CENTER FOR SPINE & PAIN MEDICINE

Patient Information

Name _____ Social Security # _____-_____-_____
Last First Middle

Date of Birth: ___/___/___ Age: _____ Marital Status: ___Single ___Married ____Widowed ____Divorced

Address _____ City _____State _____Zip Code _____

Home Phone _____Work Phone _____ Cell Phone _____

Best time to call ____ Morning ____ Afternoon ____ Evening Which number: HOME WORK CELL

Name of Employer _____ Phone _____

Spouse's Name _____ Phone _____

Primary Care Physician _____ Phone _____

Emergency Contact _____ Phone _____ Relationship _____

Primary Insurance

Insurance Company _____ ID # _____ Group # _____

Policy Holder _____ Date of Birth ___/___/___ Social Security # _____-____-_____

Relationship to the Insured _____ Policy effective date ____/____/____

Secondary Insurance

Insurance Company _____ ID # _____ Group # _____

Policy Holder _____Date of Birth ____/____/____ Social Security # _____-____-_____

Relationship to the Insured _____ Policy effective date ____/____/____

I authorize Center for Spine & Pain Medicine to, please check all that may apply:

_____ Leave messages on my answering machine /voicemail regarding appointments
_____ E-Mail information regarding appointments (e-mail address _____)
_____ Mail information to the address provided above regarding appointments
_____ Speak with a family member or other individual when returning calls or concerning appointments
(Please specify with whom we may speak (_____)

I certify that the information provided on this form is accurate and complete.

_____ _____
Patient / Guardian Signature Date

_____ _____
Printed Name Relationship

Center for Spine & Pain Medicine

Narcotic Administration Agreement

This is an agreement between you and Center for Spine & Pain Medicine. When controlled substances are being prescribed to control pain, improve the quality of life and function, and minimize disability, the following are the treating Physician's expectations:

PLEASE READ AND INITIAL EACH ONE

1. _____ The patient will provide a complete history including past pain treatment, any alcohol or drug addiction/dependency history, medical/psychiatric/legal history.
2. _____ Follow the doctor's recommendations, DO NOT take more/less of any prescribed medications without discussing this with the physician and receiving permission to do so. By doing so it may lead to discontinuation of medication and/or termination from practice.
3. _____ DO NOT share or take medications from any other persons including family members; DO NOT sell any of your medications. By doing so it may lead to discontinuation of medication and/or termination from practice.
4. _____ Patient will agree to store their medications in a safe guarded place to keep others from stealing and/or abusing them.
5. _____ CSPM will be the only source of pain medication. Written/Verbal authorization will be given when and if another care provider is going to assume medication prescribing responsibilities. (This includes Post-Surgical Prescriptions)
6. _____ Regularly scheduled appointments will be kept on a frequency determined by the physician. The patient will be seen at least once every 4-8 weeks. Cancellations or missed appointments may lead to discontinuation of the medication and/or termination from practice.
7. _____ I will submit to a urine and/or saliva sample on request at ANY time without prior notification to detect the use of non-prescribed medications, illicit drugs and to confirm the use of prescribed medications. I will submit to random pill counts without notification as per Physicians request.
8. _____ Any evidence of drug seeking behavior such as; the use of illegal drugs, use of alcohol, frequent request for dose increases, or early refills can lead to discontinuation of the medication and/or termination from practice.
9. _____ No prescriptions for controlled substances will be provided on the weekends, holidays or outside of regular business hours.
10. _____ The patient will utilize the pain medication for their medically intended purpose only. CSPM provider may prescribe you pain medication with off label indication.
11. _____ The patient authorizes CSPM to cooperate fully with any city, state, or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of medicine. The patient authorizes to provide a copy of this agreement to the pharmacy. The patient waives any right of privacy or confidentiality with respect to these authorizations.
12. _____ If your physician determines that you are not a good candidate to continue with the medication, the physician may discontinue treating you at his/her own discretion and you may be referred to a detoxification program/addiction specialist.

13. _____ The patient agrees to immediately inform CSPM if they become pregnant or intend to become pregnant.
14. _____In case of adverse reaction or inefficiency, the patient will not destroy his/her medication on their own. The patient would need to bring medication back to CSPM for pill count before any other medications will be prescribed.
15. _____Do not operate a motor vehicle if you feel mentally impaired while using controlled medications. The patient is responsible for exhibiting good judgment in daily affairs, including the use of your controlled medications. Alcohol use should be abstained from while using controlled medication.
16. _____The patient understands that the controlled substance can be discontinued immediately If the patient does not fulfill the terms of this agreement.

Use of narcotic/opiate pain medicines have certain risks including but not limited to: sleepiness, drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing and slowing of reflexes or reaction time.

Chronic use of narcotic medicines in males may be associated with low testosterone levels. This may affect mood, stamina, sexual desire, and physical performance. Females who become pregnant need to contact this office immediately. Appropriate contraception will be used while on the narcotic medication.

The patient understands that the use of narcotic medication has potential complications including: the development of tolerance (reduced effect over time), dependency (potential for withdrawal symptoms upon abrupt discontinuation), and the possibility of "addiction" (loss of control, compulsive use and continued use despite adverse social, physical or psychological consequences).

****ONLY ONE PHARMACY WILL BE USED FOR CONTROLLED SUBSTANCES****

(If you choose to use/change to another pharmacy you must notify our office)

Name of Pharmacy:_____

Pharmacy location:_____

Phone Number:_____

This document will be kept as part of the medical record and updated yearly. By signing this you acknowledge that you have read, understand and agree to the above expectations. Failure to follow these guidelines can lead to discontinuation of medication and/or treatment.

Patient Signature: _____ Date: _____

Patient Printed Name: _____

Witness Signature: _____ Date: _____

Center for Spine & Pain Medicine

Release of Medication Authorization

Due to new regulations in patient confidentiality, it is necessary for you to provide a list of people that you have authorized to pick up your prescriptions, if you are unable to do so. Please list up to 3 people that are over the age of 18. They must present a picture ID upon picking up your prescriptions. We will not release your prescriptions to anyone who we do not have written authorization.

In addition, when you call for your prescriptions to be picked up, if you are not planning to pick your prescriptions up personally, please indicate the name of the designee that will be picking up your prescription. When leaving a message on the refill line, please include the medication information and the name of the person who will be picking up the prescription. If you do not leave the name of the person picking up the prescription, we will assume that you are picking up your prescription and we will not release the prescription to anyone but you.

We appreciate your cooperation in this matter as we strive to provide more excellent care to you as our patient.

Sincerely,

Center for Spine & Pain Medicine

I give the following people authorization to pick up medication/prescriptions on my behalf.

****THEY MUST BE AT LEASE 18 YEARS OF AGE AND HAVE A PICTURE ID****

1. _____
2. _____
3. _____

Patient Signature: _____ Date: _____

Center for Spine & Pain Medicine

URINE DRUG SCREEN TESTING POLICY

Dear Patient,

As you are probably aware, some of the medications we prescribe are "controlled substances" (ex. Oxycodone, Morphine, Hydrocodone, etc.). While regulatory agencies, such as the DEA, The Board of Medical Licensure, and the police require us to monitor our patients who take these medications, most importantly we do it to promote your safety. Therefore, to help provide you with safe and responsible healthcare we will randomly require you to participate in urine drug testing three to four times a year.

Please keep in mind that this may not be the only time you could be required to have a Urine Drug Screen. We consider urine drug testing to be a normal monitoring procedure for anyone taking controlled substances. We monitor controlled substances just like your primary care physician monitors your cholesterol, blood sugar levels and blood pressure.

The billing policy for Urine Drug Screens is as follows:

- ***Patients whose insurance excludes*** Urine Drug Screens will be charged a cash price per test. This fee is expected to be paid at the time of service.
- ***Patients with insurance*** will be billed the amount put to their deductible/coinsurance by their insurance.

We appreciate your cooperation. We are all in this together. If you have any questions, please contact our office.

Patient Signature: _____ Date: _____

Center for Spine & Pain Medicine

FINANCIAL POLICY

The objective of this office is to provide you with the highest quality health care in the most cost-effective manner. However, the ability of *Center for Spine & Pain Medicine,* to achieve this depends greatly on your understanding of our financial policy.

IF YOU HAVE MEDICAL INSURANCE, WE WILL FILE YOUR CLAIMS ON YOUR BEHALF. This is done as a courtesy to our patients. We are glad to help you receive the maximum allowable benefits from your insurance. Even though we will file the insurance claim for you, we also need your active participation in the insurance claims process. Your insurance contract is between you and your insurance company. If your insurance pays only part of your bill or rejects your claim, you are financially responsible for the balance and the balance is due upon receipt of your statement. We also check your eligibility as a courtesy. If your eligibility status changes and we are made aware of the change after you have already been seen, you will be responsible for either providing an alternate insurance or payment of the balance in full. You are responsible to pay your copay/deductibles/coinsurance at the time of service. It is your responsibility to make sure that the insurance information that we have on file is correct. If you get a new insurance card in the mail from your insurance company, please bring it with you to your next appointment.

Authorization for Request of Medical Records

I hereby authorize *Center for Spine & Pain Medicine* physicians to release information from my records verbally, via fax or mail to insurance companies, utilization review companies, lawyers and other physicians. This may include diagnosis and test results, which may include drug, alcohol, psychological conditions and Acquired Immunodeficiency Syndrome.

Authorization to Release Information to Center for Spine & Pain Medicine

I hereby authorize my physicians to release information from my records verbally, via fax or mail to *Center for Spine & Pain Medicine*. This may include diagnosis and test results, which may include drug, alcohol, psychological conditions and Acquired Immunodeficiency Syndrome.

Photography Authorization

I hereby authorize *Center for Spine & Pain Medicine* to take photographs necessary to document my physical condition & identity. The photograph can/will be used for documentation & identity verification only.

Medicare Patients

As a participating provider of Medicare Part B (Physician Services), *Center for Spine & Pain Medicine* will only bill you your Medicare co- insurance, deductible or any services rendered that are not covered by Medicare. All other services will be billed directly to Medicare. PAYMENT FOR SERVICES NOT COVERED BY MEDICARE ARE TO BE PAID THE DAY SERVICE IS PERFORMED. For covered services, you will be responsible for paying your 20% co-insurance amount at the time of service if you do not have secondary insurance. If you have Medicare Part A only our services will not be covered by Medicare and payment is due at the time of service.

HMO/PPO/MANAGED CARE INSURANCE PATIENTS

Many HMO/PPO/Managed Care Plans require that you obtain a referral from your assigned primary care provider to receive care from a specialist. IT IS YOUR RESPONSIBILITY TO OBTAIN THIS REFERRAL IF REQUIRED. Services will be the financial responsibility of the patient if not done properly.

Patients with NO Insurance

ALL PATEINTS WITH NO INSURANCE WILL BE REQUIRED TO PAY FOR THEIR VISIT IN FULL AT THE TIME OF SERVICE. As a courtesy to our cash patients we will give a discount for office visits and injections. If special arrangements are deemed necessary, you will be given information regarding whom to contact to discuss arrangements.

Cancellation Policy

It is the policy of Center for Spine & Pain Medicine to require 48-hour notice for all our patients who wish to cancel their office or procedure appointments. There will be a $25 cancellation fee for office visits and $150 cancellation fee for procedure appointments which are canceled without proper notice. This fee must be paid before scheduling the next visit to our office. This fee is not insurance responsibility.

Financial Responsibility Agreement

FOR AND IN CONSIDERATION of the health care and health care related services and treatment rendered or to be rendered to the patient identified below, and the extension of credit to the patient. I promise to pay in full to *Center for Spine & Pain Medicine* upon demand, all charges incurred (including out- patient or clinic service) at our offices, Ambulatory Surgery Center, and other locations. Payments received from insurance or third-party payers for services rendered will be applied to the patient account. All outstanding balance will be patient responsibility.

I have read this Financial Agreement; understand its terms and conditions and I am signing the agreement voluntary for the purposes stated in this agreement.

Assignment of Benefits

I certify that the information given by me is correct. I hereby authorize payments directly to *Center for Spine & Pain Medicine* of the insurance benefits otherwise payable to me. I understand I am financially responsible to *Center for Spine & Pain Medicine* for any charges not covered by this authorization.

If any Collection Agency or Attorney is utilized in attempt to collect unpaid balances, any fees associated with the collection agency or attorney will be the responsibility of the patient. There will be a 30% collection fee added to any outstanding balance.

_____

Patient Name Signature Date

_____

Authorized Representative Signature Relationship Date

HIPAA Privacy Authorization Form

****1. Authorization****

I authorize **Center for Spine and Pain Medicine** to use and disclose the protected health information described below to the following people.

Name	Relationship	Phone#
Name	Relationship	Phone#
Name	Relationship	Phone#

****2. Effective Period****

This authorization for release of information covers the period of healthcare from:

a. ☐ _____ to _____ Specific Date Range. **OR** b. ☐ all past, present, and future periods.

****3. Extent of Authorization****

a. □ I authorize the release of my **COMPLETE** health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

****OR****

b. □ I authorize the release of my complete health record except for the following information:
□ Please Specify:

_____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until **12/31/2020**, at which time this authorization expires**.**

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the Insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

9. A copy of CSPM Privacy Practices is available upon request and is also posted in the lobby.

Patient Signature: _____ Date: _____

Printed name of patient or personal representative: _____

E-PRESCRIBING CONSENT FORM

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy from the point of care. E-Prescribing greatly reduces medication errors and enhances convenience for the patient while maximizing patient safety. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribe program.

These include:

• Formulary and benefit transactions – Gives the prescriber information about which drugs are covered by the patient's drug benefit plan.

• Medication history transactions – Provides the physician with information about medications the patient is already taking to minimize adverse drug events.

• Fill status notification – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription needs to be refilled, has been picked up, not picked up, or partially filled.

By signing this consent form, you are agreeing that Center for Spine & Pain Medicine, can electronically transmit your prescriptions directly to your pharmacy. E-Prescribing is an optional service and you may choose to decline. Please note that consenting to E-Prescribing also permits the use of your prescription medication history from other healthcare providers and/or third-party benefit payors (i.e., your insurance company) for treatment purposes only. Understanding all of the above, I hereby provide informed consent to Center for Spine & Pain Medicine to enroll me in the E-Prescribe Program. This authorization will remain in effect until otherwise requested by the patient.

_____ _____

Signature of Patient Date of Birth

_____ _____

Print Patient Name Today's Date

Advance Directive

By signing this form, I acknowledge that I have marked the appropriate box with regards to an Advanced Directive.

- ☐ I have executed an advanced directive or living will and will make a copy available for my records.
- ☐ I have not executed an advanced directive or living will but would like more information.
- ☐ I have not executed an advanced directive or living will and would not like more information.

Patient Name: _____

Date of Birth: _____

Patient Signature: _____

Date Completed: _____

To Be Completed by Employee

- ☐ Advanced Directive forms given to patient as requested.
- ☐ Chart marked with information given by patient
- ☐ This signed form scanned into patient's chart

Completed by: _____

PAIN MANAGEMENT INITIAL EVALUATION

Patient Name: _____ Date: _____

Referring Physician: _____ Date of Birth: _____ Age: _____

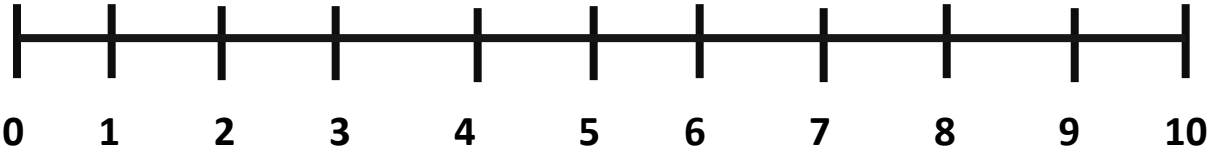
Primary Care Physician: _____ Sex: ☐ Male ☐ Female

Location of your pain _____

Date your pain first started _____

What caused your pain _____

How intense is your pain?



NO Pain **Moderate Pain** **Worst Possible Pain**

Describe your pain (circle the most descriptive words)

Constant / Intermittent (Sometimes): Stabbing - Shooting - Sharp - Dull - Aching
Tingling- Numbness - Throbbing - Burning

My pain is made WORSE by (circle the most descriptive words):

Laying - Sitting – Standing - Walking - Exercise - Bending - Lifting - Cold Weather

My pain is made BETTER by (circle the most descriptive words):

Sitting - Standing - Walking - Repositioning - Lying - Exercise - Medications - Heat - Ice

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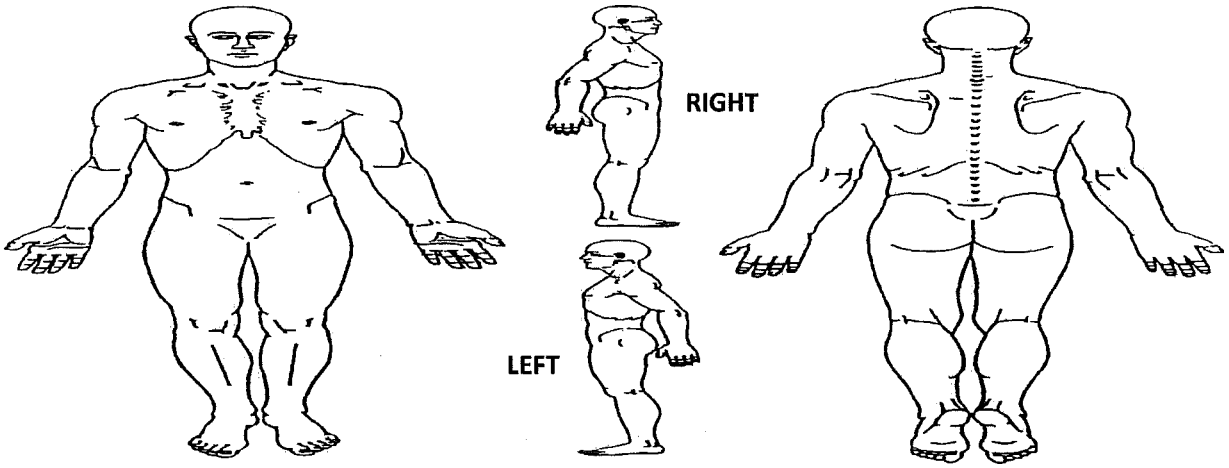
Using the drawing below, please shade all the areas of pain as specifically as possible.



FRONT **BACK**

Has your pain affected any of the following? If yes, please describe how it has affected you.

O Daily Activities _____ O Weight _____

O Sleep _____ O Mood Nerves _____

O Relationships _____ O Work (Job) _____

Which diagnostic tests have you had for your pain? Please list where and when you had these tests performed.

O X-Rays _____ O CT Scan _____

O UltraSound _____ O Bone Scan _____

O MRI _____ O EMG/NCS _____

Have you tried any of the following to help manage your pain? Did it help? Y-Yes N-No

O Bed Rest	Y/N	O TENS Unit	Y/N	O Exercise Program	Y/N
O Traction	Y/N	O Biofeedback	Y/N	O Physical Therapy	Y/N
O Heat Therapy	Y/N	O Acupuncture	Y/N	O Psychotherapy	Y/N
O Ultrasound	Y/N	O Chiropractor	Y/N	O Work Hardening	Y/N

Pain Management Procedures

Have you tried any of the following pain management procedures in the past? If you have please list when and where you had these procedures performed. Did it help? Y- Yes N- No

O Joint Injections _____ Y/N

O Trigger Point Injections _____ Y/N

O Nerve Block Injections _____ Y/N

O Spinal/Epidural Injections _____ Y/N

O Spinal Cord Stimulator _____ Y/N

O Internal Narcotic Pump _____ Y/N

Medication History

Please ONLY check the medications you have tried in the past to help manage your pain and if they helped.

O**Ibuprofen**	**Y/N**	O**Flexeril**	**Y/N**	O**Lyrica**	**Y/N**	O**Sonata**	**Y/N**
O**Naproxen**	**Y/N**	O**Robaxin**	**Y/N**	O**Risperdal**	**Y/N**	O**Ambien**	**Y/N**
O**Relafen**	**Y/N**	O**Soma**	**Y/N**	O**Pristiq**	**Y/N**	O**Lunesta**	**Y/N**
O**Arthrotec**	**Y/N**	O**Zanaflex**	**Y/N**	O**Savella**	**Y/N**	O**Klonopin**	**Y/N**
O**Celebrex**	**Y/N**	O**Valium**	**Y/N**	O**Midrin**	**Y/N**	O**Restoril**	**Y/N**
O**Mobic**	**Y/N**	O**Roxicodone**	**Y/N**	O**Fioricet**	**Y/N**	O**Ativan**	**Y/N**
O**Tramadol**	**Y/N**	O**Dilaudid**	**Y/N**	O**Amerge**	**Y/N**	O**Xanax**	**Y/N**
O**Tylenol**	**Y/N**	O**Percocet**	**Y/N**	O**Imitrex**	**Y/N**	O**Topamax**	**Y/N**
O**Hydrocodone**	**Y/N**	O**Oxycontin**	**Y/N**	O**Maxalt**	**Y/N**	O**Neurontin**	**Y/N**
O**Demerol**	**Y/N**	O**MS Contin**	**Y/N**	O**Zomig**	**Y/N**	O**Cymbalta**	**Y/N**
O**Stadol**	**Y/N**	O**Kadian**	**Y/N**	O**Trazodone**	**Y/N**	O**Butrans**	**Y/N**
O**Baclofen**	**Y/N**	O**Duragesic**	**Y/N**	O**Elavil**	**Y/N**	O**Exalgo**	**Y/N**
O**Skelaxin**	**Y/N**	O**Methadone**	**Y/N**	O**Remeron**	**Y/N**		

Past Medical History

Which of the following do you have or have you had in the past?

O Stroke	O Reflux	O Osteoporosis	O Seizures
O Ulcers	O Cancer	O Migraines	O Diverticulitis
O Hepatitis	O Asthma	O Diabetes	O HIV
O Emphysema	O Liver Disease	O Syphilis	O Gonorrhea
O Heart Disease	O Kidney Disease	O Drug/Alcohol Abuse	O Gout
O Bronchitis/Sinusitis	O Arthritis	O High Blood Pressure	O Congestive Heart Failure
O Parkinson's Disease	O Currently Pregnant	O Trying to become Pregnant	

Past Surgical History

Which, if any, of the following have you had? ***Please include the approximate date.***

O Brain Surgery	O Stomach Surgery	O Blood Vessel Surgery
O Facial Surgery	O Gallbladder Surgery	O Spine Surgery Neck
O Eye Surgery L or R	O Bowel Surgery	O Spine Surgery Back
O Oral Surgery	O Appendectomy	O Shoulder Surgery L or R
O Tonsillectomy	O Hand/Wrist Surgery L or R	O Hernia Repair
O Thyroid Surgery	O Kidney Surgery L or R	O Hip Surgery L or R
O Lung Surgery	O Bladder Surgery	O Knee Surgery L or R
O Heart Surgery	O Tubal Ligation	O Foot Surgery Lor R
O Hysterectomy		

Please list and indicate current dosage and frequency of ALL medications currently being taken including herbs, vitamins, and supplements.

Name of Medication	Dosage	Frequency

List ALL your medication allergies and their reactions:

Medication	Reaction	Other allergies:
		Are you allergic to latex? Y/N
		Are you allergic to metals? Y/N
		Are you allergic to tape? Y/N
		Are you allergic to any vaccines? Y/N

Family History
Grandparents, Parents, Brothers, Sisters

O Stroke	O Reflux	O Osteoporosis
O Seizures	O Ulcers	O Cancer
O Migraines	O Diverticulitis	O Other: _____
O Asthma	O Diabetes	O Other: _____
O Emphysema	O Liver Disease	O Other: _____
O Heart Disease	O Kidney Disease	O Other: _____
O Congestive Heart Failure	O Arthritis	O Other: _____
O High Blood Pressure	O Gout	O Other: _____
O COPD	O High Cholesterol	O Other: _____

Social History

Marital Status: O Single O Married O Divorced O Widowed

Living Situation: O Alone O W/Spouse O Family/Friend O Homeless

Your Habits: O Alcohol O Tobacco O Caffeine O Illicit Drugs

If you use tobacco, do you O Smoke O Dip/Chew How much??_____

Work Status

Are you currently: O Employed O Unemployed O Disabled O Retired
O Full Time or O Part Time

If you are disabled, is it O Long Term O Short Term

On what date did you become disabled:

Are you being treated for a Work Camp Injury? O Yes O No

Are you being treated for an automobile accident? O Yes O No

Are there legal issues to your pain problem? O Yes O No

Have you retained an attorney? O Yes O No

Name of your Attorney: _____

Address of your Attorney: _____

Phone#: _____ Fax#: _____

In your own words please describe what type of work you do or were doing prior to your injury

_____

_____

_____

_____

_____

Review of Systems

Check all that you have

General
- O Good general health lately
- O Poor Sleep
- O Fatigue

Cardiovascular
- O Angina
- O Fluid retention
- O Cardiac arrythmia
- O Heart murmur

Respiratory
- O Asthma
- O Chronic cough
- O Shortness of breath
- O Wheezing

Musculoskeletal
- O Neck pain
- O Back pain
- O Difficulty walking
- O Joint pain
- O Joint stiffness
- O Joint swelling
- O Muscle Cramps

Neurological
- O Lightheaded or dizzy
- O Stroke
- O Head Injury
- O Paralysis
- O Frequent Headaches
- O Memory Loss
- O Seizures
- O Tingling/Numbness
- O Tremors