Michigan Pain Specialists

Patient Name: _____ Referral: _____
DOB: _____ Prim Ins: _____
Age: _____ Sec Ins: _____
Gender: _____ Date: _____

Patient Demographic

Patient Name: _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Social Security Number _____

Race/Ethnicity _____ Primary Language _____

Secondary Language (if applicable) _____ E-Mail Address _____

***** Do you live in a nursing home? Yes / No If you live in a nursing home or other assisted living facility, please notify our staff.*****

Marital Status (please circle one) Single Married Divorced Widowed Committed/ Engaged

Work Status (please circle one): Full-Time Part-time Student Retired Unemployed Sick-Leave Disability

Employer/School _____ Work Phone No. _____

Address _____ City _____ State _____ Zip _____

Full Name of Referring Physician _____ Phone No. _____ Fax No. _____

Full Name of Primary Physician _____ Phone No. _____ Fax No. _____

Emergency Contact* _____ Relationship _____ Phone No. _____

*Please list an emergency contact that lives outside of your home. If you list a spouse below, we will attempt to contact them first.

Spouse's/Partner's Name _____ Date of Birth _____

Employer _____ Work Phone No. _____

Work Address _____ City _____ State _____ Zip _____

Primary Insurance _____ ID Number _____ Group _____

Policy Holder Name _____ Relationship _____ DOB _____

Secondary Insurance _____ ID Number _____ Group _____

Policy Holder Name _____ Relationship _____ DOB _____

Is your pain related to an accident? NO YES If yes, Date of Injury _____

Please circle one: Worker's Comp Auto Accident Other _____

DO YOU STILL HAVE AN ACTIVE WORK COMP OR AUTO CLAIM? NO YES If yes:

Case Mgr/Claim Adjuster Name _____ Phone No _____

Insurance Company _____ Claim No. _____

Claims Address _____ City _____ State _____ Zip _____

Preferred contact method (please circle):

Home Phone Work Phone Cell Phone E-Mail

_____ _____

Signature of Patient Date Signed

_____ _____ _____

Advocate/Authorized Signature (if Patient is a minor) Relationship Date Signed

Michigan Pain Specialists

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Gender:		Date:	

HIPAA Acknowledgement

I understand that I have the right to review the Notice of Privacy Practices of Michigan Pain Specialists, PLLC prior to signing this consent. I understand that Michigan Pain Specialists, PLLC reserves the right to change their notice and practices, and I will be given new notification if this occurs. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations, and the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I understand that I am authorizing the release of all or any part of my medical record for the purposes of treatment, payment, or practice operations. This release may include records containing information regarding the diagnosis and/or treatment of HIV or AIDS, mental illness, and/or drug and/or alcohol addiction or abuse to any person or corporation which is or may be liable under a contract for all or part of the medical charges, including but not limited to: Medicare, Medicaid, or other private or public health insurance programs, reviewing agencies, worker's compensation carriers, welfare agencies or patient's employer. The records may be needed in order to process a claim for medical services. I authorize for the release of information needed for billing purposes to entities that may provide services pertaining to my physician visit, such as reference laboratories.

I authorize any holder of medical or other information about me to release Social Security Administration and Center for Medicare and Medicaid Services (CMS) or its intermediaries or carriers any information needed for this or a Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

Signature of Patient or Legal Representative _____ Date _____

Printed Name of Patient _____ Witness _____

Release of Medical Information to Family Members

During the course of your treatment it may become necessary to discuss your condition with a family member or family friend. Below, please indicate to whom we may discuss your condition and/or treatment with:

Spouse Name: _____

Family Member or Friend(s) Name(s): _____

Restrictions

Please do not discuss my treatment with: _____

Documentation of Failure to Obtain Signed Acknowledgement

I presented this Acknowledgement to the patient. The patient refused to provide a signature when requested.

Staff Member Signature _____ Date _____

Michigan Pain Specialists

Patient Name:		Referral:	
DOB:		Prim Ins:	
Age:		Sec Ins:	
Gender:		Date:	

Financial Policy

Thank you for choosing Michigan Pain Specialists, PLLC as your health care provider. The following is our Financial Policy. If you have any questions or concerns about our payment policies please do not hesitate to ask our business office personnel. We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Forms prior to seeing the doctor.

Patient's portion of payment, as well as any past due balances, are due at the time services are rendered unless prior arrangements have been made with the billing department. We accept cash, personal checks, and all major credit cards for payment.

We accept assignment with most major insurance companies and participating provider plans (Blue Cross/Blue Shield, Medicare, Priority Health, Health Alliance Plan). However, you must understand that:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance carrier.

2. All charges are your responsibility whether your insurance company pays or not.

3. Fees for services, along with unpaid deductibles and co-payments are due at the time of treatment.

4. If the insurance company does not pay your balance in full within 30 days we ask that you contact the carrier to request prompt payment. Please inform our office of the carrier's response.

5. Returned checks will be subject to a $25.00 collection charge.

6. Balances over 90 days may be charged a handling fee.

7. Unpaid balances over 60 days are subject to collections via small claims court, attorney, and/or collection agency with applicable collection fees.

8. Failure to cancel an appointment may result in a cancellation fee/No show fee charge of $50.00 for new patients and $25.00 for return patients.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

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 here by assign to Michigan Pain Specialists, PLLC the medical and/or surgical benefits I am entitled from my insurance company and/or Medicare.

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.

Patient's Signature _____ Date _____

Printed Name of Patient _____ Relationship to Patient if not patient _____

Authorized Witness _____

Michigan Pain Specialists

Patient Name: _____ Referral: _____
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Gender: _____ Date: _____

Patient History Form

Family Doctor/Internist:
Name: _____
Address: _____
City, State, Zip _____
Send them a letter? Yes No

Who referred you to us?
Name: _____
Address: _____
City, State, Zip _____
Send them a letter? Yes No

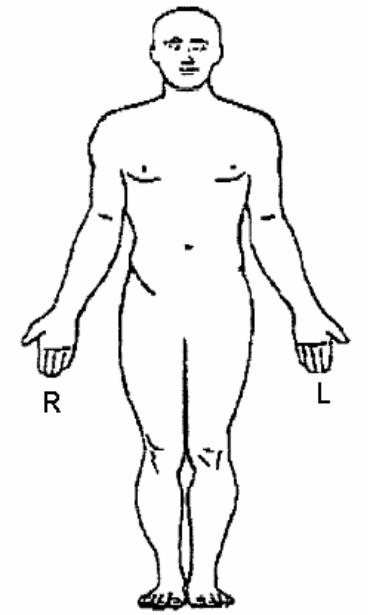
Check all that apply:

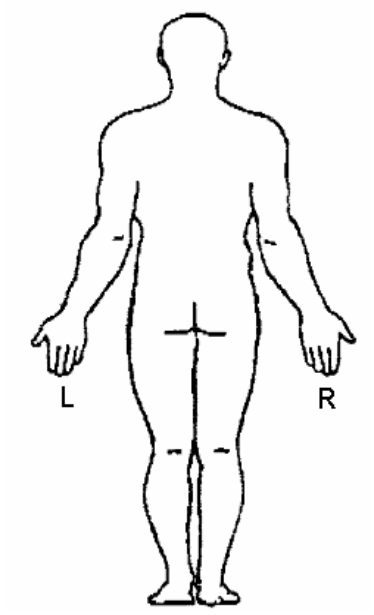
___ Injury on the job ___ Auto accident injury ___ Receiving disability income
___ Legal proceedings pending ___ Receiving workers comp. ___ Working with a rehab nurse

Describe the onset and/or cause of your problem: Date of onset: _____

Does this problem keep you from working? Yes No (If yes; date last worked:_____)
How long have you had the pain? _____Years _____Months _____Weeks
How far can you walk? _____Blocks (number_____) _____Around the house
_____Unlimited _____other: _____
Have you ever had pain like this before? Yes No
Explain: _____
How did you treat the pain or problem? _____

How often does your pain occur? Hourly Daily Weekly Occasionally Constant
Has the pain changed over time? Yes No Explain: _____





Please mark where you are on the pain scales (on average):

PAIN

BEST WORST
0 1 2 3 4 5 6 7 8 9 10

Ability to do things

I can do anything I do absolutely nothing
0 1 2 3 4 5 6 7 8 9 10

Pain level needed to return to work

BEST WORST
0 1 2 3 4 5 6 7 8 9 10

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Describe the character/quality of the pain (circle all that apply):

Cold	Hot	Aching	Throbbing	Burning	Dull	Sharp	Cramping
Electric	Spasms	Sharp	Pinching	Squeezing	Punishing	Shooting	Exhausting
Tingling	Lacerating	Stabbing	Pounding	Vicious	Penetrating	Tearing	Pressure

Do you have any of the following physical changes associated with your pain/symptoms (circle all that apply):

Hair growth Swelling Nail bed changes Vision changes Sweating Loss of consciousness
Muscle spasms Weakness Skin color changes Temperature changes Loss of bladder or bowel control
Inability to do fine movements with hands Changes in the way you walk

What makes your pain better:

_____ Lying down _____ Manipulation _____ Physical therapy _____Sitting _____ Exercise
_____ Aspirin _____ Standing _____ Prescription pain pills _____ Tylenol _____ Walking
_____ Over the counter medications _____ Muscle Relaxers
_____ Other: _____

What makes your pain worse:

_____ Lying down _____ Sneezing _____ Coughing _____Sitting _____ Standing
_____ Walking _____ Exercise _____ Bending forward _____ Bending backward
_____ Other: _____

Have you had: (check all that apply)

_____ X-rays _____ MRI _____ CAT scan _____Bone Scan _____ EMG
_____ Myelogram _____ MMPI-2 _____ Discogram

What treatments have you tried for pain relief: (check all that apply)

	Did it help?			Did it help?	
_____ Physical Therapy	YES	NO	_____ Taken time off work	YES	NO
_____ Aqua Therapy	YES	NO	_____ Altered daily activities	YES	NO
_____ Traction	YES	NO	_____ Rested	YES	NO
_____ Massage	YES	NO	_____ Used ice	YES	NO
_____ TENS	YES	NO	_____ Used heat	YES	NO
_____ Acupuncture	YES	NO	_____ Nerve Block	YES	NO
_____ Biofeedback	YES	NO	_____ Facet Block	YES	NO
_____ Anti-inflammatory meds	YES	NO	_____ Oral Steroids	YES	NO
_____ Pain medications	YES	NO	_____ Epidural Steroid Injections	YES	NO
_____ Worn a brace	YES	NO			

Who have you seen for treatment of pain/symptoms in the past? (please list names also)

- Primary care doctor _____
- Orthopaedic Spine Surgeon _____
- Neurosurgeon _____
- Rehab doctor _____
- Neurologist _____
- Emergency room _____ How many times? _____
- Pain clinic _____
- Chiropractor _____ Adjustments done? YES NO
- Psychologist _____
- Psychiatrist _____
- Naturopath _____
- Other _____

Michigan Pain Specialists

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Gender: _____ Date: _____

Past Medical History/Family History (check all that apply):
HEIGHT _____ WEIGHT _____

You	Family		You	Family		Other
_____	_____	Heart attack	_____	_____	Bleeding problem	_____
_____	_____	Heart failure	_____	_____	Stress test	_____
_____	_____	High blood pressure	_____	_____	Cancer	_____
_____	_____	Stroke	_____	_____	Hepatitis	_____
_____	_____	Kidney disease	_____	_____	Pulmonary embolus	_____
_____	_____	Heart catheterization	_____	_____	Blood clotting	_____
_____	_____	Diabetes	_____	_____	High cholesterol	_____

List all past surgeries: (include dates if known)

Are you employed? YES NO Occupation _____
Are you married? YES NO Children and ages _____
Females-are you pregnant? YES NO UNSURE
Are you or have you ever been a smoker? YES NO (# packs_____for_____years) Date Started: Date Quit:
Do you currently use or have you ever used other forms of tobacco? YES NO (What?_____) Date Started: Date Quit:
Do you drink alcohol? YES NO (# drinks weekly_____)
Have you had DUI/DWI? YES NO
Do you use illicit drugs? YES NO

Circle your highest level of education---
Post Graduate (PhD/Masters) College High school Elementary

Allergies to medications and reactions (include tape and latex allergies):

Please list all current medications, supplements, vitamins, and herbs you take:

Drug	Dose	How many times taken daily

Please circle which medicines you have tried for pain relief:

NSAIDS:	Celebrex, Vioxx, Bextra, Motrin/ Ibuprofen, Aleve/ Naprosyn, Tylenol, Aspirin
Narcotics:	Morphine, Oxycontin, Methadone, Duragesic Patch, Vicodin, Lorcet, Norco, Hydrocodone, Darvocet, Percocet, Oxycodone, Ultram
Antidepressants:	Paxil, Prozac, Celexa, Elavil/ Amitriptyline, Zoloft, Lexapro, Effexor, Desyrel/Trazadone, Pamelor/Nortrptyline, Sinequan/Doxepin
Anticonvulsants:	Neurontin, Lamotrigine, Dilantin, Tegretol
Muscle Relaxants:	Soma, Flexeril Skelaxin, Diazepam/Valium, Klonopin/ Clonazepam, Zanaflex, Baclofen
Other Medicines	Lidoderm Patch, Capsaicin, Catapress Patch

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Please note if you are taking any of the following medications (please notify your doctor)

Coumadin (warfarin)	Lovenox (enoxaparin)	Aggrenox	Xarelto (rivaroxaban)
Plavix (clopidrogrel)	Innohep (tinzaparin)	NSAIDS	Brilinta
Ticlid (ticlodipine)	Fragmin (dalteparin)	Aspirin	Arixtra (fondaparinux)
Pletal (cilostazol)	Pradaxa	Trental (pentoxifylline)	Effient (prasugrel)
Eliquis (apixaban)	HEP SQ 5,000 Units	Pentoxil	Savaysa (edoxaban)

Review of Systems (please check any that apply):

General
____ fever
____ chills
____ weight gain
____ weight loss
____ sexual dysfunction
____ cancer
____ HIV

Ears, Nose, Throat
____ cold symptoms
____ headache
____ nasal drainage
____ sore throat
____ hearing loss

Eyes
____ sharp vision
____ glaucoma
____ cataracts
____ blindness

Heart
____ chest pain (angina)
____ palpitations
____ irregular heart beat
____ poor circulation
____ valve disease

Lungs
____ shortness of breath
____ cough
____ home oxygen use

Lymph Nodes
____ enlarged lymph nodes in neck, armpits, or groin

Hormonal
____ diabetes
____ thyroid disease
____ calcium imbalance

Stomach (GI)
____ abdominal pain
____ diarrhea
____ constipation
____ nausea/vomiting
____ reflux
____ liver cirrhosis
____ loss of bowel control

Renal (Urinary)
____ renal failure
____ difficulty urinating
____ urgency
____ frequency
____ UTI
____ kidney stones
____ loss of bladder control

Muscle/ Bone
____ arthritis
____ osteoporosis
____ lupus
____ rheumatoid arthritis
____ spinal stenosis
____ disc disease
____ neck pain
____ back pain
____ sciatica
____ radiculopathy

Skin
____ rash
____ cancer
____ infection (also any history in the past of skin infection or infection after surgery)
____ blisters
____ psoriasis
____ eczema
____ ulcers

Brain/ Nerves
____ seizure
____ memory loss
____ paralysis
____ TIA
____ mini stroke
____ facial drooping
____ slurred speech
____ neuropathy
____ loss of sensation
____ Restless Leg Syndrome

Blood Disorders
____ Sickle cell anemia
____ VonWillebrands Disease
____ Hemophilia
____ excessive bleeding
____ easy bruising

Sleep/Psychological
____ Insomnia
____ excessive tiredness
____ anxiety
____ depression
____ manic depression
____ Sleep apnea

I have reviewed this entire document:

_____ Films available and reviewed
_____ Imaging reports reviewed
_____ All other systems negative except those noted above

_____ MD/DO

_____ % of time spent for counseling/coordinating care

_____ Min spent with patient

99202 - 20 min
99203 - 30 min
99204 - 45 min
99205 - 60 min

Michigan Pain Specialists

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DOB:		Prim Ins:	
Age:		Sec Ins:	
Gender:		Date:	

PATIENT PORTAL CONSENT

The Patient Portal is called the SRS Communicator and is provided through our Electronic Health Records (EHR) software vendor SRSsoft. It is a free service that will be utilized to enhance communications with our patients.

The Patient Portal currently provides an electronic summary of each of your office visits with our practice, and allows you to do basic communication with staff.

By providing your email address below you consent to allow Michigan Pain Specialists, PLLC to have your email on file, and provide you with a Patient Portal account.

Information on how to access the Patient Portal will be emailed to you.

Your Email Address: _____

Patient Consent

I agree that Michigan Pain Specialists, PLLC may keep my email address on file and sign me up for the Patient Portal.

_____ _____

Patient Signature Date

Michigan Pain Specialists

Patient Name:		Referral:	
DOB:		Prim Ins:	
Age:		Sec Ins:	
Gender:		Date:	

ePrescribing and Medication Reconciliation

ePrescribing is a federally mandated initiative that requires all physicians prescribe in this manner by 2011.

ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information.

ePrescribing software also lets your doctor see important information - like drug interactions and your prescription history.

The benefit to you:

- Less confusion over handwritten prescriptions or unclear phone calls
- Reduced possibility of medical errors
- Less chance of adverse drug reactions
- Fewer trips to drop off at the pharmacy
- A safer, faster, easier way to get your prescription filled

Your current pharmacy name: _____

City pharmacy is located in: _____ **Pharmacy Phone #: _____**

Patient Consent

I agree that Michigan Pain Specialists, PLLC may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes and release my prescription medication history to my other healthcare providers.

_____ _____

Patient Signature Date