DATE:___/____/____

LAST NAME: _____ FIRST NAME:_____

DOB: ____/____/_____ AGE: _____ GENDER: M__ F__

STREET ADDRESS:_____CITY/STATE/ZIP:_____

HOME PHONE: _____ CELL: _____ WORK: _____

EMAIL:_____ PREFERRED CONTACT METHOD: _____

SSN: _____-_____-_____ RACE:_____ LANGUAGE:_____

EMERGENCY CONTACT/RELATIONSHIP TO PT: _____ PHONE: _____

POLICY HOLDER'S NAME: _____ POLICY HOLDER'S DOB: ____/____/_____

POLICY HOLDER'S SSN: _____-_____-_____ RELATIONSHIP TO PT: _____

REFERRING PHYSICIAN: _____ PRIMARY CARE PHYSICIAN: _____

PHARMACY NAME/ LOCATION: _____

OCCUPATION: _____
IS THIS VISIT RELATED TO AN AUTOMOBILE OR WORKMAN'S COMP ACCIDENT? Y___ N___
ACCIDENT DATE: _____/_____/_____

RELEASE OF INFORMATION AND FINANCIAL CONDITIONS:

I hereby authorize Halina Snowball, M.D. to release information concerning this illness or injury to my insurance carriers or other parties responsible for payment. In addition, I authorize copies of all reports to be forwarded to my referring physicians, unless otherwise instructed.

In regards to managed care plans, I understand that it is my responsibility to request referrals from my primary care doctor in ADVANCE, and to be aware of the amount of allowable visits per referral. If a proper referral has not been obtained in ADVANCE, no appointment will be scheduled except in cases where payment is made at the time of service for services rendered.

I HAVE READ THE ABOVE AND AGREE TO THE TERMS.

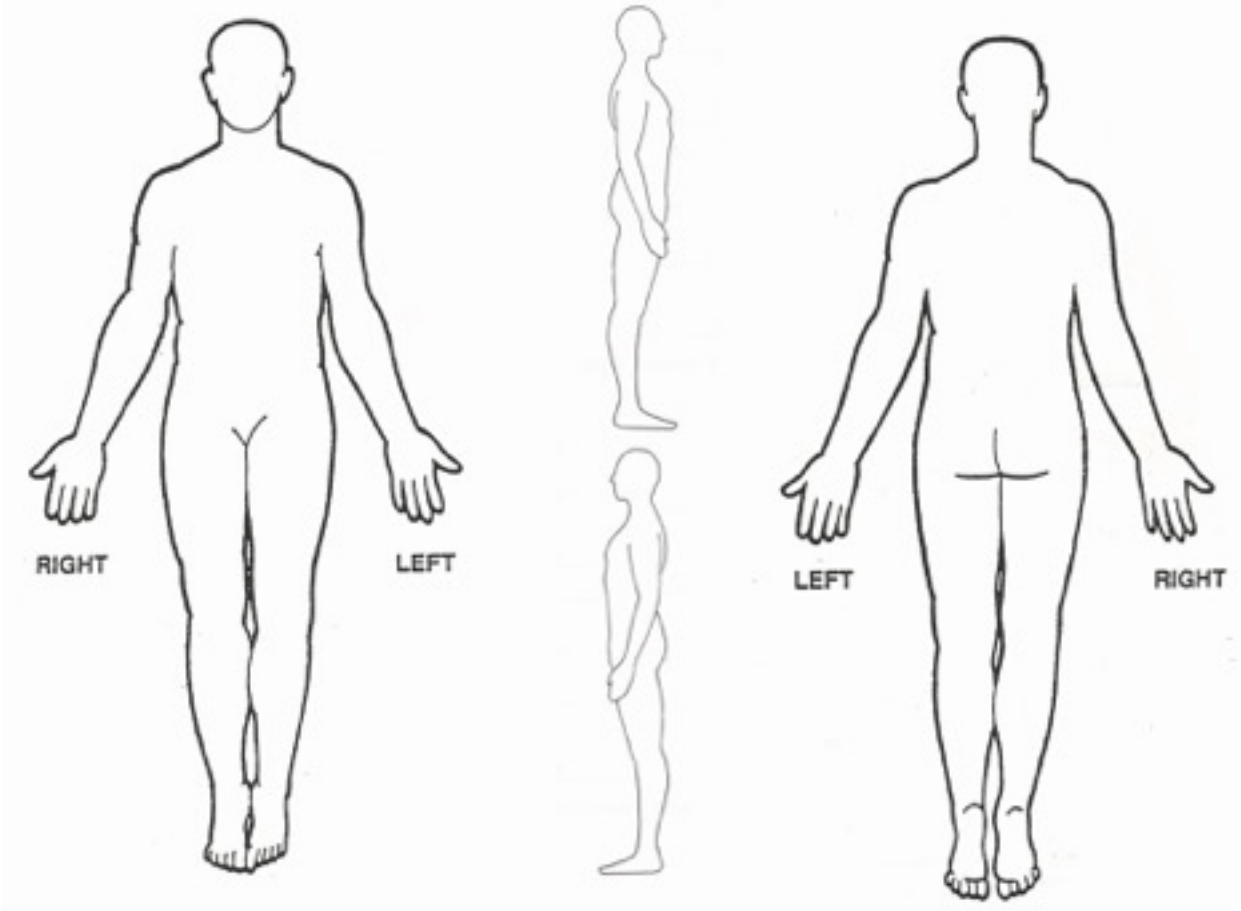
_____

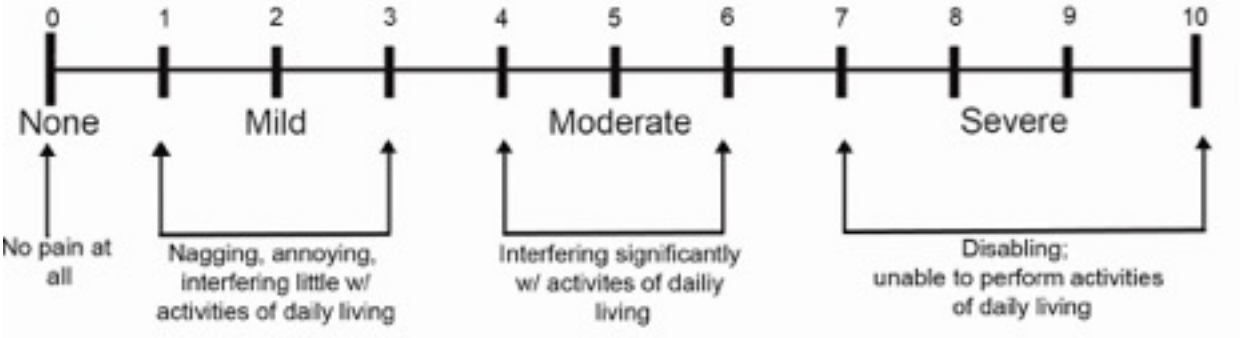
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

INTEGRATED PAIN SOLUTIONS
NON-SURGICAL MEDICAL CENTER

Name: Date:

A = ACHE B = BURNING N = NUMBNESS P = PINS AND NEEDLES S = STABBING





2015 WEST MAIN STREET, SUITE 350 STAMFORD CONNECTICUT 06902 T 203 863 4588 F 203 863 4587

Acknowledgement of Receipt of Notice of Privacy Practices

Name of Patient: _____

I hereby acknowledge that I have read this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print name: _____ Telephone: _____

If not signed by the patient, please indicate your relationship to the patient:

_____

For office use only:

- ❑ Signed form received by: _____
- ❑ Acknowledgment refused:

  Efforts to obtain:

  _____

  _____

  Reason for refusal:

  _____

  _____

CONTROLLED SUBSTANCE AGREEMENT-INFORMED CONSENT FORM

The following agreement relates to my use of controlled substances including but not limited to "narcotics/opioids," to treat chronic pain. I will be provided with prescriptions only if I understand and agree to the following:

1. I understand that, depending on the drug and dose, I can become physically dependent on the medication and can develop withdrawal symptoms if the medication is stopped suddenly or the dose reduced rapidly. Although the risk is small there is a chance of developing an addiction to controlled substances if I am placed on them to help control my pain.

2. Controlled substances can cause sedation, confusion, or other changes in mental state and thinking abilities. I understand that the decision to drive while I am taking controlled substances is my own decision, and I agree not to be involved in any activity that may be dangerous to me or someone else such as driving or operating any dangerous equipment, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself if I am in any way sedated, feel drowsy or a not thinking clearly.

3. I will not use any illegal controlled substances including, but not limited to, marijuana and cocaine. I will not drive while intoxicated with alcohol.

4. The *Integrated Pain Solutions* policy regarding the dispensing of controlled substances requires that I be seen regularly and I agree to make and keep my appointments. I will advise my doctor of all other medicines and treatments that I am receiving.

5. If the medication requires adjustment, an appointment must be made to see the doctor. No adjustments will be made over the telephone. My careful planning is required. I understand that medication refills and adjustments are done during office appointments except under very unusual circumstances. I must stay with the prescribed dosing so that I do not run out of medication early. The medication is expected to last until the GOOD UNTIL date that is found on the bottom of the prescription. I understand that the *Integrated Pain Solutions* policy is not to prescribe early. I agree that I will use my medication

exactly as prescribed and that if I run out early, I may go without medication until the next prescription is due, possibly resulting in withdrawal symptoms.

6. I understand that the prescriptions are my responsibility once they are placed in my hand and that if anything happens to my prescription (lost, stolen, accidentally destroyed), I may not receive a replacement from my physician. *Integrated Pain Solutions* expects me to file a police report if my medication is stolen. I will be prepared to bring in a copy at my next office visit.

7. My physician will prescribe whatever medication he/she is comfortable with and thinks best; he/she is not under any obligation to prescribe any specific medication.

8. I am aware of the possible risks and benefits of other types of treatments that do not involve the use of opioids. The other treatments discussed included: injections, therapy, and surgery (if indicated).

9. I agree to come to the *Integrated Pain Solutions* with my medication on the same day that I am called and submit to a pill count, and/or urine or blood screening to detect illegal substances or confirm proper use of prescribed medicine. The call to come to the *Integrated Pain Solutions* can be made either randomly, or if a concern arises. I may be required to bring my unused medication routinely to each office visit. If I do not have insurance or my insurance denies testing, I will be responsible for the cost of the test.

10. I give permission to the *Integrated Pain Solutions* staff to call any pharmacy or another health care provider at any time, without my being informed, to discuss my past or present use of controlled or illegal substances.

11. I will not use my pain medication in higher than prescribed amounts for new problems that arise (toothache, surgery, etc.) unless authorized to do so. I will inform my other doctor(s) of my use of medication for chronic pain, and I will inform the *Integrated Pain Solutions* staff if another physician prescribes controlled substances for the acute problem. My doctor *Integrated Pain Solutions* is my primary doctor with regard to my pain medications. If there is a medical emergency (e.g. broken leg, surgery requiring post-op pain medication, dental procedures, etc.), another doctor may prescribe pain medication to me, but I will advise the prescribing doctor of my care at *Integrated Pain Solutions*, authorize the doctor to disclose information to

Integrated Pain Solutions, and I will also notify my doctor at *Integrated Pain Solutions* of the medication and dosage.

12. **(Females only)** Because of the risks of certain medications to unborn children, I will inform all physicians, obstetrician/ gynecologist and *Integrated Pain Solutions*, immediately if I become pregnant or decide to try to become pregnant. I am aware that should I carry a baby to delivery while taking these medicines, the baby will be physically dependent upon opioids. I am aware the use of opioids is not generally associated with risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

13. **(Males only)** I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

14. My physician can wean me off of controlled substances at any time if he/she feels that it is in my best interest. The weaning process can result in withdrawal symptoms. If I am weaned off, the *Integrated Pain Solutions* staff may inform my other health care providers as to the reasons for the weaning.

15. Abstinence Syndrome (Withdrawal Syndrome): Stopping my opioid, anti-seizure or antidepressant medication abruptly may result in withdrawal symptoms (flu-like symptoms, GI distress, diarrhea, sweating, heart palpitations, and rarely seizures or death). I should wean from my medications rather than stopping them abruptly. If I find myself without medication, I will use the emergency line to notify my doctor.

16. I understand that in general I may be weaned off of my medication or my drug therapy may be terminated at the discretion of my physician if any of the following occur:

    - It is the opinion of my physician that controlled substances are not very effective for my pain and/or my functional activity is not improved.

    - I misuse the medication.

- I develop rapid tolerance or loss of effect from this treatment.
- I develop side effects that are significant and detrimental to me.
- I obtain controlled substances from sources other than my *Integrated Pain Solutions* physician without informing him or her.
- Pill counts or test results indicate the improper use of the prescribed medication or the use of other drugs, and/or I fail to submit to such counts/tests on the day that I am called.
- I am arrested and/or convicted for a controlled or illicit drug violation including drunk driving.
- Any violation of this agreement.

17. I further understand that my drug therapy will be terminated or detoxification in a controlled environment will be required if I give away, sell, distribute and/or transport with the intent to sell or dispense my medication.

18. I choose to use _____ Pharmacy, located at _____, for all of my pain medication prescriptions. I will not fill partial prescriptions, if my pharmacy does not stock the full quantity of medication. If I change my pharmacy for any reason, I agree to notify my pain physician.

I have read the above Agreement, understand the Agreement, have had all my questions concerning this Agreement answered to my satisfaction, and I agree to abide by the terms of this Agreement if I am placed on controlled substances (including, but not limited to narcotic analgesics). I have received a copy of the Agreement. By signing this form voluntarily, I give my consent for the treatment of my pain with narcotic/opioid pain medicines.

_____ _____
Patient Signature Date

_____ _____
Physician Signature Date

_____ _____
Witness Signature Date

PATIENT WAIVER FORM

I hereby attest that I am an eligible member of the health plan listed below.

I agree that should it be determined that I am ineligible for coverage OR if one or more services performed today are denied by my health plan, I will be responsible for payment to Halina Snowball, MD and/or Pain Management for any ineligible, non-covered or partially covered services up to the stated allowable amount. I also agree that I will not hold my insurance company responsible for the denied services.

HEALTH PLAN: _____

PATIENT NAME: _____

SUBSCRIBER NAME: _____

SIGNATURE OF RESPONSIBLE PARTY: _____

DATE OF SERVICE: _____

WAIVER01/12

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24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Integrated Pain Solutions reserves the right to charge a fee. Due to high patient demand, and limited availability of appointments we have instituted a $50.00 charge for missed appointments ("no shows") and appointments which absent of a compelling reason, are not cancelled with a 24-hour advance notice.

"No show" fees will be billed to the patient. The fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "no shows" in any 12 month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____

Printed Name

_____ _____

Signature Date

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PATIENT NAME: _____ DATE: _____

Family History- Please check all that apply

Father: Alive__ Deceased__
Inherited Disease__ Cancer__ Diabetes__ Epilepsy__ Heart Trouble__ Kidney Trouble__
Sickle Cell Disease__ Mental Illness__ Stroke__ Tuberculosis__ Bleeding Problems __

Mother: Alive Deceased
Inherited Disease__ Cancer__ Diabetes__ Epilepsy__ Heart Trouble__ Kidney Trouble__
Sickle Cell Disease__ Mental Illness__ Stroke__ Tuberculosis__ Bleeding Problems__

Paternal Grandmother: Alive__ Deceased__
Inherited Disease__ Cancer__ Diabetes__ Epilepsy__ Heart Trouble__ Kidney Trouble__
Sickle Cell Disease__ Mental Illness__ Stroke__ Tuberculosis__ Bleeding Problems__

Paternal Grandfather: Alive__ Deceased__
Inherited Disease__ Cancer__ Diabetes__ Epilepsy__ Heart Trouble__ Kidney Trouble__
Sickle Cell Disease__ Mental Illness__ Stroke__ Tuberculosis__ Bleeding Problems__

Maternal Grandmother: Alive__ Deceased__
Inherited Disease__ Cancer__ Diabetes__ Epilepsy__ Heart Trouble__ Kidney Trouble__
Sickle Cell Disease__ Mental Illness__ Stroke__ Tuberculosis__ Bleeding Problems__

Maternal Grandfather: Alive__ Deceased__
Inherited Disease__ Cancer__ Diabetes__ Epilepsy__ Heart Trouble__ Kidney Trouble__
Sickle Cell Disease__ Mental Illness__ Stroke__ Tuberculosis__ Bleeding Problems__

INTEGRATED PAIN SOLUTIONS
NON-SURGICAL MEDICAL CENTER

SOCIAL HISTORY

Are you a smoker? _____Yes ____No

If yes, how often?

- ❑ Fewer than one pack daily
- ❑ About one pack daily
- ❑ More than one pack daily

If yes, how long?

- ❑ Less than 5 years
- ❑ 5-10 years
- ❑ More than 10 years

Do you drink caffeine? ____Yes ____No

If yes, how often?

- ❑ 2-3 drinks per month
- ❑ 3-5 drinks per week
- ❑ Daily
- ❑ Multiple drinks daily

If yes, how long?

- ❑ Less than 5 years
- ❑ 5 – 10 years
- ❑ More than 10 Years

Do you drink alcohol? ____Yes ____No

If yes, how often?

- ❑ Fewer than 10 drinks per year
- ❑ 2-3 drinks per month
- ❑ 3-5 drinks per week
- ❑ More than 5 drinks per week

If yes, how long?

- ❑ Less than 5 years
- ❑ 5 – 10 years
- ❑ More than 10 Years

Do you use street drugs? ____Yes ____No
If yes, what types? For how long? _____

INTEGRATED PAIN SOLUTIONS
NON-SURGICAL MEDICAL CENTER

PAST MEDICAL HISTORY

Hypertension	__Yes	__No
Stroke	__Yes	__No
Diabetes Mellitus	__Yes	__No
Atrial Fibrillation	__Yes	__No
Fibromyalgia	__Yes	__No
Neuropathy	__Yes	__No
Epilepsy	__Yes	__No
Lyme Disease	__Yes	__No
Surgery	__Yes	__No

If yes, date and type of surgery: _____

Cardiology

Chest Pain	__Yes	__No
Palpitations	__Yes	__No

Dermatology

Rash	__Yes	__No

ENT/Respiratory

Ringing in ears	__Yes	__No
Sinus Problems	__Yes	__No

Gastroenterology

Diarrhea	__Yes	__No
Constipation	__Yes	__No
Nausea	__Yes	__No
Bloating after meals	__Yes	__No

General

Fatigue	__Yes	__No
Lightheadedness	__Yes	__No
Imbalance	__Yes	__No
Vertigo (spinning)	__Yes	__No

Musculoskeletal

Neck Pain	__Yes	__No
Back pain	__Yes	__No
Muscle Cramping	__Yes	__No

Neurology

Headache	__Yes	__No
Tingling numbness	__Yes	__No
Memory Problems	__Yes	__No
Tremors	__Yes	__No
Disorientation	__Yes	__No

Ophthalmology

Blurring of vision	__Yes	__No

Psychiatry

Anxiety	__Yes	__No
Depression	__Yes	__No
Tension/stress	__Yes	__No
Sleep disturbances	__Yes	__No

Hematology

Easy Bruising	__Yes	__No

MEDICATIONS

DRUG ALLERGIES: _____

PLEASE LIST ALL CURRENT MEDICATIONS, DOSE AND FREQUENCY PER DAY.

Medication Name	Dose	How many times a day?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		