

Phone #: 703-522-2727

Thomas J. Raley, MD (MD/VA)

Fax #: 703-542-3753

Vipul Mangal, MD (VA)

Alex Matz, MD (MD)

Christie Robbins, NP (MD)

Kathleen Gorham, NP (VA)

Cherith Zorbas, NP-C (VA)

**ADVANCED SPINE AND PAIN
PATIENT REGISTRATION**

Personal Information

Name: _____

DOB: _____

Male: _____ Female: _____ Age: _____

Single: _____ Married: _____ Divorced: _____

Race: _____

Ethnicity: _____

Address: _____

Phone #: _____

SSN: _____

Email address: _____

Referring Doctor (First & Last Name): _____

Insurance Information

Primary Insurance: _____

Subscriber: Self: _____ Other: _____

If Other, Subscriber Name: _____

Subscriber DOB: _____ SSN: _____

Secondary Insurance: _____

Subscriber: Self: _____ Other: _____

Subscriber Name: _____

Pharmacy Information

Insurance Name: _____

Pharmacy Name: _____

Pharmacy phone: _____

Mail-order Name: _____

Mail-order Phone: _____

Employment Information:

Employer: _____

Employer Phone #: _____

Spouse Name: _____

Spouse's #: _____

Did this injury occur at work? Yes/No

If YES, do you have an active claim? YES/NO

Emergency Contact Information

Contact Name: _____

Relationship: _____

Phone #: _____

Address: _____

Signature on File:

By signing below, I agree to the following:

I allow ASAP to participate in the treatment of my health

I authorize the release of this information to my insurance company

I understand I am responsible for my account

I authorize my doctor to act as my agent in helping me to obtain payment from the insurance

I authorize payment directly to ASAP

I permit a copy of this authorization to be used in place of the original

Patient/Responsible Party Signature

Date

Phone #: 703-522-2727

Thomas J. Raley, MD (MD/VA)

Fax #: 703-542-3753

Vipul Mangal, MD (VA)

Alex Matz, MD (MD)

Christie Robbins, NP (MD)

Kathleen Gorham, NP (VA)

Cherith Zorbas, NP-C (VA)

ADVANCED SPINE AND PAIN FINANCIAL POLICY

Name: _____

Date: _____

Thank you for choosing us as your medical provider. Please read the following for a complete understanding of our Financial Policy. If you have any questions, please call our billing department at **703-522-2727**.

- ❖ Payment for services is due at the time services are rendered or upon receipt of the patient billing statement.
*****ALL SELF-PAY PATIENTS MUST PAY AT THE TIME OF VISIT*****
- ❖ We accept cash or credit cards only (**Visa and MasterCard**).
- ❖ Failure to cancel your appointment with 24 hour notice results in a \$50 no show/same day cancellation fee for follow-up appointments and a \$100 no show/same day cancellation fee for injections. These fees **MUST** be paid before your next appointment.
- ❖ There will be a \$25 late fee for all appointments, if more than 30 minutes late. If provider agrees to see patient, this fee **MUST** be paid prior to being seen.
- ❖ Any forms that need to be filled out or written by a provider will be \$20 per page.
- ❖ For patients with insurance, we will submit the appropriate claim to your provider. You may be responsible for a copay the day of your appointment.
- ❖ We are a provider for the following insurance companies: **Medicare, Tricare (Prime & Standard), Blue Cross Blue Shield, Aetna, Cigna (PPO), United Healthcare (PPO), PHCS, Coventry, & Workers Compensation**. Please be advised that our services are Out of Network for **every other** policy, which could result in you having to meet an additional deductible or coinsurance.
- ❖ If you are out of network, your insurance company may submit a check for our services directly to you. It is then your responsibility to endorse the check to us immediately. Failure to do so may result in further penalty, including reporting to a collection agency and criminal prosecution.
- ❖ After our office has received payment from your insurance company, and the appropriate adjustments have been made, your remaining balance will be billed to you and is due and payable upon receipt of the bill.
- ❖ All prior balances must be paid before any new appointment can be made.
- ❖ **Workers Compensation:** If you are here as a result of a work related injury, we will require information regarding both your health insurance and your employer's Workers' Compensation insurance. WE will also need to verify that your employer assumes responsibility for charges incurred. If we cannot verify responsibility, or we are unable to obtain information on employer's Workers' Compensation insurance, we will bill your private/personal insurance carrier. In the case that you have no other insurance and we have not received payment from any third party, we will bill you directly.

I understand that if the office agrees to bill insurances as a courtesy, I must submit information as needed to ensure payment for services rendered to me. I understand that I am ultimately responsible for payment of all services.

In the event that a delinquent account is place in the hands of a collection agency, or attorney for collection, or suit is instituted on this account, I agree to pay, in addition to the amount of the delinquent account plus interest, reasonable collector's or attorney's fees.

1715 N. George Mason Dr. #102 ~ 2296 Opitz Boulevard #210 ~ 450 Garrisonville Rd #109 ~ 1499 Chain Bridge Rd #101 ~ 11230 Waples Mill Rd #114C ~ 3500 Boston St #J2
Arlington, VA 22205 Woodbridge, VA 22191 Stafford, VA 22554 McLean, VA 22101 Fairfax, VA 22030 Baltimore, MD 21224

Phone #: 703-522-2727

Thomas J. Raley, MD (MD/VA)

Fax #: 703-542-3753

Vipul Mangal, MD (VA)

Alex Matz, MD (MD)

Christie Robbins, NP (MD)

Kathleen Gorham, NP (VA)

Cherith Zorbas, NP-C (VA)

Patient/Responsible Party Signature

Date

**ADVANCED SPINE AND PAIN
PATIENT CONSENT FORM**

Name: _____

Date: _____

Advanced Spine and Pain, Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our office may change. If we change our notice, you may obtain a revised copy from our website or front desk receptionist at ASAP.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing this form you consent, to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent. You also allow our office to contact you by phone or by mail to provide appointment reminders or information about treatment alternatives or other health benefits and services that may be of interest to you. We may also contact you to raise funds for covered entity.

Patient/Responsible Party Signature

Date

I give permission for **Advanced Spine and Pain** to discuss my care, appointments, and financial information with the following person(s):

Name

Relationship

Date of Birth

Telephone

Name

Relationship

Date of Birth

Telephone

1715 N. George Mason Dr. #102 ~ 2296 Opitz Boulevard #210
Arlington, VA 22205 Woodbridge, VA 22191

~ 450 Garrisonville Rd #109 ~ 1499 Chain Bridge Rd #101 ~ 11230 Waples Mill Rd #114C ~ 3500 Boston St #J2
Stafford, VA 22554 McLean, VA 22101 Fairfax, VA 22030 Baltimore, MD 21224

Phone #: 703-522-2727

Thomas J. Raley, MD (MD/VA)

Fax #: 703-542-3753

Vipul Mangal, MD (VA)

Alex Matz, MD (MD)

Christie Robbins, NP (MD)

Kathleen Gorham, NP (VA)

Cherith Zorbas, NP-C (VA)

Patient/Responsible Party Signature

Date

Phone #: 703-522-2727

Thomas J. Raley, MD (MD/VA)

Fax #: 703-542-3753

Vipul Mangal, MD (VA)

Alex Matz, MD (MD)

Christie Robbins, NP (MD)

Kathleen Gorham, NP (VA)

Cherith Zorbas, NP-C (VA)

**ADVANCED SPINE AND PAIN
AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

Patient Name: _____ DOB: _____

SSN: _____

By signing this form, I hereby authorize _____ to disclose the health information described below to the office of **ADVANCED SPINE AND PAIN**.

CHECK ALL THAT APPLY:

- All health information
- Last (3) office visits, MRI, or X-ray notes, Injection procedure notes
- Health information relating to the following treatment or condition

- Health information for the date(s)

- Other specific health information or dates

REASONS FOR THIS AUTHORIZATION:

- At my request
- Other (specify)

This authorization expires upon: _____ (date or description of event)

I understand that I may refuse to sign this authorization. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on signing an authorization if to do so would be prohibited by federal or state law. I understand an authorization may be required to participate in research or where health services are provided solely for the purpose of creating health information for a third party, and that if I refuse to sign an authorization those services may be denied.

I may revoke this authorization in writing. If I do, it will not affect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may revoke this authorization by writing a letter and mailing it by certified mail, return receipt requested, to the Privacy Office at the health care provided listed above. Once health information is disclosed pursuant to the authorization, it may be re-disclosed and may no longer be protected by privacy laws.

Patient/Responsible Party Signature

Date

1715 N. George Mason Dr. #102 ~ 2296 Opitz Boulevard #210
Arlington, VA 22205 Woodbridge, VA 22191

~ 450 Garrisonville Rd #109 ~ 1499 Chain Bridge Rd #101 ~ 11230 Waples Mill Rd #114C ~ 3500 Boston St #J2
Stafford, VA 22554 McLean, VA 22101 Fairfax, VA 22030 Baltimore, MD 21224

Phone #: 703-522-2727

Thomas J. Raley, MD (MD/VA)

Fax #: 703-542-3753

Vipul Mangal, MD (VA)

Alex Matz, MD (MD)

Christie Robbins, NP (MD)

Kathleen Gorham, NP (VA)

Cherith Zorbas, NP-C (VA)

ASAP

ADVANCED SPINE AND PAIN

To: All Insured Patients

From: Advanced Spine and Pain, PLLC
Billing Department

Please be aware that the Urine Drug Screens processed in our offices will be sent to an approved reference laboratory for confirmation testing. If your insurance plan requires that all labs be sent to a specific lab (i.e. LabCorp, Quest), the cost of testing may not be covered because we do not utilize the services of that laboratory.

All patients are required to sign this document that represents an insurance waiver stating they have been notified the Urine Drug Screen testing may not be covered by their insurance company and they understand they may be charged our self-pay fee of **\$125.00**. *This fee is subject to change at any time and patients will be notified accordingly.*

Patient Waiver:

I have read the above statement and understand its contents. I also understand that if I receive a bill for any Urine Drug Screen processed by my insurance company as non-covered, I am responsible for the balance.

Patient Name: _____

Patient Signature: _____

Date: _____

Phone #: 703-522-2727

Thomas J. Raley, MD (MD/VA)

Fax #: 703-542-3753

Vipul Mangal, MD (VA)

Alex Matz, MD (MD)

Christie Robbins, NP (MD)

Kathleen Gorham, NP (VA)

Cherith Zorbas, NP-C (VA)

New Patient Medical History Form

Patient Name	
Date of Birth	
Gender	
Primary Care Physician:	
Office Location of this Physician:	

Pain History Background																																																																			
What is your age?	<p>Please shade the areas where you are having pain</p> <p><i>For the scales below, circle a number using 0 to indicate none up to 10 to indicate most extreme/severe</i></p> <table border="1"> <tr> <td colspan="11">Please indicate your current pain</td> </tr> <tr> <td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td> </tr> <tr> <td colspan="11">Please rate your worst pain in the last week</td> </tr> <tr> <td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td> </tr> <tr> <td colspan="11">Please rate your least pain in the last week</td> </tr> <tr> <td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td> </tr> </table>	Please indicate your current pain											0	1	2	3	4	5	6	7	8	9	10	Please rate your worst pain in the last week											0	1	2	3	4	5	6	7	8	9	10	Please rate your least pain in the last week											0	1	2	3	4	5	6	7	8	9	10
Please indicate your current pain																																																																			
0		1	2	3	4	5	6	7	8	9	10																																																								
Please rate your worst pain in the last week																																																																			
0		1	2	3	4	5	6	7	8	9	10																																																								
Please rate your least pain in the last week																																																																			
0		1	2	3	4	5	6	7	8	9	10																																																								
What is your main pain complaint?																																																																			
If pain is located in the neck or back, does it radiate into your arms or legs? <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																			
How long has this pain been present? (Indicate number of months or years) Months _____ Years _____																																																																			
Is the pain associated with any other symptoms? <input type="checkbox"/> None <input type="checkbox"/> Difficulty walking <input type="checkbox"/> Numbness, where _____ <input type="checkbox"/> Weakness, where _____ <input type="checkbox"/> Sexual dysfunction _____ <input type="checkbox"/> Other _____																																																																			
What words best describe how the pain feels? <input type="checkbox"/> Sharp <input type="checkbox"/> Burning <input type="checkbox"/> Shooting <input type="checkbox"/> Deep <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing <input type="checkbox"/> Aching <input type="checkbox"/> Pressure <input type="checkbox"/> Dull <input type="checkbox"/> Tingling <input type="checkbox"/> Other _____																																																																			
How often is the pain present? <input type="checkbox"/> Constant <input type="checkbox"/> Frequent (several times per hour) <input type="checkbox"/> Sporadic (several times per day) <input type="checkbox"/> Occasional (several times per week) <input type="checkbox"/> Rare (several times per month)																																																																			
What makes your pain better? <input type="checkbox"/> Rest <input type="checkbox"/> Heat <input type="checkbox"/> Cold <input type="checkbox"/> Medication <input type="checkbox"/> Exercise <input type="checkbox"/> Other _____																																																																			
What makes your pain worse? <input type="checkbox"/> Heat <input type="checkbox"/> Cold <input type="checkbox"/> Walking <input type="checkbox"/> Bending/Twisting <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Lying <input type="checkbox"/> Stress <input type="checkbox"/> Coughing/Sneezing <input type="checkbox"/> Standing from sitting																																																																			
Since your pain began, have you experienced any of the following? <input type="checkbox"/> Bowel incontinence <input type="checkbox"/> Bladder incontinence <input type="checkbox"/> Neither																																																																			
Has the pain affected your sleep? <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																			

Phone #: 703-522-2727

Thomas J. Raley, MD (MD/VA)

Fax #: 703-542-3753

Vipul Mangal, MD (VA)

Alex Matz, MD (MD)

Christie Robbins, NP (MD)

Kathleen Gorham, NP (VA)

Cherith Zorbas, NP-C (VA)

Pain History	
Is this a workmen's compensation injury? YES / NO	
If YES, please explain what happened and when:	
<input type="checkbox"/> Motor Vehicle accident Date: _____ <input type="checkbox"/> Fall or other trauma Date: _____ <input type="checkbox"/> Following surgery Date: _____ <input type="checkbox"/> Following illness Date: _____ <input type="checkbox"/> Unknown reason <input type="checkbox"/> Other _____	How did your main pain complaint begin? <i>Please give details</i> _____ _____ _____ _____
<input type="checkbox"/> No diagnosis has been given	What diagnosis, if any, have you been given for your current pain? _____ _____

Treatment History			
Have you ever been treated by another pain management physician or clinic? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of physician/clinic	Location	Dates of treatment	Reason for leaving
Name of physician/clinic	Location	Dates of treatment	Reason for leaving
Have you ever been evaluated by a surgeon for your main pain complaint? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of Surgeon	Date	Was surgery recommended? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Surgeon	Date	Was surgery recommended? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you had surgery intended to treat your current pain complaint? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Surgery #1	Procedure name	Date	Surgeon
Surgery #2	Procedure name	Date	Surgeon
Have you seen any other specialists related to your main pain complaint? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of specialist	Specialty	Date seen	
Name of specialist	Specialty	Date seen	
Have you had an Electromyography or EMG test to evaluate nerve function? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Performed on arms/legs/both?	Physician performing test	Date	
Performed on arms/legs/both?	Physician performing test	Date	
Have you had Radiologic Imaging for your current pain complaint? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please bring actual films or CD containing the images to your initial appointment</i>			
Study type	Body part imaged	Date of study	Where study was performed
X-ray			
MRI			
CT			
Ultrasound			
Bone Scan			
Other			

Past Medical History

Have you been diagnosed with any of the following conditions at any point in your life?

<input type="checkbox"/> Abnormal heart beat	<input type="checkbox"/> Depression	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Stomach ulcer or GI bleed	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Heartburn/Acid Reflux	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Peripheral Neuropathy
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizures	<input type="checkbox"/> Stroke	<input type="checkbox"/> Multiple Sclerosis (MS)
<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Asthma	<input type="checkbox"/> Irritable bowel
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Hypothyroid/Hyperthyroid	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Psychiatric Conditions	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Vascular disease
<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Broken Bones

Other conditions not listed above:

Past Surgical History

Surgery	Date (month/year)	Surgeon

Current Medications

Name of Medication	Dose	Frequency	Prescribing Doctor

Vaccinations

Have you received a current flu vaccination? Yes No Have you received a pneumonia vaccination? Yes No

Allergies

Do you have any known allergies? Yes No Are you allergic to shellfish? Yes No
If yes, please list your allergies below Are you allergic to IV contrast dye? Yes No
 Are you allergic to local Anesthetics? Yes No
 Are you allergic to latex? Yes No

Family History

Please list medical problems of your immediate family such as diabetes, high blood pressure, heart disease, etc.

Relation	Medical Condition	Relation	Medical Condition
Father		Sister	
Mother		Sister	
Brother		Daughter	
Brother		Son	

Additional Siblings or Children:

Please check here if you are adopted

Phone #: 703-522-2727

Thomas J. Raley, MD (MD/VA)

Fax #: 703-542-3753

Vipul Mangal, MD (VA)

Alex Matz, MD (MD)

Christie Robbins, NP (MD)

Kathleen Gorham, NP (VA)

Cherith Zorbas, NP-C (VA)

Social History			
Are you currently working? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unemployed <input type="checkbox"/> Homemaker <input type="checkbox"/> Student			
If working, what is your present work status? <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Disability <input type="checkbox"/> Workers Compensation			
If not working, what was your last job?		If not working, what was your last job?	
Did you stop working due to your pain? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did you stop working due to your pain? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What is your marital status? <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Do you have children? <input type="checkbox"/> Yes <input type="checkbox"/> No How many? _____ What age? _____			
What is your highest education level? <input type="checkbox"/> Did not graduate High School <input type="checkbox"/> High School <input type="checkbox"/> GED <input type="checkbox"/> Vocational Degree <input type="checkbox"/> Some College <input type="checkbox"/> College Degree <input type="checkbox"/> Graduate Degree			
Do you use tobacco? <input type="checkbox"/> Never <input type="checkbox"/> Occasional <input type="checkbox"/> Smokeless <input type="checkbox"/> Cigarettes ___ packs/day <input type="checkbox"/> Cigars ___/day			
Do you use alcohol? <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Socially <input type="checkbox"/> Regularly ___ drinks/day			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever used recreational (street) drugs within the past 5 years? <i>If yes, please list what and when in the space below</i>		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any history of recreation or street drug addiction?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any history of alcohol dependence or alcoholism?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been enrolled in a drug or alcohol treatment program?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any history of prescription drug abuse?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any history of physical or sexual abuse?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you receiving workers compensation?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you receiving disability payments?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you applied, or do you plan to apply for workers compensation or disability?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a pending lawsuit related to your pain?		
Review of Systems			
Please check any of the following symptoms or problems you have experienced in the past 6 months			
Constitutional <input type="checkbox"/> No Problems <input type="checkbox"/> Weight Gain <input type="checkbox"/> Weight Loss <input type="checkbox"/> Difficulty Sleeping <input type="checkbox"/> Fever <input type="checkbox"/> Fatigue Other:	Eyes <input type="checkbox"/> No Problems <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Double Vision <input type="checkbox"/> Eye Pain <input type="checkbox"/> Redness and Drainage <input type="checkbox"/> Excessive Watering Other:	Ears, Nose, Throat <input type="checkbox"/> No Problems <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Snoring <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Dizziness Other:	Cardiovascular <input type="checkbox"/> No Problems <input type="checkbox"/> Chest Pain/Pressure <input type="checkbox"/> Irregular Heart Rate <input type="checkbox"/> Rapid Heart Rate <input type="checkbox"/> Swelling in Legs/Feet <input type="checkbox"/> Poor Circulation Other:
Respiratory <input type="checkbox"/> No Problems <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Home Oxygen Use Other:	Gastrointestinal <input type="checkbox"/> No Problems <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Blood in Stool <input type="checkbox"/> Abdominal Pain Other:	Genitourinary <input type="checkbox"/> No Problems <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Incontinence of Urine <input type="checkbox"/> Painful Urination <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Kidney Stone Other:	Musculoskeletal <input type="checkbox"/> No Problems <input type="checkbox"/> Joint Pain <input type="checkbox"/> Stiffness of Joints <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Muscle Spasms/Cramps <input type="checkbox"/> Muscle Weakness Other:
Dermatologic <input type="checkbox"/> No Problems <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Itching <input type="checkbox"/> Color Change <input type="checkbox"/> Rashes <input type="checkbox"/> Nail or Hair Change Other:	Neurological <input type="checkbox"/> No Problems <input type="checkbox"/> Fainting <input type="checkbox"/> Headache <input type="checkbox"/> Poor Memory <input type="checkbox"/> Recent Falls <input type="checkbox"/> Seizures Other:	Psychiatric <input type="checkbox"/> No Problems <input type="checkbox"/> Excessive Worry <input type="checkbox"/> Frequent Sadness <input type="checkbox"/> Depression <input type="checkbox"/> Feeling Hopeless <input type="checkbox"/> Excessive Stress Other:	Endocrine <input type="checkbox"/> No Problems <input type="checkbox"/> Heat Intolerance <input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Changes in Appetite <input type="checkbox"/> Abnormal Sweating <input type="checkbox"/> Hair Loss Other:

Phone #: 703-522-2727

Thomas J. Raley, MD (MD/VA)

Fax #: 703-542-3753

Vipul Mangal, MD (VA)

Alex Matz, MD (MD)

Christie Robbins, NP (MD)

Kathleen Gorham, NP (VA)

Cherith Zorbas, NP-C (VA)

Name: _____ DOB: _____

Advanced Spine and Pain
PATIENT RESPONSIBILITY FOR CHRONIC OPIOID
(NARCOTIC) THERAPY

This document represents patient expectations regarding the use of opioid (narcotic) pain medications for treating my pain. Opioid medications are only one part of an overall treatment plan; therefore, I will regularly attend and participate in all prescribed therapies. By signing this, I understand and agree to the following risks and conditions, which may be associated with long-term use of opioid medications.

RISKS:

1. Constipation (which may be severe enough to require medical treatment)
2. Urinary retention (difficulty with urination)
3. Change in appetite and/or in weight
4. Drowsiness or confusion which may affect thinking abilities or emotions
5. Itching
6. Nausea
7. Problems with coordination or balance that may make it unsafe to operate motor vehicles or heavy equipment
8. Depressed respiration (breathing too slowly, overdose can lead to respiratory arrest, coma or death)
9. Physical dependence (which means that quickly stopping opioids may lead to withdrawal symptoms)
10. Psychological dependence (which means that quickly stopping opioids may lead to drug cravings)
11. Sexual difficulties
12. If I become pregnant, my baby might be born physically dependent on opioids. This can be treated successfully. There may be other, unknown risks to unborn children (female patients only)
13. Other, rare side effects may occur

Initial _____

Phone #: 703-522-2727

Thomas J. Raley, MD (MD/VA)

Fax #: 703-542-3753

Vipul Mangal, MD (VA)

Alex Matz, MD (MD)

Christie Robbins, NP (MD)

Kathleen Gorham, NP (VA)

Cherith Zorbas, NP-C (VA)

Conditions

1. I am not currently using any illegal pain medication. I have fully informed my physicians of any current, previous use, sale or diversion of legal or illegal drugs. (i.e. cocaine, cannabis, heroine, etc.)

****We also ask that you please inform your physician if you are on probation****

Are you on Probation: _____ Yes _____ No

If yes, reason:

Name of Probation Officer: _____ **Ph#:** _____

2. I am not currently abusing alcohol, and have fully informed my physicians about any previous alcohol abuse.
3. I will obtain all prescriptions for opioids only from ASAP physicians. I am not permitted to obtain similar medication from any other doctor or clinic without the expressed authorization of ASAP physicians. If an emergency occurs and opioid medications are prescribed from another doctor, I will notify ASAP physicians as soon as possible. **Virginia patients can only fill in Virginia. Maryland patients can only fill in Maryland***
4. Prescriptions will not be mailed, unless otherwise specified.
5. I will take opioids only as prescribed by ASAP physicians and under no circumstances will I allow other individuals to use these medications, nor will I obtain these medications from other individuals.
6. The use of these medications will be **strictly** monitored.
7. Extra medication will not be given if the prescription runs out early due to excessive use. Lost, stolen, or misplaced prescriptions or medications will not be replaced.
8. No unplanned or emergency refills will be allowed. **No prescriptions will be filled or renewed over weekends, after 4 pm on weekdays, or on holidays.**
9. Patients needing refills must call the office at least 5 days before current supply of opioid pain medications run out.
10. Prescriptions and refills **Will Not** be telephoned into pharmacies, and must either be picked up by patients, or mailed to pharmacy via standard delivery mail
11. Only one pharmacy will be used to fill prescriptions. ASAP physicians have my permission to communicate with the pharmacist about my use of medications. If I change pharmacies, I will notify ASAP in advance

Pharmacy Name: _____ **Ph#:** _____

Mail in Pharmacy: _____ **Ph#:** _____

Phone #: 703-522-2727

Thomas J. Raley, MD (MD/VA)

Fax #: 703-542-3753

Vipul Mangal, MD (VA)

Alex Matz, MD (MD)

Christie Robbins, NP (MD)

Kathleen Gorham, NP (VA)

Cherith Zorbas, NP-C (VA)

- 12. I will be required to have unannounced blood or urine tests, or pill counts in order to assess the effect of the opioid as well as my abstinence from illegal drug use. By signing this patient responsibility form, I give permission for and agree to cooperate with any such test if I am asked to do so; failure to comply may result in discharge from the practice.
- 13. Before receiving any opioids, a psychological evaluation with follow up therapy may be required by the physicians at ASAP. Other medical evaluations and/or treatments may also be required.
- 14. Due to known and unknown risks to unborn children, which include physical dependence, I will notify my physician if I am pregnant or if I become pregnant in the future.
- 15. I understand that opioid medications will be slowly reduced and safely stopped if I violate any aspect of this patient responsibility form (at the discretion of the provider), or if the ASAP physicians feel that opioids are not effective in controlling my pain. It may be necessary for me to enter a chemical dependence program in order to completely stop the medication.
- 16. I must visit the ASAP physicians at ***least every four to eight weeks*** for monitoring my medications. I understand that if I don't show for my regular scheduled appointment, I may not receive my refill medications. After three No Show appointments, I may be subject to discharge due to noncompliance.
- 17. I give ASAP physicians permission to communicate with any of my other physicians regarding my use of controlled substances.
- 18. I take all responsibility for the cost of medication, urine/blood tests, which insurance may not cover.
- 19. I understand that any violation of the above terms may lead to my immediate discharge from the office.
- 20. I understand that my physician will cooperate fully with any city, state, or federal law enforcement agency, including state Board of Pharmacy, in the investigation of any misuse, sale, or other diversion of my pain medicine, and he/she does not need my specific authorization to do so.
- 21. Other conditions: _____

I have read and understand this agreement, and I agree to all of the above. I will be given a copy of this form and I give permission for a copy to be sent to my other treating physicians, caregivers, pharmacists, and insurance providers.

Patient: _____ Date: _____

Physician: _____ Date: _____

INTERPRETER'S STATEMENT: I have translated the information and advice presented orally to the individuals giving consent by the person obtaining this consent. To the best of my knowledge and behalf, he/she understood this explanation.

Interpreter: _____ Date: _____

Phone #: 703-522-2727

Thomas J. Raley, MD (MD/VA)

Fax #: 703-542-3753

Vipul Mangal, MD (VA)

Alex Matz, MD (MD)

Christie Robbins, NP (MD)

Kathleen Gorham, NP (VA)

Cherith Zorbas, NP-C (VA)

ATTENTION PATIENTS

Please be aware that we are a Specialist office. This means that your insurance plan may require you to obtain a referral from your Primary Medical Doctor in order to be seen. The most common plans that require referrals are HMO policies, and Tricare Prime. If you are unsure of the type of policy you have, or whether a referral is required, you may call the Customer Service number on the back of your insurance card. If you have Tricare Prime, you can call 877-874-2273 for this information.

Please note that it is your responsibility to know your insurance. If you fail to obtain the proper authorization for you appointments, you may receive a bill. Be aware that this is for office visits only, as we will request authorization on your behalf for all other services or care you may require.

By signing below, you acknowledge that you have read and understand this policy

Patient Name: _____ Date: _____

Patient Signature: _____

Phone #: 703-522-2727

Thomas J. Raley, MD (MD/VA)

Fax #: 703-542-3753

Vipul Mangal, MD (VA)

Alex Matz, MD (MD)

Christie Robbins, NP (MD)

Kathleen Gorham, NP (VA)

Cherith Zorbas, NP-C (VA)

ATTENTION PATIENTS

Beginning March 1st, 2013 there will be a \$15 fee for any and all prior authorizations on medications this office handles. It is unfortunate that we have to implement this fee, however the volume of these requests has increased dramatically and the time it takes to complete them is growing.

This fee will be billed to you at the following appointment and has to be paid in full prior to being seen again by our practice. This fee is for all of our patients regardless of insurance carrier.

By signing below, you acknowledge that you have read and understand this policy. You have the option not to sign and agree to this policy; however, doing so would mean that we are unable to process any medication prior authorization requests on your behalf.

Thank You.

Patient Name: _____ Date: _____

Patient Signature: _____