New Patient Information

Please complete the following information:

Name:_____ DOB:_____

Address: _____

Home phone: _____

Cell phone: _____

SSN: _____

Emergency Contact Name & phone number: _____

I authorize Dr. Lonseth and his staff to discuss personal information with the aforementioned person. (Initial below) ____ *Yes* ____ *No*

Other

Race/Ethnicity: ▢ White/Caucasion, Non-Hispanic ▢ Hispanic/Latino ▢African American/Black

Other _____

Primary Language:

▢ English ▢ Spanish ▢ Vietnamese ▢ Other _____

Insurance Information:

Primary: _____ Member ID: _____

Secondary: _____ Member ID: _____

Is this visit related to an motor vehicle accident (MVA) or workplace injury?

▢ MVA ▢ Workplace Injury ▢ Not Applicable

Do you have attorney representation related to the MVA or workplace injury? If yes, please provide name and contact information. _____

_____

If this is related to a workplace injury, please provide the name of your worker's compensation adjustor and contact information.

_____

Claim number:_____ Date of injury:_____

Medical History

List any food and/or drug allergies: _____

_____

List any surgeries you have had (if any): _____

_____

Do you smoke or use tobacco products? ▢ Yes ▢ Formerly ▢ No

Do you drink alcohol? ▢ Socially ▢ Frequently ▢ Daily ▢ No

Do you have a history of substance abuse? ▢ Yes ▢ No

Marital Status: ▢ Single ▢ Married ▢ Widowed ▢ Divorced
How many children do you have (if any)?
Employment status: ▢ Employed ▢ Retired ▢ Disabled ▢ Unemployed

Primary care provider and/or cardiologist:

_____

(Name and phone number)

Preferred pharmacy: _____

Pharmacy Name Phone Number City, State

CURRENT MEDICATIONS Please include whether or not you take aspirin.

Medication name: Dosage: Directions:

_____

_____

_____

_____

_____

FAMILY HISTORY OF DISEASE Please check any familial diseases.

Condition	Relation
▢ Hypertension	_____
▢ Heart Disease	_____
▢ Diabetes	_____
▢ Cancer (Specify)	_____
▢ Anxiety	_____
▢ Depression	_____

▢ Fibromyalgia _____
▢ Stroke _____
▢ Blood Disorder _____
▢ COPD or Emphysema _____

PAST MEDICAL HISTORY: Please check all that apply.

▢ Hypertension	▢ Asthma	▢ Seizure Disorder	▢ Hyperthyroidism	▢ Headaches/ Migraines
▢ Diabetes I or II	▢ Chemotherapy	▢ Shingles	▢ Multiple Sclerosis	▢ Heart Murmur
▢Anemia	▢ COPD/Emphysema	▢ Kidney Stones	▢ Dementia	▢ Heart Attack
▢ Arthritis	▢ HIV/AIDS	▢ TMJ	▢ Alzheimer's	▢ Clotting Disorder
▢ Artificial Joints	▢ Peripheral Vascular Disease	▢ Hypothyroidism	▢ Glaucoma	▢ Hemophilia
▢ Hepatitis O A O B O C	▢ Liver Failure	▢ Other psychological disorder _____	▢ Post-Herpetic Neuralgia	
▢ Kidney Disease	▢ Anxiety	▢ Fibromyalgia	▢ Sleep Apnea	
▢ Kidney Failure	▢ Depression	▢ GERD/Gastric Reflex	▢ Cancer _____	
▢ Liver Disease	▢ Post-Traumatic Stress Disorder	▢ Diabetic Peripheral Neuropathy		

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REVIEW OF SYSTEMS: Circle ALL that apply to you within the last 30 days

GENERAL HEALTH

Fever
Chills
Night sweats
Fatigue
Recent weight loss
Recent weight gain

Heart/Cardiac

Chest pain
Chest pressure
Palpitations
SOB when lying down
Edema (swelling) legs
Calf pain with walking

MUSCLE/BONE

Back pain
Neck pain
Knee pain
Shoulder pain
Hip pain
Joint stiffness
Muscle weakness

EYES

Double vision
Blurry vision
Skin color changes

STOMACH

Stomach pain
Heartburn
Reflux or GERD
Nausea
Vomiting
Constipation
Diarrhea
Blood in vomit or stool
Can't control bowels

Neurology

Headaches
Dizziness
Seizures
Problems with memory
Trouble concentrating
Confusion
Not steady when walking

EAR, NOSE, & THROAT

Decreased hearing
Ringing in ears
Sinus problems
Sore throat
Difficulty swallowing
Neck mass or growth
Dry mouth

GENITOURINARY

Blood in urine
Urinary urgency
Can't control urine
Erectile dysfunction

BLOOD

Easy bruising
Easy bleeding
Anemia

DERMATOLOGICAL

Rash
Itching
Changes to skin color
Sores that do not heal

LUNGS

Short of breath at rest
Short of breath when active
Hard to breath at night
Wheezing
Snoring/stop breathing

ENDOCRINE/ HORMONES

Excessive thirst
Excessive sweating
Get hot too easily
Excessive urination

PSYCHIATRIC

Anxiety
Pain
Hopelessness
Depression
Insomnia
Thoughts of suicide

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Metairie, LA 70006
PH: 504-327-5857
Fax: 504-324-3569

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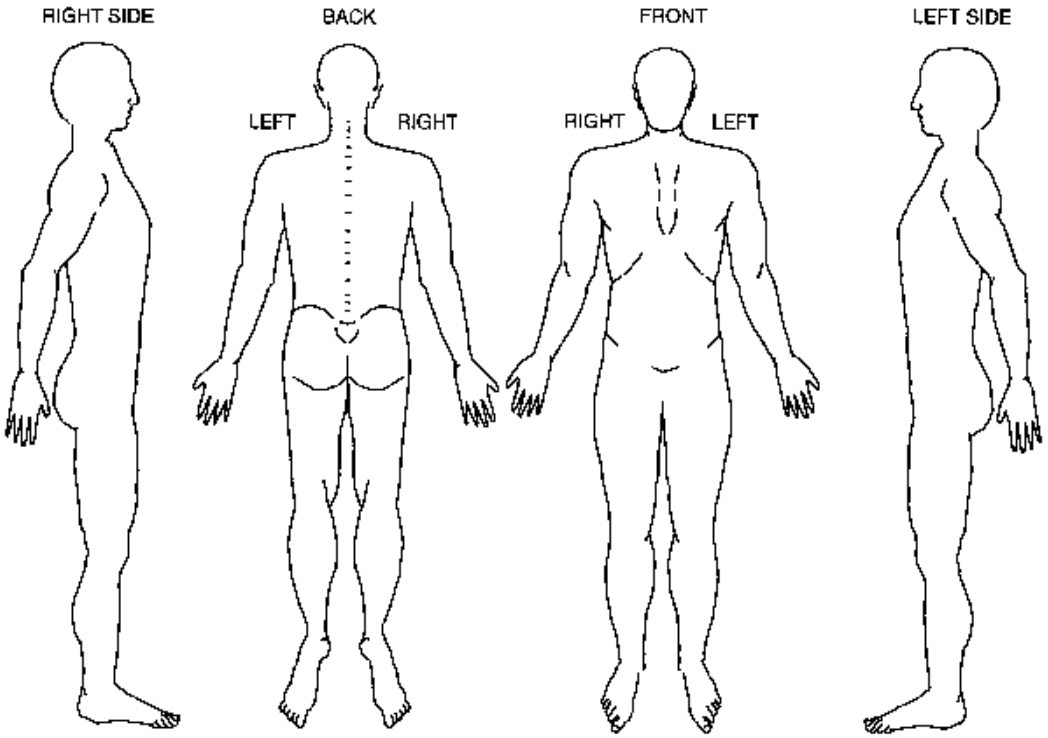
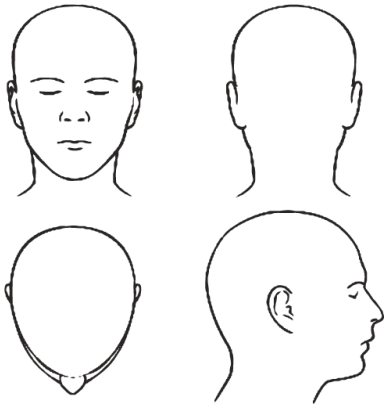
Patient Name:_____ **DOB:**_____ **Date:** _____

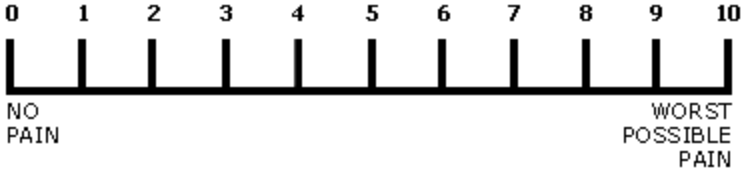
Pain Diagram

- **Indicate the area of your pain.**





Circle the level of your pain.



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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME (LAST, FIRST, MIDDLE)	**DOB**		
ADDRESS	**SSN**		
CITY	**STATE**	**ZIP**	
PROVIDER AUTHORIZED TO RELEASE PHI:	**ENTITY REQUESTING PHI:**		
	NAME **Lonseth Interventional Pain Centers**		
	ADDRESS **4213 Teuton St.** **P: 504.327.5857** **F: 504.324.3569**		
	CITY : **Metairie**	**STATE** **LA**	**ZIP** **70006**
	ATTENTION: Medical Records		

This authorization will expire on the following date or event: If date or event is not indicated, authorization will expire in 12 months from date signed.

Date: **Event:**

PURPOSE OF THIS DISCLOSURE:

PHI AND DATES OF PHI AUTHORIZED FOR USE OR DISCLOSURE

Description	Start Date	End date
( ) All PHI in the record		
( ) Progress notes		
( ) Laboratory tests		
( ) X-ray tests / reports		
( ) History and physical examination		
( ) Discharge summary		
( ) Consultation reports		
( ) Itemized billing statements		
( ) Other:		

The following information will be released when included in the above information unless you indicate Otherwise:

( ) AIDS or HIV results ( ) Alcohol, drug, or substance abuse treatment ( ) Other (specify):

I understand that:

1. I may refuse to sign this authorization and it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing to the provider authorized to release the protected with information, but if I do, it will not have any affect on any actions taken prior to receiving the revocation.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I have the right to receive a copy of this form after I sign it.

Signature of Patient:	**Date:**
Signature of Personal Representative: **Relationship:**	**Date:**

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Patient Financial Liability Agreement

Patient's Responsibility:

- To know their insurance policy: Patients should be aware of their benefit coverage including which physicians are contracted with their plan, covered and non-covered benefits, authorization requirements, and cost share information such as deductibles, co-insurance, and co-pays. If you are not familiar with your plan coverage, we recommend you contact your carrier directly.
- To obtain a referral from their Primary Care Physician (PCP) and/ or obtain authorization for treatment from their insurance carrier prior to receiving services. Any non-covered services are the financial responsibility of the patient.
- To pay their co-pay at the time of service. There may be a $10 additional charge to bill for any co-pay not paid at the time of service.
- To pay any Medicare deductible and co-insurance amounts not covered by their supplemental insurance.
- To promptly pay any patient responsibility indicated by their insurance carrier.
- To facilitate in claims payment by contacting their insurance carrier when claims have not been paid.
- A 60 –day period will be extended for pending insurance payments, after which the patient may be held responsible for the balance.
- We require the worker compensation carrier's name and address prior to your visit. If the information is not provided, you are responsible for paying the full amount for all services on the day of service. Additionally, if your worker compensation claim is denied, you are responsible for all charges incurred.

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- **Third Party Liability Injuries.** If you receive medical care, treatment, or other services from Eric Lonseth, M.D. d/b/a as Lonseth Interventional Pain Centers (hereafter, "Lonseth Interventional") as a result of a personal injury in which a third-party (i.e., someone other than you) may be at fault or responsible for your injuries (for example: motor vehicle accidents, premises liability, or any other personal injury claim), theamount due for the medical care, treatment, and other services provided by Lonseth Interventional is considered due in full at the time of the service, except as provided below. Except as provided below, Lonseth Interventional does not permit any delay in payment due to anticipated, prospective, or pending litigation.

Notwithstanding the above, Lonseth Interventional or its designees may, at their respective sole and absolute discretion, invoice or bill an insurance company of a potential at-fault party in a personal injury dispute (whether anticipated or pending). In such instances, Lonseth Interventional may collect certain information from you about your personal medical insurance to the extent the insurance company of the potential at-fault party denies, in full or in part, your claim and/or payment for your treatment, care, or other services provided by Lonseth Interventional. Nonetheless, you are ultimately responsible for all amounts due to Lonseth Interventional to the extent the insurance company of the potential at-fault party denies, in full or in part, your claim and/or payment for your treatment, care, or other services provided by Lonseth Interventional. Additionally, by signing below, you acknowledge, understand, consent, and agree that Lonseth Interventional or its designees may, at their respective sole and absolute discretion, sell, assign or otherwise transfer the obligations, debts, accounts, receivables, or charges (hereafter, the "Accounts") (owed by you to Lonseth Interventional or its designees) to any company that purchases, loans against, and/or services lien-based or subrogation based accounts receivables from persons or companies who provide health care related services (hereafter, said purchasing company is referred to as "Purchaser") . By signing below, you acknowledge, understand, consent, and agree that, to the extent your Accounts owed to Lonseth Interventional or its designees are sold, assigned, or transferred to any Purchaser, you: (i) are responsible to the Purchaser for the full amount of the Accounts, notwithstanding

any amounts paid by the Purchaser to obtain those Accounts and (ii) you agree to cooperate in full with Purchaser and provide Purchaser with any information it requests regarding the nature and circumstances of your personal injury claim and/or medical care or treatment for your injuries.

- **Financial Policy Acknowledgement:**

  I have read and understood the above financial policy: I understand that, regardless of my insurance claim status or absence of insurance coverage, I am ultimately responsible for the balance on my account for any services rendered. I understand that payments can be made by cash, MasterCard, Visa, American Express, check or money order. I agree that if my account is referred to a collection agency or attorney I will be responsible for all cost of collection on my account including attorney's fees, and any interest or money due.

  Patient Name (Please print): _____

  Patient Signature: _____

  Date of Birth: _____ Date: _____

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DISCLOSURE OF FINANCIAL INTEREST

As Required by LA R.S. 37:1744 and LAC 46:XLV.4211-4215

FROM: **Eric Lonseth, MD** Date:_____

To: _____
(Printed Name of Patient)

_____
(DOB)

Louisiana law requires physicians and other health care providers to make certain disclosures to a patient when they refer a patient to another health care provider or facility in which the physician has a significant interest. I am referring you, or the named patient for who you are the legal representative, to:

Advanced Surgery Center of Metairie, LLC

720 Veterans Blvd, Suite 100

Metairie, LA 70005

to obtain the following health care services, products, or items:

Surgery

I have a financial interest in the health care provider to who you are being referred, the nature and extent are as follows:

I own an interest of greater than five percent (5%) in the health care provider.

PATIENT ACKNOWLEDGEMENT

I, the above named patient, or legal representative of such patient, hereby acknowledge receipt, on the date indicated and prior to the described referral, of a copy of the foregoing "Disclosure of financial interest."

_____
(Signature of patient or legal representative)

_____
(Printed name of person signing)

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Patient Name _____ DOB: _____

IF YOU ARE FILING UNDER YOU HEALTH INSURANCE PLEASE COMPLETE BELOW:

Insurance company:_____ Phone:_____

Policy number:_____ Group #:_____

Policy Holder:_____ DOB:_____

IF THIS IS WORKMAN'S COMPENSATION FILL IN THE FOLLOWING

Employer details:

Employer Name: _____

Employer address: _____

Employer phone number: _____

Adjuster's Name: _____ Phone #: _____

Claim #: _____ Date of Injury: _____

IF THIS IS AN ATTORNEY CASE FILL IN THE FOLLOWING

Attorney Name: _____ Phone: _____

TREATMENT AND PAYMENT AGREEMENT:

I authorize examination and treatment for this and all following physician visits.
I authorize to release any medical information necessary to process any insurance billing.
I authorize payment and assignment of insurance benefits to the doctor's office.
I understand I am financially responsible for all charges and deductibles not covered by my insurance.
I am personally responsible for supplying accurate and current insurance information.
I authorize a photocopy of this statement to serve as an original.

Patient Signature **Date**

HIPAA Privacy Practices Acknowledgement

I understand it is the policy of Lonseth Interventional Pain Center to comply with the privacy rules and regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I have received a copy of Lonseth Interventional Pain Center HIPAA Privacy Policies and have read it carefully.

I hereby acknowledge that I have reviewed and understand the above referenced policies and procedures.

_____

Print Name

_____

Patient Signature **Date**

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INTERVENTIONAL PAIN CENTERS

4213 Teuton St. Metairie, LA 70006
P: 504-327-5857 F: 504-324-3569

Pain Management Agreement
(Required for all patients)

Please Initial and Sign Below

_____ **I understand that if I violate any of the terms of this agreement, my treating physician (Dr. Lonseth) may discharge me from the practice.**

_____ **I will treat the office staff respectfully at all times. I understand that if I do not, my treatment may be stopped.**

_____ **I will keep all scheduled appointments. In the event an office visit has to be canceled, I will do so with at least 24 hours' notice. In the event a procedure appointment has to be canceled, I will do so with at least 72 hours' notice. Dr. Lonseth reserves the right to charge a cancellation fee.**

_____ **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 am currently not abusing illicit drugs or prescription drugs and I am not undergoing treatment for substance dependence or abuse.**

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

_____ **I will make sure I have an appointment for medication refills. I will tell a member of the treatment team immediately if I am having trouble making an appointment.**

_____ **I consent for my doctor, his associates, and medical staff to communicate directly with my pharmacy to obtain information regarding my prescription history. I agree to waive any applicable privileges or right of confidentially with respect to the prescribing of my pain medication. I authorize my pain management physician (Dr. Lonseth) and pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the Louisiana Board of Pharmacy, in the investigation of my possible misuse, sale, or diversion of my pain medication; I authorize a copy of this agreement to be provided to my pharmacy and my consulting physician.**

_____ **For females only: I certify that I am not pregnant and do not plan to become pregnant. I also certify that I am taking all precautions, which may include use of contraceptives to prevent my becoming pregnant while undergoing treatment. In the event I do become pregnant, or I am trying to become pregnant, I will notify Dr. Lonseth or a member of his treatment team immediately.**

_____ **I understand that an appointment does not guarantee a prescription.**

_____ **I agree to a urine specimen request for toxicology screening as required for all new patients.**

_____ **I understand that I may lose my right to treatment in this office if I break any part of this agreement.**

Pain Management Agreement
(Required for Opiates)

_____ I agree to use controlled substances (narcotics/non-narcotics, painkillers, sleeping pills) in the treatment of my pain only as prescribed by Dr. Lonseth. I understand the goal of the treatment can include physical therapy, minimally invasive procedures, psychological services, and may or may not included prescription strength medication. The overall goal will be to decrease the amount of narcotics used concurrently with other treatments.

_____ I will take my medication as instructed and not change the way I take it without first speaking to the doctor or other member of the treatment team. I understand stopping controlled substances suddenly may result in withdrawal symptoms that can lead to possible heart attack or seizures.

_____ I agree to random pill counts while under the care of Dr. Lonseth.

_____ I understand that misplaced, lost, or stolen medications or prescriptions will not be replaced, and I take responsibility in safe guarding my medication and storing them properly.

_____ I assume responsibility for operating any type of automobile, vehicle, machinery, or any potentially hazardous task while taking controlled substances that are prescribed by Dr. Lonseth.

_____ I assume responsibility in making any decisions legal (or otherwise) while taking controlled substances as controlled substances can decrease mental function.

_____ I am not allowed to flush, "throw away", "give away", or otherwise dispose of a controlled pain medication. I must bring in any remaining medication to the office to be disposed of and documented properly by Dr. Lonseth or his treatment team. Medication changes will not be made unless I comply with this policy.

_____ I agree to adhere to all conditions from my doctor and pharmacy for safe use of my prescribed medications.

_____ I understand that If I refuse to initial or sign any of the items in this agreement I will not be prescribed opioids or scheduled opioids by Dr. Lonseth.

_____ _____

Patient/Guardian (Please Print) **Date**

_____

Patient/Guardian Signature

_____ _____

Witness **Date**

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INTERVENTIONAL PAIN CENTERS

4213 Teuton St Metairie, LA 70006
P: 504-327-5857 F: 504-324-3569

MEDICATION REFILL PROCESS & APPOINTMENT POLICY

Dear Patient:

Current practice and regulatory requirements require frequent office visits for medication management. Therefore medication refills can be provided at office visits only.

An office visit is required for any new prescriptions or changes to prescriptions.

Controlled substances cannot be phoned in to your pharmacy**; therefore you must make an appointment to receive your prescription.**

Please understand that it is your (the patients responsibility) to keep up with your medication refills.

As a courtesy to other patients, we reserve the right to reschedule your appointment if you are more than 15 minutes late.

Effective June 1, 2021, any patient who fails to show or cancels/reschedules a scheduled procedure and has not contacted our office **within 24 hours notice** will be considered a No Show and charged a **$150.00 fee.**

Thank for you for your understanding.

Sincerely
Dr. Eric Lonseth

My signature below acknowledges I understand, medication refills and medication changes both require and can only be done at an appointment **and** a no show fee can and will be added to my balance when applicable.

_____ _____

Signature Date

SOAPP® Version 1.0-14Q

Name: _____ Date: _____

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you have mood swings?	0 1 2 3 4
2. How often do you smoke a cigarette within an hour after you wake up?	0 1 2 3 4
3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	0 1 2 3 4
4. How often have any of your close friends had a problem with alcohol or drugs?	0 1 2 3 4
5. How often have others suggested that you have a drug or alcohol problem?	0 1 2 3 4
6. How often have you attended an AA or NA meeting?	0 1 2 3 4
7. How often have you taken medication other than the way that it was prescribed?	0 1 2 3 4
8. How often have you been treated for an alcohol or drug problem?	0 1 2 3 4
9. How often have your medications been lost or stolen?	0 1 2 3 4
10. How often have others expressed concern over your use of medication?	0 1 2 3 4

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0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

11. How often have you felt a craving for medication?	0 1 2 3 4
12. How often have you been asked to give a urine screen for substance abuse?	0 1 2 3 4
13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0 1 2 3 4
14. How often, in your lifetime, have you had legal problems or been arrested?	0 1 2 3 4

Please include any additional information you wish about the above answers. Thank you.

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Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Questionnaire developed by Lynn R. Webster, MD to asses risk of opioid addiction.

Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk too. Pain Med. 2005; 6 (6) : 432

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COMM™

Please answer each question as honestly as possible. Keep in mind that we are only asking about the **past 30 days**. There are no right or wrong answers. If you are unsure about how to answer the question, please give the best answer you can.

Please answer the questions using the following scale:	**Never**	**Seldom**	**Sometimes**	**Often**	**Very Often**
	0	1	2	3	4
1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?	O	O	O	O	O
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments)	O	O	O	O	O
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e., another doctor, the Emergency Room, friends, street sources)	O	O	O	O	O
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?	O	O	O	O	O
5. In the past 30 days, how often have you seriously thought about hurting yourself?	O	O	O	O	O
6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?	O	O	O	O	O

 The COMM™ was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

PainEDU.org
IMPROVING PAIN TREATMENT THROUGH EDUCATION

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INTERVENTIONAL PAIN CENTERS

Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
7. In the past 30 days, how often have you been in an argument?	O	O	O	O	O
8. In the past 30 days, how often have you had trouble controlling your anger (e.g., road rage, screaming, etc.)?	O	O	O	O	O
9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?	O	O	O	O	O
10. In the past 30 days, how often have you been worried about how you're handling your medications?	O	O	O	O	O
11. In the past 30 days, how often have others been worried about how you're handling your medications?	O	O	O	O	O
12. In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?	O	O	O	O	O
13. In the past 30 days, how often have you gotten angry with people?	O	O	O	O	O
14. In the past 30 days, how often have you had to take more of your medication than prescribed?	O	O	O	O	O
15. In the past 30 days, how often have you borrowed pain medication from someone else?	O	O	O	O	O
16. In the past 30 days, how often have you used your pain medicine for symptoms other than for pain (e.g., to help you sleep, improve your mood, or relieve stress)?	O	O	O	O	O

 The COMM™ was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

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Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
17. In the past 30 days, how often have you had to visit the Emergency Room?	O	O	O	O	O