

Demographics				
Patient Name:	Home Phone:	Work Phon	e:	-
Address:	City/State:		Zip:	_
Date of Birth:	Social Security Number:			
Employer:	Employer Address:			_
Spouse's Name:	Spouse's Employ	/er:		_
Emergency Contact:				
Name:	Relationship:	Phone:		
Referring Physician:		Phone:		_
PRIMARY INSURANCE:	CONTI	RACT #:		_
GROUP #:	SUBSCRIBER'S NAME:		DOB:	_
SECONDARY INSURANCE:	CONTR	RACT #:		_
GROUP #:	SUBSCRIBER'S NAME:		DOB:	_
IS INJURY COVERED BY AN AUTO	OMOBILE ACCIDENT INSURANCE?	YES	NO	
DATE OF ACCIDENT:	STATE: CLAIM N	UMBER:		_
NAME OF INSURANCE COMPANY	:P	HONE #:		_
ADDRESS:	NAME OF ADJUSTER: _			_
	PHONE:			
ATTORNEY ADDRESS:			_	
	PHONE:			
Market and the second and the second and the second				
IS INJURY COVERED BY WORKER	RS COMPENSATION?	YES	NO	_
DATE OF INJURY:	STATE: CLAIM NL	JMBER:		_
NAME OF INSURANCE COMPANY	:P	HONE #:		_
	NAME OF ADJUSTER: _			
				MILE TOTAL OF THE PROPERTY OF THE PERSON OF
	AUTHORIZATION / RESPONS	SIBILITY AGREEME	ENT	
1. I hereby authorize any insurance	company to pay the proceeds of any be	enefits due for medic	cal services provid	ed by Enhance Center
Interventional Spine & Sports to	be paid to Enhance Center Interventiona	al Spine & Sports or	to my Attorney of	record. I authorize the release
of any medical or other information	on necessary to process my claim. A cop	py of my signature b	elow can be consi	dered an original for insurance
claims processing purposes. YES	S: (initial)			
2. I have been informed of the HIPA	AA Notice of Privacy. YES: (initial)		
3.				
Patient Signature:		D	ate.	



HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Our practice is dedicated to maintaining the privacy of our individual identifiable health information. We are required by law (HIPAA, Health Insurance Portability and Accountability Act) to maintain the confidentiality of health information that identifies you.

Our Notice of Privacy Practices can be provided to you. You have a legal right to obtain a copy and review our Notice before signing this consent. You also have a right to restrict how your protected health information is restriction, but if we do, we shall honor that agreement.

The patient understands that:

- 1. Protected health information may be disclosed or used for treatment, payment of health care operations.
- 2. This office has a Notice of Privacy Practices and that the patient has the opportunity to review that Notice and keep a copy of the same.
- 3. The patient has the right to request us to restrict how we use and disclose protected health information, but we are not required by law to grant your request.
- 4. The patient may revoke this consent in writing at any time and all future disclosures will then cease'
- 5. We reserve the right to change the Notice of Privacy Practices
- 6. Get and inspect a copy of your health record.
- 7. Add information to your health record
- 8. Get a list of the times we gave out your information

Complaints:

If you believe your privacy rights have been violated, you may complain to the Privacy Offices. You may also complain to the Department of Health and Human Services. You will not be mistreated for filing a complaint.

I consent for use / disclosure of Protected Health Information & Acknowledge that I have received a copy of the Notice of Privacy Practices.

Print Name of Patier	t: Date:	
Signature of Patient Representative:	Date:	
and the reason wh	ement is not obtained, explain below the good faith efforts to obtain the ackry the acknowledgement was not obtained (describe reason, such as emergential barrier to communication):	
Print Name:	Date:	
Signature of Associa	te: Date:	

and kritis in a succession as a second artist of the set of the analysis of the second of the control of the co 化大克尔二氏连续基础合作类的复数形式 自然民族政策的法 网络沙丘亚属山丘 မေလလေး လည်းကောင် လူတွင် လူသေးသည်။ ၁၂၂၈ (၁၈) ကြို့သည် သည် သည်သည် မြောင်းသည်သည်။ မြောင်းသည်။ မေလည်းသည် မေလည်းသည် သည် မေလည်း မေးသည်မှာ မြောင်းသည်။ ၁၁၂၆၆၆ (သည်လည်းမြော်မြောက်သည်) မြောင်းသည် မြောင်းသည်။ ကြို့သို့ မေလွှေများသည် 0.25 - 22.55 E was programmed by the form the control of the state of th Transplantes and State Transplantes grand graft tig til stærkholde skrigter heldsky er en krig skrigt den er bligt til Grækk kritisk han til stærk skritisk fra skrigt for e 海绵 建铁锅 经自销货的证券 1915 la di mata din pina Carlotte Stage of the Stage 2-1 and the first of the street o r ingli anta wakika rikura ta maranza a na magazing waki galagina kan menggan menggan menggan menggan menggan menggan salah menggan segi Tanggan menggan menggan penggan menggan menggan menggan menggan menggan menggan menggan menggan menggan mengga The state of the field state of the control of the



Authorization to Release Medical Information

I authorize: Enhance Center

Interventional Spine & Sports 34020 W. 7 Mile Rd. Suite 101

Livonia, MI 48152 P: 248-516-5016 F: 248-516-5017

To release my medical records to:	
Unless otherwise revoked by me, this authorization is to be considered valid for on the stated date on this document. I understand that revocation may not be made if already been taken in reliance on this authorization.	
Patient Name: (Last) (First) Date of Birth: Phone number: Address:	
Patient's Signature:	
Parent/Legal Guardian:	



Patients Name:	Date of Birth:	

Opioid Treatment Agreement

The purpose of this agreement is to prevent misunderstandings about certain medicines you will be taking for pain management and allow the physician to prescribe to you in a safe manner. This is to help both you and your physician to comply with the laws regarding controlled pharmaceuticals.

I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship that my physician undertakes to treat me based on this agreement. I will tell the abovenamed physician all medicines which I am prescribed and understand that mixing medications which have not been prescribed to me by my physician can result in bodily harm and possibly death.

I understand that if I break this agreement, my physician will stop prescribing this class of pain medicines. In this case, my physician will taper me off the medicine over a time- period that is appropriate to avoid withdrawal symptoms. I also realize that a drug-dependence treatment program may be recommended in conjunction with an opioid taper.

I will communicate fully with my physician about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to improve my overall functionality and ability to complete activities of daily living.

I will not use any illegal substances including but not limited to the following: marijuana, cocaine, heroin, etc.

I understand that if I am pregnant or becoming pregnant while taking these opioid medications, my child would be physically dependent on these medications and withdrawal can be life-threatening.

I will not share, trade, sell, or otherwise permit others to have access to my medication with anyone. It should be also understood that any medical treatment is initially a trial, and that continued treatment is contingent upon evidence of benefit.

I understand that my opioid medication will be prescribed by one physician and I agree to fill my prescription at only one pharmacy. I agree not to take any pain medications or mind-altering medications prescribed by any other physician without first discussing it with the above-named physician. I give my physician permission to verify that I am not seeing other physicians for opioid medications or going to other pharmacies.

I agree to store this medication safely and understand that lost, stolen or misplaced medication may not be replaced without a valid police report.

I agree to take this medication as prescribed and not to change the amount or frequency of the medication without discussing it with the prescribing physician. Running out early, needing early refills, escalating doses without permission are signs of misuse and may be reason for this physician to discontinue this agreement.

I agree that refills of my opioid medications will be made only at my scheduled office visits. I also agree to make a return office visit prior to my prescriptions end. I will bring all used and unused medications with me to each of my appointments and realize that my failure in doing so can end this opioid

om til en flytte pråstallen stom til etter sammen, och bleger att i till et att en kallen en kallen. Till till till etter kallen kommen stom til etter kommen kallen etter till etter skillen kallen kallen kommen

a Major dia aliang gregoria. In and dia ang aliang an gga barais an ga magasa dibbata aga sa sa bada Bada ga ga ang dia dia gregoria, manamang ang digitang kangkang kanadak anag dia dag kangga bada ga mag

tin der nige er <mark>kontresse</mark>n er militar i det er den montressen i till blikken med en med er er det er er det er Det er det ekken kom til statt godern det er tilken er til en er blikken et et et er til kommerkjoksen en gode

ou de tronsée de jugidens et luggign des la relation et et établique de june de la cellante de la journaise de La compressión de la compresión de la filte de la material de fortales en la filte de la seste de la compresión

प्रतापक करते हैं के स्थापन के किस के समाने के स्थापन के स्थापन के किस के स्थापन के स्थापन के स्थापन के किस कर इस के समाने के किस के समाने के किस के समाने के इस के समाने के समाने

,我们*我没*身婚^我就不能不停。我们

i maggardas idielikas, no k

医多类性 医维克氏检查检检尿病 医皮肤 第一天的建筑模型 人名巴西斯 多人。

with tradel to appropriate could be appropriate

医多克氏 医二甲酚 医二氏试验检尿

and the contract of the state o

o digregio surpo estresso o capación de

त्र । इंग्रह्मानी स्वयं असीत राज्य जे असी एका असेकारी स्वयं असी

· 医糖尿管 的复数 高 斯特斯 医多角性病

建多 化电离管

r British i Arthrida (1964, 184, 184).

glade on the confidence of the continue of

granda kurusta je i je koja ki u kojajana sadaj prakljaj koja, dila ale. Programa stranska je in jedana stranska je in jedana in jedana in jedana je in jedana in jedana in jedana in j

からx Appropriate National Setting Common Texting Texting Common T

a to the same of a make an energy at the

De la companya della companya della companya de la companya della companya della

o anto rejective los tronses, que traba de la comito de la Carriera de la comito de la comi

and the self-time and self-time to the self-time territory



agreement. No refills will be provided without a scheduled appointment. No refills will be provided on weekends or after clinic hours.

I will go to all appointments, treatments and meetings that my physician wants me to, such as Behavioral Health.

I have been instructed that I will be asked to provide urine samples randomly to insure I am taking the appropriate medications and avoiding medicines or drugs which are not being prescribed by the above-mentioned physician.

I agree that disruptive behavior in the clinic, by telephone, or other electronic media will result in immediate dismissal from the Pain Clinic.

I understand that opioid medications have numerous side effects including but not limited to the following: confusion, changes in thinking ability, decreased reaction time, constipation, dry mouth, vomiting, aggravation, depression, sleepiness, drowsiness, problems with coordination or balance that may make it unsafe to operate dangerous equipment or motor vehicles, hormonal imbalance (feminization in men, masculinization in women), decreased respiratory rate, addiction and death. These side effects can be made worse if opioids are taken with other drugs including alcohol.

I understand that there is a risk that opioid addiction can occur. People with a history of alcohol or drug abuse problems are more susceptible to addiction. Should I exhibit signs of addiction the medications I am being prescribed will be discontinued and I will be referred to a drug treatment program for help with this problem.

This instrument embodies the whole agreement of the parties and there are no promises, terms, conditions or obligations other than those contained her in. This agreement shall supersede all previous communications and agreements, verbal, or written, between the parties hereto and not contained herein. This agreement may be amended in writing without affecting the validity of the remaining portions and provisions contained therein.

By signing below, I agree to the above-mentioned terms. If I chose to not abide by the above mentioned, the prescribing physician may refer me to drug-dependence treatment and/or could be terminated from the clinic.

Patient Signature:	 Date:	
0		



CONSENT FOR DIAGNOSTIC AND THERAPEUTIC PROCEDURES

I hereby consent to and authorize a physician of Enhance Center Interventional Spine & Sports and any other Health Professionals as designated, to perform a physical examination and diagnostic testing which is deemed medically necessary for my treatment. I also consent and authorize Enhance Center Interventional Spine & Sports physicians to prescribe a therapeutic treatment plan, which I shall follow. Unless I explicitly refuse, I consent to diagnostic procedure(s) ordered by the physician despite the risks involved and/or complications that may occur, which will be explained to me at the time the procedures are ordered.

PERMIT TO SUBMIT MEDICAL CLAIMS

I request that payment of Medicare benefits (or other insurance company benefits) be made on my behalf of Enhance Center Interventional Spine & Sports, for any services provided by those physicians or by Enhance Center clinical staff upon physicians' orders. I authorize the release of the medical information about me, which is necessary to process my claims, to the insurance companies with which I have coverage. I understand that it is my responsibility to provide complete and accurate information about any insurance(s) that I have. I authorize my insurance companies to release information about me that is related to my eligibility for benefits or coverage of specific services, to Enhance Center. I understand that Enhance Center agrees to accept the payment made by Medicare and/or other insurance companies as its full charge. I am only responsible for the deductible amount, co-payment amount or any amount for services not covered by my insurance.

Patient (Print):	Date:	
Patient (Signature):	Date:	

gar interdesion di Honta data georgi in ing Pilang Dagar Hannagar n<mark>g padagaikan bibalan ing waka</mark> and the first of the control of the second o 나 그들은 그렇게 되는 그림으로 하는 말을 그렇게 그렇게 되는 사람들은 사람들이 나를 다 나를 다 다 다른 사람들이 없었다.

ta de la compatible de l'estrega y versa para de fill de la compatible de la compatible de la compatible de la ရေးကျက် ကြောက်မြေရေးများများ ရှင်းကြိုင်းမှာမြောက် ကြိုင်းမှာ မြောင်းမှာပြုပေးသည်။ မြောင့်ကြောင်းများမြောင်းသည်။ ၁၉၉၆ ချ का करा है। इस बार के बार के अपने का अपने का अपने के अपने के लिए हैं। उन्हें कि अपने की अपने की अपने की अपने की



ACKNOWLEDGEMENT

I hereby authorize Enhance Center Interventional Spine and Sports to furnish my attorney with a full report of services for myself in regards to the accident in which I was involved.

I hereby authorize and direct you my attorney to pay directly to said facility such sums as may be due and owing them for services rendered both by reason of this accident and by reason of any other bills that are due and to withhold such sums from any settlement, judgment or verdict as may be necessary adequately to protect said facility. I herby further give a lien on my case to said facility, again any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, of myself as a result of the injuries for which I have been treated or injuries in connection herewith.

I fully understand that I am directly and fully responsible to said facility for bills submitted by them for services rendered me and that this agreement is made solely for facility additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover sad fee.

I agree to promptly notify said facility of any changes, additions of attorney(s) used by me in connection with accident and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substitution of added attorney(s)

Signature:	Date:
Patients Name (print):	
agreement and agrees to	ttorney of record for the above patient does hereby agree to observe all the terms of this withhold such sums from any settlement judgment or verdict as may be necessary, nance Center Interventional Spine and Sports.
I hereby consent to hono client's providers.	r the terms of the above agreement in its entirety. I further agree to dispense all fees to my
Signature:	Date:
Attorney's Name (print):	
Address:	
Attorney's Phone #:	

The region of the experience of the second of the energy of the property of the experience of the expe

the first of the f

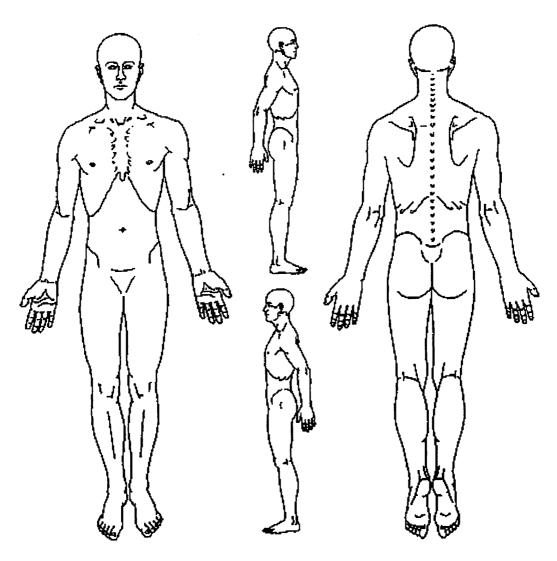
ति स्वाहित है। ति स्वाहित के क्षेत्र के प्रकार के प्रकृति के प्रकृति है। विकास के किया के किया है। विकास के कि स्वाहित के किया के किय स्वाहित के किया के किय

PAIN DATA:

1. Please mark an "X" on the line which best represents how SEVERE your pain problem is:

NO PAIN MOST SEVERE PAIN YOU CAN IMAGINE

2. PLEASE SHOW WHERE YOUR PAIN IS. DOES THE PAIN TRAVEL?



3. Please indicate your pain score on a scale of 0-10. $0 = No pain an$	nd 10 = Worst pain you can imagine	
Your pain score at its BEST is:, at its WORST is:	and on AVERAGE is:	
4. Are any of these symptoms associated with your pain?	5. When is your pain worse?	
(Please check if any apply) □ Numbness	□ Morning	
□ Weakness	☐ Afternoon	
☐ Loss of bladder control	☐ Evening	
 Loss of bowel control 	☐ No typical pattern	

				•
		r garaga		S. Davidson (1996)
			eraka fijile di kabupatè Kabupatèn	The state of the s
		135 (1) (1) (1) (1) (1) (1) (1) (1) (1) (1)		
				See the second
		1 (4) 1 (1 (4) (4) (4) (4) (4) (4) (4) (4) (4) (4)		
en e				
	Parking and Table 1	For state of the first	ing series of the series of th	jana ar kudibi n
		ing the least of the least		erine gerale erine e Erine erine er
				· · · · · · · · · · · · · · · · · · ·
	r karangan karang Kabupatèn Kabupatèn			on the second of
	•		**************************************	

Please check the word(s) in	each column that best describe	s your average pain in the past me	Jimi.
Internates:	Reaction		Sensation
Intensity	☐ Intolera	ble	☐ Piercing
☐ Excruciating	☐ Misera		☐ Stabbing
☐ Extremely strong	☐ Distres		□ Shooting
☐ Very strong		-	□ Burning
□ Strong	☐ Tolerat		☐ Grinding
☐ Moderate	□ None		☐ Throbbing
□ Mild	None		☐ Cramping
□ Weak			□ Aching
□ Very weak	•		□ Stinging
☐ Just noticeable			□ Squeezing
□ None			□ Numbing
□ Variable			□ Itching
			☐ Tingling
			□ None
			□ Non-descriptive
How do the following affec	t your pain? (Please check one	for each item)	
	Pain is better	Pain is worse	No difference
Chandina			
Standing Sitting			
Walking	0		
Lying down			
Cough or sneeze			0
Lifting			
Bending forward	0		
Bending backward	0		
Turning			<u> </u>
Climbing stairs			
Going down stairs			
Medication			The state of the s
Application of ice			
Application of heat			
Rest			
Weather changes			0
Urination			
Bowel movement			
Traveling in a car		<u> </u>	
	eep? YES NO	(please circle)	
8. Does pain interrupt your sle	eep?	(Product control)	
0. When did you first experies	nce the pain for which you are r	ow seeking help?	
9. When did you mist experies			
		_ , _ ,	estances currounding the onset of your
10. How did your pain beg	in?		nstances surrounding the onset of your
☐ Accident at work		pain:	
☐ Accident at home			
□ Car accident			
☐ Other accident	••		
☐ At work (not an acc	eident)		
☐ Following surgery			
☐ Following illness	any trigger (cannot		
☐ Pain began without relate to anything)	any ingger (cumor		
relate to anything)			

			· 1		
e de la companya del companya de la companya del companya de la co					
	•				
•	· · · · · · · · · · · · · · · · · · ·	n fin in de la light million	Strategy paragraph	taati ee dhaa	
÷ .					
			e imagin		N
		<u></u>			
	nghi et chil				
				्रिक और दूर राज्यकर है।	
	The state of the s			1987 (A. 1988) (A.	٠
•					
•					
	The state of the s				. •
	ে ইছমঞ্চিট্, পুন				*
	and the second of the second of the second				
			ľ		
	in the state of th				
				Carlotte Car),14
	Talong of the			- Distriction of the	
	Taking St		1		· · · ·
	वस्त्रीक्ष्मी, क्रि				
	The state of the s				
					4
•	•	《····································		and the state of t	yzerii.
	e e e e e e e e e e e e e e e e e e e				., .
			[46] s		•
					M. 1. K
			1		in figure
:					
			3		
				AND THE RESERVE OF	
				그 그 그 그 그 그 이 생각 속하는 것.	
					40,000
*					
The second second	#-				
				ering of the second of the sec	
		the state of the s		The state of the same	
•					
•		er navnasti kirja koja programa i se		化放射 化射线电影电影电影	
	Significant Control	or the text of the constitution of	. 1		
				o proporti de la compania de la comp La compania de la co La compania de la compania del compania de la compania del compania de la compania del la compan	
					•
er e				en e	
				And the second of the second o	
				- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	
			No. 1		

11. Since your pain conditio	n began, whic	h of the followin	g therapies I	have you	ı received?	(Check	all tha	it appl	ly)	
 □ Acupunctur □ Manipulatio □ Nerve block □ Operations □ Psychologio □ Family or n □ Biofeedback 	nscutaneous Ne e on-chiropracto ss cal/psychiatric narriage couns k and/or relax	counseling seling ation training								
12. Please list all of the drug (by circling the appropriate r	gs, including n number) how o	onprescription (c effective these dr	over-the-cou ugs were.	nter) dr	ugs, you hav	e take	n for y	our Pa	AIN condi	tion and indicate
Medication	Dose	Frequency	Prescrib	ed by	Not at	Effe	ctiven		Very Effective	Check here if still taking
					1	2	3	4	5	
					1	2	3	4	5	
					1	2	3	4	5	
					1	2	3	4	5	
					1	2	3	4	5	
					1	2	3	4	5	
					1	2	3	4	5	
					1	2	3	4	5	
			 		1	2	3	4	5	
	lies related to	your pain condit	ion:							
13. Previous diagnostic stud	nies related to	When			Where	:			Orderin	g Physician
□ MRI										
□ EMG/NCV										
□ CAT Scan				<u>.</u>			<u></u>			
☐ Myelogram										
☐ Bone scan										
☐ Arthrogram										
□ Plain X-RAY										
□ Diskogram										

			e su diserbil			
						• *
			* 1		,	
						en kjerreger i se i se i se
				•	.1	
		e,		•	ignorial factorial for the state of the stat	
est to the				e de la companya de La companya de la co		
					- (40). - (41).	
					The second section of the second	
	•		14.	**		新文
and the second second	gay 🌬 - e saet i k	and the same			en in the english of	
	•		until grander Line grander Line grander Line grander			하는 사람들이 되는 말다. 생각 사람들이 되었다.
	100		n Parish a n			
	가 사용하는 경우 기계 기계 기					
		<u>.</u>				
en e		the state of the state of				
		•				e to the second of the second
			And the second s	- 4	No. of the second	
	ï.	•	e e e e e e e e e e e e e e e e e e e	. 1 25		
	- , - ,					· · · · · · · · · · · · · · · · · · ·
						in the second of
	= 1					
			<u>.</u>	•		
		*•				
e de la companya del companya de la companya de la companya del companya de la co			• •			
				•		
and the second of the second o		**	· John Sta			NO. 1
		A. Carrier				
						angent in the specific of
	And the second s					
			And the second		t seed to the seed of	en e
			<u> </u>	***		
• • • • • • • • • • • • • • • • • • •				* * *		
						N. Weilliam March 1997 and St. Communication of the
	* *			÷. •		
		1		-		
	9 · ·				VIII 100 140	
	1,7		•			
	•					
		······································				
			*			
		. *				
•						
				* .		
			•		•	
	•					•
	en egua e e care a c				r dag var	

NAME	SPECIALTY	DATES	
15. Are you currently receiving problem? YES NO (please c If yes, please check ALL the appropriate the compensation.	ircle)	to your pain? YES No	n any legal action (e.g., court case) related O (please circle) what type of legal action you are involved
 □ Workers' Compensation □ No-fault Auto Insurance □ Social Security Disabili □ Supplemented Security □ Sick Leave Disability B □ Long-term Medical Disability 	e ty Income enefits	automobile, owi	lt Insurance iird party (Employer, driver of another ner of the company where you got hurt, a
MEDICAL DATA: 1. Past medical history (Please chespiratory Asthma COPD/Emphysema	eck if you have had any of these services of the ser	medical conditions before) Endocrine Diabetes Thyroid disorde	Blood Disorder Anemia HIV/AIDS
Cardiovascular ☐ Congestive heart failure ☐ High blood pressure ☐ Blood clots in the leg ☐ Heart attack	Neurology ☐ Seizures ☐ Stroke (CVA) ☐ Mini Stroke (TIA) ☐ Paralysis ☐ Headaches	GI/Hepatic/Pancreatic Cirrhosis Pancreatitis Ulcer Gastritis Hepatitis	Rheumatoid/Connective Tissue Disorder Gout Arthritis Sceleroderma Ankylosing Spondylitis Fibromyalgia
Cancer ☐ Type: 2. Review of symptoms: Have ye	ou had any of the following symp	toms in the last 2 weeks?	☐ Lupus
General ☐ Unexpected weight loss ☐ Fever	Endocrine	lange	Neurological Headaches Dizziness
Gastrointestinal/Abdomen Nausea/vomiting Constipation Abdominal Pain Blood stool	Hematologic/Hepa Jaundice <u>Cardiopulmonary</u> Chest pain	<u></u>	Genitourinary Urinary retention Blood in urine Abnormal menstrual cycle
Musculoskelatal Muscle weakness Swelling of extremities	☐ Fast heart i ☐ Cough ☐ Wheezing ☐ Shortness o		Eyes ☐ Visual disturbance Ear, Nose, Throat ☐ Ringing in the ears
<u>Skin</u> □ Rash	□ Require ox	3 Pen auphiement	☐ Hearing disturbance☐ Bleeding gums

	to and the transfer where the state of the s	्रा क्षित्रे के किया है। जिस्से के प्राप्त के किया है किया है। जिस्से के किया है किया है किया है कि किया है कि किया किया किया किया किया है कि किया किया किया है कि किया किया किया किया किया किया किया क
en e		
en e		
	in the second of	
	(唐·大学) 新一克 (1) (1) (2) (##1065	
	The second of th	
A CHANGE AND A BEBLE OF THE COMMENT OF THE COMMENT A CHANGE OF THE COMMENT OF TH		The state of the s
		August Springer
and the second of the second o		
		s military is a superior of the superior of th
		A State of the Sta
		The first of American Section 1
र प्राप्त असे सुन्दारिको है। स्टब्स् भागीतिक वस्त पुरस्कार है।		
		A Part of the second second
er en		
のでは、 最後の数据をよっては表現である。 となっては、	· 문화가 살아야 하는 것 같습니다.	
A STATE OF THE STA		•
		1.14 i 2.44 f

3. Family History: Does any blood relat ☐ Rheumatoid arthritis	ive in your family	have the fo	ollowin	ig? (Pleas	e check, if yes to any)	
☐ Cancer						
□ Lupus□ Headaches						
☐ Headaches ☐ Heart disease						
☐ Diabetes						
☐ Fibromyalgia						
☐ Blood disorder						
4. Please list any major surgeries that yo	u have had in the	past:		W	nere	Surgeon
Type of Surgery	When				icic	
e a sussimilar and blood th	inners?	YES	or	NO	(please circle)	
5. Are you currently taking any blood the If YES, please list out all blood thinners	immers: (anticoagulants) ir				(р.одос систе,	
Medication Dose	<u>F</u>	requency		<u> </u>	rescribed by	For how long
	-					
			~			
c a l'annual de la malatad	modications?	YES	or	NO	(please circle)	
Are you taking any non-pain related If YES, please list out all of the medication	ons that you are cu				(
Medication	<u>Dose</u>	•			Frequency	
				-		
		YES	or	NO	(please circle)	
7. Are you allergic to any medications? If YES, please list which medications: _		1 63	OI.	110	(produce entere)	
ii 1 Eo, piease list which medications.						
8. Are you allergic to contrast dye?		YES	or	NO	(please circle)	
9. Are you allergic to latex?		YES	or	NO	(please circle)	

en e		A control of the cont
		The first of the f
•		
and the state of t		The state of the s
		- Settle : Depth party of a set of the set of
and the second of the second o	en e	
		• · · · · · · · · · · · · · · · · · · ·
	en e	- Comment of the second of the
	en e	A STATE OF THE STA
		The state of the s

SOCIAL HISTORY:							
1.	1. Marital Status (choose one):SingleMarriedSeparatedDivorcedWidowed						
2.	Present living situation (if living with more than one individual, ch	neck primary	head of househol	ld):			
	AloneWith spouseWith childrenWith parentsWith friendWith other family member						
3.	Substance intake per day:						
Caffeine (coffee, tea, cola, etc.): Number of drinks							
	Nicotine (cigarettes, cigar, pipe, etc.):		Pk/day	′	_ Yrs		
4.	Alcohol intake (choose one):						
	NoneRarely(less than 1 drink per month)Occasi	onally (less th	nan I drink per w	eek)			
	Regularly (2-3 times per week)DailyFormer abu	ıser					
5.	Have you used any of the following drugs? (Choose all that apply):					
	MarijuanaAmphetaminesCocaineHeroin	_None of th	ese _Other (p	lease sp	pecify):		
	Former abuser						
	When was the last time you abused any of the above drugs?						
P	SYCHOLOGICAL HISTORY:					D 1	
ſ	Do you feel sad?		Frequently				
	Do you feel helpless?	Always	Frequently	_Oc	casionally	Rarely	
	Do you feel hopeless?	Always	Frequently	_Occ	casionally	Rarely	
	Do you feel tense and worry all the time?		Yes		_No		
	Do you ever act in angry or aggressive ways? (for example: breaking objects, hitting other people) Yes No						
	Do you have any history of mental health treatment by aYesNo psychiatrist, psychologist, or other mental health professional?						
	Have you ever been hospitalized for psychiatric reasons?		Yes		No		
	Do you have panic attacks?		Yes		No		
	Are you a claustrophobic?		Yes		_No		
	Have you ever had any thoughts of wanting to die?		_Yes		_No		
	Do you presently have any thoughts of harming or hurting anyone or yourself?		Yes		_No		

er in eggil keers with to incurre a trible entre The sound of the sound of sound the site of the i i i i erro g spirit ay a Military de la traditional de la secondad धर्म (क्षेत्र) स्थाप स्ट्राप्तको २ The first of the particular texts of the medical capacity of the officer Capting to the open and the control of ti i tinggang i tinggang katalong an ma The state of the s Carried Control of the Control of th The same of the sa 的 医海绵性溶液 建氯酚磺胺异亚酚 Andrew Line



CONSENT FOR DIAGNOSTIC AND THERAPEUTIC PROCEDURES

I hereby consent to and authorize a physician of Enhance Center for Interventional Spine & Sports and any other Health Professionals as designated to perform a physical examination and diagnostic testing which is deemed medical necessary for my treatment. I also consent and authorize Enhance Center for Interventional Spine & Sports physicians to prescribe a therapeutic treatment plan, which I shall follow. Unless I explicitly refuse, I consent to diagnostic procedures(s) ordered by the physician despite the risks involved and/or complications that may occur, which will be explained to me at the time the procedures are ordered.

Patient Signature/Guardian Signature

Date

and the strategies of the figure of the company of the figure and the company of o etros massignos especias de país infrar in a fill especia de ser el como de la persona de como de la como de Total partir de la capacidad de la compansión de la capacidad de la capacidad de la capacidad de la capacidad out biselo del teologico en februar i con l'Agent del Carleges e la continue di servici del Afric

ENHANCE CENTER ASSIGNMENT OF RIGHTS

FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFITS (Michigan)

I understand that I am responsible for paying my copayments, coinsurance, and deductibles at the time of service. I also understand that I am responsible for any balance due after payment by my insurance company.

I, the undersigned, understand that Enhance Center will bill my insurance carrier for services rendered upon verification of coverage by my insurance company. I understand that verification of benefits is not a guarantee of payment and my financial responsibility is subject to change. If my insurance company fails to render payment for services rendered, I hereby personally guarantee payment for medical care and services rendered. If my insurance company does not remit payments, I understand that I will be responsible for the balance due in full.

Pursuant to the assignment of benefits herein; I hereby request that my insurance carrier make payment directly to Enhance Center for all services rendered by this facility. If my current policy prohibits direct payment to Enhance Center, I hereby instruct and direct my insurance carrier to make the check out in my name but send the check to Enhance Center, 34020 W. 7 Mile Rd., Livonia MI 48152. If my insurance carrier makes payments to me I agree to immediately pay over these funds to Enhance Center. I also authorize Enhance Center to deposit check received on my account when made out to me. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees. (Name of Patient/Legal Guardian/Parent responsible for payment on account:

Charges related to Workers Compensation injury shall be forwarded to the Workers Compensation Insurance carrier and I will not be held personally responsible for these charges. However, if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

We accept assignment from Medicare, so payment will be made directly to our office. We are required by law to collect the 20% coinsurance either by supplement insurance or it is the patient responsibility. If you do not have any supplemental insurance this will be collected from you at the time of service.

ASSIGNMENT OF BENEFITS

I, the undersigned, herby assign to Enhance Center any and all rights, cla benefits available to me under the policy affording coverage to me for a resulting from an automobile accident that occurred on	
. This is to act as an assignment of my rights and be the event that I do not have insurance coverage, I understand that I rem rendered including all costs of collection, including attorney's fees and co	•
I agree that as consideration for this assignment, the burden to pursue p insurance company or entity responsible to pay for such services may in	•
1)submitting bills directly to the insurance company or entity, 20 pursuing to pay bills for payment of bills, 3) incurring any expense associated with retaining the services of an attorney or collection agency to pursue payment terminated by mutual agreement in writing by assignee and assignor.	pursuing payment of assignee's bills, 4) hiring or
Print Name of Patient	Date
Patient Signature/Guardian Print and Sign Name	Relationship to Patient

ntiga. <mark>Pro Paraja kota 1984</mark>.

or was careful to the end of and whight or an interfer a paid

of the congress and appropriate and best

State of the state

A Company of the control of the cont

and the second of the second

And the spring of the second

to the control of the

3. 1

e man ar e li li li li li

and the state of the control of the

nere l'especies estrops d'appresent le la segment et en le la propriété en en estre de la company de la compan La responsión en al l'emperiment de la la responsión de la company de la company de la major de la company de La responsión de la l'emperiment de la company de la c

and the second of the second o

The configuration of the first section of the configuration of the confi

But the contract of the contra Here we have the constant of the constant of the second $x \neq \infty$

a program i seggi e i salaka karana a manana a salah permanya i salah ke

ang an isang manggaran kanala sa 🚀 sa sa sa pa

en la recommuna de la communicación de la communicación de la communicación de la communicación de la communic

the first of the second section is a second second

and the comment of the first that it is a first of the fi

to see the second of the secon

OPIOID START TALKING (MUST BE INCLUDED IN THE PATIENT'S MEDICAL RECORD)

Michigan Department of Health and Human Services

Patient Name				Date of Birth				
Nan	Name of Controlled Substance containing an Opioid							
Dos	Dosage Quantity Prescribed (For a minor, if signature is not the parent or guardian, the prescriber must limit the opioid to a single, 72 hour supply)							
Nun	nber of refills	L						
		bstance is a drug or other substance that the		ment Administration has				
a.	The risks of	substance use disorder and overdose associa	ted with the controlled substance	e containing an opioid.				
b.	Individuals	with mental illness and substance use disorders (Required only for minors.)						
C.		ids with benzodiazepines, alcohol, muscle relax cause serious health risks, including death or c						
d.		e who is pregnant or is of reproductive age, the it not limited to neonatal abstinence syndrome.	heightened risk of short and lon	g-term effects of opioids,				
e.		nformation necessary for patients to use the dru section of the labeling for the controlled substa		in the patient counseling				
f.	f. Safe disposal of opioids has shown to reduce injury and death in family members. Proper disposal of expired, unused or unwanted controlled substances may be done through community take-back programs, local pharmacies, or local law enforcement agencies. Information on where to return your prescription drugs can be found at http://www.michigan.gov/deqdrugdisposal .							
g.	g. It is a felony to illegally deliver, distribute or share a controlled substance without a prescription properly issued by a licensed health care prescriber.							
I acknowledge the potential benefits and risks of an opioid medication as described by my provider along with the responsibility of properly managing my medication as stated above.								
Sign	nature of Prescrit	per (when prescribing to a minor)		Date				
Signature of Patient, if a minor, patient's parent/guardian Date								
Signature of Patient's Representative or other authorized adult Date								
Printed Name of Parent/Guardian; Patient's Representative or other authorized adult								
disc natio	riminate against onal origin, color,	tment of Health and Human Services (MDHHS) does not any individual or group because of race, religion, age, , height, weight, marital status, genetic information, sex, ender identity or expression, political beliefs or disability.	COMPLETION: Required.	_ 333.7303b and MCL 333.7303c enial, fine, suspension, revocation or				

kalangan madakan di dikebengal kalang mengalangkal di mengalangan di mengalangkan sebagai kang sebagai kang se Belanggan mengalanggan mengalanggan mengan meng representative that a recommendative the contract of the contr

An Albandar da de la companya de la La companya de la co and a complete make the transfer of a complete when the transfer

and the second of the second process of the second of the

"我们,我们就是不知识的的的,我们就是这种的事,我就是一样,这个有事。"

are for the second second