Treatment Will Be **TERMINATED**.
- ___ **03.** The physician prescribing the medication reserves the right to decrease or discontinue the medication at any time strictly at his or her own discretion. An appropriate detoxification program will be recommended if deemed necessary.
- ___ **04.** I agree to use only one pharmacy to receive my pain medications. If I change pharmacies, I will inform Southern Pain Institute. If my home address changes, I will contact Southern Pain Institute and report the new address.
- ___ **05.** I will notify other health providers as well as emergency room providers that I am signed into a pain management program prior to taking any outside pain medication prescriptions.
- ___ **06.** I understand that I am **required** to bring **ANY/ALL MEDICATIONS** prescribed to me by Southern Pain Institute to any and every visit to Southern Pain Institute. I can be discharged from the program if **I miss a scheduled appointment**
- ___ **07.** Refills will be obtained every thirty days or as otherwise agreed. Refills will be made at time of scheduled appointment or by calling the designated refill line a **MINIMUM** of 7 days **BEFORE** running out of medication.
- ___ **08.** I may be allowed (**upon discretion**) one replacement prescription refill for lost, stolen, or missing prescription or medication. After this one replacement, I will only be able to obtain a refill at the usual scheduled time. Furthermore, I will not only notify the physician immediately, but also the local police of the missing medication or prescription. A copy of the police report will be sent to the prescribing physician. A second loss will be immediately treated as a breach of contract and I can be released from the care of the pharmacological management of my conditions/symptoms by the attending physician.
- ___ **09.** I understand that combining other medications with Opioids may cause drowsiness, intoxication, or death. Some of these medications are tranquilizers (downers), stimulants (uppers), diet pills, sleeping pills, alcohol or other street drugs.
- ___ **10.** I understand that if I use more of any of the medications prescribed, sell, let other people use, collect, or obtain them and it is not authorized by Southern Pain Institute; Southern Pain Institute may refuse to continue to prescribe medication of potential dependence therapy. A referral to and addiction treatment center may be made; a medication change may occur.
- ___ **11.** I understand that I must be seen by my pain management physician regularly. This requires a scheduled visit to the clinic. Refills **will not** be made if I do not keep **ANY** appointment. My response to therapy will be evaluated at each visit
- ___ **12.** I understand psychological evaluation and/or follow-up may be required by Southern Pain Institute for Opioid maintenance.
- ___ **13.** I understand that I may be given a **SUPERVISED** urine or blood drug screening test, to check if I am following rules.
- ___ **14.** I must notify my Southern Pain Institute physician of any changes in pain status and of any dosage or schedule changes in the administration of the prescribed medication made by myself or other provider.
- ___ **15.** PROFANITY, VOICE RAISING, THREATS, and other EXAGGERATED BEHAVIOR (Directed toward Physician/ Staff or other patients on premises) will be grounds for IMMEDIATE DISCHARGE.
- ___ **16.** I WILL NOTIFY THE PHYSICIAN IF I AM PREGNANT.

I HAVE READ THE ABOVE CONTRACT AND UNDERSTAND THE RULES REGARDING PRESCRIBING AND USE OF PAIN MANAGEMENT MEDICATIONS. I AGREE TO COMPLY WITH THIS PROGRAM. I ALSO AGREE TO TESTING AND DETOXIFICATION IF NECESSARY. _____ Chronic Narcotic use carries risk of **DEPENDENCE, TOLERANCE, ADDICTION, AND OTHER MEDICAL SIDE EFFECTS.**

Patient Signature _____ Date _____
 Witness Signature _____ Date _____ Physician Signature _____ Date _____

REQUESTS FOR MEDICATION CAN ONLY BE MADE AT 615.459.3206 FAX 615.459.6525
 Remember call 7 days **BEFORE** you are Due!!!!

Pharmacy _____ Phone # () _____ Address _____



SOUTHERN PAIN INSTITUTE

Pain management, EMG/NCV and IME
Anna-Louise O. Molette, M.D. ABPMR

Contact Information

Privacy official

Lawanna Stewart
Southern Pain Institute
739 President Place, Suite 220
Smyrna, Tennessee 37167

p.615.459.3244

f.615.459.6525

southernpaininstitute.net

PRIVACY PRACTICES

As required by the Privacy Regulation,
Created as a Result of the Health
Insurance Portability and Accountability
Act of 1996 (HIPAA)

**THIS NOTICE DESCRIBES HOW
YOUR HEALTH INFORMATION
MAY BE USED, DISCLOSED, AND
OBTAIN ACCESS TO YOUR
INDIVIDUAL IDENTIFIABLE
HEALTH INFORMATION.
PLEASE REVIEW THIS NOTICE
CAREFULLY.**



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Anna-Louise Molette, MD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided the Southern Pain Institute (SPI) Notice of Privacy Practices ("Notice"):

It tells me how (SPI) will use my health information for the purposes of my treatment, payment for my treatment, and SPI's healthcare operations.

The notice also explains in more detail how SPI may use and share my health information for other than treatment, payment, and healthcare operations.

SPI will also use and share my health information as required/permitted by law.

CONSENT FOR TREATMENT

The following information is to be completed by the patient or the patient's legally authorized parent, guardian or representative:

I consent to medical treatment for myself or for the patient for whom I am the legally authorized representative. I understand that Southern Pain Institute will share patient health information according to federal and state law regarding treatment, payment, and operative procedures.

I understand that the patient is responsible for all charges incurred, regardless of the patient's insurance status. The patient agrees to pay for services rendered as the patient incurs the charges. I authorize my insurance provider to pay Southern Pain Institute for services rendered.

Printed Legal Name of Patient: _____ Signature _____

Patient's Date of Birth: _____ Today's date _____

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Smyrna Tennessee 37167
P: 615.459.3244
F: 615.459.6525

Authorization to Release Medical Records

I _____ hereby authorize _____ to disclose my medical records to Southern Pain Institute.

Patient's Name _____
Address _____

Phone # _____

Information to be disclosed to the following person/organization:

**Southern Pain Institute
739 President Place, Suite 220
Smyrna, Tennessee 37167
P: 615.459.3244
F: 615.459.6525**

Specific Information _____

Use of copies: A copy of this authorization may be utilized with the same effectiveness as an original until _____ (expiration date)

Signature of Patient _____

Signature of Guardian _____

Date _____