Barr Center for Innovative Pain & Regenerative Therapies
933 First Colonial Road, Suite 200
Telephone: (757) 578-2260 Fax: (757) 578-2261

Patient Name:	Sex:	DOB:	Age:	SS#:
Home Address:		Primary Phone #:		Secondary Phone #:
Email Address:		Referring Physician:		Primary Care Physician:
Preferred Pharmacy:			Pharmacy Phone:	
Employer Name & Address:			Employer Phone #:	

SPOUSE/GUARANTOR INFORMATION AND EMERGENCY CONTACT

Spouse/Guarantor (if patient is a minor):	Primary Phone #:	Secondary Phone #:
Home Address:		
Patient's Relationship to Guarantor: □ Self □ Spouse □ Dependent Child □ other _____	SS#:	DOB:
Employer's Name & Address:		
In case of Emergency please list a contact:		Phone #:

INSURANCE INFORMATION
(If Workers Comp, please write W/C under Primary Insurance, Please notify the Front Desk if you have Tertiary Coverage)

Primary Insurance Plan Name:	Policy ID#:	Group #:
Secondary Insurance Plan Name:	Policy ID#:	Group #:

The information below will be used to improve the quality of healthcare by granting us the ability to measure and minimize care disparities based on ethnicity, race and preferred language. It gives the practice an accurate estimate of our patient population, and accordingly assesses the need for different services such as interpreter services translated patient forms and cultural competency.

Ethnicity:	Race:		Language:
□ Hispanic or Latino	□ White	□ African American	□ English
□ Not Hispanic or Latino	□ American Indian	□ Alaska Native	□ Spanish
□ Declined	□ Asian	□ Native Hawaiian	
	□ Other Pacific Islander	□ Other	
	□ Declined		

ASSIGNMENT and RELEASE

- I hereby assign my insurance benefits to be paid directly to the physician.
- I understand that I am financially responsible for all non-covered services.
- I authorize the physician to release any information required to process this claim.

_____ _____ _____

Patient/Guarantor Signature Witness Date

BARR CENTER FOR INNOVATIVE PAIN & REGENERATIVE THERAPIES

Authorization to Disclose Protected Health Information

Patients Name:		
DOB:	**Daytime Phone:**	**Cell:**

The requested medical information may be disclosed to and used by the following individual(s) or organization:

Name:	**Relationship:**	**Phone #:**	**For the purpose of:** (please circle all that apply)
1.			**Medical Insurance Other**
2.			**Medical Insurance Other**
3.			**Medical Insurance Other**

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 or treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time by notifying Barr Institute for Innovative Medicine & Regenerative Therapies in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise **revoked**, this authorization will **expire one year** from the date this form is signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I **do not** need to sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524.

I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by Federal confidentiality rules. If I have questions about disclosure of my health information, I may contact the Privacy Officer at Barr Center for Innovative Pain & Regenerative Therapies in person and/or I may request a read a more detailed version of Barr Center for Innovative Pain & Regenerative Therapies Notice of Privacy.

Patient/Guarantor (Please Print) **Patient/Gaurantor (Signature)**

Witness (Please Print) **Witness (Signature)** **Date**

BARR INSTITUTE FOR INNOVATIVE MEDICINE & REGENERATIVE THERAPIES
CONSENT FOR TREATMENT & FINANCIAL AGREEMENT

1. CONSENT FOR TREATMENT: I voluntarily consent to outpatient care and treatment performed by the physicians and all other healthcare providers at Barr Institute for Innovative Medicine & Regenerative Therapies (The Barr Center). I also consent to routine services, diagnostic procedures, medical treatment, and other services as deemed necessary by the healthcare providers treating me.

2. AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize Barr Institute for Innovative Medicine & Regenerative Therapies to utilize confidential health information contained in my medical record as necessary for insurance claims payment, medical management or quality of care review purposes. I further authorize the release and discharge of such confidential information to my insurance company or other health coverage plan as necessary for claims payment, medical management and quality review activities conducted by such company or plan, or its designees. I understand this authorization for release of information can be revoked by me in writing at any time but only with respect to the proposed treatment and not with respect to care and treatment that has already been rendered to me.

3. OBLIGATION OF PAYMENT: I direct and assign payment from any insurance coverage, workers compensation, governmental agency or disability benefits, and assignment of proceeds from all settlements, judgments or verdicts in favor of the undersigned from third party liabilities claims for injuries treated hereunder, in an amount equal to the full amount of all charges (including attorney's fees, collection agency fees, costs and interest due to Barr Institute for Innovative Medicine & Regenerative Therapies. I understand that if I have insurance, my insurance policy is a contract between me and my insurance company. I am responsible to Barr Institute for Innovative Medicine & Regenerative Therapies for any and all charges not covered by insurance, including but not limited to co-payments, deductibles and fees for non-covered services. Barr Institute for Innovative Medicine & Regenerative Therapies will send all billing information to the person responsible for payment of my bill. It is my sole responsibility, or the responsibility of the Guarantor, to comply in a timely manner with all requirements, supply all information and documents necessary to obtain payment of benefits by any third party or governmental entity as listed above.

4. PAST DUE BALANCES AND PROCEDURES FOR COLLECTION: Any balance remaining on the account after any insurance pays will be due upon receipt of my statement. Charges for non-covered services are due at the time of service. If I have no insurance, my payment for services is due upon receipt of my services. The undersigned agree(s) to pay all charges made by medical providers at their current rate. The obligation of each undersigned is an original, direct and independent promise to pay based on the exclusive credit of each, and not a collateral or contingent promise to answer for the debt of another. If payment is not made, I understand Barr Institute for Innovative Medicine & Regenerative Therapies may take action to collect its fees. I agree to pay all costs incurred by Barr Institute for Innovative Medicine & Regenerative Therapies for collecting its fees, including an attorneys fee of thirty-five (35%) of the unpaid bill. The return check fee is $38.00.

5. NOTICE OF DEEMED CONSENT FOR INFECTIOUS DISEASE TESTING: Virginia Code Section 32.1-45.1 provides that when either a person providing health care service or a patient is directly exposed to the body fluids of the other in a way that may transmit human immune- deficiency virus or Hepatitis B or C virus, such other person is deemed to have consented to testing for those viruses and to release of the test results to the person so exposed, and actual consent is not required.

6. NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received, have previously received, or have been offered but decline to receive, the Barr Institute for Innovative Medicine & Regenerative Therapies Notice of Privacy Practices Summary.

I understand that as a condition of my treatment at Barr Institute for Innovative Medicine & Regenerative Therapies, if litigation arises from my injuries which I am being treated for, neither the physician nor office staff will be available to appear in court. Conferences and depositions will be scheduled if required.

Patient Name (Please Print)	Patient/Guarantor (Signature)	Date
Witness (Please Print)	**Witness (Signature)**	**Date**

Payment Authorization of Medicare Benefits

I request that payment of authorized MEDICARE benefits be made either to me or on my behalf to Barr Institute for Innovative Medicine & Regenerative Therapies for any services furnished to me by that provider. 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 payable for related services.

SIGNATURE of Patient or Authorized Representative:	Date	Witness

Barr Institute for Innovative Medicine & Regenerative Therapies files your insurance as a courtesy to you. If a co-payment is due from you, your insurance company requires us to collect this payment at the time of service. We accept cash, check, Master Card, Visa, and debit cards.

Barr Center
for Innovative Pain & Regenerative Therapies

AUTHORIZATION FOR RELEASE

OF

PRESCRIPTION MEDICATIONS

I,_____hereby authorize The Barr Center to release my prescriptions to_____', in the event that I am unable to pick up my prescriptions.

_____ _____

Printed Name of Patient or Personal Representative Date

_____

Signature of Patient

Revised: 12/2018

Barr Center
for Innovative Pain & Regenerative Therapies

Medical History Questionnaire

DATE: _____

Name: _____ Age: _____ ☐ Right-Handed ☐ Left Handed

Referring Physician: _____ Primary Care Physician (PCP): _____

Preferred Pharmacy: _____ Phone: _____

Pharmacy Address: _____ City: _____

Reason for Visit: _____

Was there an initiating event for your pain? ☐ Yes ☐ No. If yes, please describe the event and any initial treatment

PAIN CHARACTERISTICS:

Describe your pain: ☐ Aching ☐ Burning ☐ Stabbing ☐ Sharp ☐ Shooting ☐ Numbness ☐ Pulsating ☐ Tingling ☐ Weakness ☐ Other: _____

Does the pain shoot or refer to another part of the body? ☐ Yes ☐ No

If yes, where? _____

Your pain is: ☐ constant ☐ Intermittent ☐ occasional _____

How many hours per day do you have pain? _____ Hours/day _____

How long have you been in pain? _____

Do you occasionally need to stop all activities because of pain? ☐ Yes ☐ No

If yes, number of times? ☐ Daily _____ ☐ Weekly _____ ☐ Monthly _____ ☐ Yearly _____

Have you ever previously experienced this type of pain? ☐ Yes ☐ No

If yes, what was done for you? _____

Pain Analogue Scale:

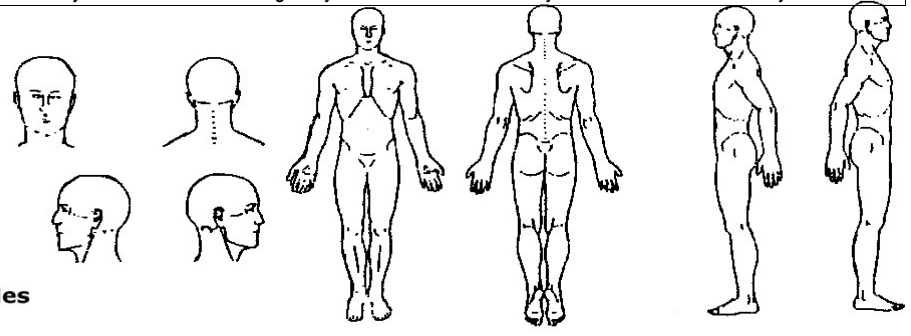
No Pain	*Minimal*		*Moderate*		*Intense*		*Emergency*
0	*1*	*2* *3*	*4*	*5* *6*	*7*	*8* *9*	*10*

Pain Diagram:

Please rate your pain: Today: ____ /10 Average day: ____ /10 Good Day: ____ /10 Bad Day ____ /10

- Please mark the areas of your pain. You may use the key to indicate different kinds of pain sensations.
- Please number each painful area in order of the most troublesome, i.e., 1-10 on the diagram.

Key:
- → - shooting
- /// - stabbing
- xxx - aching
- 000 - throbbing
- ●●● - pins & needles
- ••• - burning



Alleviating Factors: What makes your pain better? (please check all that apply)

☐ Medication ☐ Heat ☐ TENS ☐ Massage ☐ Traction ☐ Rest ☐ Movement ☐ Activity ☐ Exercise ☐ Stretching ☐ Sleep ☐ Lying down ☐ Sitting ☐ Standing ☐ Walking ☐ Nothing

☐ Other: _____

Exacerbating Factors: What makes your pain worse? (please check all that apply)

☐ Movement ☐ Lying down ☐ Sitting ☐ Standing ☐ Walking ☐ Driving ☐ Sleep ☐ Lack of sleep ☐ Stretching ☐ Exercise ☐ Bending ☐ Lifting ☐ Coughing ☐ Sneezing ☐ Tension ☐ Reaching over head ☐ Getting in/out of a chair ☐ Nothing

☐ Other _____

*****Please complete the following section ONLY IF you were involved in a motor vehicle accident.*****

Date of Accident: You were the: □ Driver □ Passenger in the □ front □ rear

You were: □ Rear-ended by another vehicle □ Rear-ended another vehicle □ Involved in a head on collision

□ T-boned by another vehicle □ Driver's Side □ Passenger's side □You T-boned another vehicle

□ Side-swiped driver's side □ Side-swiped on the passenger's side

You were the □ restrained □ unrestrained □ Driver □ Passenger in the □ front seat □ rear seat

Was there an air bag? □ Yes □ No Did it deploy? □ Yes □ No

Was anyone else injured in the accident? □ Yes □ No

Is there a Lawyer involved in your case? □ Yes □ No If yes, Name: _____

MEDICATION HISTORY

Please list all current medication (including over the counter medications) ***Please feel free to attach additional sheets if necessary.***

Medication	Indication	Dose	Prescribing Physician

ALLERGIES

□ **NO KNOWN DRUG ALLERGIES** □ Iodine □ Contrast Dye (IVP) □ Latex

Please list drug allergies, type or reaction and onset date, if known: _____

Any severe allergic Reactions (Anaphylaxis) to anything? □ Yes □ No If yes, to what, type of reaction and onset date:

_____

REVIEW OF SYSTEMS

CONSTITUTIONAL	□ Fever □ Weight Loss □ Weight Gain □ Weakness □ Fatigue □ Difficulty Sleeping □ Chills □ Night Sweats
EYES	□ Visual Problems □ Glaucoma
HENT	□ Headaches □ Sinus Problmes □ Hearing Problems □ Sleep Apnea
CARDIOVASCULAR	□ Heart Trouble □ Swelling of feet □ Hypertension □ Lower Extremity Swelling
RESPIRATORY	□ Cough □ Shortness of Breath
GASTROINTESTINAL	□ Liver Disease □ Hepatitis □ Gall Bladder Problems □ Reflux □ Bowel Problems □ Consitpation □ Diarrhea
GENITOURINARY	□ Kidney Stone □ Kidney Disease □ Bladder Problems □ Blood in Urine □ Reduced Libido (desire for sex)
INTEGUMENT	□ Dry Skin □ Rashes
NEUROLOGICAL	□ Seizures □ Stroke □ Peripheral neuropathy □ Numbness □ Memory or concentration difficulties □ Loss of Balance □ Falls □ Head Injuries
MUSCULOSKELETAL	□ Neck Pain □ Shoulder Pain □ Elbow Pain □ Wrist/Hand Pain □ Carpal Tunnel Syndrome □ Low Back Pain □ Hip Pain □ Knee Pain □ Foot/Ankle Pain □ Gout
ENDOCRINE	□ Thyrod Problem □ Diabetes □ Excessive Thirst
PSYCHIATRIC	□ Depression □ Anxiety □ Anger □ Guilt
HEME-LYMPH	□ Easy Bruising □ HIV Exposure □ Bleeding Problems
ALLERGIC-IMMUNOLOGIC	□ Seasonal Allergy Allergies □ Anaphylactic (Severe) Medication Allergies □ Anaphylactic (severe) Reaction to Bee Stings

PAST MEDICAL HISTORY

- ☐ **No significant Past Medical History**
- ☐ Alzheimer's disease/Dementia
- ☐ Anxiety
- ☐ Asthma/COPD
- ☐ Atrial fibrillation
- ☐ CANCER-Type: _____
- ☐ Cardiac pacemaker
- ☐ Chronic Regional Pain Syndrome (CRPS)
- ☐ Depression
- ☐ DVT (blood clot)
- ☐ Ehler's Danlos Syndrome
- ☐ Gastric ulcer
- ☐ Glaucoma
- ☐ Head Injury or Concussion
- ☐ Heart Disease (Coronary Artery Disease)
- ☐ Heart Failure
- ☐ Hernia
- ☐ High Cholesterol
- ☐ HIV/Aids Disease
- ☐ Hypertension (High Blood Pressure)
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Lyme Disease
- ☐ Marfan Syndrome
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Peripheral Neuropathy
- ☐ Peripheral Vascular Disease
- ☐ Rheumatoid arthritis
- ☐ Seizure disorder
- ☐ Shingles
- ☐ Sleep Apnea
- ☐ Stroke (CVA)
- ☐ Other Past Medical History:

SURGICAL HISTORY

☐ **No Pertinent Past Surgical History**

Please list all surgeries: _____

PREVIOUS TREATMENT

- ☐ Physical Therapy
- ☐ TENS
- ☐ Chiropractic
- ☐ Psychological support ☐ Yes ☐ No Name: _____
- ☐ Work Hardening
- ☐ Injections: _____
- ☐ Acupuncture
- ☐ Other: _____

Pain Clinics ☐ Yes ☐ No If yes, Where: _____ When? _____

FAMILY MEDICAL HISTORY

☐ **No Significant Family History** ☐ **Family History Unknown**

Condition:	Relative	Age	Condition	Relative	Age
☐ Cancer: TYPE: _____			☐ High blood pressure (Hypertension)		
☐ Diabetes			☐ Stroke		
☐ Heart disease (coronary artery disease)					

☐ **Other Family Medical Problems:** _____

SOCIAL HISTORY

- ☐ Able to care for self
- ☐ Able to drive
- ☐ Climbs stairs daily
- ☐ Regular exercise

Alcohol:

- ☐ Denies use ☐ Occasional use
- ☐ more than 15 drinks/week

Marital status:

- ☐ Single ☐ Married
- ☐ Divorced/separated ☐ Widow/Widower

Smoking: ☐ Denies

☐ Admits to smoking (____ packs/day) ☐ Former Smoker: Date Quit: _____

Substance Abuse : ☐ Denies

- ☐ In past (including alcohol)
- ☐ Use of illegal drugs in the last year

Work status:

- ☐ Student
- ☐ Does not work outside the home: ☐ Disabled ☐ Retired
- ☐ Works outside the home

Occupation: _____

Other important social issues: _____