

Name:

Date:

Date of Birth:

Marital Status:

SS# ___ - ___ - ___

Age:

Height:

Weight:

Address:

Phone #

Referring Dr.

Psychologist/ Psychiatrist:

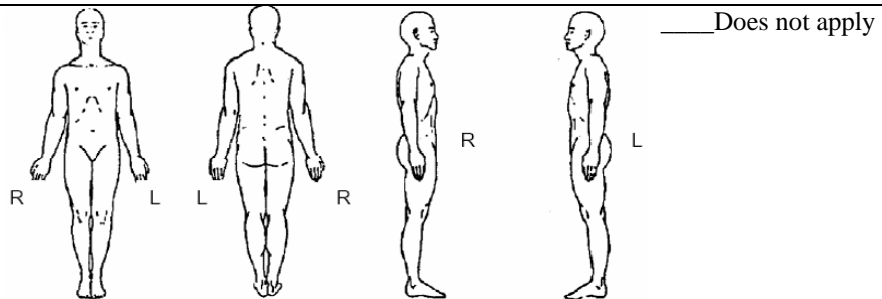
History of Illness:

What is your main area of pain?

How long?

When did it start?

Shade Complaint area(s)



Rate your pain severity using the following scale. Circle the number that applies. ___ None apply

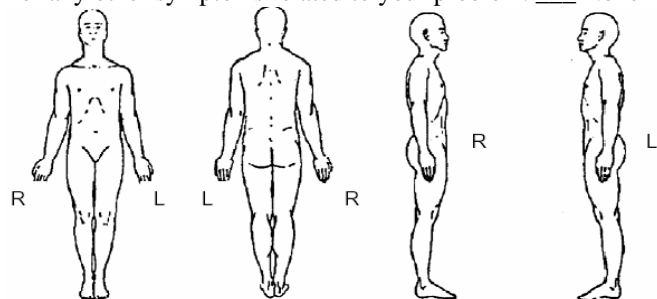
1 2 3 4 5 6 7 8 9 10
None Slight Moderate Severe Extreme Could not be worse

On the following illustration, draw the location of any other symptoms related to your problem. ___ None
 Use the following symbols.

Numbness/tingling = (xx).

Weakness = (oo).

Other symptoms = (++). List symptoms below



Describe your type of pain (check all that apply)

	Right arm	Left Arm	Right Leg	Left Leg	How Long
Sharp					
Dull					
Numbness					
Weakness					
Tingling					
Pins & needles					
Radiating					

For the following questions answer yes or no				Yes	No	If yes, when and how long?	
Has the problem become worse?				_____			
Is this problem the result of a traffic accident?				_____			
Is this the result of a work accident?				_____			
Have you missed work because of condition?				_____			
Symptoms associated with your major complaint (check all that apply) _____None Apply							
___Pain Where? _____		___Weakness Where? _____					
___Numbness Where? _____							
When are your symptoms most noticeable? (check all that apply)							
___ Evenings		___ Mornings		___ Sitting		___ Standing	
___ Going upstairs		___ Going Downstairs		___ Laying down		___ Running	
___ At Work		___ Typing		___ Bending		___ Lifting <50 lbs	
___ Lifting > 50 lbs		___ Watching TV		___ Eating		Other(list) _____	
Does anything make your major complaint better? ___Yes ___No							
If yes please explain: _____							
Does anything make your major complaint worse? ___Yes ___No							
If yes please list: _____							
Have you received physical therapy? ___Yes ___No							
Have you received an epidural? ___Yes ___No							
Have you received an other injection? ___Yes ___No							
Treatments of your major complaint have included (check all that apply) _____None apply							
Physical Therapy		Exercise		Manipulation		Anti-inflammatory medication	
Pain Medication		Massage		Ultrasound			
Traction		Braces		TENS Unit			
Doctors Seen for this problem:							
Name:		Specialty:		Location(city)		Treatment:	
_____		_____		_____		_____	
_____		_____		_____		_____	
Tests done to evaluate your problem (check all that apply) _____None Apply							
Test	Area tested		Date of test		Facility performed		
___ Plain X-Ray	_____		_____		_____		
___ MRI	_____		_____		_____		
___ CAT Scan	_____		_____		_____		
___ Bone Scan	_____		_____		_____		
___ Myelogram	_____		_____		_____		
Review of Systems: (check all that apply now or in the past)							
___ Weight Change		___ Swollen ankles or feet		___ Swollen Joints		___ Nerves	
___ Blurry Vision		___ Poor Circulation		___ Neck or back pain		___ Exhaustion	
___ Frequent Headaches		___ Diarrhea or constipation		___ Leg or arm pain		___ Depression	
___ Heart or Chest Pain		___ Stomach Pain		___ Weak arms or legs		___ Anxiety	
___ Short of breath when walking		___ Rashes		___ Poor Balance		___ Difficult Sleep	

Have you ever taken any of the following medications?

Circle Y (yes) or N (no) for each ___N/A

Aspirin	Y N	Lorcet(Hydrocodone)	Y N	Roxicet(Oxycodone)	Y N
Baclofen	Y N	Lortab(Hydrocodone)	Y N	Roxicodone (Oxycodone)	Y N
Codeine	Y N	Methadone	Y N	Roxilox (Oxycodone)	Y N
Darvocet(Propoxyphene)	Y N	Mexitil (Mexilitine)	Y N	Soma	Y N
Darvon (Propoxyphene)	Y N	Morphine	Y N	Prozac(flouxetine)	Y N
Dexadrine	Y N	Motrin/ Advil(Ibuprofen)	Y N	Tylox (Oxycodone)	Y N
Dilantin(Phenoytoin)	Y N	Neurotin(Gabaoentin)	Y N	Ultram (Tramadol)	Y N
Diavidid	Y N	Norpramine (desipramine)	Y N	Valium	Y N
Duragesic (fentanyl patch)	Y N	Norco	Y N	Vicoden (hydrocodone)	Y N
		Oxycontin	Y N	Xanax	Y N

Current medications with dosage(if more medications, write them on back of form:

Do you have any allergies or adverse reactions to any medications? ___Yes ___No, if yes list

Are you taking any blood thinners (Coumadin, Lovenox, Warfarin, Plavix, Aspirin) ?

___Yes ___No

Are you pregnant? ___Yes ___No

Do you have any latex allergies? ___Yes ___No

Patient Medical History (Check all that apply)

Heart Attack	Transplants	Headaches	Alzheimer's
Chest Pain	Nerve Disorder	Head Injury	Depression
High Blood Pressure	Osteoporosis	Hepatitis	Bipolar/Manic
Stroke	Spondylitis	Liver Trouble	Panic Attacks
Diabetes	Osteoarthritis	Kidney Stones	Phobias
High Cholesterol	Rheumatoid Arthritis	Kidney Failure	Chronic anxiety
Blood Clots in legs	Asthma	Thyroid disorder	Suicide Attempts
Anemia	Emphysema	Seizures	Physical/Sexual abuse
Cancer(Type)_____	OCD /ADD /ADHD	Epilepsy	Other_____
		HIV/AIDS	_____

Surgical History (If more write on back of form) ___None

Operation	Surgeon	Where Performed	Date

Psychiatric History: ___None

List any psychiatric problems from which you suffer or have suffered in the past. _____

Has your pain or its treatment disrupted your relationship with family members or friends? ___Yes ___No
If yes explain: _____

Family History

Relation	Medical Problems		Age of Death	Cause of death
Father				
Mother				
Brothers #				
Sisters #				

Social History

Are you involved in or planning litigation related to your injury?	___ Yes ___ No
Are you receiving workers' compensation related to your injury?	___ Yes ___ No
Are you receiving SSDI benefits?	___ Yes ___ No
Do you Drive?	___ Yes ___ No
Do you drink caffeinated beverages?(coffee, tea, cola) How many per day?	___ Yes ___ No
Work Status Occupation _____ Work Name _____ Work Address _____ ___ Working ___ Not Working ___ Retired ___ Student ___ Disabled ___ Veteran	
Alcohol Use: ___ Never ___ Rare ___ Social ___ Alcohol dependant Drinks per week _____	
Drug Use: ___ Never used ___ Used in past ___ Currently using ___ Do you use illicit "street drugs" ___ Y ___ N ___ Marijuana (Year last used ___) / ___ Heroin(Year last used ___) / ___ Cocaine(Year last used ___)	
Have you been treated for substance abuse (including alcohol)? ___ Yes ___ No If yes, when? _____ For what substance? _____ Name of facility: _____	
Have you had any legal problems relating to the use of drugs, alcohol, or medications? Y N If yes what year did this occur? _____ Describe the circumstances: _____ _____	
Tobacco use (check all that apply) ___ Never ___ Cigarettes I have smoked ___ Packs a day for ___ years total. (If less than one pack per day) I have smoked ___ cigarettes per day for ___ years total. ___ Cigars I have smoked ___ cigars per day for ___ years total. ___ I quit smoking on (date) _____	
My signature confirms that the answers to the above questions are accurate to the best of my ability.	
Parent or guardian (If under 18) signature: _____ Date: _____	
Assignment of Benefits-Financial Agreement I hereby give lifetime authorization for payment of insurance benefits to be made directly to PAIN AND SPINE INSTITUTE, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.	
Date: _____ Signature: _____	

PAIN AND SPINE INSTITUTE

CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS ACCORDING TO HIPPA LAWS

I, _____, understand that as part of my health care, Pain and Spine Institute originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.
- . It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
- You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
- We agree to provide patients with access to their records in accordance with state and federal laws.
- You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request
- We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry our treatment, payment or health care operations.

I understand that Pain and Spine Institute is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the code of Federal Regulations.

I further understand that Pain and Spine Institute reserves the right to change their notice and practice and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Pain and Spine Institute change their notice, they will send a copy of any revised notice to the address I've provided.

I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

Patient's Signature

Date

PAIN AND SPINE INSTITUTE

FINANCIAL POLICY

Thank you for choosing Pain and Spine Institute as your healthcare provider. We are committed to providing the best medical care possible. Please understand that payment of your bill is considered a part of your treatment. The following statement explains our Financial Policy which we ask you to read, sign and return to us prior to your treatment.

- All patients should provide accurate and complete personal and insurance information prior to being seen by the doctor.
- All applicable co-pays, personal balances, both current and prior, are due at the time of service
- We accept cash, personal checks, MasterCard and Visa.

Regarding Insurance

We participate on most insurance plans. Read and understand your insurance policy. Your policy is a contract between you and the insurance carrier. Read it, understand it and ask questions. **DO NOT ASSUME YOUR POLICY AUTOMATICALLY COVERS EVERYTHING.** Even different policies from the same insurance company can have different requirements. It is YOUR responsibility to know what your policy covers and what it does not. Always carry your insurance card with you. You will need it for all office visits and may need it in case of an emergency. Some insurance carriers require we verify your coverage for each office visit. Without this information, we may have to reschedule your appointment or you may have to pay at time of service. Some carriers require a referral or prior authorization from your primary care provider. It is YOUR responsibility to obtain this referral. **IF YOU DO NOT HAVE A REFERRAL OR PRIOR AUTHORIZATION, YOU WILL BE RESPONSIBLE FOR PAYMENT OR WE WILL RESCHEDULE YOUR APPOINTMENT.**

Usual and Customary Rates

We are committed to providing the best treatment for our patients and we charge what we believe to be reasonable and customary fees for our region and specialty. If your insurance company uses a different fee schedule, you will be responsible for any balance remaining.

Past Due Accounts

Over due accounts will be referred to a collection agency. Legal fees that we pay to secure past due balances will be added to your account.

Returned Checks

For checks returned to us for non sufficient funds by your bank, we will charge a \$25.00 fee.

Insurance Denials

In the event that any date of service is denied by the insurance carrier for ineligibility or no referral, the remaining balance will be turned over to patient responsibility.

Insurance Non-payment

If a claim is forty-five (45) days old and there has been no response from the insurance carrier, the balance due will be turned over to patient responsibility for payment.

Please contact our Billing Department if you have any questions or concerns at (815) 729-0700

I have read the Financial Policy. I understand and agree to the Financial Policy.

Print Name

Signature

Date

*Pain & Spine Institute
2400 Glenwood Ave. Suite 210
Joliet IL 60435 815-729-0700*

Patient Information

Today's date: _____

<i>Patient Name:</i> _____	<i>Date of birth:</i> _____	
<i>Address:</i> _____	<i>SS#</i> _____	
<i>City:</i> _____	<i>State:</i> _____	<i>Zip code:</i> _____
<i>Marital Status : Married</i> ___ <i>Single</i> ___ <i>Divorced</i> ___ <i>Widowed</i> ___ <i>Sep</i> ___		
<i>Height:</i> _____	<i>Weight:</i> _____	<i>Male:</i> _____ <i>Female:</i> _____
<i>Phone number:</i> _____		
<i>Cell Phone:</i> _____	<i>Which # can you be reached at?:</i> _____	
<i>Emergency contact:</i> _____	<i>Phone#</i> _____	
<i>Employer:</i> _____	<i>Occupation</i> _____	

Insurance Information

<i>Name of Person responsible for account:</i> _____	
<i>Relationship to patient:</i> _____	<i>Date of birth:</i> _____
<i>SS#</i> _____	
<i>Insurance Company:</i> _____	<i>Subscriber ID#</i> _____
<i>Group#</i> _____	

Secondary Insurance

<i>Name of Person responsible for account:</i> _____	
<i>Relationship to patient:</i> _____	<i>Date of birth:</i> _____
<i>SS#</i> _____	
<i>Insurance Company:</i> _____	<i>Subscriber ID#</i> _____
<i>Group#</i> _____	

Workman's compensation or Auto insurance information

<i>Name of W/C Carrier or Auto Insurance Carrier:</i> _____	
<i>Carrier billing address:</i> _____	

<i>Adjuster name:</i> _____	
<i>Adjuster phone number:</i> _____	
<i>Employer:</i> _____	
<i>Address:</i> _____	<i>Phone#</i> _____
<i>Claim#</i> _____	<i>Date of Injury:</i> _____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Workers Compensation benefits or insurance is denied.

Patient Signature _____

Date _____



Pain & Spine
INSTITUTE

2400 Glenwood Avenue, Suite 210 • Joliet, IL 60435 • Phone: (815) 729-0700 • Fax: (815) 729-0707 • www.pain-spine.com

Udit V. Patel, DO, MS
Samir Sharma, MD



Narcotics Prescribing Policy Contract

I, _____ have read and understand the
Print Full Name
Narcotics Prescribing Policy. In addition, if I break any terms of
The agreement, The Pain & Spine Institute has the right to
discharge me from the practice.

DATE: _____

Patient's Signature _____

Date: _____

Witness: _____

Date: _____

*****Pharmacy Name:** _____

Address: _____

Phone #: _____

We have 2 pharmacies we work closely with Basinger's in Joliet or Streator Drugs in Streator.

NARCOTIC PRESCRIBING POLICY

1. The prescribing of narcotics for chronic pain is a challenge under the best of circumstances due to issues of substance abuse, addiction, legal requirements, the historical high percentage of drug abusers intermingled with the chronic pain population, and other factors. The goal of our medical practice is to provide narcotics when deemed appropriate utilizing the guidelines of the Federation of State Medical Boards. In order to continue prescribing narcotics to patients, it is necessary to have tight controls and rigid rules established to eliminate those who procure narcotics for illegal purposes or for substance abuse, to protect the privileges of our practice to prescribe, maintain the health and welfare of the patients, and to obey the laws under which we operate, both federal and state.
2. Narcotics are but one avenue of pain therapy and **never** represent the sole method of pain control. Narcotics have potential for addiction and substance abuse, are diverted by some for sale or for improper routes of administration or shared with others. Narcotics may produce dependence, tolerance, and addiction. Side effects of narcotics include sedation, respiratory depression, swelling in the feet, dental decay acceleration, hives, itching, slurred speech, impaired thinking and function to the point a person may be dangerous when driving or operating machinery when taking narcotics, ICU admission, coma and death. For reasons, we reserve the right to change to a non-narcotic therapy at any time it is medically indicated. We also reserve the right to insist on an in or out patient treatment for narcotic dependence. There is no implied or expressed patient right to narcotic therapy in a physician's office or in a hospital.
3. **EXPECTATIONS OF APPROPRIATE PATIENT BEHAVIOR AND RESPONSIBILITY:**
 - A.) Our medical practice will be the only entity prescribing narcotics for chronic pain. If there is acute pain for a new condition for which the patient seeks care elsewhere, our practice must be called to let us know of the other physician's prescribing, and at that time we may adjust your chronic pain medications. If it is discovered patients are chronically receiving narcotics from multiple physicians, we will immediately discontinue medication prescribing and notify pharmacies and other treating physicians of the patient's substance abuse.
 - B.) In certain states, there may be laws prohibiting patients from obtaining narcotics under false pretenses (eg. Seeing multiple physicians for narcotics without notifying the other physicians). In all states, there are laws which prohibit sharing of prescription narcotics with others, changing or altering a narcotic prescription in order to obtain early refills or an increased quantity of narcotics, or the selling or trading of narcotics. These events are felonies under federal law and are not protected by the patient-doctor professional relationship. Therefore any information we receive regarding the commission of a felony will be reported to the police or US Drug Enforcement Agency.
 - C.) One pharmacy must be used for scripts. If that pharmacy does not have the prescription, then we expect patients to go to another pharmacy rather than receive a partial refill on the narcotic. We will not write additional scripts to cover the balance of a shortfall from a pharmacy with insufficient supplies. Therefore in advance, ask the pharmacist not to fill the script with a partial refill if the pharmacy lacks sufficient stocks to carry out the prescription filling. If a second pharmacy must be used to fill a script of narcotics, then notify our practice at the time regarding the situation.
 - D.) Refills of scripts for narcotics are only performed during scheduled office visits. We will not call in narcotic prescriptions nor write prescriptions at the time of patient procedures or during non-office hours.
 - E.) There are no early refills period. The patient is expected to make the prescription quantity last until the next office visit. We do not refill prescriptions that were lost, stolen, spilled, eaten by the cat etc... The responsibility for safekeeping of these medications lies solely with the patient. Therefore, each patient is expected to keep a lock box or location for safekeeping for the main supply of the narcotic medication instead of carrying around the entire month's supply.
 - F.) On request of our medical practice, the patient will submit a urine sample to a designated laboratory for testing to assure the medications being prescribed are actually in the urine. On request, a pill count may be necessary and the patient has to bring in the narcotics to be counted by our staff. For patients out of town, it is acceptable to have a local pharmacist perform a pill count and we will call the pharmacist to verify.
 - G.) There will be no alcohol or illicit drug use while taking narcotic medications. Discovery of such via internal or external sources may result in discontinuation of narcotics immediately.
 - H.) It is the policy of our practice that driving or operating machinery while taking narcotics may have untoward consequences, and if the patient elects to operate machinery or equipment, they do so at their own risk of injury or death.
 - I.) Sudden cessation of narcotics causes injury to the patient only in very rare circumstances however, sudden cessation of high dose narcotics will result in severe abdominal cramping, severe anxiety, rapid heart rate, elevated blood pressure, nausea, etc. Therefore it is prudent to use the narcotics as prescribed rather than running out early or violation of our policies which will result in sudden cessation of narcotic prescribing.
4. **REASONS NARCOTICS MAY BE IMMEDIATELY DISCONTINUED:**

Reasons for which narcotics will be stopped immediately and without any withdrawal medications include but are not limited to: evidence of Prescription alteration or fraud or solid evidence presented to our clinic that the patient has been selling the narcotics, sharing narcotics with others, injection of oral or trans dermal narcotics, threats of legal action or violence made against any of our staff in order to obtain narcotics, etc.. In such cases the police will be called immediately to report a felony drug diversion or attempted extortion, and the patient will be immediately discharged from our practice. Committing a narcotics related crime is not protected by doctor-patient privilege and will not be tolerated by our practice. Additionally, refusal to take a urine drug screen of the request, refusal to bring in medications for a pill

count when requested, a positive drug test for illicit drug use or narcotics not prescribed by our clinic, or a negative urine drug screen for narcotics we are prescribing will be met with discontinuation of narcotics. External source confirmation of "doctor shopping" or obtaining narcotics chronically from multiple physicians simultaneously will require sudden narcotic discontinuation. Impairment of the patient to such a degree that in the opinion of our medical practice that the patient poses a risk to themselves or to others may require narcotic discontinuation. Using suicide as a threat or suicidal attempts will result in immediate and complete discontinuation of all medications with the potential of self harm.

5. REASONS NARCOTIC THERAPY MAY BE MODIFIED OR REDUCED:

Reasons for which narcotic therapy will be modified or discontinued with the possibility of a drug taper or non-narcotic withdrawal medication administration: loss of scripts, overuse of medications, failure of escalating doses of narcotics provide relief in the absence of any demonstrable worsening findings on clinical examination including x-rays/MRI, arrest for driving while impaired, arrest for any alcohol related offense, excessively frequent calls to our clinic regarding chronic pain issues, prevarication regarding prior treatment and substance abuse, canceling appointments for procedures but showing up for office visits, failure to participate in the integrated therapies of our practice, etc.

6. Chronic pain is just that... it is a long standing problem which has been present for months or years. It is important that patients keep a long term perspective on the treatment of this condition. Frequent calls to our clinic for non-urgent issues, frequent requests of narcotics changes outside appointment times, or histrionic behavior in the absence of new conditions may make patients non-candidates for continued therapy in our center. However, in the case of potentially life threatening emergencies such as severe respiratory depression and over sedation, our physicians may be contacted 24 hours a day by calling the designated number and asking for the Pain Physician on call. Calls made for non-emergent issues or issues which should be handled during office hours may jeopardize continued treatment in our practice.

7. For questions regarding our narcotic policy call our office and ask to speak to the office manager. The Modified Federation of State Medical Board Narcotic Prescribing Guidelines 2004 used by our practice is found below.

Modified Federation of State Medical Board Opiate Prescription Guidelines

Evaluation of the Patient---A medical history and physical examination must be obtained, evaluated, and documented in the medical record. The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse. The medical record also should document the presence of one or more recognized medical indications for the use of a controlled substance.

Treatment Plan---The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

Informed Consent and Agreement for Treatment---The physician should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient or with the patient's surrogate or guardian if the patient is without medical decisions-making capacity. The patient should receive prescriptions from one physician and one pharmacy whenever possible. If the patient is at high risk for medication abuse or has a history of substance abuse, the physician should consider the use of a written agreement between physician and patient outlining patient responsibilities, including urine/serum medication levels screening when requested; number and frequency of all prescription refills; and reasons for which drug therapy may be discontinued (e.g. violation of agreement). *Consent for narcotic treatment by our practice is given on the initial visit as part of the paperwork packet.*

Periodic Review---The physician should periodically review the course of pain treatment and any new information about the etiology of the pain or the patient's state of health. Continuation or modification of controlled substances for pain management therapy depends on the physician's evaluation of progress toward treatment objectives. Satisfactory response to treat may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Objective evidence of improved or diminished function should be monitored and information from family members or other caregivers should be considered in determining the patient's response to treatment. If the patient's progress is unsatisfactory, the physician should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities.

Our medical practice's periodic patient review is usually 1 month for initial patients or during changes in therapy, 2-3 months for chronic stable Schedule III (hydrocodone/codeine/Darvocet) opiate therapy in addition to physical therapy and psychological treatment where appropriate, and review may be as often as one week or less for high risk patients or those with a substance abuse history. Patients receiving Schedule III medications (Oxycontin, Duragesic, MS Contin, MS IR, Kadian, Avinza, dilaudid, methadone) are seen at monthly intervals.

Consultation---The physician should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those patients with pain who are at risk for medication misuse, abuse or diversion. The management of pain in patients with a history of substance abuse or with a co morbid psychiatric disorder may require extra care, monitoring, documentation and consultation with or referral to an expert in the management of such patients.

Compliance with Controlled Substances Laws and Regulations---To prescribe, dispense or administer controlled substances, the physician must be licensed in the state and comply with applicable federal and state regulations. Physicians are referred to the Physicians Manual of the U.S. Drug Enforcement Administration and (any relevant documents issued by the state medical board) for specific rules governing controlled substances as well as applicable state regulations.

Pain & Spine Institute General Policies

Health Care Providers

Dr. Samir Sharma M.D.
Dr. Udit Patel D.O.
Phone #: 815-729-0700 fax: 815-729-0707

Contact Information

2400 Glenwood Avenue, Suite 210
Joliet, IL 60435

Our Mission

At Pain and Spine Institute, we offer a multidisciplinary evaluation/treatment for acute and chronic pain syndromes, as well as cancer pain. Our goal is to achieve maximum pain relief for the greatest length of time possible and to facilitate the return to a normal productive life.

Pain and Spine Institute is a smoke free facility.

Office Hours

Monday – Friday 8:30am – 5:00pm

For after hours emergencies Call 911

Hospital Affiliations:

Provena St. Joseph's Hospital – Joliet, IL
Hinsdale Hospital – Hinsdale, IL
Community Hospital Ottawa – Ottawa, IL
Adventist Bolingbrook Hospital – Bolingbrook IL

Appointments

Please call during regular clinic hours. If you are unable to keep your appointment, please let us know as far in advance as possible. **If you call to cancel with less than 24 hours notice you may be subject to a late cancellation fee of \$35.00 and if you no show for your scheduled appointment you will be charged \$50.00**

Phone Calls

The reception desk will return phone calls in order of urgency. All calls will be returned within a 24hr period.

Prescription Refills

Prescription refills will only be given during regular office hours with a 48 hour advance notice. No refills/new prescriptions will be given on weekends or on Fridays. **STRICTLY ENFORCED**

Notice of Privacy Practices

The Pain & Spine Institute respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes us to do so. The law protects the privacy of health information we create and obtain in providing our care and services to you. State law also requires us to get your authorization to disclose this information for payment purposes.

Financial Policy

Preferred method of payment is cash, but we will accept personal checks, debit cards, master card, and visa. Private Pay patient's cash or credit card only!

Payment in full is due at the time of service (or appointment will be rescheduled)

Co-Pays

Insurance requires that co-payments are collected at the time of service. If you cannot provide your co-payment we are required to reschedule your appointment.

Medical Forms: Pain & Spine Institute management charges 10.00/per page fee which applies to forms that need to be completed and signed by the physician. Forms will take from 7 – 10 business days to be completed. Forms not accompanied with payment will be returned incomplete. **We must have payment before the forms are filled out so we can block adequate time for the doctor to complete forms.**

Delinquent Accounts If your account is delinquent you will receive a letter from our Billing Department notifying you that you need to make a payment to clear your account. If payment is not made, your account will be turned over to a collection agency.

Random Drug Screening

We reserve the right to administer random drug screening at our facility, please be aware we do not discriminate due to gender, age, race etc.