Welcome, new patient!

Thank you for choosing Twin Cities Pain Clinic! We strive to provide the best possible medical care. It is our pleasure to welcome you as a patient.

Before you arrive, collect your medical records and imaging results, such as MRI films or X-rays. If you are not sure where these are, contact your referring physician. If you need an interpreter, contact our office ten working days before your appointment.

Bring to your first appointment:

- Address/Insurance Form
- Medical History Form
- Financial Policy Form, signed and dated
- Review MPay Brochure- You will be required to do an authorization on a credit or debit card at each visit. Please call our Business Office with any questions prior to your appointment.
- Driver’s license or other photo identification
- Insurance card or workers comp/auto claim #
- Medical records, imaging results (MRI films)
- Any medications you are taking

If you have questions about the forms or your appointment, call us at (952) 841-2345. We look forward to meeting you!

Clinic Location:
7235 Ohms Lane * Edina, MN 55439
Tel: (952)-841-2345 Fax: (952)-841-2346
www.twincitiespainclinic.com
**Office Hours**
The clinic is open from 8:00 am to 5:00 pm, Monday - Friday. Receptionists answer calls during this time. Our nurse triage line is open 8:30am-4pm Monday – Friday. At other hours, you may leave a voice message.

In emergencies, call 911. If you have an important question that is not an emergency, but is so urgent that it cannot wait for normal business hours, contact our physician, Dr. Will, at (612) 991-9433.

**Scheduling**
Appointments are generally between 8:00 am and 4:00 pm. Physical therapy may start as late as 4:45 pm on some days.

Please respect other patients who also need to see us by giving **24 hours notice** to cancel or reschedule an appointment. You will be charged for missed appointments. If you miss an appointment or cancel more than two appointments, we reserve the right to discontinue your care at our clinic.

**Your Appointment**
On your first visit, you will be seen by Dr. Will, and a nurse practitioner who will be your assigned provider. We try to schedule the same provider for all of your follow-up appointments. However, we do get busy and may ask you to see a different provider.

**What is a Physiatrist?**
Our medical director is board certified in physical medicine and rehabilitation. A physician in this specialty is known as a **physiatrist** (pronounced fizz eye uh trist).

Physiatry is a small specialty representing only 1% of medical doctors. In addition, physiatrists often subspecialize. Our practice focuses on the spine and other musculoskeletal problems.

Andrew Will, MD, is a third-generation physician. He is a graduate of St. John’s University and the University of Minnesota Medical School. He completed his residency in Physical Medicine and Rehabilitation at the Medical College of Wisconsin, where he was chief resident. Dr. Will is a diplomate of the American Board of Pain Medicine and president of the Minnesota Physiatric Society. He is a member of the International Spine Intervention Society and the American Society of Interventional Pain Physicians.

**Nurse Practitioners**
Our nurse practitioners provide healthcare services similar to those of a doctor. NPs have master’s or doctoral education and clinical training. They are board certified and recognized as expert healthcare providers. They collaborate daily with Dr. Will.

**Physical Therapy**
Our physical therapists confer daily with medical staff to treat a full spectrum of ailments. If your condition requires both medical care and physical therapy, we can schedule the appointments on the same day.

Additional information about our staff can be found at twincitiespainclinic.com

**Injections**
Most injections – muscle, tendon, and joint – are done at our clinic. If you need a spinal injection, Dr. Will performs them under fluoroscopy (X-ray).

**Pain Medications**
In some cases, we prescribe opioids. Such medications are federally regulated and carefully controlled. We strictly monitor patient compliance. **Bring all pain medications you are taking**, in their prescription bottles. Be prepared to provide a urine sample for drug testing.

We require substantial medical records before prescribing medications. Therefore, we may not be able to issue a prescription at your first appointment.
# Address & Insurance Form

## I. PATIENT:

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First</th>
<th>Middle Initial</th>
<th>Marital Status</th>
<th>S.S. #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>M_____ S_____ D_____ W_____</td>
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</table>

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Sex:</th>
<th>S.S. #</th>
</tr>
</thead>
<tbody>
<tr>
<td><em><strong><strong>/</strong></strong></em>/___________</td>
<td>F_____ M_____</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Primary Phone #</th>
<th>H / W / C</th>
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<tr>
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</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Secondary Phone #</th>
<th>H / W / C</th>
</tr>
</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Race:</th>
<th>Language:</th>
<th>Pharmacy Name &amp; #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

## II. GUARANTOR OF ACCOUNT (if different than above):

<table>
<thead>
<tr>
<th>Last First</th>
<th>Middle</th>
<th>Marital Status</th>
<th>S.S. #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>M_____ S_____ D_____ W_____</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Sex:</th>
<th>S.S. #</th>
</tr>
</thead>
<tbody>
<tr>
<td><em><strong><strong>/</strong></strong></em>/___________</td>
<td>F_____ M_____</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Primary Phone #</th>
<th>H / W / C</th>
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<tr>
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</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Secondary Phone #</th>
<th>H / W / C</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationship to Patient:</th>
<th>Alternate Phone #</th>
<th>H / W / C</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## III. PATIENT PRIMARY INSURANCE: (present insurance card)

<table>
<thead>
<tr>
<th>Insurance Company</th>
<th>Effective Date</th>
<th>Policy Holder Name</th>
<th>Policy # (or S.S.#)</th>
<th>Group #</th>
<th>Address</th>
<th>Adjuster name &amp; phone #</th>
<th>Check if Applicable:</th>
<th>Date of Injury</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Worker’s Compensation</td>
<td></td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Automobile Insurance</td>
<td></td>
</tr>
</tbody>
</table>

## IV. PATIENT SECONDARY INSURANCE: (present insurance card)

<table>
<thead>
<tr>
<th>Insurance Company</th>
<th>Effective Date</th>
<th>Policy Holder Name</th>
<th>Policy # (or S.S.#)</th>
<th>Group #</th>
<th>Address</th>
<th>Adjuster name &amp; phone #</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

## V. NOTIFY IN CASE OF EMERGENCY:

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Phone #</th>
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<tbody>
<tr>
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</table>

Assignment of Benefits Clause: I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services. I authorize direct payment of medical benefits to Twin Cities Pain Clinic for services rendered. I also authorize release of any information concerning my past medical care to my insurance companies, referring physician, or legal guardian.

Date: _____/_____/___________

<table>
<thead>
<tr>
<th>Patient Signature</th>
<th>Guarantor Signature</th>
</tr>
</thead>
</table>
Medical History Form

Date: ____/____/_______

Name: ______________________________________________

Date of Birth: _____/_____/__________    Age: _____ yrs.    Sex:    M  /  F

How did you hear about our clinic? Circle Answer:
Referring Physician/Clinic     Internet          Phone book         Family/Friend

Name of Physician or Referral Source_________________________________________

Who is your primary care physician/clinic? ____________________________________

When did your pain begin? _________________________________________________

What started your pain?
  □ Accident at work   □ Following an illness or medical treatment
  □ Exposure at work   □ Just began spontaneously
  □ Auto accident   □ Other __________________________
  □ Accident somewhere else

In the space below, describe how the pain began (details about the injury or pain onset):

Use the following scale to answer the next 3 questions.

<table>
<thead>
<tr>
<th>10</th>
<th>9</th>
<th>8</th>
<th>7</th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>9</td>
<td>8</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
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</tr>
<tr>
<td>10</td>
<td>9</td>
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<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

What is your pain at its worst? 0 1 2 3 4 5 6 7 8 9 10
What is your pain at its best? 0 1 2 3 4 5 6 7 8 9 10
What is your pain most often? 0 1 2 3 4 5 6 7 8 9 10

What makes the pain worse? ________________________________________________
What makes the pain better? ________________________________________________
Mark the drawings where you hurt, using the letters that best describe the pain in that particular area (for example, put an “A” over the low back if you have aching pain in the low back):

A = Aching       B = Burning       S = Stabbing       N = Numbness       P = Pins and needles

Treatments you have tried:

Medications: ________________________________________________  Was this helpful?  Yes  No

P.T. Or Chiropractic: _________________________________________  Yes  No

Injections: _________________________________________________  Yes  No

What types of treatments are you interested in?

____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________
Past Medical History:

( ) Frequent Infections  ( ) Asthma  ( ) Heart Attack
( ) Circulatory Disease  ( ) Thyroid Problems  ( ) Stroke
( ) Respiratory Problems  ( ) Liver Disease  ( ) Hepatitis
( ) Kidney Disease  ( ) Stomach Ulcers  ( ) Seizure Disorders
( ) Bleeding Disorders  ( ) Anemia  ( ) Arthritis
( ) Skin Problems  ( ) Diabetes  ( ) High Cholesterol
( ) Depression  ( ) Anxiety Disorder  ( ) Hypertension (High B/P)
( ) Immune Disorder  ( ) Osteoporosis  ( ) Other________________

Past Surgical History:

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Date</th>
<th>Surgery</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>____________________________</td>
<td>_____________</td>
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<tr>
<td>____________________________</td>
<td>_____________</td>
<td>__________________________</td>
<td>_____________</td>
</tr>
</tbody>
</table>

List all allergies you have, including medications, food, latex, or other substances. Describe what kind of reaction you had to each (for example, rash, short of breath, etc.)

______________________________________________________________________________________________________

______________________________________________________________________________________________________

______________________________________________________________________________________________________

List the names of all the medications you are taking now:

Example: Tylenol  500mg  2 tablets twice a day

______________________________________________________________________________________________________

______________________________________________________________________________________________________

______________________________________________________________________________________________________

______________________________________________________________________________________________________

______________________________________________________________________________________________________

The following questions are to help us understand your situation better so we can help you deal with any social or work stresses that this medical problem may be causing you.

Marital status: □ single, never married □ single, divorced □ single, widowed
□ married  □ living with significant other

Number of children and their ages: __________________________________________

Last school level you attended: __________________ ________________________

Are you currently working? □ Yes □ No; if “yes”, answer the next 3 questions:

What is your current type of work? __________________

Are you currently working: □ Full time □ Part-time
Are you working: □ Without restrictions □ With restrictions written by a physician
Are you receiving any financial compensation now for lost income due to disability? □ Yes □ No
Are you involved in any litigation regarding your pain condition? □ Yes □ No

Some of the medications we prescribe could be addictive or abused. Please answer the following questions honestly so that we can help you assess your potential risk if these medications become necessary.

Do you smoke? □ Yes □ No; If yes, how many packs per day do you smoke? _____

How many alcoholic drinks do you normally consume?

________per day / week / year (circle).

Do you have any history of drug or alcohol abuse? □ Yes □ No
If yes, did you undergo treatment for this? □ Yes □ No

If yes, please describe, including the year and what treatment was for:
_____________________________________________________________________________________________________

Have you ever had any traffic violations related to drugs or alcohol? □ Yes □ No
If yes, please describe.__________________________________________________________________________________

Is there a history of any back pain or other chronic pain in your family? □ Yes □ No
If yes, please describe.__________________________________________________________________________________

Check any of the following problems you are currently or recently suffering from:

(   ) Weight Loss   (   ) Immune system disorder
(   ) Difficulty sleeping   (   ) Depression
(   ) Diabetes   (   ) Fever
(   ) Decreased hearing   (   ) Swelling of ankles
(   ) Chest Pain   (   ) Cough
(   ) Shortness of breath   (   ) Diarrhea
(   ) Constipation   (   ) Bladder incontinence
(   ) Difficulty urinating
(   ) Bleeding disorders (even if due to a medication like Coumadin)
(   ) Visual impairment requiring glasses or contacts
**FINANCIAL POLICY**

You are responsible for all charges you incur at Twin Cities Pain Clinic. We accept cash, check, and credit cards. We know that both cost and quality of care are important to you. Ask if you have questions about fees.

**INSURANCE**

As your medical provider, our relationship is with you. Your insurance is a contract between you and your insurer, which may not cover all your care. We will file your claim as a courtesy. You must pay any charges that are not reimbursed.

To prevent fraud, you must present a valid insurance card or claim, photo ID, and any applicable co-payment or past-due balance at each visit.

If your insurance has changed, you may need to pay the full cost of your visit. We understand your frustration and will assist you in obtaining reimbursement or credit from your insurer.

We can schedule your check-up conveniently after your physical therapy. Some insurers treat these as separate visits and require two co-pays.

**MPAY- New billing service**

We will require you to authorize your services with a credit card. We will bill your insurance company and after receiving an explanation of benefits charge your credit card any outstanding balances up to the authorized amount on the date of service. Please see inserted Brochure or contact our billing office prior to your first appointment with any questions regarding this billing service.

**REFERRALS**

Some insurers require a referral from your primary doctor; refer to your medical policy. Please bring the referral to your appointment. Without a referral, insurers may require you to pay for your visit in full.

**FORMS/PRIOR AUTHORIZATION/APPEALS**

Insurance covers only your medical care. It does not cover submitting forms that may assist you in collecting disability benefits, maintaining employment, or prior authorization for certain medications. There are fees for these services which reflect the resources diverted to the effort.

Your insurance may not cover all treatments or medications. You may pay cash, forego treatment, or appeal to your insurer. If you ask us to appeal, we will bill you an hourly rate as this is not medical care.

**ASSIGNMENT OF BENEFITS**

I authorize all insurance benefits to be paid directly to Twin Cities Pain Clinic, d/b/a/ Andrew J. Will, M.D., P.A. I authorize the release of all necessary information to file and complete all insurance claims.

**UNPAID BILLS**

Accounts that are 30 days past due will be assessed a late fee. You may also be responsible for collection costs including court and attorney fees. Returned checks are subject to a $20 service charge.

** MISSED AND CANCELLED APPOINTMENTS**

Be respectful to other patients. If you cannot keep an appointment, please give us at least 24 hours notice, so that we can make this time available for other patients. We will charge a $50.00 fee if sufficient notice is not given (weekends not included). If you arrive ten minutes or later to an appointment, you may be asked to reschedule. This type of missed appointment will also acquire a charge.

---

**I HAVE READ AND UNDERSTAND ALL THE INFORMATION ON THIS FINANCIAL POLICY. I AGREE TO ITS TERMS, AND TO THE ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION DESCRIBED ABOVE. WITH MY SIGNATURE I AM ALSO AUTHORIZING MEDICAL TREATMENT TO BE PERFORMED BY TWIN CITIES PAIN CLINIC.**

________________________________________
(PATIENT/GUARDIAN SIGNATURE)

________________________________________
(PRINT PATIENT/GUARDIAN NAME)

________________________.DATE
OSWESTRY PAIN QUESTIONS

NAME:__________________________________________________
DATE:________________________

Please read: this questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by marking in each section the ONE BOX that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE JUST MARK ONE BOX THAT MOST CLOSELY DESCRIBES YOUR PROBLEM.

SECTION 1 – PAIN INTENSITY
  □ The pain comes and goes and is very mild.
  □ The pain is mild and does not vary much.
  □ The pain comes and goes and is moderate.
  □ The pain is moderate and does not vary much.
  □ The pain comes and goes and is severe.
  □ The pain is severe and does not vary much.

SECTION 2 – PERSONAL CARE
  □ I would not have to change my way of washing or dressing in order to avoid pain.
  □ I do not normally change my ways of washing or dressing even though it causes some pain.
  □ Washing and dressing increase the pain, but I manage not to change my way of doing it.
  □ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
  □ Because of the pain, I am unable to do some washing and dressing without help.
  □ Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3 – LIFTING
  □ I can lift heavy weights without extra pain.
  □ I can lift heavy weights but it causes extra pain.
  □ Pain prevents me from lifting heavy weights off the floor.
  □ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned e.g. on a table.
  □ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
  □ I can lift very light weights at the most.

SECTION 4 – WALKING
  □ Pain does not prevent me from walking any distance.
  □ Pain prevents me from walking more than 1 mile.
  □ Pain prevents me from walking more than ½ mile.
  □ Pain prevents me from walking more than ¼ mile.
  □ I can only walk using a cane or on crutches.
  □ I am in bed most of the time and have to crawl to the toilet.
SECTION 5 – SITTING
☐ I can sit in a chair as long as I like.
☐ I can only sit in my favorite chair as long as I like.
☐ Pain prevents me from sitting more than one hour.
☐ Pain prevents me from sitting more than 30 minutes.
☐ Pain prevents me from sitting more than 10 minutes.
☐ I avoid sitting because it increases pain right away.

SECTION 6 – STANDING
☐ I can stand as long as I want without pain.
☐ I have some pain when standing, but it does not increase with time.
☐ I cannot stand for longer than one hour without increasing pain.
☐ I cannot stand for longer than ½ hour without increasing pain.
☐ I cannot stand for longer than 10 minutes without increasing pain.
☐ I avoid standing because it increases the pain right away.

SECTION 7 – SLEEPING
☐ I get no pain while in bed.
☐ I get pain while in bed, but it does not prevent me from sleeping well.
☐ Because of pain, my normal night sleep is reduced by about 25%.
☐ Because of pain, my normal night sleep is reduced by about 50%.
☐ Because of pain, my normal night sleep is reduced by about 75%.
☐ Pain prevents me from sleeping at all.

SECTION 8 – SOCIAL LIFE
☐ My social life is normal and gives me no pain.
☐ My social life is normal but increases the degree of my pain.
☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
☐ Pain has restricted my social life, and I do not go out very often.
☐ Pain has restricted my social life to my house.
☐ I have hardly any social life because of pain.

SECTION 9 – TRAVELING
☐ I get no pain while traveling.
☐ I get some pain while traveling, but none of my usual forms of travel make it worse.
☐ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
☐ I get extra pain while traveling which requires me to seek alternative forms of travel.
☐ Pain restricts all forms of travel.
☐ Pain prevents all forms of travel except that done by lying down.

SECTION 10-CHANGING DEGREE OF PAIN
☐ My pain is rapidly getting better.
☐ My pain fluctuates but overall is definitely getting better.
☐ My pain seems to be getting better, but improving is slow at present.
☐ There has been no change in my pain.
☐ My pain is gradually worsening.
My pain is rapidly worsening.

## Depression Screen

### Patient Health Questionnaire (PHQ-9)

<table>
<thead>
<tr>
<th>Name _______________________________________</th>
<th>Date ____________________</th>
</tr>
</thead>
</table>

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(please circle your answer)*

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so figety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead, or of hurting yourself</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

10. If you checked off *any problems*, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (please circle your answer)

<table>
<thead>
<tr>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
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<tbody>
<tr>
<td></td>
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