TOUCHSTONE
INTERVENTIONAL PAIN CENTER

WELCOME TO OUR OFFICE

Our office is committed to providing you with state-of-the-art interventional pain management and clinical services. Our office provides specialized treatments and pain management to our referred patients. By partnering with the referring physician, we optimize patient care by communicating with the referring physician regarding patient conditions, treatment plans, and treatment outcomes.

ABOUT YOUR APPOINTMENT

Your first visit to our office is an evaluation and will last approximately 30 minutes. During your examination, the doctor will discuss your condition and determine a treatment plan. We will call to confirm your appointment one business day prior to your appointment. Please read the following instructions carefully prior to your appointment:

- Patients who are late for their appointment check-in time will be rescheduled.
- If you have had any x-rays, CT Scans, MRI's etc. taken which pertain to this appointment, please be sure the imaging reports are at our office on the day of your scheduled appointment.
- Please be sure to bring your insurance card(s) with you to your appointment.
- We accept most major insurance companies. Insurance co-payments and/or co-insurance payments will be collected at the time of service. As a convenience to our patients, we accept cash, Visa, and MasterCard. If you are unsure of coverage, please verify this information with your insurance carrier.
- Your paperwork must be filled out completely before your check-in time.

Thank you for considering Touchstone, Southern Oregon's Pain Relief and Wellness Center for your pain care. We are looking forward to meeting you at your scheduled appointment!

AppointmentDay	*AppointmentDate*	*Check-inTime*	*Provider*

*Please have your paperwork completed prior to your appointment.

2925 Siskiyou Blvd, Medford, OR 97504
(p) 541-773-1435 (f) 541-858-6828

TOUCHSTONE

INTERVENTIONAL PAIN CENTER

Notice of Touchstone Policies

INSURANCE/COPAYS

As a courtesy, Touchstone will file all claims to your insurance carriers for services provided. In order to extend this courtesy, we will need a picture ID and copy of insurance cards during each visit. If there are any changes in your insurance coverage or benefits while being treated at Touchstone you are responsible to notify us immediately. If your insurance coverage requires a co-pay, it will be collected at the time of check in.

ATTENDANCE POLICY

Touchstone is dedicated to patient satisfaction and providing the highest quality care while attempting to accommodate your schedule. We currently provide reserved appointments for each patient in order to minimize waiting and assure the continuity of your care. Your consistent attendance is vital to your care. Please adhere to the duration and frequency of our patient care visits and evaluation with your provider. Cancellations, along with no-shows, decrease our ability to accommodate the scheduling needs of other patients. Your full cooperation with the following policy is requested.

Cancellations: If you are unable to keep a scheduled appointment, please notify our office 24 hours in advance via phone at (541)773-1435.
No-Shows: If you miss an appointment and did not cancel, it is called a no-show.

*All cancellations and no-shows will be documented in your medical record and appropriately reported to your provider.
*If you accumulate four cancellations or two no-shows or more, your provider may choose to refer you back to your primary physician before scheduling another appointment or may choose to discharge you from Touchstone and report this to your primary physician.

Late Arrivals: If you have not arrived 10 minutes after your scheduled appointment time, your appointment may need to be rescheduled. Please notify our office by calling 541-773-1435 if you are running late for your appointment.
*Missing or rescheduling appointments may result in you running out of pain medications, which could possibly result in undesirable withdrawal symptoms. Long-term use of opiate medications is not without risk and it is up to the patient to be responsible for their care.

REFERRAL POLICY

Touchstone is a specialty-based practice. Patients are accepted for care only by referral from your healthcare provider.

PRIMARY CARE PHYSICIAN

If another specialist refers you to Touchstone, it is important that you have a relationship with a **primary care physician.** Our physicians serve as consultants and cannot assume the role provided by a primary care doctor.

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NEW PATIENT WORKSHEET

Patient Name:_____ DOB:_____/_____/_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work:_____ Cell :_____

Marital Status:_____ SSN:_____-_____-_____

Email:_____

Would you like to sign up for access to our Patient Portal? (Circle One): Yes No
*email address required for the Patient Portal

Ethnicity (Circle One): Hispanic or Latino / Non-Hispanic or White/ Refuse to Report

Race (Circle One): American Indian or Alaska Native/Asian/Native Hawaiian or other Pacific Islander/Black or African Amer./White/ Hispanic/ Other Race/ Other Pacific Islander/ Refuse to Report

Emergency Contact:_____ Phone:_____

Relationship: _____

Referring Physician:_____ Phone:_____

Primary Care Physician:_____ Phone:_____

Pharmacy Name:_____ Location:_____

Employer Name:_____ Employer Phone:_____

INSURANCE INFORMATION

Primary Insurance: _____

Address:_____ Phone:_____

Subscriber Name:_____ Subscriber DOB:_____/_____/_____

Subscriber ID:_____ Group Number:_____

Secondary Insurance: _____

Address:_____ Phone:_____

Subscriber Name:_____ Subscriber DOB:_____/_____/

Subscriber ID:_____ Group Number:_____

Worker's Comp Insurance / Motor-Vehicle Accident Insurance **(circle one)**

Insurance Name:_____

Address:_____ Phone:_____

Employer at the time of injury:_____ Date of Injury:_____/_____/

Claim Number:_____ Adjuster : _____

Adjuster's Phone Number:_____ Ext:_____

Patient Signature:_____ Date:_____/_____/_____

TOUCHSTONE
INTERVENTIONAL PAIN CENTER

HIPAA Medical Information Release Form

Name:_____Date of Birth_____/_____/_____

Release of Information

☐ I hereby authorize Touchstone, Southern Oregon's Pain Relief and Wellness Center to release information regarding my medical, billing, and/or appointment information:

To my Primary Care Physician(please list): _____

Other physicians (please list): _____

And any of the following (print full name):

☐ Spouse:_____

☐ Child(ren): _____

☐ Other: _____

☐ Information is not to be released to anyone (other than my referring physician as stated in HIPAA)

This Release of Information will remain in effect until termi nated by me in writing.

Messages

I authorize Touchstone to call the phone numbers listed on my new patient worksheet. If unable to reach me:

☐ you may leave a detailed message

☐ please leave a message asking me to return your call

☐ other:_____

Patient Signature:_____Date: _____

Staff Witness Signature:_____ Date:_____

TOUCHSTONE
INTERVENTIONAL PAIN CENTER

Notice of Privacy Practices

I understand that Touchstone, Southern Oregon's Pain Relief and Wellness Center (referred to below as "This Practice") will use and disclose health information about me.

I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health related information.

I understand and agree that this practice may use and disclose my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinating among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective healthcare.

I also understand that I have the right to receive and review written description of how this practice will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other office personnel of this practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or summary of the most current version of this practice's Notice of Privacy Practices in effect will be posted in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that this practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of this Notice of Privacy Practices (if I have requested a copy).

_____ Date: _____
(Patient Signature)

OR

_____ Date: _____
(Patient Representative Signature)

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TOUCHSTONE
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Financial Policy

Patient Name:_____ **Date of Birth:** _____

Our practice is committed to giving you the best healthcare possible. We understand that health insurance can be confusing. Therefore, while it is ultimately your responsibility to know your insurance plan, we will make reasonable efforts to assist you.

Verification of Benefits: I understand that Touchstone may be out of network with my insurance plan and I understand that I may have more out of pocket expense when receiving treatment from out-of-network providers.

Insurance Co-Pays, Deductibles & Co-Insurance: In accordance with my insurance plan, I understand that all co-pays, unmet deductibles and co-insurance amounts are due at the time of service and at the time procedures are scheduled.

Non-Covered Services: I understand that some services may not be covered by my insurance policy. Touchstone will attempt to assist me in verifying if services are covered by my plan, however if the insurance carrier denies my services as non- covered, I understand that I am financially responsible for the denied services.

Private Pay: If I have no insurance coverage, or if Touchstone is unable to verify current insurance coverage, I understand full payment is expected at the time of service and at the time procedures are scheduled.

Motor Vehicle Accident Accounts: It is the policy of this office to bill your MVA carrier until your Personal Injury Protection (PIP) is expired or exhausted, whichever comes first. Once PIP coverage is no longer available your account will be switched to your private insurance and all balances will become your responsibility. We will not accept a letter from your attorney in lieu of billing your medical insurance. If you do not have medical insurance you will become a self pay patient.

Secondary Insurance: I understand that Touchstone will file a claim with my secondary insurance as a courtesy, but I am fully responsible for all secondary insurance amounts left unpaid by my secondary insurance.

Refund Policy: Refunds will be paid as soon as complete insurance reimbursement for all medical services on the account has been received.

Finance Charges & Collections: I understand that balances greater than 60 days are subject to a finance charge of 1.5% a month, 18% a year. Once an account has been referred to an outside agency for collections no further appointments may be scheduled with a provider at Touchstone. I will be responsible for all collection fees and interest costs.

Cancellations & "No-Show" Appointments: Any canceled or missed appointments with less than 24 hours notice are subject to a $50 cancellation fee that **must be paid prior to scheduling the next appointment.** Continued missed appointments interfere with your treatment and therefore non compliance may result in discharge from our clinic.

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INTERVENTIONAL PAIN CENTER

Financial Policy (continued)

Authorization to Release and Assign Insurance Benefits: I authorize release of any information required to act on any insurance claim and permit photographic or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to Touchstone the medical and/or surgical benefits I am entitled from my insurance company(s) and/or Medicare and Medicaid.

This authorization is in effect for all future claims, until I choose to revoke it in writing.
I, the undersigned, understand and agree to the above Financial Policy. I understand that I am financially responsible for all charges incurred for my medical treatment. I have had the opportunity to ask and have my questions answered to my satisfaction.

Patient's Signature (OrAuthorized Signature) _____ Date _____

Printed Name of Patient _____ Relationship to patient _____

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TOUCHSTONE
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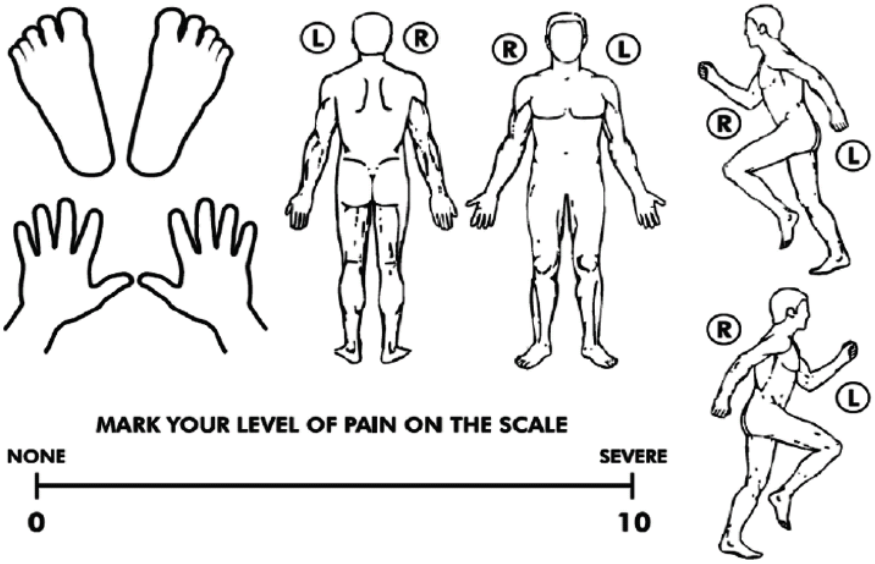
MEDICAL HISTORY IN TAKE FORM

Description of Pain

Please mark on the diagram your main area of pain



FILL IN THE BUBBLE of a few words that describe your pain

O Flickering	O Pricking	O Pinching	O Crushing	O Hot	O Tingling
O Quivering	O Boring	O Pressing	O Tugging	O Burning	O Itchy
O Pulsing	O Drilling	O Gnawing	O Pulling	O Scalding	O Smarting
O Pounding	O Stabbing	O Cramping	O Wrenching	O Searing	O Stinging
O Dull	O Tender	O Cool	O Miserable	O Radiating	O Numb
O Sore	O Tiring	O Cold	O Intense	O Penetrating	O Drawing
O Hurting	O Exhausting	O Freezing	O Unbearable	O Piercing	O Squeezing
O Aching	O Nagging	O Annoying	O Spreading	O Tight	O Troublesom

Today's Date: _____

Name:_____DOB:_____

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Patient Questionnaire

HISTORY OF PRESENT ILLNESS

Where is your main pain area? _____

How long has your pain been present?_____

How did the injury take place? _____

Is there anything that relieves your pain? _____

Is there anything that worsens your pain? _____

Where in your body does your pain radiate to?_____

If your pain radiates, is the pain more in your spine or in your limbs? _____

Are you experiencing any bowel or bladder incontinence? YES NO

Does your pain limit you to do any of the following? (circle all that apply)

Dressing	Mobility/transferring	Shopping	Housework
Grooming	Walking	Cooking	Doing laundry
Oral hygiene	Climbing stairs	Managing Medications	Driving
Bowel/bladdercontrol	Eating	Using the phone	Managing finances

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PREVIOUS THERAPIES

If you have tried any of the following therapies to treat your pain, please indicate number of sessions and the outcome in the table below:

Modality	Number of Sessions	Outcome
Physical Therapy		
Acupuncture		
Chiropractics		
Other Manual Therapy (Ex: massage, Rolfing, Barnes Therapy, Etc.)		
Counseling		
Injection		

Have you tried (circle all that apply): TENS BRACING ALPHA STIMULATOR NEUROFEEDBACK

Have you had prior surgery for this pain? YES NO Please List: _____

Have you had any imaging studies for you pain area? If yes, please circle all that apply:

X-Ray MRI Ultrasound CT

PAIN MANAGEMENT GOALS

Set 4 goals/activities that you would like to achieve if your pain improves (ex. gardening, grocery shopping, return to work)

1. _____

2. _____

3. _____

4. _____

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MEDICATIONS YOUR ARE CURRENTLY TAKING FOR PAIN

Medication	Strength (Mg)	Amount & Frequency
Example: Motrin	**200 mg**	**1 pill three times daily**

PLEASE LIST THE NAME OF ALLOTHER MEDICATIONS	**DATE**	**DURATION**

PREVIOUS PAIN MEDICATIONS TRIEDAND FAILED	**DATE**	**DURATION**

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PAST MEDICAL HISTORY

Arthritis ◯
Chronic Pain ◯
Asthma/COPD ◯
High Blood Pressure ◯
Heart Disease ◯
Hepatitis ◯
Diabetes ◯
Thyroid Trouble ◯
Cancer ◯

Other:_____
_____
_____
_____
_____
_____
_____
_____

Type of Hepatitis: _____
Type of Cancer:_____ Date Diagnosed:_____

MEDICATION ALLERGIES

Penicillin ◯
Sulfa ◯
Latex ◯
Iodine ◯

Others:_____
_____
_____
_____

SURGERIES

Tonsils ◯ YEAR_____
Appendix ◯ YEAR_____
Gallbladder ◯ YEAR_____
Stomach ◯ YEAR_____
Breast ◯ YEAR_____
Uterus/Ovary ◯ YEAR_____

Thyroid ◯ YEAR_____
Heart ◯ YEAR_____
Hernia ◯ YEAR_____
Back ◯ YEAR_____
Neck ◯ YEAR_____

Other: _____

HOSPITALIZATIONS (Other than for Surgeries):

List:_____
_____

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FAMILY HISTORY

Cancer ◯
Heart Disease ◯
Lung Disease ◯
High Blood Pressure ◯
Diabetes ◯
Thyroid Trouble ◯

Other: _____

_____

_____

_____

_____

_____

SOCIAL HISTORY

Do you drink alcohol? ◯ Amount per day: _____

Do you smoke cigarettes? ◯ Amount per day: _____

History of substance abuse/addiction? ◯

Have you ever been through detox? ◯

Explain:

_____

_____

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Review of Systems

Have you recently experienced any of the following? **(Fill in bubble if YES)**

GENERAL

- Tire easily,weakness ◯
- Marked weight change ◯
- Night sweats ◯
- Fevers ◯

CARDIO/RESPITORY

- Chest pain ◯
- Palpitations ◯
- Shortness of breath ◯

DIGESTIVE SYSTEM

- Nausea ◯
- Vomiting ◯
- Constipation ◯
- Diarrhea ◯

GENITOURINARY SYSTEM

- Increased frequency ◯
- Feel the need to urinate ◯
- Loss of Bladder Control ◯
- Pain with urination ◯

ENDOCRINE

- Thyroid trouble ◯
- Adrenal trouble ◯
- Diabetes ◯

NEUROLOGIC

- Numbness ◯
- Weakness ◯
- Headaches ◯

EYES

- Trouble seeing ◯
- Eye pain ◯
- Inflamed eyes ◯
- Double vision ◯

EARS

- Loss of hearing ◯
- Ringing ◯

SKIN

- Rash ◯
- Change in color ◯
- Change in hair ◯
- Change in nails ◯

PSYCHIATRIC

- Anxiety ◯
- Depression ◯
- Bipolar Disorder ◯

HEMATOLOGY

- Abnormal Bleeding ◯
- Abnormal Bruising ◯

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Sleep Apnea Screening Tool

Please fill in the bubble if YES for the following questions:

1. Do you SNORE loudly (louder than talking or loud enough to be heard through Closed doors)? OYES
2. Do you often feel TIRED, fatigued, or sleepy during the daytime? OYES
3. Has anyone OBSERVED you stop breathing during your sleep? OYES
4. Do you have or are you being treated for high blood PRESSURE? OYES
5. Body Mass Index (BMI) more than 35? OYES
6. Are you over 50 years of AGE? OYES
7. NECK circumference greater than 15.75 inches? OYES
8. Are you a MALE (males are more likely to suffer from sleep apnea)? OYES

3 or more YES answers: High-risk for Obstructive Sleep Apnea

Less than 3 YES answers: Low-risk for Obstructive Sleep Apnea

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Name_____ Date_____

Modified Oswestry Neck/Back Pain Questionnaire

This questionnaire is designed to enable us to understand how much your neck and/or back pain has affected your ability to manage your everyday activities. Please answer each section by marking in each section one circle that most applies to you. We realize that you may feel that more than one statement may relate to you, but **please just mark the circle that most closely describes your problem.**

Pain Intensity
O I can tolerate the pain I have without having to use pain medication.
O The pain is bad, but I can manage without having to take pain medication.
O Pain medication provides me with complete relief from pain.
O Pain medication provides me with moderate relief from pain.
O Pain medication provides me with little relief from pain.
O Pain medication has no effect on my pain.

Personal Care (e.g., Washing, Dressing)
O I can take care of myself normally without causing increased pain.
O I can take care of myself normally, but it increases my pain.
O It is painful to take care of myself, and I am slow and careful.
O I need help, but I am able to manage most of my personal care.
O I need help every day in most aspects of my care.
O I do not get dressed, I wash with difficulty, and I stay in bed.

Lifting (skip if you have not attempted lifting since the onset of your back pain)
O I can lift heavy weights without increased pain.
O I can lift heavy weights, but it causes increased pain.
O Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (e.g., on a table).
O Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
O I can lift only very light weights.
O I cannot lift or carry anything at all.

Walking
O Pain does not prevent me from walking any distance.
O Pain prevents me from walking more than 1 mile. (1 mile = 1.6 km).
O Pain prevents me from walking more than 1/2 mile.
O Pain prevents me from walking more than 1/4 mile.
O I can walk only with crutches or a cane.

Sitting
O I can sit in any chair as long as I like.
O I can only sit in my favorite chair as long as I like.
O Pain prevents me from sitting for more than 1 hour.
O Pain prevents me from sitting for more than 1/2 hour.
O Pain prevents me from sitting for more than 10 minutes.
O Pain prevents me from sitting at all.

Standing
O I can stand as long as I want without increased pain.
O I can stand as long as I want, but it increases my pain.
O Pain prevents me from standing for more than 1 hour.
O Pain prevents me from standing for more than 1/2 hour.
O Pain prevents me from standing for more than 10 minutes.
O Pain prevents me from standing at all.

Sleeping
O Pain does not prevent me from sleeping well.
O I can sleep well only by using pain medication.
O Even when I take medication, I sleep less than 6 hours.
O Even when I take medication, I sleep less than 4 hours.
O Even when I take medication, I sleep less than 2 hours.
O Pain prevents me from sleeping atall.

Social Life
O My social life is normal and does not increase my pain.
O My social life is normal, but it increases my level of pain.
O Pain prevents me from participating in more energetic activities (e.g., sports, dancing).
O Pain prevents me from going out very often.
O Pain has restricted my social life to my home.
O I have hardly any social life because of my pain.

Traveling
O I can travel anywhere without increased pain.
O I can travel anywhere, but it increases my pain.
O My pain restricts my travel over 2 hours.
O My pain restricts my travel over 1 hour.
O My pain restricts my travel to short necessary journeys under 1/2 hour.
O My pain prevents all travel except for visits to the physician / therapist orhospital.

Employment/Homemaking
O My normal homemaking / job activities do not cause pain.
O My normal homemaking / job activities increase my pain, but I can still perform all that is requiredof me.
O I can perform most of my homemaking / job duties, but pain prevents me from performing more physically stressful activities (e.g., lifting, vacuuming).
O Pain prevents me from doing anything but light duties.
O Pain prevents me from doing even light duties.
O Pain prevents me from performing any job or homemaking chores

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Headache

O I have no headache at all.
O I have slight headaches, which come infrequently.
O I have moderate headaches, whichcome infrequently.
O I have moderate headaches, whichcome frequently.
O I have severe headaches, which comefrequently.
O I have headaches almost all thetime.

Concentration

O I can concentrate fully when I want to with no difficulty.
O I can concentrate fully when I want to with slight difficulty.
O I have a fair degree of difficulty in concentrating when I want to.
O I have a lot of difficulty in concentrating when I want to.
O I have a great deal of difficulty in concentrating when I want to.
O I cannot concentrate at all.

LAST SCORE:_____ CURRENT SCORE:_____

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Opiod Risk Tool (ORT)

Patient Name: _____

Date: _____

MARK EACH BOX THAT APPLIES	
FAMILY HISTORY OF SUBSTANCE ABUSE	
Alcohol	☐
Illegal Drugs	☐
Rx drugs	☐
PERSONAL HISTORY OF SUBSTANCE ABUSE	
Alcohol	☐
Illegal drugs	☐
Rx drugs	☐
AGE BETWEEN 16-45 YEARS	☐
HISTORY OF PREADOLESCENT SEXUAL ABUSE	☐
PSYCHOLOGIC DISEASE	
ADD, OCD, bipolar, schizophrenia	☐
Depression	☐
SCORING TOTALS	

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Dealing with pain both physically and emotionally is a complicated matter. Acute pain is generally something that is treated as it occurs over a short period of time and it usually resolves. Chronic pain is a totally different animal (or matter).

Chronic pain is a very personal and private issue and can be, and often is, associated with multiplefears.

The fear of always having pain and being disabled by it.
The fear of becoming an addict.
The fear of others becoming aware of your use of narcotics an accusing you of being an addict.
The fear that treatment of your pain will result in loss of employment.

The complicating factor is that most people, believe that treatment of pain always involved narcotics and that narcotic usage leads to addiction. The reality is that pain is successfully treated with so many other modalities that are not narcotic in nature and that even though narcotics may be used in the beginning, there is always the goal of attaining pain relief with other methods.

Dr. Shawn Sills and his staff at Touchstone focus on the whole patient and work with the patient to develop a plan that may include some narcotic usage but also implements the use of non-narcotic pain meds, anti-inflammatories medications, massage, acupuncture, epidurals, e-stim, a-stim, therapy, counseling and the list goes on. The incredible thing about Dr. Sills and his group is that they include you, the patient in developing the plan and settinggoals.

The goals of treatment at Touchstone is to provide care that meets the needs of the patient while helping them regain the highest possible quality of life. This is accomplished while also providing care that is compassionate, empathetic and professional.

P.K, Touchstone Patient

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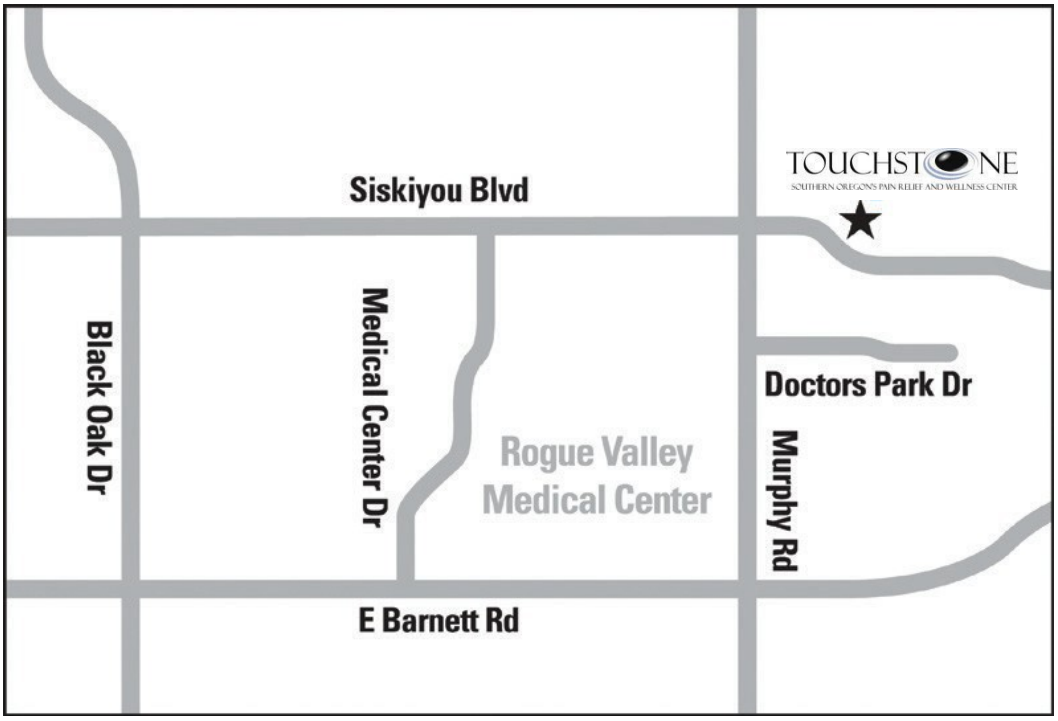
Directions to Our Office!

1. From I-5 take exit27
2. Once at the top of the ramp, turn toward Barnett Rd (LEFT if coming from Grants Pass, RIGHT if coming from Ashland)
3. At the light, turn RIGHT onto Barnett Rd
4. Turn LEFT on Murphy Rd at the light
5. Turn RIGHT on Siskiyou Blvd at the 4-way stop
6. Turn into 2925 SISKIYOU BLVD on the left hand side.



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