The Lemons Center for Chronic Pain Rehabilitation Medical History

Name:_____ DOB:_____ Date:_____ Gender:_____
Address _____City_____State_____Zip_____
Phone (H)_____(W)_____(C)_____Email_____
Employer_____ SS#_____ Marital Status_____
Emergency Contact & Phone_____
Physician: Referring_____ Primary_____

Primary location of Pain: _____

Where else do you have pain or other unusual sensations? _____
_____

Description of pain (circle all that apply):

Constant Intermittent Dull Achy Sharp Stabbing Tingling Hot Other

Range of Pain: (Circle lowest and highest number in range):

0 1 2 3 4 5 6 7 8 9 10

Average level of pain (circle one)

0 1 2 3 4 5 6 7 8 9 10

When was the onset of your pain? _____

Was there a known cause? _____

What makes your pain better? _____

What makes your pain worse? _____

Is your pain (circle one): Improving Staying the same Getting worse

What previous treatment have you had for your pain? _____
_____

Do you have any psychological/psychiatric disorders? YES NO

If yes, please list: _____
_____

Do you or a family member have a history of substance abuse:

Alcohol YES NO Illegal drugs YES NO Other YES NO

Who _____ Who _____ What/Who _____

Do you have any history of abuse (emotional, sexual, physical) YES NO

Do you feel unsafe in your home or has someone tried to hit or hurt you in any way? YES NO

During the past month have you been feeling down, depressed, or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Is this something with which you would like help? YES YES, BUT NOT TODAY NO

Medical History:

Have you noted any of the following in the past 6 months:

__Fatigue
__Fever/chills/sweats
__Nausea/vomiting
__Weight change
__Balance problems
__Dizziness
__Numbness or tingling
__Memory loss/forgetfulness
__Shortness of breath
__Chest pain
__Fainting
__Swelling
__Cough
__Wheezing
__Difficulty sleeping
__Indigestion
__Changes in bowel or bladder function
__Bruising easily
__Nose bleeds
__Excessive blood loss
__Other _____
_____
_____

Have you **ever** been diagnosed with:

__Cancer
__Heart problems
__Chest pain
__High Blood pressure
__Lung problems
__Tuberculosis
__Asthma
__Arthritis
__Circulation problems
__Blood clots
__Anemia
__Heart defect
__Lung problems
__GERD
__Pneumonia
__Kidney or bladder problems
__Urinary tract infection
__Thyroid problems
__Diabetes
__Osteoporosis
__Seizures/epilepsy
__Hepatitis/liver problems
__Neurological disorder
__Allergies
__Other_____
_____

Do you have any allergies? _____

Do you smoke? YES NO If yes, for how many years? _____ How much? _____

Do you exercise regularly? YES NO

Please list any recent tests in the last 6 months_____

_____

_____

Please list any surgeries or other hospitalizations related to your pain: _____

_____

_____

_____

Signature Date

Name:_____ DOB:_____ Date:_____

Medication List

Please List <u>ALL</u> Prescription, Over-the-counter and Supplements

NAME	DOSAGE	FREQUENCY
EXAMPLE: Aspirin	81mg	1 time/day

Pharmacy:_____ Location:_____

Phone:_____ Fax_____

FORM OF WRITTEN ACKNOWLEDGEMENT OF RECEIPT
LEMONS CENTER, LLC
NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge receipt of Lemons Center, LLC Notice of Privacy Practice ("Acknowledgement")

_____ _____
Client or legal representative SIGNATURE Date

_____
Client or legal representative PRINTED NAME

_____ _____
Employee SIGNATURE Date

_____
Employee PRINTED NAME

15700 College Blvd., Suite 201, Lenexa, KS 66219
913-383-8977 fax: 913-383-3116

HIPPA NOTICE OF PATIENT PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can access this information. Please review it carefully.

Lemons Center, LLC is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment and health care operations. Protected health information is the information we create and obtain while providing our services to you. Such information may include documenting our self-report of physical and emotional symptoms, examination and test results, diagnoses, treatment and applying for future care of treatment. It also includes billing documents for those services.

Your Health Information Rights

The records we maintain are the physical property of Lemons Center, LLC. The information in it belongs to you. You have a right to request a restriction on certain uses and disclosures of our health information by delivering the request in writing to our office. We are not required to grant the request, be we will comply with any request to obtain a paper copy of the Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office during normal business hours. By this request you will be allowed to inspect and copy your health record and billing information. You may exercise this right by delivering the request in writing, to our office using the form we provide to you during normal business hours.

You may request that your health record be amended to modify incomplete or incorrect information by delivering a written request to our office using the form we provide to you during normal business hours. If your request is denied, you may file a statement of disagreement with our Privacy Officer, with the reason for the amendment included. You may obtain an accounting of disclosures of your health information as required by law. An accounting will not include internal uses of information for treatment, payment for operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care.

Our Responsibilities

The Lemons Center, LLC is required to maintain the privacy of your health information as required by law. We will abide by the terms of the Notice Form. We will always accommodate your reasonable requests regarding methods to communicate health information with you. We do reserve the right to amend, change or eliminate provisions in our privacy practices. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our Notice or by visiting our office.

To Request Information or File a Complaint

If you have questions and would like additional information or want to report a problem regarding the handling of your information, you may contact the Privacy Officer. If you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to our Privacy Officer. You may also file a complaint with the Secretary of Health and Human Services. We cannot and will not require you to waive the right to file a complaint with the Secretary of Health and Human Services as a condition of receiving care or treatment. We cannot and will not retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Disclosures and Uses

Unless you object in writing, we may use or disclose your protected health information to notify or assist in notifying family members, personal representatives or other persons responsible for your care about your location and about your general conditions or your death. Using our best judgment or in an emergency, we may disclose to a family member, other relative, close personal friends or any other person you identify, health information relevant to that person's involvement in your health or legal authorities charged with preventing or controlling disease, injury or disability as required by law. We may disclose your protected health information to public authorities to report abuse or neglect as allowed by law. We may disclose your protected health information for law enforcement purposes as required by law, such as when required by court order, or in cases involving felony prosecutions, or to the extent, an individual is in the custody of law enforcement. We may disclose to the correctional institution or agents your protected health information necessary for your health and the health and safety of other individuals if you are an inmate of a correctional facility.

We may disclose your protected health information to appropriate health oversight agencies and for health oversight activities as permitted by federal law. We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization or as directed by a proper court order. We may disclose information to researchers when their research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information. We may use and disclose your protected health information to assist in disaster relief efforts. We have business associates with whom we may share your protected health information. For example, in preparing our annual financial statement, auditors may need to review samples of the medical care given. We may disclose your health information to the accounting firm to prepare this material. All business associates sign a letter of confidentiality and are held to the highest professional standards in regards to personal health information.

We may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation. We may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public to avert a serious threat to health or safety. We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes or to public assistance program personnel. Other uses and disclosures besides those identified in the Notice will be made only as otherwise authorized by law or with your written authorization. You may revoke the authorization as previously provided.

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LEMONS CENTER FOR CHRONIC PAIN REHABILITATION
CLIENT RIGHTS AND RESPONSIBILITIES

All clients of the Lemons Center will have equal access to appointment times during the business hours of 8:00 am and 5:00 pm, Monday through Friday. Special arrangements for emergency or special time slots will be considered and accommodated.

All clients will sign an informed consent for treatment and an authorization for appropriate release of information. This release also includes an authorization regarding insurance and personal responsibility for payment of services.

All clients will be informed of their expected costs and responsibility for payment of services rendered.
In case of a complaint or appeals for any services rendered at the Lemons Center, the client is to address the concern with any staff member, treating or non-treating that they deem appropriate. Confidentiality and anonymity will always be supported in this process.

All appropriate family and significant others will be considered in the care and treatment decisions for clients.

Privacy and confidentiality will be honored in all circumstances associated with client care including but not limited to personal treatment, staff interactions with fellow staff members and other clients, business/financial interactions, and all medical records.

All staff members of the Lemons Center are held to the highest personal and professional standard of behavior/ethics. This includes non-discrimination of any client. If our services are deemed as helpful and therapeutic, there will be no grounds for discrimination of care. It will be the client's responsibility to follow specified levels of participation. If these levels of behavior are not met then and only then will the client be placed in another level of care or discharged. Staff concerns and intentions regarding any client's care will always be clearly and directly communicated to the client.

The Lemons Center recognizes all clients as individuals with personal spiritual, psychosocial, cultural and personal belief systems. An appropriate holistic treatment plan will be developed with the individual.
The Lemons Center will maintain a safe and supportive environment that will best facilitate recovery and restoration of self: body, mind and spirit.

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LEMONS CENTER FOR CHRONIC PAIN REHABILITATION
CONSENT FOR TREATMENT
AUTHORIZATION TO RELEASE INFORMATION and INSURANCE AUTHORIZATION

I, _____, give my expressed written consent to

(Please print Client's name)

Lemons Center, LLC to release any and all of my records to the following:

Please list any party to whom evaluations and notes or conversation would benefit in continuing your care, (i.e. referring physicians, primary care physician, caseworker, attorneys, or family members.) For anyone other than your referring physician to who records need to be sent, please list the address and phone number.

_____ _____ _____

_____ _____ _____

I understand that I am giving my right for informed consent for treatment procedures and have the right to refuse any treatment or procedure at will. I understand that this authorization does not bind any provider to open its records for inspection to release records, which are not essential to the purpose for which the authorization is requested. I understand my surgical, medical, psychiatric, chemical/substance, HIV testing, and/or Federal and State Regulations and Statutes which determine the extent and nature of the information which may be disclosed, may protect outpatient records. I understand that pursuant to these statutes and regulations any provider may refuse to disclose portions of my records. I do hereby give this consent to the release of records described above freely and voluntarily. I also understand that the provision of medical and psychological treatment will not be denied by reason of refusal to sign this consent form. The above consent may be revoked by the undersigned at any time, except to the extent the action has been taken or information disclosed pursuant to this request. This consent shall expire one year from the date entered below.

INSURANCE AUTHORIZATION: I request that payment of authorized benefits be made to The Lemons Center on my behalf for any services provided to me. I authorize any holder of medical and other information about me to release to any insurance company, other third party payer, state medical assistance agency, Medicare and its agents, or any other governmental or private payer responsible for paying such benefits for related services. It is my responsibility to notify The Lemons Center of any insurance changes **before** the changes take effect. **I agree to pay for all charges not covered by a third party payer.** I authorize a copy of this authorization to be used in place of the original.

SINGNATURE: DATE:

Signature of Client or Parent/Guardian/POA and Relationship to Client

Cancellation and No Show Policy

We understand that situations arise that require you to cancel your appointment. Therefore, if you must cancel your appointment, please provider more than 24 hours notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours in advance, we are unable to offer that slot to other patients.

Office appointments that are canceled with less than 24 hours notice will be subject to a $30 cancellation fee.

Patients who do not come to their scheduled appointment without a call to cancel the appointment will be considered a No Show. Patients who No Show two (2) or more times in a 12-month period will be dismissed from the practice and denied any future appointments. Patients will also be subject to a $30 No Show fee.

The cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in these instances may be waived with management approval.

Our practice firmly believes that a good patient/provider relationship is based on understanding and good communication. Questions about our Cancellation and No Show fees may be directed to the practice manager.

Please sign that you have read, understand, and agree to this Cancellation and No Show Policy.

_____ _____

Patient Name (Please Print) Date of Birth

_____ _____

Signature of Patient or Patient Representative Date

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