LONSETH
INTERVENTIONAL PAIN CENTERS

Attorney Representation Packet

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*

Preferred Pharmacy: ____

Pharmacy Name   Phone Number   City, State

Primary Language:

▢ English   ▢ Spanish   ▢ Vietnamese   ▢ Other ______________

Please Circle One:

African American/Black   White/Caucasion, Non-Hispanic   Hispanic/Latino

Other: _________________

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:________________________

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NEW PATIENT FORM **Today's Date:** ____________ **DOA:** ________________

Patient Name: __________________________ **Date of Birth:** ____________ **SSN:** __________________

Referring Doctor: ___________________________ **Name of Attorney:** _____________________

Is your visit today the result of an auto accident? YES ☐ NO ☐

If NO, is this a result of a slip-and-fall? YES ☐ NO

Were you the driver? Yes ☐ NO ☐ **Seat belt worn? YES ☐ NO ☐**

Did the car air bag deploy? YES ☐ NO **Did you go to the ER? YES ☐ NO ☐**

Did you lose consciousness? YES ☐ NO ☐ **If so, where?** __________________________

Car deemed totaled by insurance? YES ☐ NO ☐ **Did you go by ambulance? YES ☐ NO ☐**

Prior to your injury, have you been treated for neck or back pain? YES ☐ NO ☐

Have you had chiropractic or physical therapy? YES ☐ NO ☐

Name of chiropractor or physical therapist? ____

Circle which treatments you've had: Heat Massage Traction Manual Therapy Ultrasound

Electrical Stimulation/TENS

Did it help? No Relief Some Relief Moderate Relief Great Relief

Which medications have you tried for this pain before coming today?

None Aspirin Tylenol Ibuprofen Aleve Mobic Flexeril Zanaflex Gabapentin Steroids Tramadol Hydrocodone Percocet

Please Circle ALL Descriptions That Best Fit Your Pain

NECK PAIN

constant	sometimes	aching	stabbing	sharp	dull	electric	burning

Does the neck pain radiate or travel? YES ☐ NO ☐ If yes circle everywhere it travels:

left	shoulder	arm	forearm	hand	fingers
right	shoulder	arm	forearm	hand	fingers

What makes the neck pain worse?

standing	sitting	walking	lying down	typing	work	exercise	other

What makes the neck pain better?

heat	ice	massage	rest	sitting	standing	other

NECK PAIN SCALE

Circle the number that describes your pain (0 is no pain at all, and 10 is the worst pain you can imagine)

Rate your pain that you have now 0 1 2 3 4 5 6 7 8 9 10

Rate your pain when it is at its worst 0 1 2 3 4 5 6 7 8 9 10

Is there any muscle weakness of the arms or hands? YES ☐ NO ☐

Are there any associated headaches with the neck pain? YES ☐ NO ☐

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BACK PAIN

constant	sometimes	aching	stabbing	sharp	dull	electric	burning

Does the back pain radiate or travel? YES ☐ NO ☐ If yes circle, please indicate where?

left	buttocks	hip	leg	groin	knee	calf	foot
right	buttocks	hip	leg	groin	knee	calf	foot

What makes the back pain worse?

standing	sitting	walking	lying down	typing	work	exercise	other

What makes the back pain better?

heat	ice	massage	rest	sitting	standing	other

BACK PAIN SCALE

Circle the number that describes your pain (0 is no pain, and 10 is the worst pain you can imagine)

Rate your pain that you have now 0 1 2 3 4 5 6 7 8 9 10

Rate your pain when it is at its worst 0 1 2 3 4 5 6 7 8 9 10

Is there any muscle weakness of the legs? YES ☐ NO ☐

Are there any new bowel or bladder problems? YES ☐ NO ☐

ALLERGIES

Do you have a **LATEX** allergy? YES ☐ NO ☐ If yes what occurs:______________________

Do you have any **CONTRAST DYE** allergy? YES ☐ NO ☐ If yes what occurs:______________________

Do you have an **IODINE** allergy? YES ☐ NO ☐ If yes what occurs:______________________

Do you have any known **DRUG** allergies? YES ☐ NO ☐ If yes, list them here:___________________

Do you have a problem with **ANESTHESIA**? YES ☐ NO ☐ If yes, please explain:___________________

MEDICATION HISTORY **Please list ALL current medications, including pain medications and over-the-counter medications**

Are you currently taking any blood thinners (anticoagulants)? YES ☐ NO ☐

If yes, please circle which:

Plavix Brilinta Heparin Xarello

Coumadin Effient Lovenox Aspirin

Aggrenor Eliquis Ticlid

Who prescribes your blood thinner? If known, provide phone number:

Are you currently taking any antibiotics? YES ☐ NO ☐

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FAMILY HISTORY

Circle if your Mother or Father have any of the following medical problems and then mark (M) or (F) next to it. If none, please indicate.

Cancer	Heart disease	Migraines	Other
Diabetes	Hypertension	Seizures	Other
Fibromyalgia	Lung disease	Stroke	NONE

PAST MEDICAL HISTORY

Circle any of the following for which you have ever received treatment. If none, please indicate.

Alcohol Abuse	Congestive Heart Failure	Heart disease/Heart attack	Osteoporosis
Anemia	COPD	Hepatitis	Psoriasis
Anesthesia Complications	Coronary Artery Disease	Hernia	Psychological Trauma
Anxiety	CVA (stroke)	HIV	Seizure Disorder
Arthritis	Depression	Hypercholesterolemia	Sleep Apnea
Asthma	Diabetes	Hypertension	Spinal Cord Injury
Bleeding disorder	Drug Abuse	Hyper/Hypothyroidism	Spinal Fusion
Cancer (type)	Emphysema	Kidney Disease	TIA
Coagulopathy	Fibromyalgia	Liver Disease	NONE

PAST SURGICAL HISTORY: List all past surgeries, including Caesarian Sections and Hysterectomies

SOCIAL HISTORY

Do you smoke? YES ☐ NO ☐ If yes how much?______________________________

Do you drink? NO ☐ SOCIALLY ☐ OCCASIONALLY ☐ DAILY ☐

History of substance abuse? YES ☐ NO ☐

Marital status: SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐

Do you have any children? YES ☐ NO ☐ If yes, how many?______________________________

Employment status:

UNEMPLOYED ☐ DISABLED ☐ RETIRED ☐ EMPLOYED ☐ HOMEMAKER ☐

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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

4213 Teuton St
Metairie, LA 70006
PH: 504-327-5857
Fax: 504-324-3569

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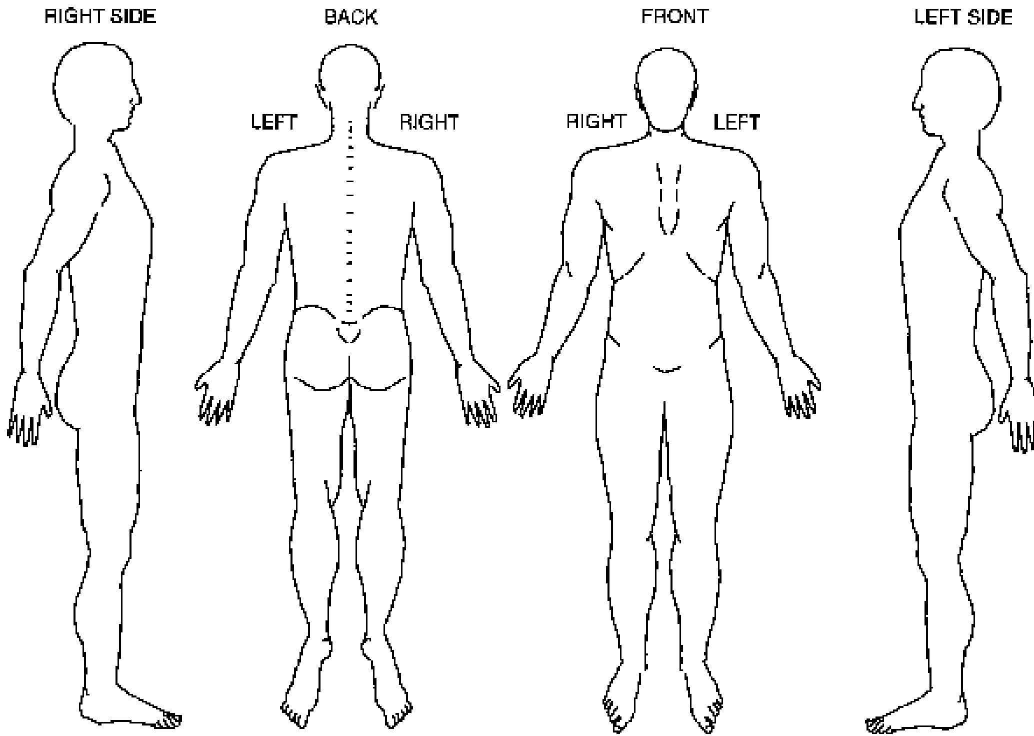
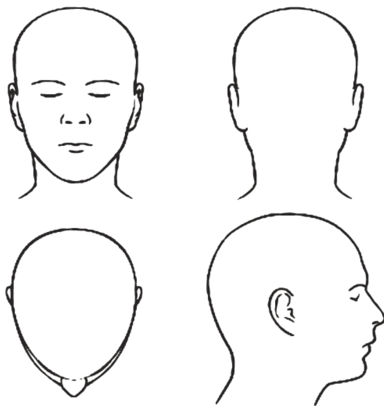
Patient Name:____ DOB:_________________ Date: _________________

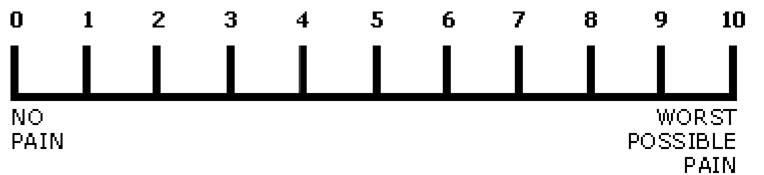
Pain Diagram

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





Circle the level of your pain.



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:**

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**

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 **$50.00 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

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**

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)

Revised 05/2018

Patient Name_______________________________DOB:____________________________

IF THIS IS **WORKMAN'S COMPENSATION** FILL IN THE FOLLOWING

Adjuster's Name:____________________________Phone #:_________________________

Claim #:_________________________________Date of Injury:_____________________

*** **We require the worker compensation carriers 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 workers compensation **claim is denied, you are responsible for all charges incurred.**

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 deductible 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

Medical Provider
Eric Lonseth, MD
Eric Lonseth, MD, APMC
4213 Street
Metairie, LA 70006

Patient Name:	Attorney/Law Firm Name:
Address:	Attorney/Law Firm Address:
Telephone:	Attorney/Law Firm Telephone:
Email	DOA:

Assignment of Interest & Attorney Letter of Protection

I, Patient, do hereby authorize and direct the above-named Medical Provider, or its designee, to furnish my attorney with protected health information relating to my medical care and treatment, including all reports, findings, interpretations, impressions, diagnostic studies, examinations, medication lists, procedures, etc. and including those in connection with any accident in which I was involved.

I, Patient, authorize and direct my Attorney, who is identified above, as well as any subsequent attorney I may obtain in addition to or replacement of my above identified attorney, to pay directly to the above-named Provider, or its designee or assignee, all amounts that may be due and owing for medical services rendered to me both in connection with the accident in which I was involved, and amounts owed by me for services unrelated to the accident. I hereby authorize a direct my attorney (as well as any future attorneys) to withhold from any settlement, judgment, verdict, or other economic recovery I may receive such amounts as are necessary to adequately protect the above-named Provider for the care provided and amounts owed. I understand that, by this agreement, I am giving the above-named Medical Provider a lien on any settlement, judgment, verdict, or other economic recovery I may obtain in my case, including any amounts held by attorney that are payable to me.

I, Patient, fully understand that, notwithstanding this agreement, I am directly and fully responsible to the above-named Medical Provider for all medical bills associated with the services provided to me and this agreement is made solely for additional protection and consideration of the Medical Provider agreeing to await payment. I understand and intend that this agreement tolls and extends the laws that limit the time for the Medical Provider to take action to collect amounts I may owe for the services provided and that my obligations to pay the same are not contingent on my receiving any recovery in my case. I further understand and agree this agreement is not a payment arrangement with respect to the satisfaction of my whatsoever.

I, Patient, do hereby authorize my attorney to communicate with the above-named Medical Provider (or provider's assignee) concerning the status of me and my case and direct my attorney to answer all questions that may be asked concerning me or my case. I agree to notify, and hereby direct my attorney to notify, the above-named Medical Provider (or provider's assignee) in writing at the address provided above of any change in my legal representation within 10 days of such change.

I, Patient, agreed to notify, and hereby direct my attorney to notify, the Medical Provider (or provider's assignee) in writing within 2 weeks of the settlement of my case. I hereby authorize my attorney to provide to Medical Provider (or provider's assignee) a breakdown of the total settlement amount, along with all costs, fees, or other expenses to be paid from the settlement proceeds.

I, Patient, attest that I have had a fair and adequate opportunity to inquire into Medical Provider's fees and I acknowledge that that the provider's charges for its services are fair and reasonable. I further acknowledged that this agreement is an agreement that provides collateral for the amount I owe with respect to the services rendered to me and does not constitute a payment arrangement or other arrangement regarding the payment of any amounts I may owe with respect to services rendered to me. I hereby authorized the Medical Provider (or provider's assignee) to assign my account receivable and to provide copies of all my records relating to the assigned portion of my account receivable to the assignee. I understand and agree that any assignee of the Medical Provider is entitled to all of the rights and privileges provided to the Medical Provider by this agreement. I understand that such an assignment will not affect my obligations or my attorney's obligations under, or the consents I am giving in, this agreement.

If there is a controversy or claim (each a "Dispute") arising from or otherwise relating to the terms of this agreements, I hereby consent and agree that such dispute that cannot be amicably resolved can only be pursued and enforced in the State Court in Jefferson Parish Louisiana, under the laws of the State of Louisiana. If Medical Provider prevails at Court, the Patient will be responsible for any and all attorneys' fees and costs expended to enforce the agreement.

Patient signature__________________________Print name _______________Date________

The undersigned being the attorney of record for the above Patient does agree to honor the above lien and assignment and agrees to withhold such sums for any settlement, judgment or verdict as may be necessary to adequately protect the above Medical Provider for the care provided and all amounts owed.

Attorney signature_________________________Print name________________Date________

Attorney: Please date, sign and return 1 copy to the Medical Provider. Keep one copy for your records.