908 South 10th Street
Leesville, LA 71446
Office: 337.392.2330
Fax: 337.392.2580

West State Orthopedics and Sports Medicine Clinic, LLC

Shawn Granger, MD
David Steiner, MD
Brenda Willis, FNP-C

Patient Registration Form

Date:_____

Patient Name:_____ Birth Date: _____
(last) (first) (mi)

Address: _____ Home#:_____
_____ Work# :_____
City: _____ ST: _____ Zip: _____ Email: _____

Social Security #_____-_____-_____ Sex: ☐ Male ☐ Female

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ( ) White
☐ Native Hawaiian/Other Pacific Islander
Language: ☐ English ☐ Spanish ☐ German ☐ Other: _____

Marital Status?
☐ Single ☐ Married ☐ Separated
☐ Divorced ☐ Widowed

Employment?
☐ Full Time ☐ Part Time ☐ Retired
☐ Unemployed ☐ Disabled
Student ☐ Grade ☐ Junior High ☐ High School

Primary Insurance Information

Company:_____
ID#:_____
Group #: _____
Insured Date of Birth: _____
Relationship to Patient: _____
Social Security # _____-____-_____
Policy Holders Name: _____

Secondary Insurance Information

Company: _____
ID # _____
Group #_____
Insured DOB: _____
Relationship to Patient: _____
Policy Holders Name: _____
Social Security # _____- _____ -_____

Emergency Contacts:

Name: _____ Phone # _____
Address: _____ Relationship:_____

I authorize the release of any medical information necessary to process insurance claims filed on my behalf.

Assignment of Benefits
I authorize my Health Insurance Company to make payment directly to West State Orthopedics & Sports Medicine for services rendered to my dependents or myself. I understand I am responsible at the time of services for paying any required co-payment and deductible

Patient: _____ Guardian: _____

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RELEASE OF MEDICAL INFORMATION

TO: _____
Name of Healthcare Provider/Facility

RE: _____ _____
Patient Name Date of Birth

I authorize and request the disclosure of all protected information for the purpose of review and evaluation. I expressly request that the designated record custodian under HIPAA identified above disclose full and complete protected medical information including the following:

> All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, prescription history, statements, questionnaires/histories, correspondence, photographs, videos, telephone messages, and records received from other medical providers.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome, or human immunodeficiency virus, and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the following purposes: continued medical evaluation and/or treatment.

You are authorized to release the above records to the following:

West State Orthopedics and Sports Medicine, LLC
Shawn Granger, MD Brenda Willis, FNP-C

908 South 10th Street
Leesville, LA 71446
337-392-2330 fax: 337-392-2580

I understand that I have a right to revoke this authorization in writing at any time, except to the extent the information has been release in reliance upon this authorization; the information release in response to this authorization may be re-disclosed to other parties; my treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two (2) years from the date of execution, at which time this authorization shall expire.

_____ _____
Signature of Patient or Legal Guardian Date

Authorization for the Use or Disclosure of Protected Health Information
&
Assignment of Benefits

Tony Jennings, Office Manager/Privacy officer 337.392.2330

As required by the Health Insurance Portability and Accountability Act of 1996. West State Orthopedics may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to this office.

AUTHORIZATION SECTION

I, _____ (print name) hereby authorize the use and disclosure of the following health information that pertains to me: **Any and all information** or as outlined below:

_____
_____

Purpose: For the treatment of my condition(s) as related to the privacy act notice.

I authorize **West State Orthopedics and Sports Medicine Clinic, LLC** to make disclosures of my health information to the following individuals in my absence:

_____
_____
_____
_____

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to **West State Orthopedics 908 South 10th St Leesville, La 71446**. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand that I am under no obligation to sign this authorization. I further understand that West State Orthopedics may refuse to provide treatment or refuse to continue treatment if this notice is unsigned or refused.

I understand that I have the right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

I understand that West State Orthopedics will receive compensation for the uses and disclosures that I have authorized.

_____ _____
Signature Date

REVOCATION SECTION

I hereby revoke this authorization.

_____ _____
Signature Date

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Shawn Granger, MD
Brenda Willis, FNP-C

Acknowledgement of Receipt of Notice

Tony Jennings, Office Manager/Privacy officer 337.392.2330

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Yes No (circle one) I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at: _____.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate.

Relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

Name of Patient: _____

***For Office Use Only*:**

- Signed form received by: _____
- Acknowledgment refused:

Efforts to obtain:

_____

_____

Reasons for refusal:

_____

_____

APPOINTMENT POLICIES

If you believe that your concern is a medical emergency, CALL 911.

APPOINTMENTS

Appointments will be made by calling (337) 392.2330. Follow up appointment will be made prior to leaving the clinic on the day of visit. Appointments will be made as available. You will be notified by our automated system one day prior to your appointment. This system will only call you primary number on file. You will be asked to make an appointment for issues of general consultation other than medication side effects. If you are having issues after surgery, you will be made an appointment as soon as possible or worked into the clinic schedule to be seen.

CANCELLATIONS

Please notify this office NO LATER than 24 hours prior to your scheduled appointment if you cannot be present. You will be billed a $35 "No Show" fee for failure to cancel or show at your appointment time. Following three (3) "No Show" fees, all fees will be paid prior to further appointments will be made.

DISABILITY FORMS

Insurance forms will only be completed at time of a clinic visit. Please present form to office personnel at the beginning of your visit. YOU MAY BE BILLED FOR THE COMPLETION OF FORMS FOR DISABILITY CLAIMS.

Additional Testing

This clinic performs random toxicology testing on all patients. Tests will check for levels of medications in your system and/or illegal drugs. Patients who refuse to submit to testing will be seen and treated; however, they may be refused pain medications. We also perform periodic cognitive testing and medication effectiveness monitoring.

CO-PAYS, INSURANCE, and BALANCE DUE

Insurance co-pays are due at the time of visit. You will also be asked to pay any remaining balance on your account prior to being seen for a scheduled appointment. Patients with large balances will be asked to set up a payment plan to bring your account into good standing. Patients who fail to set up and maintain payment plans may be denied access to the clinic until such time as their balance or plan is brought into good standing. **There will be a $ 35.00 charge on all returned checks.**

QUESTIONS, AND CONCERNS

Please call (337) 392-2330. You will be directed to the appropriate personnel for your specific question or concern. Phone calls will be returned within 24 hours of receipt during normal office hours of 8 am-5 pm M-F. Please be available during this time period to return your call. Please do not make multiple phone calls to the office, we will return your call promptly.

MEDICATIONS ***EARLY REFILLS ARE NOT ALLOWED FOR PAIN MEDICATIONS***

-You should take the medications for your condition EXACTLY according to the instructions. If you take the medication other than the manner it was prescribed or discontinue taking a medication due to side effects, you are instructed to notify the office immediately. Failure to take medications as prescribed or excessive requests for refills, may lead to your discharge from the clinic.

You must call the office at (337) 392.2330 NO LATER THAN 72 hours prior to running out of other medications. Please provide medication name, strength, and dispensing directions. Please allow 72hrs before medication is called into your pharmacy or available for pick-up. Please include pharmacy name, area code, and phone number. We will only call you if we have questions. If you have missed your appointment for any reason and are in need of a refill, you must be seen in the clinic before refills are called in. Please DO NOT make multiple phone calls to the office about medication refills.

Please remember, some pain medications CAN NOT be called in so it is imperative to keep scheduled appointments. There is a $5 fee for prescription refills that are not made at the time of your appointment.

Patient Signature: _____Date: _____

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West State Orthopedics and Sports Medicine Clinic, LLC

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Brenda Willis, FNP-C

New Appointment Questionnaire

Welcome to our clinic! Prior to being seen, we ask that you fill out these forms as accurately as possible. While some of the questions may not seem relevant to your problem, they give us an idea about your medical status, the circumstances relating to your problem and your overall situation. We realize these forms are long and we appreciate your patience in filling these out. Please provide as much detail as possible. Please sign and date the bottom of the second and third page.

Thank You,

Shawn P. Granger, MD

Name: _____ Date: _____

Were you referred to our office by another physician? Yes ☐ No ☐

If so, what was the Physician's Name: _____

If not, how did you find out about us? (If another person referred you, please provide their name)

_____

History of Present Illness

What is the purpose of today's visit (what body part and the reason)?

_____

How long have you had this problem? _____

How did it begin? (Example: a fall, car wreck, twisting injury, etc.)

_____

Is this a work related injury? Yes ☐ No ☐

Are there any law suits pending or have you hired a lawyer? Yes ☐ No ☐

If you are having pain, how would you rate the pain (10 is the worst pain you've ever had, 0 is no pain)?

☐ *0* ☐ *1* ☐ *2* ☐ *3* ☐ *4* ☐ *5* ☐ *6* ☐ *7* ☐ *8* ☐ *9* ☐ *10*

If anything, what makes your pain better?

_____

What makes your pain worse?

_____

How would you describe your pain? (burning, aching, throbbing, etc.)

_____

Have you had any previous treatment for this problem? If so, what has been done so far?

_____

Review of Systems:

Do you currently or have recently had any problems listed below? Please give details next to the question and comment on whether another physician is addressing it.

YES	NO	CONDITION	DETAILS
☐	☐	Unexplained weight loss	_____
☐	☐	Fevers or chills	_____
☐	☐	Change in vision	_____
☐	☐	Ear Pain	_____
☐	☐	Loss of Hearing	_____
☐	☐	Unexplained Nosebleeds	_____
☐	☐	Hoarseness	_____
☐	☐	Sore throats	_____
☐	☐	Unexplained Cough	_____
☐	☐	Chest Pain at Rest	_____
☐	☐	Chest Pain w/ Walking	_____
☐	☐	Shortness of Breath	_____
☐	☐	Heart Palpitations	_____
☐	☐	Badly Swollen Ankles	_____
☐	☐	Calf Pain With Walking	_____
☐	☐	Nausea or Vomiting	_____
☐	☐	Blood in Stool	_____
☐	☐	Black Stool	_____
☐	☐	Frequent Heartburn	_____
☐	☐	Diarrhea	_____
☐	☐	Constipation	_____
☐	☐	Frequent Urination	_____
☐	☐	Burning with Urination	_____
☐	☐	Blood in Urine	_____
☐	☐	Tea-colored Urine	_____
☐	☐	Rashes	_____
☐	☐	Dizziness	_____
☐	☐	Headaches	_____
☐	☐	Blackouts	_____
☐	☐	Drug Addiction	_____
☐	☐	Alcohol Addiction	_____

Women Only

☐	☐	Menopause	_____
☐	☐	Irregular Periods	_____
☐	☐	Back Pain with Periods	_____
☐	☐	New Breast Lumps	_____

Primary Pharmacy: _____

Allergies

Are you allergic to any medications, food or Metals? If so, what medicines and what type of reaction(s)?

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medications

Please list all medications you are taking (include Over-the-Counter and any you have recently stopped):

Medication	**Dosage**	**how taken (i.e. 1 tablet once a day)**

Past Medical History

Please list your medical conditions, if any (i.e. diabetes, heart disease, etc.)?

_____ _____ _____

_____ _____ _____

_____ _____ _____

Past Surgical History

Please list any surgeries you have had in the past (also list when you had each surgery)?

_____ _____ _____

_____ _____ _____

_____ _____ _____

Family History

Please list any medical problems in the family members listed as well as any others?

Father **Deceased ☐ Living ☐**

Medical problems_____

Mother **Deceased ☐ Living ☐**

Medical problems_____

Brothers/sisters **How many? Brothers** _____ **Sisters**_____

Any medical problems? _____

Others (grandparents, aunts, uncles, etc.)

_____

Social History

Do you use any form of tobacco? Yes ☐ No ☐

☐ Smokeless Tobacco

☐ Current Every day Smoker If so, how much?_____

☐ Former Smoker

☐ Never Smoked

☐ Vape

Do you drink alcoholic beverages? Yes ☐ No ☐ If so, how much?_____

Which is your dominant hand? **Right Handed ☐ Left Handed ☐**

What kind of work do you do? Is there heavy lifting? Do you stand for long periods?

_____

Are you involved in any sports? List all including hunting, fishing, coaching as well as routine exercise programs.

_____

Patient's Signature _____ **Date** _____

Reviewed By _____**MD** **Date** _____

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PAIN MANAGEMENT AGREEMENT

Purpose of this Agreement is to prevent misunderstanding about certain medications you will be taking for pain management of your chronic condition. This is to help you and your PCM to comply with the law regarding controlled pharmaceuticals.

I understand that there is a risk of psychological and/or physical dependence and addition associated with chronic use of controlled substances
I understand that this agreement is essential to the trust and confidence necessary in a provider/patient relationship that my provider undertakes to treat me based on this Agreement
I understand that if I break this Agreement, my provider may stop prescribing this pain control medications.
In this case, my provider may taper off the medications over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence program may be recommended.
I am willing to seek psychiatric, psychotherapy, and/or psychological treatment if my provider deems necessary.
I will communicate truthfully with my provider about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medications is helping to relieve the pain.
I will not use any illegal controlled substances, including, but not limited to, marijuana (non-RX), cocaine, heroin, methamphetamine, etc., nor will I misuse or self-prescribe/medicate with legal controlled substances. Use of alcohol will be allowed within the Law.
I will not share my medications with, nor accept medications from anyone, for any reason.
I will not obtain any controlled medications, including opioid pain medications, controlled stimulants or anti-anxiety medications from another provider without prior approval from my provider.
I will safeguard my pain medications from loss, theft or unintentional use by others. Lost or stolen medications will not be replaced, unless law enforcement is notified of loss/theft and a police report has been furnished to the clinic.
I understand that missed appointments may result in me running out of my pain medications and I will be scheduled back into the clinic as the schedule permits.
I authorize the provider and my pharmacy to cooperate fully with any city, parish, state or federal law enforcement agency, including the LA Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medication.
I authorize my provider to provide a copy of this Agreement to my pharmacy and PCM.
I Agree to waive any applicable privilege, right of privacy or confidentiality with respect to these authorizations
I Agree that I will submit to random blood or urine tests if requested by my provider to determine my compliance with my pain control medications. I may be called in for random pill count without notice.
I understand that my provider will be verifying that I am receiving controlled medications from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program website periodically throughout my treatment period.
I agree to use my medications as prescribed and not to a greater extent. Taking a greater number of my medication may leave me without medications until it is time for my scheduled refill.
I understand and agree that I may be required to have certain laboratory testing performed, as deem necessary by my provider, to evaluate my progress and overall health.
I agree to follow these guidelines that have been fully explained to me and all of my questions and concerns regarding my treatment and this Agreement were adequately answered.

Date of Agreement: _____

Primary Pharmacy Used: _____ located in _____

Provider Signature: _____
Shawn Granger, MD

Patient Name: _____ Signature: _____

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Pain Catastrophizing Scale Assessment (PCS)

Patient Name: _____ Age: _____

Date: _____ Gender: _____

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

INSTRUCTIONS

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

ACTIVITY	0	1	2	3	4
MEANING	Not at all	To a slight degree	To a moderate degree	To a great degree	All the time

When I'm in pain...

NUMBER	STATEMENT	RATING
1	I worry all the time about whether the pain will end.	0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐
2	I feel I can't go on.	0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐
3	It's terrible and I think it's never going to get any better.	0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐
4	It's awful and I feel that it overwhelms me.	0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐
5	I feel I can't stand it anymore.	0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐
6	I become afraid that the pain will get worse.	0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐
7	I keep thinking of other painful events.	0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐
8	I anxiously want the pain to go away.	0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐
9	I can't seem to keep it our of my mind.	0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐
10	I keep thinking about how much it hurts.	0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐
11	I keep thinking about how badly I want the pain to stop.	0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐
12	There's nothing I can do to reduce the intensity of the pain.	0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐
13	I wonder whether something serious may happen.	0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐

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Current Opioid Misuse Measure (COMM)

Patient Name: _____
Date: _____

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain

INSTRUCTIONS

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.

In the Past 30 Days:	Never	Seldom	Sometimes	Often	Very Often
1. How often have you had trouble with thinking clearly or had memory problems?					
2. 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)					
3. 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 ER, friends, street sources)					
4. How often have you taken your medications differently from how they are prescribed?					
5. How often have you seriously thought about hurting yourself?					
6. How much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?					
7. How often have you been in an argument?					
8. How often have you had trouble controlling your anger (e.g., road rage, screaming, etc.)?					
9. How often have you needed to take pain medications belonging to someone else?					
10. How often have you been worried about you're handling of your medications?					
11. How often have others been worried about how you're handling of your medications?					
12. How often have you had to make an emergency phone call or show up at the clinic without an appointment?					
13. How often have you gotten angry with people?					
14. How often have you had to take more of your medication than prescribed?					
15. How often have you barrowed pain medication from someone else?					
16. 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)?					
17. How often have you had to visit the Emergency Room?					

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DRUG USE QUESTIONAIRE (DAST-20)

Patient's Name: _____ **Date:** _____

The following questions concern information about your potential involvement with drugs not including alcoholic beverages during the past 12 months. Carefully read each statement and decide if your answer is "Yes" or "No". Then, circle the appropriate response beside the question.

In the Past 12 months have you:

1. Have you used drugs other than those required for medical reasons?	☐ Yes No ☐
2. Have you abused prescription drugs?	☐ Yes No ☐
3. Do you abuse more than one drug at a time?	☐ Yes No ☐
4. Can you get through the week without using drugs?	☐ Yes No ☐
5. Are you always able to stop using drugs when you want to?	☐ Yes No ☐
6. Have you had "blackouts" or "flashbacks" as a result of drug use?	☐ Yes No ☐
7. Do you ever feel bad or guilty about your drug use?	☐ Yes No ☐
8. Does your spouse (or parents) ever complain about your involvement with drugs?	☐ Yes No ☐
9. Has drug abuse created problems between you and your spouse or your parents?	☐ Yes No ☐
10. Have you lost friends because of your use of drugs?	☐ Yes No ☐
11. Have you neglected your family because of your use of drugs?	☐ Yes No ☐
12. Have you been in trouble at work because of drug abuse?	☐ Yes No ☐
13. Have you lost a job because of drug abuse?	☐ Yes No ☐
14. Have you gotten into fights when under the influence of drugs?	☐ Yes No ☐
15. Have you engaged in illegal activities in order to obtain drugs?	☐ Yes No ☐
16. Have you been arrested for possession of illegal drugs?	☐ Yes No ☐
17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	☐ Yes No ☐
18. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	☐ Yes No ☐
19. Have you gone to anyone for help for a drug problem?	☐ Yes No ☐
20. Have you been involved in a treatment program specifically related to drug use?	☐ Yes No ☐