Pain & Spine INSTITUTE

Patient Name:_____ Today's Date:____/____/____

Last First M.I

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Marital Status:_____

DOB:__/__/____ SSN:___-___-____ Drivers Lic #:_____

Email :_____

Employer Name:_____ Occupation:_____

Emergency Contact:_____ Phone:_____

Relationship:_____

Referring Physician:_____ Phone:_____

Primary Care Physician:_____ Phone:_____

Insurance Information

Primary Insurance:_____

Subscriber Name:_____ Subscriber DOB:__/__/____

Subscriber ID:_____ Group Number:_____

Secondary Insurance:_____

Subscriber Name:_____ Subscriber DOB:__/__/____

Subscriber ID:_____ Group Number:_____

Worker's Comp Insurance * Motor-Vehicle Accident Insurance (circle one)

Insurance Name:_____

Address:_____ Phone:_____

Employer at the time of injury:_____

Date of Injury:____/____/____ Claim Number:_____ Adjustor:_____

Adjustor Phone Number:_____ Ext._____

Attorney Name:_____ Attorney Phone Number:_____

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

Patient Signature:_____ Date:____/____/____

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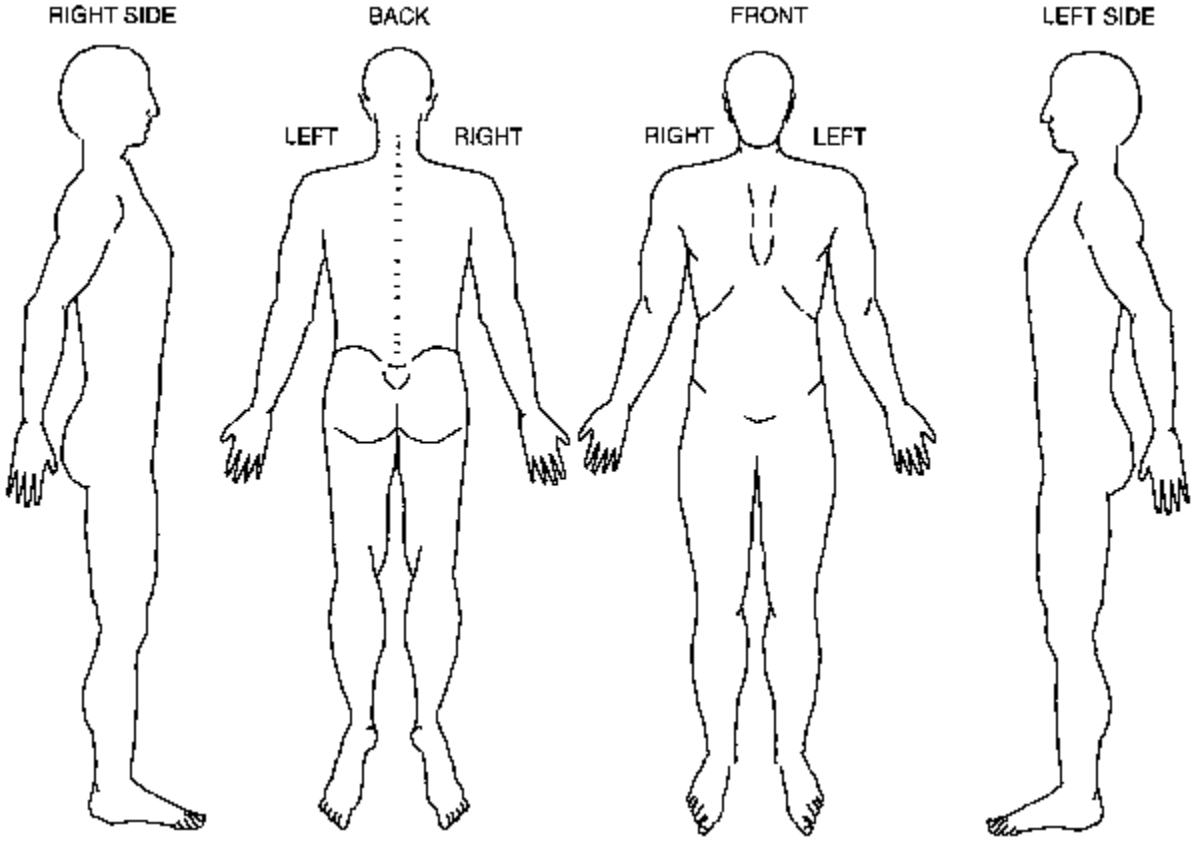
Description of Pain

Patient Name:_____ DOB:_____ Height:_____Weight:_____

Shade in areas of pain



Please CIRCLE your pain score below:

0 1 2 3 4 5 6 7 8 9 10

No Pain **Moderate** **Severe Pain**

Check Words That BEST Describe Your Pain

□Dull □Aching □Sharp □Shooting □Stabbing □Burning □Radiating □Pounding

□Numb □Tingling □Cramping □Electric □Pulling □Throbbing □Tearing □Unbearable

Are you experiencing any Weakness? □Yes □No

Are you experiencing any Loss of Bowel/Bladder Control? □Yes □No

Is this a Work Injury/Auto Injury? □Yes □No ***If Yes: Skip to appropriate Work/Auto Injury Box* on the next page!**

History of Present Illness

Date of injury or when pain began? ____/____/____How long has the pain been present?_____

How did the injury or pain occur (Use back of page if more space is needed)?_____

_____

_____

_____

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Patient Name_____

Work Injury

What is the Date of Injury? _____/_____/_____

What body part was injured? □Right □Left □Bilateral

□Abdomen	□Ankle	□Arm	□Calf	□Chest	□Clavicle	□Elbow
□Face	□Foot	□Groin	□Hand	□Head	□Hip	□Knee
□Leg	□Low Back	□Mid Back	□Neck	□Pelvis	□Shoulder	□Sternum
□Upper Back	□Wrist					

Cause and Circumstances of accident_____

_____

Employment status: □Full Time □Part Time □Light Duty □Other

Did you report your accident that day? □Yes □No Did you complete that day of work? □Yes □No

How many days of work did you miss immediately after the injury?_____

Has a Physician taken you off of work? □Yes □No If Yes: Dr. _____

Are you working now? □Yes □No If no, last day of work_____/_____/_____

When did you first seek medical care? _____ With whom/where?_____

Any chronic/pre-existing injuries contributing to current injury_____
_____

Have you had any other occurrences? □Yes □No If Yes: □ Work □ Slip and fall □Motor Vehicle □Sports Inj.

What injuries did you sustain as a result of other occurrences _____

Did those other injuries resolve: □Yes □No If NO, what injuries are you still undergoing treatment for?_____
_____

Auto Injury

What is the Date of Injury? _____/_____/_____

What body part was injured? □Right □Left □Bilateral

□Abdomen	□Ankle	□Arm	□Calf	□Chest	□Clavicle	□Elbow
□Face	□Foot	□Groin	□Hand	□Head	□Hip	□Knee
□Leg	□Low Back	□Mid Back	□Neck	□Pelvis	□Shoulder	□Sternum
□Upper Back	□Wrist					

Location of Accident: _____

Where was the car hit? □Struck from behind □Head on □Driver's side hit □Passenger side hit
□Vehicle lost control

Where was the patient sitting in the car? □Driver □Front passenger □Rear Passenger

Did the car rollover? □Yes □No

Was the patient wearing a seatbelt? □Yes □No

Did the car have an air bag? □Yes □No If yes, did the airbag deploy? □Yes □No

Did the patient experience Loss of Consciousness? □Yes □No

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Patient Name_____

Auto Injury Cont'd

Damage to the vehicle? □Minimal □Extensive □Car Totaled

Was this a Pedestrian vs. Car injury? □Yes □No

Did you go to the hospital? □Yes □No If so, which hospital? _____

Were you given any pain medication? □Yes □No Please List: _____

Did you seek treatment after the hospital? □Yes □No If Yes, explain: _____

_____

History of Present Illness (Cont'd)

Has your pain affected your daily activities or relationships with family or friends? □Yes □No

If yes, please explain: _____

Frequency of your pain: □Constant □Intermittent

Is there anything that *worsens* the pain? (Mark below)

□Bending □Coughing □Daily Activities □House Work □Prolonged

□Stairs □Twisting □Kneeling □Lifting □Lying Down

□Nothing □Neck Movement □Prolonged Positions □Sitting □Standing

□Stretching □Coughing/Sneezing □Getting Dressed □Walking □Weather Changes

□Other, Explain _____

Is there anything that makes the pain *better*? (Mark below)

□Rest □Bending Forward □Bending Backward □Twisting □Massage □Ice □Heat

□Walking □Stretching □Lying down □NSAID's □Muscle Relaxant □Medication

□Narcotics □Switching Position

Does your pain radiate? □Yes □No

If yes: □Right Arm □Left Arm □Right Leg □Left Leg □Buttocks □Shoulder Blades

□Orbit □Other:_____

Have you missed work due to your condition?_____If so, what date?_____

Are you currently on work restriction?_____

Are you, or could you possibly be pregnant? □Yes □No

Treatments (eg: Physical Therapy/Chiropractic/Occupational Therapy/ Massage)

	Type of Therapy			
	Physical Therapy	Chiropractic	Occupational Therapy	Massage
Most Recent Visit:				
Treatment provided by:				
Length of treatment:				
Duration of relief (eg: temporary/long lasting...)				

Home Exercise Program? (Please circle) YES or NO? If so, when did you start?_____

Type of exercise Duration(minutes) Frequency (times per week)

_____

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Patient Name_____

Previous Injection Therapy			
Type of Injection?	**Injection Date/How long ago?**	**Did the injection help?**	**Length of relief?**

Tests performed to evaluate the problem (Circle all that apply)

X-Ray MRI CAT Scan Bone Scan EMG Other None

Test Area Tested Date Tested Facility

_____

_____

_____

Review of Systems

General (Constitutional)

Chills	□Yes	□No
Fatigue	□Yes	□No
Fever	□Yes	□No
Night Sweats	□Yes	□No
Weight Change	□Yes	□No

Cardiovascular

Chest Pain	□Yes	□No
Dizziness	□Yes	□No
Palpitations	□Yes	□No

Genitourinary System

Abdominal Pain	□Yes	□No
Bloating	□Yes	□No
Pain w/urination	□Yes	□No

Neurologic

Dizziness	□Yes	□No
Headache	□Yes	□No
Seizures	□Yes	□No

Eyes

Blurred Vision	□Yes	□No
Eye Pain	□Yes	□No
Eye Drainage	□Yes	□No

Respiratory

Cough	□Yes	□No
Wheezing	□Yes	□No
Short of breathe	□Yes	□No

Musculoskeletal

Back Pain	□Yes	□No
Joint Stiffness	□Yes	□No
Limb Pain	□Yes	□No

Hematology

Bleeding	□Yes	□No
Bruising	□Yes	□No

Psychiatric

Anxiety	□Yes	□No
Depression	□Yes	□No
Mood Change	□Yes	□No

Ears

Loss of hearing	□Yes	□No
Ringing	□Yes	□No

Gastrointestinal

Nausea	□Yes	□No
Vomiting	□Yes	□No
Diarrhea	□Yes	□No
Constipation	□Yes	□No

Skin (Integumentary)

Rash	□Yes	□No
Atypical Mole	□Yes	□No
Change in Nails	□Yes	□No

Endocrine

Enlarged Hands/Feet	□Yes	□No
Hot/Cold Intolerance	□Yes	□No
Hair Loss	□Yes	□No

Medical History

(Check all that apply)

□AIDS/HIV □Aneurysm □Osteoarthritis □Rheumatoid Arthritis □Osteoporosis □Asthma

□Blood Clots □Cancer □COPD □Heart Attack □Depression □Diabetes

□Fibromyalgia □Heart Disease □Hepatitis □Hypercholesterolemia □Other (please describe below)

_____

_____

Surgical History

Operation Surgeon Facility Date

_____

_____

_____

_____

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Patient Name_____

Family History

Relationship to Patient (mother, father, etc.) Medical Problem

_____

_____

_____

_____

_____

Social History

Marital Status: □Married □Single □Divorced □Widowed □Separated

Do you use tobacco? □Yes □ No If yes: Smoking Since:_____

How many cigarettes per day? _____ Cigars per day?_____ Pipe?_____

Have you ever smoked? □Yes □No If Yes, How many years did you smoke? _____

Do you Drink Alcohol? □Yes □No □Former

Alcohol Frequency: □Daily □Weekly □Monthly □Rare □Socially □Never

Do you have a history of alcohol abuse? □Yes □No

Do you drink caffeinated beverages (coffee, tea, soda) □Yes □No

If yes, what is the frequency of use? □Daily □Weekly □Monthly □Rare □Socially □Never

Are you on a specialized/FAD diet? □Yes □No If yes, describe:_____

Do you use recreational drugs? □Yes □No □Former

Do you have a history of drug abuse? □Yes □No

Have you ever used any street drugs? □Yes □No

What drugs have you used? _____ When did you last use it? _____

How often? _____

Hobbies: List your hobbies: □Fishing □Golf □Hunting □Sports □Gardening □Sewing □Reading

□Others _____

Are you participating in these activities now? □Yes □No If yes, how often? _____

Psychiatric History

Have you ever been treated for emotional/behavioral disorder? □Yes □No

If yes, when?_____

Do you currently have ACTIVE suicidal thoughts? □Yes □No

Do you have a history of suicidal attempts? □Yes □No

Name of Psychiatrist:_____

Allergies

□Penicillin □Sulfa □Tetracycline □Radiographic Dyes □Topical Iodine □Shellfish

□Latex □Foods □Other:_____

Blood Thinners

Do you take blood thinners? □Yes □No If yes, check below:

□Coumadin/Warfarin □Pletal(Cilostazol) □Plavix(Clopidrogel) □Aspirin □Aggrenox □Pradaxa

□Brilinta □Dipyridamole □Ticagrelor □Ticlid □Trental □Persantine

□Others:_____

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Patient Name_____

Supplements

Herbal Medication	Yes	No
Dietary	Yes	No
Vitamins	Yes	No
Other (list)	_____ _____	

Current Medications (please provide list if possible)

Medication Name	Dose	Frequency

My signature confirms that the answers to the above questions are accurate and stated to the best of my ability.

Parent or Guardian Signature (if under 18):_____Date:_____

Patient Signature:_____Date:_____

Physicians Signature:_____Date:_____

Pain & Spine INSTITUTE

Pain Disability Index

Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/Home Responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school).
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Recreation: This disability includes hobbies, sports, and other similar leisure time activities.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Social Activity: This category refers to activities, which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Occupation: This category refers to activities that are part of or directly related to one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Sexual Behavior: This category refers to the frequency and quality of one's sex life.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Self Care: This category includes activities, which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed, etc.)
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Life-Support Activities: This category refers to basic life supporting behaviors such as eating, sleeping and breathing.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Pain Disability Index Total: _____

Signature_____

PleasePrint_____

Date_____/_____/_____

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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 vial fax.

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

_____ _____

Patient's Signature **Date**

Pain & 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
Overdue 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.

_____ _____

Patient Signature **Today's Date**

Narcotic Prescribing Policy

<u>PLEASE READ</u>
<u>VERY IMPORTANT</u>

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, and the historical high percentage of drug abusers intermingled with the chronic pain population, and other factors. 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 or 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. <u>EXPECTATIONS OF APPROPRIATE PATIENT BEHAVIOR AND RESPONSIBILITY:</u>

   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, **out practice must be called to let us know of the other physician's prescribing, 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**, please be aware you will be subject to immediate discharge as well.** 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.

   A.) **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.

   B.) **<u>Refills of scripts for narcotics are only performed during scheduled office visits</u>**. We will not call in narcotic prescriptions nor write prescriptions at the time of patient procedures or during non-office hours.

   C.) **<u>There are no early refills</u>**. The patient is expected to make the prescription quantity last until the next office visit typically your prescription is for a 30 day supply, if you are unsure ASK. 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.__ *****

   D.) 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.

   E.) 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 and leave you subject to immediate discharge.

   F.) 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.

   G.) Sudden cessation of narcotics may cause 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.

   H.) **Please be aware you may be asked to submit a urine sample before any narcotics will be prescribed**. It is also possible you may have a brief waiting period before medications can be prescribed pending results of screen. If you are a cash patient there is a $50.00 fee that **MUST** be paid in **CASH before** your next visit.

   I.) The patient will be told that under no circumstances is the patient to operate heavy machinery while under the influence of opiate medications that may impair their judgment. Such activities may result in severe civil and/or criminal penalties. The patient will be carefully instructed regarding the risk of the use of opiates in combination with other medications or substances that may depress the CNS including anxiety, muscle relaxants, narcotics, ETOH, illicit drugs, etc. The patient will also be advised that the combination of these medications may have serious adverse consequences including respiratory depression, coma, and death (accidental poisoning). **The patient agrees to inform Pain & Spine Institute (PSI) regarding any medications prescribed by other physicians that fall into the classes mentioned above, and if they are not sure what type of medication it is, notify PSI immediately before taking new medications**. The patient expresses understanding that, if prescribed these types of medications whether by a physician in this office or another physician, they must be extremely cautious the first time they use these medications in conjunction with each other. The patient also expresses understanding that they must be extremely careful at all times utilizing these medications together because of their additive and possible synergistic effects.

   J.) We do NOT fill 90 day supply mail order prescriptions if it is for narcotic medication.

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4. **REASONS NARCOTICS MAY BE IMMEDIATELY DISCONTINUED AND POSSIBLE DISCHARGE:**
   A.) 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 Transdermal narcotics.
   B.) 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 out practice. **Committing a narcotics related crime is not protected by doctor-patient privilege and will not be tolerated Period!**
   C.) 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.
   D.) External source confirmation of "**doctor shopping**" or obtaining narcotics chronically from multiple physicians simultaneously will require sudden narcotic discontinuation.
   E.) 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.
   F.) 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 OR POSSIBLE DISCHARGE FROM CLINIC:**
   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,** excessive frequent calls to our clinic regarding chronic pain issues or medication refills, 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.**
   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.

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. **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.**

Pain & Spine INSTITUTE

General Policies

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.

Office Hours

Monday – Friday 7:00am – 5:00pm

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, in addition if you chronically NO SHOW or cancel your appointment 3 times or more you will be discharged from our practice. Remember it is the responsibility of the patient to be at your scheduled appointment, reminder calls are a courtesy. If you are more than 10 min. late you will be asked to reschedule.**

Phone Calls

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

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: please be aware we do not give out 90 day supply of controlled medication no exceptions!**

Notice of Privacy Practices

The Pain & Spine Institute respects your privacy. We understand that your personal health information is very sensitive.

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 is due in full at time of service no exceptions!**

Insurance

It is the patient's responsibility to contact your insurance to make sure you are eligible for services.

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.

Appropriate Conduct

We have a Zero tolerance policy for any patient who behaves inappropriately to clinical staff, office staff and physicians will be discharged from our clinic immediately (ex: cursing, violence, verbal threats etc.)

Medical Forms: Pain & Spine Institute management charges a flat fee of $50.00 (you may be subject to a FCE test to determine your functional capacity before the forms can be filled out*please note this may or may not be covered by your insurance) 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. In addition these forms must be turned in to the doctor at your scheduled appointment for disability determination.**

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 or if you cannot pay the whole bill we expect you to contact the billing department to make payment arrangements. If payment is not made, your account will be turned over to a collection agency, in addition you will no longer be offered services until this has been taken care of.

Pain & Spine INSTITUTE

Patient Counseling Document on Extended Release / Long-Acting Opioid Analgesics

Patient Name:

The DOs and DON'Ts of Extended-Release/Long - Acting Opioid Analgesics Patient Specific Information

DO:
• Read the Medication Guide
• Take your medicine exactly as prescribed
• Store your medicine away from children and in a safe place
• Flush unused medicine down the toilet
• Call your healthcare provider for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

Call 911 or your local emergency service right away if:
• You take too much medicine
• You have trouble breathing, or shortness of breath
• A child has taken this medicine

Talk to your healthcare provider:
• If the dose you are taking does not control your pain
• About any side affects you may be having
• About all the medicines you take, including over-the counter medicines, vitamins, and dietary supplements

DON'T:
• Do not give your medicine to others
• Do not take medicine unless it was prescribed for you
• Do not stop taking your medicine without talking to your healthcare provider
• Do not cut, break, chew, crush, dissolve, snort, or inject your medicine. If you cannot swallow your medicine whole, talk to your healthcare provider.
• Do not drink alcohol while taking this medicine

Pain & Spine INSTITUTE

Narcotics Prescribing and General Office Policy Contract

I, _____ have read and understand the Narcotics prescribing and general office policies. In addition, if I break any terms of the agreement, The Pain & Spine Institute has the right to discharge me from the practice immediately.

I am also giving my physician (Dr. Samir Sharma MD, Dr. Udit Patel DO or Dr. Rajesh Patel MD) permission to view my medication history.

Patient's Signature _____**Date**: _____

***Pharmacy Name**: _____

Address: _____

Phone #: _____

Notice of Privacy Practices for PHI, with Omnibus rules 2014

Pain & Spine Institute is committed to maintaining and protecting the confidentiality of our patient's personal information The Plans are required by federal and state law to protect the privacy of your individually identifiable health information and other personal information. We are required to provide you with this Notice about our policies, safeguards and practices. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

OUR OBLIGATIONS: We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS: ***As Required by Law***. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorize federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care., If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS: You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to _____. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to Pain & Spine Institute Office Administration.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Pain & Spine Institute Billing Department manager.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Pain & Spine Institute office administration. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to Pain & Spine Institute Medical Records Department. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.pain-spine.com. To obtain a paper copy of this notice, ask the front desk.

CHANGES TO THIS NOTICE: We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Pain & Spine Institute office administrator. All complaints must be made in writing. **You will not be penalized for filing a complaint**. You may contact: Pain & Spine Institute; 744 Essington Rd. Joliet IL 60435 815-729-0700 The Plans may change the terms of this Notice at any time. If the Plans change this Notice, the Plans may make the new Notice terms effective for all of your PHI that the Plans maintain, including any information the Plans created or received before we issued the new Notice. If the Plans change this Notice, the Plans will make it available to you.

Print Name:_____ Signature:_____ Today's Date:_____