Demographics

Patient Name: ______________________ Home Phone: ______________ Work Phone: ____________

Address: ___________________________ City/State:___________________________ Zip: __________

Date of Birth: _________________ Social Security Number: ____________________

Employer: ________________________________ Employer Address: ____________________________

Spouse's Name: ____________________________ Spouse's Employer: ___________________________

Emergency Contact:

Name: ____________________________Relationship: ____________Phone: ________________

Referring Physician: ____ Phone: ______________

PRIMARY INSURANCE: _______________________________CONTRACT #: _____________________

GROUP #: ____________________SUBSCRIBER'S NAME: ________________________DOB:_______

SECONDARY INSURANCE: ___________________________ CONTRACT #: _____________________

GROUP #: ______________________SUBSCRIBER'S NAME: _______________________DOB:_______

IS INJURY COVERED BY AN AUTOMOBILE ACCIDENT INSURANCE? YES ______ NO ______

DATE OF ACCIDENT: ____________________ STATE: ____ CLAIM NUMBER: ____________________

NAME OF INSURANCE COMPANY: ___________________________ PHONE #: _____________________

ADDRESS: ____________________________NAME OF ADJUSTER: ____________________________

ATTORNEY: ___________________________ PHONE: ____________________

ATTORNEY ADDRESS: ____

CASE MANAGER: __________________________________ PHONE: ________________________

IS INJURY COVERED BY WORKERS COMPENSATION? YES ______ NO ______

DATE OF INJURY: ______________________ STATE: ____ CLAIM NUMBER: ____________________

NAME OF INSURANCE COMPANY: ___________________________ PHONE #: _____________________

ADDRESS: ____________________________NAME OF ADJUSTER: ____________________________

AUTHORIZATION / RESPONSIBILITY AGREEMENT

1. I hereby authorize any insurance company to pay the proceeds of any benefits due for medical services provided by Enhance Center Interventional Spine & Sports to be paid to Enhance Center Interventional Spine & Sports or to my Attorney of record. I authorize the release of any medical or other information necessary to process my claim. A copy of my signature below can be considered an original for insurance claims processing purposes. YES: _____ (initial)

2. I have been informed of the HIPAA Notice of Privacy. YES: _____ (initial)

3.

Patient Signature: ____ Date: ____________________

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, **H**ealth Insurance **P**ortability and **A**ccountability **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 Patient: ______________________________ Date: ______________

Signature of Patient Representative: ______________________________ Date: ______________

If any acknowledgement is not obtained, explain below the good faith efforts to obtain the acknowledgement and the reason why the acknowledgement was not obtained (describe reason, such as emergency treatment situation of substantial barrier to communication):

____

____

Print Name: ______________________________ Date: ______________

Signature of Associate: ______________________________ Date: ______________

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 one year from the stated date on this document. I understand that revocation may not be made if action has 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 above-named 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

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: ________________________

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: ______________________________

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): ______________________________

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of this agreement and agrees to withhold such sums from any settlement judgment or verdict as may be necessary, adequately to protect Enhance Center Interventional Spine and Sports.

I hereby consent to honor the terms of the above agreement in its entirety. I further agree to dispense all fees to my client's providers.

Signature: ______________________________ Date: ________________

Attorney's Name (print): ______________________________

Address: ______________________________

____

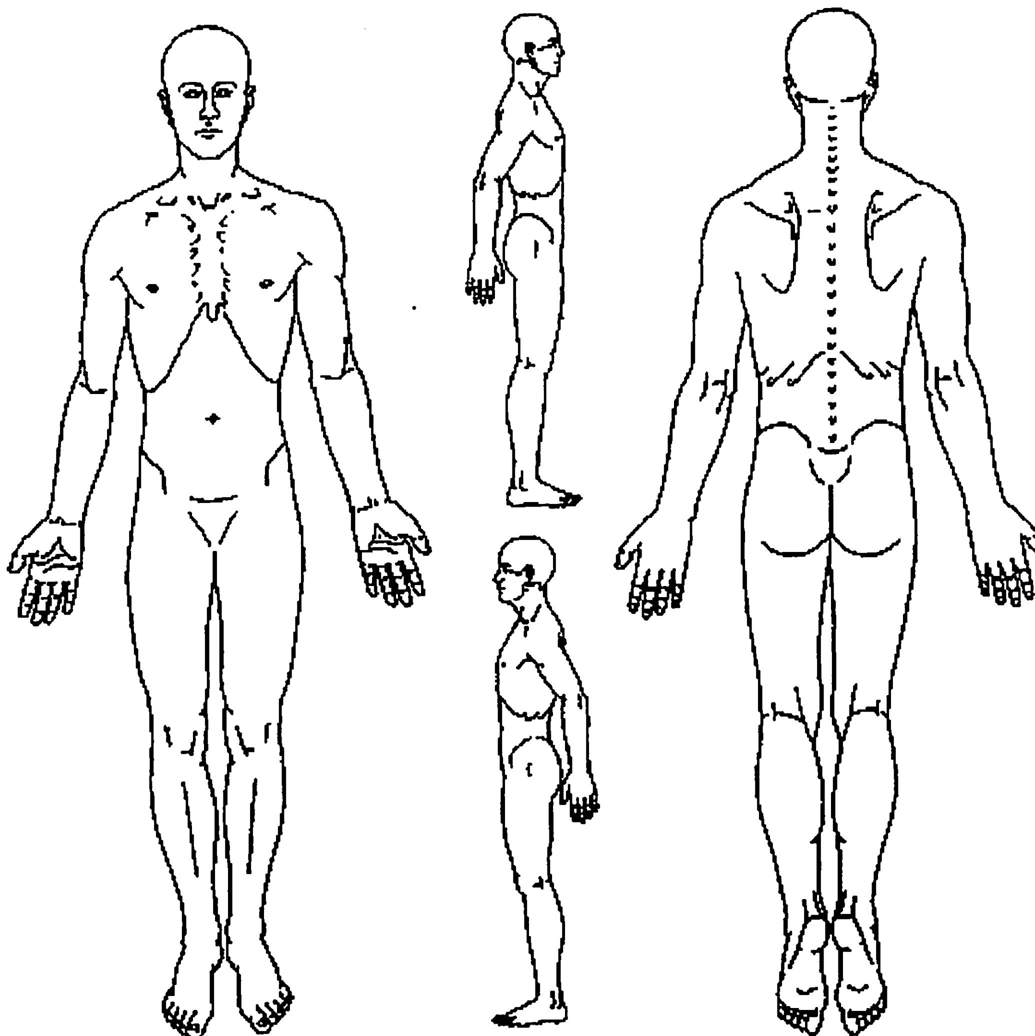
Attorney's Phone #: ______________________________

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?**

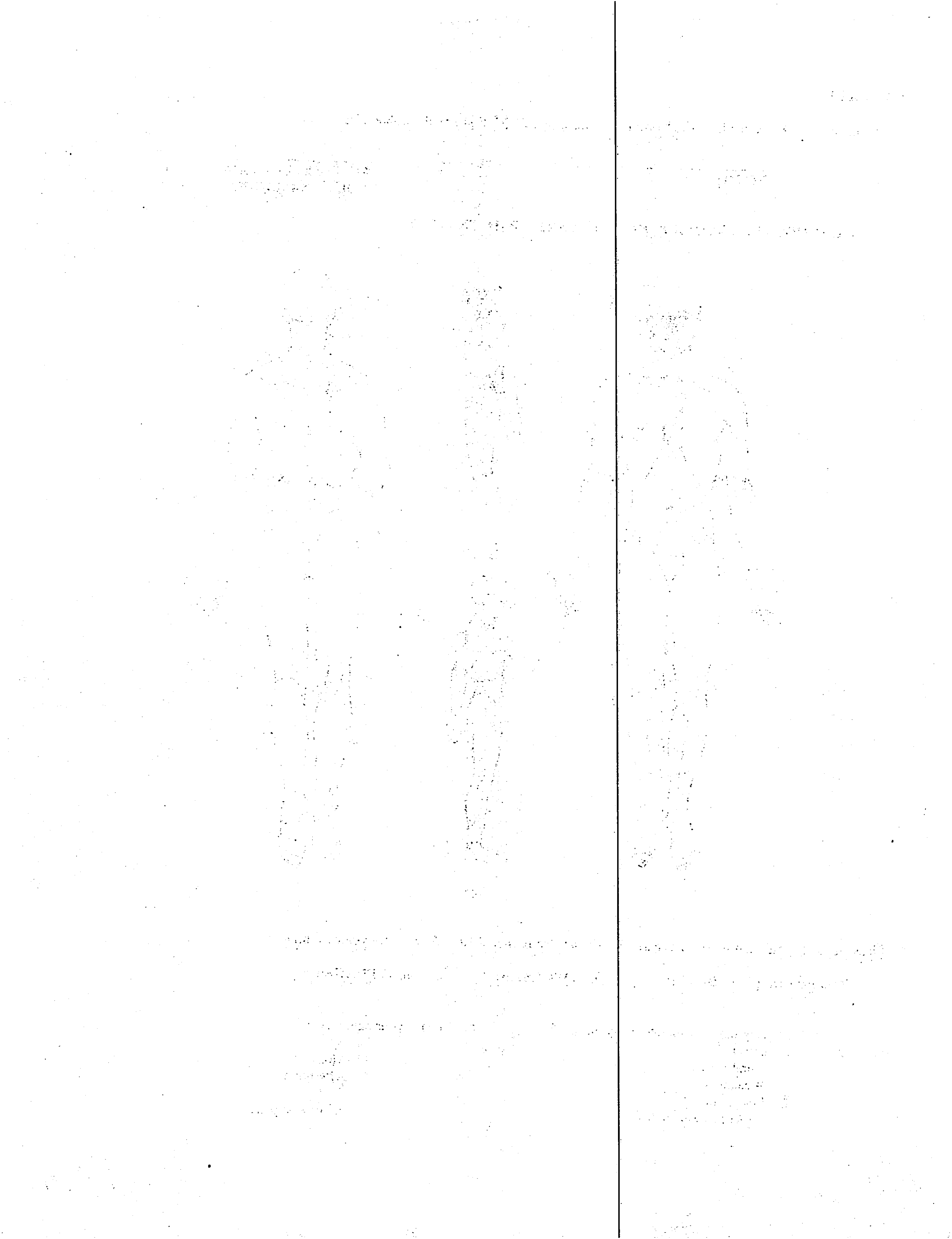


3. Please indicate your pain score on a scale of 0-10. **0** = **No pain** and **10** = **Worst pain you can imagine**

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? (Please check if any apply)
   - ☐ Numbness
   - ☐ Weakness
   - ☐ Loss of bladder control
   - ☐ Loss of bowel control

5. When is your pain worse?
   - ☐ Morning
   - ☐ Afternoon
   - ☐ Evening
   - ☐ No typical pattern



6. Please check the **word(s) in each column** that best describes your average pain in the past month:

Intensity
- ☐ Excruciating
- ☐ Extremely strong
- ☐ Very strong
- ☐ Strong
- ☐ Moderate
- ☐ Mild
- ☐ Weak
- ☐ Very weak
- ☐ Just noticeable
- ☐ None
- ☐ Variable

Reaction
- ☐ Intolerable
- ☐ Miserable
- ☐ Distressing
- ☐ Uncomfortable
- ☐ Tolerable
- ☐ None

Sensation
- ☐ Piercing
- ☐ Stabbing
- ☐ Shooting
- ☐ Burning
- ☐ Grinding
- ☐ Throbbing
- ☐ Cramping
- ☐ Aching
- ☐ Stinging
- ☐ Squeezing
- ☐ Numbing
- ☐ Itching
- ☐ Tingling
- ☐ None
- ☐ Non-descriptive

7. How do the following affect your pain? (Please check one for each item)

	Pain is better	Pain is worse	No difference
Standing	☐	☐	☐
Sitting	☐	☐	☐
Walking	☐	☐	☐
Lying down	☐	☐	☐
Cough or sneeze	☐	☐	☐
Lifting	☐	☐	☐
Bending forward	☐	☐	☐
Bending backward	☐	☐	☐
Turning	☐	☐	☐
Climbing stairs	☐	☐	☐
Going down stairs	☐	☐	☐
Medication	☐	☐	☐
Application of ice	☐	☐	☐
Application of heat	☐	☐	☐
Rest	☐	☐	☐
Weather changes	☐	☐	☐
Urination	☐	☐	☐
Bowel movement	☐	☐	☐
Traveling in a car	☐	☐	☐

8. Does pain interrupt your sleep? **YES** **NO** (please circle)

9. When did you first experience the pain for which you are now seeking help?

____

10. How did your pain begin?
- ☐ Accident at work
- ☐ Accident at home
- ☐ Car accident
- ☐ Other accident
- ☐ At work (not an accident)
- ☐ Following surgery
- ☐ Following illness
- ☐ Pain began without any trigger (cannot relate to anything)

Briefly describe the circumstances surrounding the onset of your pain:

____
____
____
____
____

11. Since your pain condition began, which of the following therapies have you received? (Check all that apply)

- ☐ Physical Therapy
- ☐ TENS (Transcutaneous Nerve Stimulation)
- ☐ Acupuncture
- ☐ Manipulation-chiropractor or osteopath
- ☐ Nerve blocks
- ☐ Operations
- ☐ Psychological/psychiatric counseling
- ☐ Family or marriage counseling
- ☐ Biofeedback and/or relaxation training

12. Please list all of the drugs, including nonprescription (over-the-counter) drugs, you have taken for your **PAIN** condition and indicate (by circling the appropriate number) how effective these drugs were.

Medication	**Dose**	**Frequency**	**Prescribed by**	**Effectiveness** **Not at All** … **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	

13. Previous diagnostic studies related to your pain condition:

	When	**Where**	**Ordering Physician**
☐ MRI			
☐ EMG/NCV			
☐ CAT Scan			
☐ Myelogram			
☐ Bone scan			
☐ Arthrogram			
☐ Plain X-RAY			
☐ Diskogram			

14. Since your pain began, which doctors or other health professionals have you consulted? Please list their names, specialties and approximate dates in the order in which you saw them.

NAME	SPECIALTY	DATES

15. Are you currently receiving compensation for your pain problem? **YES** **NO** (please circle)
If yes, please check ALL the appropriate sources of compensation.

- ☐ Workers' Compensation
- ☐ No-fault Auto Insurance
- ☐ Social Security Disability
- ☐ Supplemented Security Income
- ☐ Sick Leave Disability Benefits
- ☐ Long-term Medical Disability

16. Are you involved in any legal action (e.g., court case) related to your pain? **YES** **NO** (please circle)
If yes, please indicate what type of legal action you are involved in.

- ☐ Suit for Workers' Compensation
- ☐ Suit for No-Fault Insurance
- ☐ Suit against a third party (Employer, driver of another automobile, owner of the company where you got hurt, a government agency, a doctor)
- ☐ Suit to increase your current compensation benefits

MEDICAL DATA:

1. Past medical history (Please check if you have had any of these medical conditions before)

Respiratory
- ☐ Asthma
- ☐ COPD/Emphysema

Cardiovascular
- ☐ Congestive heart failure
- ☐ High blood pressure
- ☐ Blood clots in the leg
- ☐ Heart attack

Cancer
- ☐ Type:

Renal
- ☐ Infections
- ☐ Kidney failure

Neurology
- ☐ Seizures
- ☐ Stroke (CVA)
- ☐ Mini Stroke (TIA)
- ☐ Paralysis
- ☐ Headaches

Endocrine
- ☐ Diabetes
- ☐ Thyroid disorder

GI/Hepatic/Pancreatic
- ☐ Cirrhosis
- ☐ Pancreatitis
- ☐ Ulcer
- ☐ Gastritis
- ☐ Hepatitis

Blood Disorder
- ☐ Anemia
- ☐ HIV/AIDS

Rheumatoid/Connective Tissue Disorder
- ☐ Gout
- ☐ Arthritis
- ☐ Sceleroderma
- ☐ Ankylosing Spondylitis
- ☐ Fibromyalgia
- ☐ Lupus

2. Review of symptoms: Have you had any of the following symptoms in the **last 2 weeks**?

General
- ☐ Unexpected weight loss
- ☐ Fever

Gastrointestinal/Abdomen
- ☐ Nausea/vomiting
- ☐ Constipation
- ☐ Abdominal Pain
- ☐ Blood stool

Musculoskelatal
- ☐ Muscle weakness
- ☐ Swelling of extremities

Skin
- ☐ Rash

Endocrine
- ☐ Appetite change
- ☐ Cold intolerance

Hematologic/Hepatic
- ☐ Jaundice

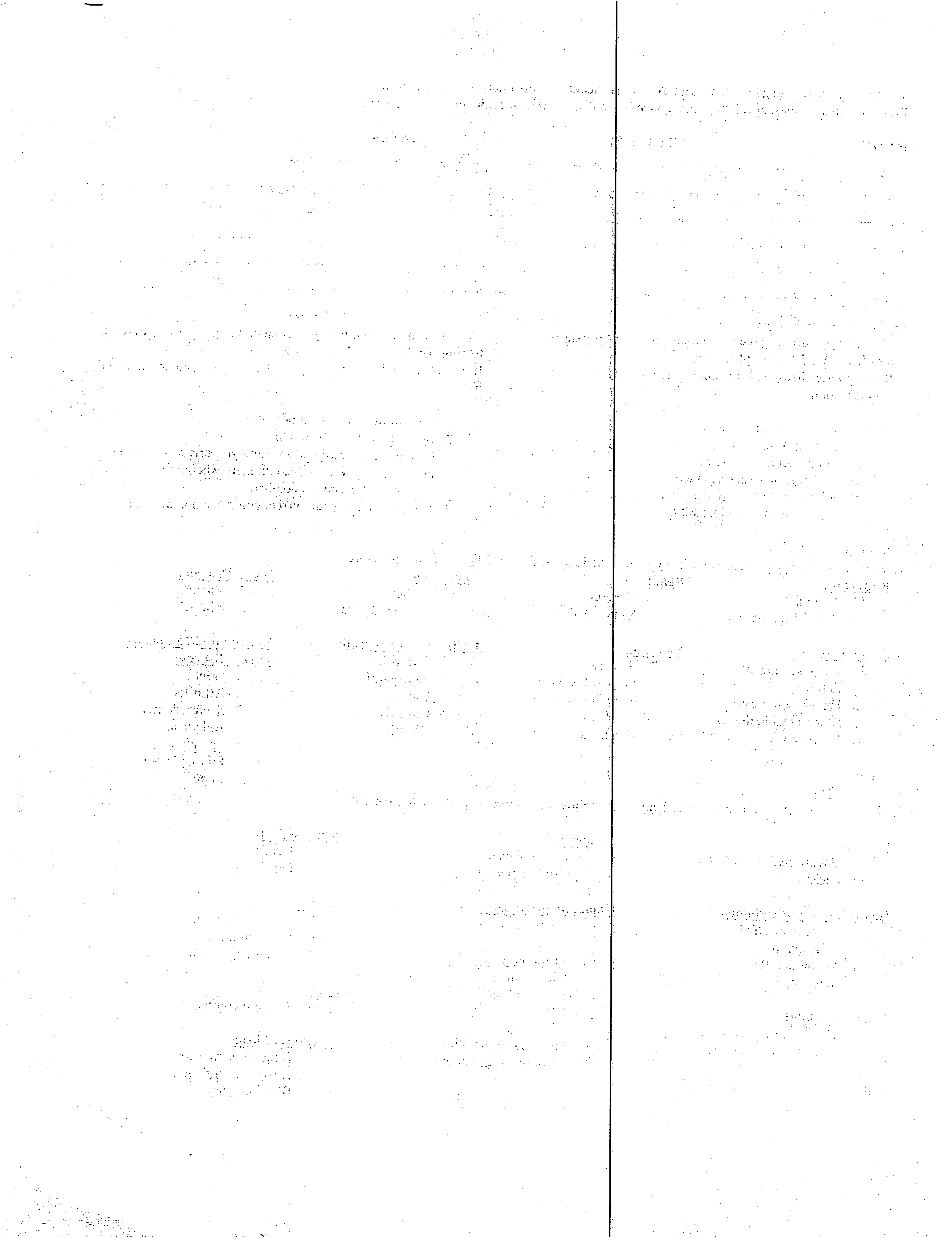
Cardiopulmonary
- ☐ Chest pain
- ☐ Fast heart rate
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Require oxygen supplement

Neurological
- ☐ Headaches
- ☐ Dizziness

Genitourinary
- ☐ Urinary retention
- ☐ Blood in urine
- ☐ Abnormal menstrual cycle

Eyes
- ☐ Visual disturbance

Ear, Nose, Throat
- ☐ Ringing in the ears
- ☐ Hearing disturbance
- ☐ Bleeding gums



3. Family History: Does any blood relative in your family have the following? (Please check, if yes to any)
   - ☐ Rheumatoid arthritis
   - ☐ Cancer
   - ☐ Lupus
   - ☐ Headaches
   - ☐ Heart disease
   - ☐ Diabetes
   - ☐ Fibromyalgia
   - ☐ Blood disorder

4. Please list any major surgeries that you have had in the past:

Type of Surgery	When	Where	Surgeon

5. Are you currently taking any **blood thinners**? **YES** or **NO** (please circle)

If YES, please list out all blood thinners (anticoagulants) including aspirin:

Medication	**Dose**	**Frequency**	**Prescribed by**	**For how long**

6. Are you taking any **non-pain related medications**? **YES** or **NO** (please circle)

If YES, please list out all of the medications that you are currently taking:

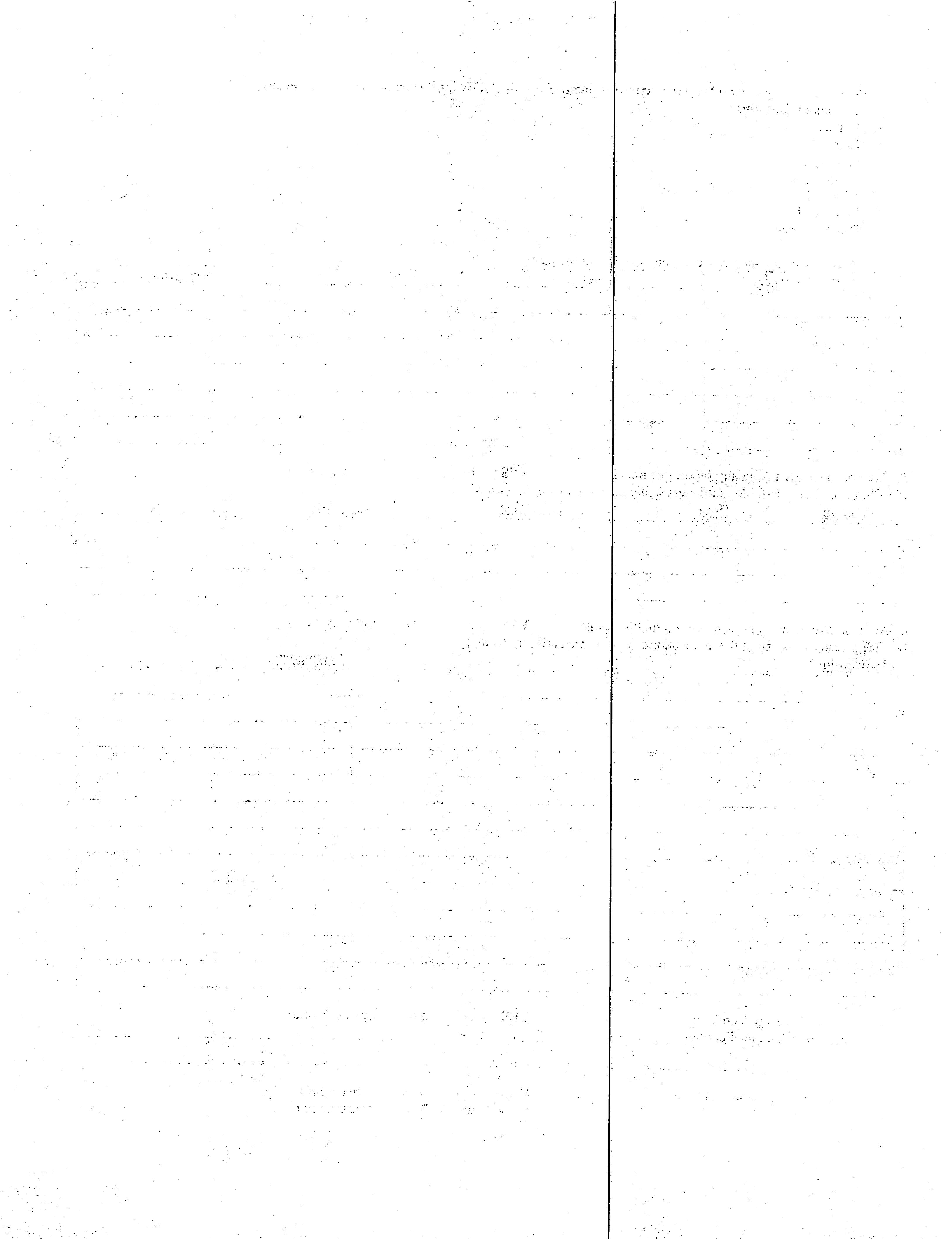
Medication	**Dose**	**Frequency**

7. Are you allergic to any medications? **YES** or **NO** (please circle)

If YES, please 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)



SOCIAL HISTORY:

1. Marital Status (choose one): __Single __Married __Separated __Divorced __Widowed
2. Present living situation (if living with more than one individual, check primary head of household):

   __Alone __With spouse __With children __With parents __With friend __With 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):

   __None __Rarely(less than 1 drink per month) __Occasionally (less than 1 drink per week)

   __Regularly (2-3 times per week) __Daily __Former abuser

5. Have you used any of the following drugs? (Choose all that apply):

   __Marijuana __Amphetamines __Cocaine __Heroin __None of these __Other (please specify): ____________

   __Former abuser

   When was the last time you abused any of the above drugs? ____________________

PSYCHOLOGICAL HISTORY:

Do you feel sad?	**__Always __Frequently __Occasionally __Rarely**
Do you feel helpless?	**__Always __Frequently __Occasionally __Rarely**
Do you feel hopeless?	**__Always __Frequently __Occasionally __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 a psychiatrist, psychologist, or other mental health professional?	**__Yes __No**
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**

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

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, claims, benefits, and causes of action for medical payment benefits available to me under the policy affording coverage to me for any and all treatment, services, and medical claims resulting from an automobile accident that occurred on

__________________. This is to act as an assignment of my rights and benefits to the extent of Assignee's services provided. In the event that I do not have insurance coverage, I understand that I remain personally responsible for payment of services rendered including all costs of collection, including attorney's fees and costs.

I agree that as consideration for this assignment, the burden to pursue payment for services rendered by the assignee from the insurance company or entity responsible to pay for such services may include doing some or all of the following:

1)submitting bills directly to the insurance company or entity, 20 pursuing the insurance company or entity which responsible to pay bills for payment of bills, 3) incurring any expense associated with pursuing payment of assignee's bills, 4) hiring or retaining the services of an attorney or collection agency to pursue payment of bills. This assignment shall be irrevocable unless terminated by mutual agreement in writing by assignee and assignor.

____

Print Name of Patient Date

____

Patient Signature/Guardian Print and Sign Name Relationship to Patient

OPIOID START TALKING
(MUST BE INCLUDED IN THE PATIENT'S MEDICAL RECORD)
Michigan Department of Health and Human Services

Patient Name	Date of Birth
Name of Controlled Substance containing an Opioid	
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)
Number of refills	

A controlled substance is a drug or other substance that the United States Drug Enforcement Administration has identified as having a potential for abuse. My provider shared the following:

a. The risks of substance use disorder and overdose associated with the controlled substance containing an opioid.

b. Individuals with mental illness and substance use disorders may have an increased risk of addiction to a controlled substance. (Required only for minors.)

c. Mixing opioids with benzodiazepines, alcohol, muscle relaxers, or any other drug that may depress the central nervous system can cause serious health risks, including death or disability. (Required only for minors.)

d. For a female who is pregnant or is of reproductive age, the heightened risk of short and long-term effects of opioids, including but not limited to neonatal abstinence syndrome.

e. Any other information necessary for patients to use the drug safely and effectively as found in the patient counseling information section of the labeling for the controlled substance.

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. 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.

Signature of Prescriber (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	

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.	AUTHORITY: PCA 246 of 2017, MCL 333.7303b and MCL 333.7303c COMPLETION: Required. PENALTY: Probation, limitation, denial, fine, suspension, revocation or permanent revocation.