NAME:____
Last *First* *Middle initial*

Birthdate______________________ **SSN** ________________________ **Sex:** □Male □Female

Address:____

City: ____ **State**: ________________ **Zip** _____

Home Phone (_________) _________________ **Cell** (________) _______________ **Work** (_________) _________

Email: ____

Emergency Contact: _________________________________ **Phone number**: (________) ___________________

Relationship: _____________________________

Pharmacy: ____ **Phone** (________) _______________________

Address _________________________________ **City** _________________ **State** ____________ **Zip** ________

Marital Status: □ Single □ Married □ Widowed □ Partnered □ Divorced □Separated

Tobacco Use: □ Former □ Never □ Current ______pack(s)/day **How many years**? _______

Alcohol use: □ No □ Yes **Illicit drug use**: □ No □ Yes

Race: □ Caucasian □ African American □ Asian □ Hispanic □ Mixed race

□ Indian □ Other____________________

Ethnicity: □ Hispanic □ Non-Hispanic □ Caucasian □ African American

Preferred Language: □ English □ Spanish

Is there a chance you may be pregnant: □ Yes □ No

PHYSICIAN INFORMATION

Primary Care Physician: ____ **Phone** (________) ______________

Address _________________________________ **City** _________________ **State** __________ **Zip** _______

Referring Physician: ____ **Phone** (________) ______________

Address _________________________________ **City** __________________ **State** __________ **Zip** __________

INSURANCE INFORMATION:

Primary Insurance Carrier: _____________________________ **Policy ID #**: ______________________________

Secondary Insurance Carrier: ____________________________ **Policy ID #**: ______________________________

Tertiary Insurance Carrier: ______________________________ **Policy ID #**: ______________________________

Consent for Purposes of Treatment, Payment & Healthcare Operations

I consent to the use or disclosure of my protected health information by the Center for Interventional Pain Spine for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills. I understand that analysis, diagnosis or treatment of me by the Center for Interventional Pain Spine may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Center for Interventional Pain Spine is not required to agree to the restrictions that I may request. However, if Center for Interventional Pain Spine agrees to a restriction that I request, the restriction is binding. I have a right to revoke this consent, in writing at any time except to the extent that Center for Interventional Pain Spine has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, or my employer. This protected health information related to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have full access to view, and request a copy if needed, the Notice of Privacy Practices of the Center for Interventional Pain Spine. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of the Center for Interventional Pain Spine. The Notice of Privacy Practices for the Center for Interventional Pain Spine is posted in the waiting room. This Notice also describes my rights and duties of the practice with respect to my protected health information.

Center for Interventional Pain Spine reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Center for Interventional Pain Spine and requesting a revised copy be sent in the mail or asking for one at the time of my appointment.

Acknowledgement of Privacy Statement

I acknowledge receipt of the Notice of Privacy practice from Center for Interventional Pain & Spine. I understand that it is my responsibility to read the information provided therein.

Signature: ____ **Date** __________

Authorization and Assignment of Benefits

I authorize the release of any medical or other information necessary to process the insurance claim(s) for services rendered by Center for Interventional Pain & Spine LLC. I request payment of government benefits, if applicable, to the party who accepts assignment. I authorize payment of medical benefits to Center for Interventional Pain & Spine. I understand that even though I may have insurance coverage, I am ultimately responsible for payment of services rendered.

Signature: ____ **Date** __________

Appointments and Prescriptions

Should it become necessary, the following people have my permission to schedule, confirm, cancel or reschedule an appointment for me. They may also pick up prescriptions, refills, samples or anything that I have requested from the Center for Interventional Pain Spine as long as they provide valid photo ID. *NO medical information will be given.* I understand that if I need to change this information, it is my responsibility to request this in writing.

1) **Name** ______________________________________ **Relationship**: _________________

   Phone No. __________________________________

2) **Name** ______________________________________ **Relationship**: __________________

   Phone No. __________________________________

Signature ____ **Date**: _____________________

Release of Medical Information

Should it become necessary, the Center for Interventional Pain Spine and medical staff have my permission to discuss my health information, including test results, with the individuals listed below. The people that are listed below are also authorize for the above statement regarding appointments and prescriptions. I understand that if I need to change this information, it is my responsibility to request this in writing.

1) **Name** ______________________________________ **Relationship**: _________________

   Phone No. __________________________________

2) **Name** ______________________________________ **Relationship**: __________________

   Phone No. __________________________________

Signature ____ **Date**: _____________________

Financial Policy

Insurance Referrals
Our office will not see a patient without the proper referrals from your insurance company, please check with your primary care physician to make sure all referrals have been completed and also keep track of the number of visits authorized as it is the *patient's responsibility.*

Attendance Policy/No Show Fees
Three consecutive or accumulated "No Show" appointments will result in being discharged from this practice. A patient who is more than 15 minutes late for an appointment may be considered a no show. If you cancel your procedure at one of our surgery centers within less than 24-hour time frame or do not show, you will be charged a fee of $100. 00.

Self-Pay Patients/Non-Covered Services
Insurance companies do not pay for all medical services, even those that might be helpful to the patient. When a service is not covered by your insurance policy, you are responsible for the amount owed. Patients who do not have an insurance policy will be required to make a payment at the time services are rendered.

Change of Information
In order to bill your insurance carrier accurately and in a timely manner, we require you to provider our office with the following.

- Accurate Demographic Information (insurance coverage, address, phone number)
- A copy of your current insurance card (required to be presented at every visit)
- If your visit is related to an injury, you are required to provide ALL of the following information: date of injury, state of injury, injured body part, name of the insurance carrier, name and phone number of insurance adjustor, insurance policy number, and applicable attorney information.

It is the responsibility of the patient to notify us of any changes with information (insurance, phone number and/or address), and any changes in primary care physicians or other treating physicians. **If insurance claims are denied and not paid due to incorrect, outdated or insufficient information provided by the patient, the outstanding balance will become the patient's responsibility.**

Other Fees
Medical Records: Request for personal copies of medical records will take 3-5 business days to be completed. A processing fee up to $25.00 will be due at the time of request.
Medical forms will take 5-10 business days to complete; there is also a fee depending on the length and complication of the form ranging up to $25.00 and higher.
Bounced check fee is $40.00

Signature: ____ **Date** __________

Consent for Chronic Opioid Therapy

In the chance that Center for Interventional Pain Spine will prescribe opioid medication/narcotic analgesics to me, the decision was made because my condition is serious or other treatments have not helped my pain.

I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breath rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction, and possibility that the medicine will not provide complete pain relief.

I understand that suddenly stopping some pain medicines can result in withdrawal symptoms, heart attack, stroke, seizures, permanent damage, disability or death.

I recognize my chronic pain represents a complex problem and chronic opioid therapy is only one part of my overall pain management plan. I understand my condition may also benefit from physical therapy, psychotherapy, behavioral medicine and other pain control strategies. I agree to cooperate and actively participate in all aspects of the pain management program to maximize functioning and improve coping with my condition.

I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug, and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine is very low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge.

Patient Printed Name: ____

Patient Signature: ______________________________ **Date:** ____________

Opioid Patient Prescriber Agreement (PPA)

This Opioid Patient/Prescriber Agreement (PPA) is designed to:

- Create an open conversation between the patient and the prescriber about the benefits, risks, and limitations of opioid medicines
- Be used as a decision-making tool before an opioid medicine is used for acute or persistent pain
- Ensure the appropriate and safe use of opioid medications

Part 1: For the Patient: Deciding whether to use opioid medications for pain. Each item will be discussed with my prescriber:

1. Pain and pain treatment are different for each person. Opioid medicines are a type of analgesic (pain reliever) medicine used to reduce moderate to severe pain. Opioid medicines can reduce some (but not all) types of pain. It is not known how much improvement in pain, activity and quality of life I may have by using these medicines. My prescriber will routinely check how I am doing to determine whether the benefits of opioid medicines outweigh the side effects of continuing to use them.

2. My goal with opioid medication use are to reduce pain, making it easier to do things including but not limited to:

- Go back to work
- Sleep through the night
- Climb stairs
- Daily household chores
- Walk short distances
- Perform a light exercise program

3. My prescriber and I may also try alternative treatment options for my condition, including but not limited to:

- Non-opioid medicines (for example, over-the-counter medicines such as Tylenol®, Motrin®, Aleve®), prescription medicine such as antidepressants, or anticonvulsants, as appropriate
- Physical therapy, appropriate exercises
- Acupuncture; Manipulation

- Self-management techniques and coping strategies such as meditation, stress reduction, counseling and coaching, massage therapy, social support group, and attention to proper sleep
- Surgical or other medical procedures

4. I need to be aware of the following side effects of using opioid medications

- Physical dependence - If I suddenly stop taking an opioid medicine, I may experience withdrawal symptoms such as a runny nose, chills, body aches, diarrhea, sweating, nervousness, nausea, vomiting and trouble sleeping. This is called physical dependence. If this happens, it can be difficult for me to stop taking an opioid medicine, even if it's not working well. So, when I discontinue use of an opioid medicine, I understand I will need medical supervision. My prescriber will assist in me gradually lowering the dose and discontinue the opioid medication or refer me to the necessary specialist.
- Tolerance - Over time, I may need more opioid medicine to provide the similiar pain relief. This is referred to as tolerance. It means that the opioid medicine may begin to feel like it's not working anymore. My prescriber can help me by making changes to the opioid medicine or refer me to the necessary specialist.
- Addiction - I may develop an intense craving for the opioid medicine, even if I take it as prescribed. When a person is not able to control their opioid medicine use and continues using the medicine despite the side effects, this is called addiction. If addiction occurs, it can be difficult to stop taking the opioid medicine, and I will need medical supervision. My prescriber can assist me in gradually lower the dose in order to discontinue the opioid medicine or refer me to the necessary specialist.

5. Opioid medicine can impair my judgment and responses. I understand that I must be cautious if I drive or operate machinery or do any activity that requires me to be alert until I am sure I can perform such activities safely.

6. Taking even small amounts of alcohol or taking medicines such as sleeping pills, antihistamines, and anti-anxiety medicines while taking an opioid medicine will increase the chance of opioid medicine side effects. These side effects can include drowsiness, dangerously slowed breathing, and decreased alertness.

7. It may be necessary that I routinely provide a urine, saliva, or blood sample before or while I am taking opioid medicine.

8. I agree to abide by the random pill count policy which requires I bring all of my medication into the office within the allotted timeframe provided to me by the office.

9. I agree to discuss with my prescriber my and my family's past and present use of any habit-forming substances before we decide to try to treat my condition with an opioid medicine. These habit-forming substances can include tobacco and alcohol, as well as other opioid medicines or street drugs.

10. Opioid Side Effects: The table below lists common and potential opioid side effects in alphabetical order and the percentage of patients that experience them.

OPOID SIDE EFFECTS	**PERCENTAGE OF PATIENTS**
Addiction	5-30%
Breathing problems during sleep/Disruption of sleep	25%
Confusion	*
Constipation	30-40%
Depression	30-40%
Drowsiness	15%
Dry mouth that can cause tooth decay	25%
Intestinal blockage	<1% per year
Itching	*
Lowered testosterone levels, infertility, and impotence	25%-75%
Nausea or vomitting	*
Overdose, can lead to death	<1% per year
Physical dependence	*
Tolerance	*
Unexpected increased pain	*

**Percentage of patients experiencing side effect unknown*

11. My prescriber and I have discussed all the information above and have made a decision about using opioid medicines.

Part 2: For the Patient: My obligation to using opioid medicines safely

Now that my prescriber and I have agreed that I will try an opioid medicine, I understand that I need to take an active role in my own health care to get the most benefit and reduce the chance of side effects from using an opioid medicine. My prescriber wants me to have the following information so that I may have the best possible pain reduction while also protecting my health and reducing the chances of possible harm to myself and others while I am taking an opioid medicine.

12. I told my prescriber about all the medicines I am taking, including any prescription, over the counter and herbal medicines. I will also discuss with my prescriber any new medicine that I take in the future. Some medicines and other substances such as alcohol, sleeping medicines, antihistamines and anti-anxiety medicines can increase the chance of opioid medicine side effects. If I use these medicines along with an opioid medicine, they can slow my breathing. This can lead to serious problems, including an increased chance of stopping breathing and death.

13. If I start to have more pain or other unusual or severe side effects, I will contact my prescriber right away. We may need to change the dose or try a different opioid medicine. I will not make any changes to the opioid medicine without first talking to my prescriber.

14. I will tell my prescriber if I am pregnant or planning to become pregnant. Taking opioid medicine during pregnancy can harm my unborn baby.

15. I will not share this opioid medicine with other people. My prescriber and I have selected this opioid medicine for me, and it is only for me. It is against the law to share an opioid medicine with other people. Sharing an opioid medicine with another person can cause serious harm to them, including death.

16. I will keep my opioid medicine in a secure place where other people cannot reach it. If someone accidently takes some of my opioid medicine or I accidentally take too many doses, I will contact my prescriber or call the Poison Control Center at 1-800-222-1222.

17. I will remove expired, unwanted, or unused opioid medicine from my home to avoid accidentally harming children, other adults, or myself, and correctly dispose of them.

- I may be able to drop off unused opioid medicine through a “medicine take-back program”. A “medicine take-back program” is an official place and time for dropping off unused opioid and other medicines.
- If I cannot find a “medicine take-back program” or if I want to remove the medicine from my home right away, I can flush my opioid medicine down the toilet.

- My opioid medicine can also be mixed with cat litter or coffee grounds and thrown out with the household trash.

- I can get more information about disposing of my opioid medicine by calling 1-888-FDA-INFO (1-888-463-6332) or at the following website http://www.fda.gov/drugs/resourcesforyou/consumers/buyingusingmedicinesafely/ensuringsafeuseofmedicine/safedisposalofmedicines/ucm186187. htm

Patient Printed Name: ____

Patient Signature: ________________________________ **Date:** _____________