AMERICAN PAIN & SPINE CENTER, PC

3845 Monroe St
Dearborn, MI 48124

AUTHORIZATION TO TAKE PHOTOGRAPH

I, _____, hereby authorize a representative of the American Pain & Spine Center, PC, to take a photograph of me. This photograph will be attached to my electronic medical records and will not be used for any reason other than for the purpose of identification.

_____ _____
Signature of Patient/Representative Date

_____
Signature of Witness

AMERICAN PAIN & SPINE CENTER, PC

3845 Monroe St
Dearborn, MI 48124

AMERICAN PAIN & SPINE CENTER (AP&SC) CONSENT FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

I. CONSENT TO TREATMENT

1. I, _____**(print or type name)** on behalf of _____(**write "myself" or the patient's name and your relationship to patient)** consent to the provision of treatment that may include medical examination and treatment, interventional procedures or minor surgeries, and diagnostic procedures which my physician or his/her authorized agent may consider necessary or advisable. I understand that special consent forms may need to be signed for specific procedures. If I have a religious objection to specific care to be provided I may ask AP&SC not to provide such care.

2. I understand that my care may include examinations, diagnostic tests, medical treatment, and taking x-ray or photographs that may be used for my care and/or for education.

3. I understand and agree that others, under the direction of a physician, may assist or participate in providing medical care to me at AP&SC. These people may include but are not limited to assistants, students, residents, fellows, or others.

4. I give AP&SC and its designees permission to use my information as described in the AP&SC *Notice of Privacy Practices.*

5. If applicable, I give AP&SC permission to appropriately dispose of any specimens/tissue (such as blood or urine samples, skin tags, etc.) taken from my body. Once disposed, the specimens/tissues cannot be retrieved.

6. I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment. Results of any examination and/or treatment are kept confidential.

II. MEDICARE CERTIFICATION (IF APPLICABLE)

I certify that the information given by me in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services or its intermediaries or carriers, any information needed for this or any related Medicare Claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization providing the services or authorize that physician or entity to submit a claim to Medicare for payment to me.

III. MEDICAID CERTIFICATION (IF APPLICABLE)

I certify that the information given on this consent is true, complete, and accurate. I understand that payment and satisfaction of this claim will be from federal and state funds and that any false claims, statement, documents, or concealment of material facts, may be prosecuted under applicable federal and state laws.

IV. FINANCIAL ARRANGEMENTS / RELEASE OF INFORMATION

I agree to the following terms related to payment for services provided by AP&SC and affiliates.

1. I authorize AP&SC to bill my insurance carrier and request such payments to be made directly to AP&SC. I certify that the information I have given about my insurance coverage or other payment sources is correct.

2. I assign to AP&SC all rights to insurance payments or benefits to which I may be entitled for services provided to me by AP&SC. I authorize AP&SC to act on my behalf and as my representative to request reconsideration (internal and/or external review process) by my managed care plan or utilization review entity for coverage or grievance review.

3. I authorize AP&SC to release any medical or other information about AP&SC services, or services provided by third parties, if required to obtain payment from my insurer or other payors and their agents to process payments. I also authorize AP&SC to release any medical or other information required by my insurer, other payors and their agents. I also authorize AP&SC to release medical or other information required by my insurer, other payors and their agents, government agencies or their designees for review of the care provided to me.

4. I understand that any amounts not paid by my insurance, including deductibles and co-payments, are my responsibility. AP&SC will not charge me beyond what's allowed by my insurance carrier if AP&SC is In-Network with my insurance carrier.

5. I have been provided the AP&SC *Notice of Privacy Practice*, which is also available on the AP&SC official website at www.theAPSC.com. I also understand that additional copies of this Notice are available for my review upon request.

7. I consent to access by any AP&SC affiliates to my medical or other information maintained on electronic information systems or stored in various forms related to my treatment and/or services. I also consent to AP&SC providing such information to my primary care/family physician(s) and other healthcare providers as necessary for referral, consultation, treatment and/or the provision of other treatment-related healthcare services to me. However, my specific consent to release behavioral health information will be obtained as required by law.

8. I understand that my information may be released if required by local, state or federal law.

V. PATIENT VALUABLES

I relieve AP&SC of any responsibility for loss of clothing, money, valuables, dentures, glasses, or any other items that I decide to keep with me while I am a patient at AP&SC. I further understand that AP&SC will not be responsible and will not replace any property lost, broken, or stolen, which I decide to keep with me, or any property brought to me while I am a patient.

VI. AGREEMENT TO MEDIATE CLAIMS

I agree that any claim which may result from the care provided to me by the doctors, nurses and other health care providers in any AP&SC facilities shall be subject to the laws of Michigan. I also agree that before any lawsuit is filed related to the care provided to me, I must attempt to resolve any claim through mediation, which must take place in the State of Michigan. I am not waiving my right to a jury trial. Mediation is a process in which a neutral third person tries to help settle a claim. This agreement is binding on me and any person making a claim on my behalf.

I have read this Consent for Treatment, Payment and Health Care Operations form or have had it read to me, and it has been explained to my satisfaction.

_____ _____

Signature of Patient/Representative Date

_____

Signature of Witness

AMERICAN PAIN & SPINE CENTER, PC

3845 Monroe St
Dearborn, MI 48124

Financial Policy

Thank you for choosing the American Pain & Spine Center, PC (AP&SC) for your pain management care. The following is our Financial Policy. If you have any questions or concerns about our payment policies, please do not hesitate to ask our personnel for clarification. We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Forms prior to seeing the doctor.

Patient's portion of payment, as well as any past due balances, is due at the time service are rendered. We accept cash, personal checks, and all major credit cards for payment.
We accept assignment with most major insurance companies and participation provider plans. However, you must understand that:

1. Your insurance policy is a contract between you and/or your employer, and the insurance company. We are NOT a third party to that contract. Our relationship is with you, not your insurance carrier.

2. All charges are your responsibility whether your insurance company pays or not, unless otherwise prohibited by Medicaid and/or Medicare. AP&SC will not charge you over what's allowed by your insurance company if AP&SC is in In-Network with that insurance company.

3. You should inform the AP&SC of any changes in your insurance coverage as soon as possible.

4. Fees for services, along with unpaid deductibles and co-payments are due at the time of treatment.

5. If the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier to request prompt payment. Please inform our office of the carrier's response.

6. Returned checks will be subject to a $30.00 collection charge. We will notify you by mail. If the check is not picked up within 10 days, the check may be turned over to law enforcement.

7. Balances over 90 days may be charged a handling fee.

8. Unpaid balances over 60 days may be subject to collections via small claims court, attorney, and/or collection agency with applicable collection fees.

9. Failure to cancel an appointment may result in a "No Show" fee of $50.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we may assist you in the management of your account.

Authorization to Release and Assign Insurance Benefits: I authorize release of any information required to act on any insurance claim and permit photographic or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to the American Pain & Spine Center, PC (AP&SC) the medical and surgical benefits I am entitled from my insurance company and/or Medicare. This authorization is in effect for all future claims, until I choose to revoke it in writing.

I, the undersigned, understand and agree to the above Financial Policy. I understand that I am financially responsible for all charges incurred for my medical treatment.

_____ _____

Signature of Patient/Representative Date

_____

Signature of Witness

Date of this Visit: _____

AMERICAN PAIN & SPINE CENTER

Patient Initial Intake Questionnaire

NAME _____ Age:_____ Date of Birth:_____

Email Address: _____ Phone Number: _____

Referring Physician: _____Phone Number:_____Fax Number:_____

PCP name:_____Phone number:_____Fax Number:_____

PLEASE TRY TO ANSWER ALL THE QUESTIONS IN THIS QUESTIONNAIRE

Chief Complaint (Briefly describe your main pain complaint):_____

When did your pain FIRST begin? _____ years ago _____ months ago _____ weeks ago _____ days ago

How did your pain originally begin? (Check one and explain):

____ Pain started without any preceding trauma, injury, or any other incident that I can recall

____Auto accident (specify): Date?_____ You were the driver of the car? *Yes No* You were wearing seatbelt (Circle one)? *Yes No*

From where was the car hit?_____ Were you taken to the hospital? *Yes No* If yes, how long you stayed in the hospital?_____

Any other information? _____

___Accident at work: Date:_____ Describe what happened:_____

____Following an injury/trauma: Date:_____ Describe what happened:_____

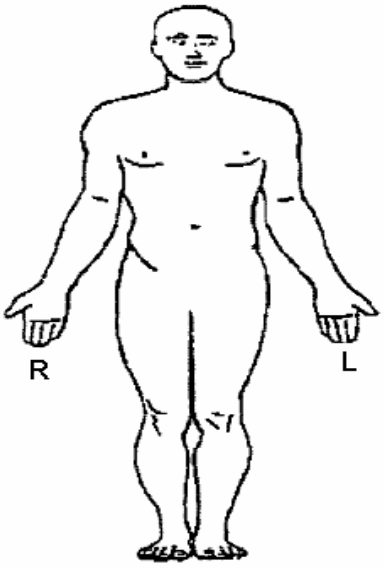
____Following surgery: Date:_____ Describe what happened:

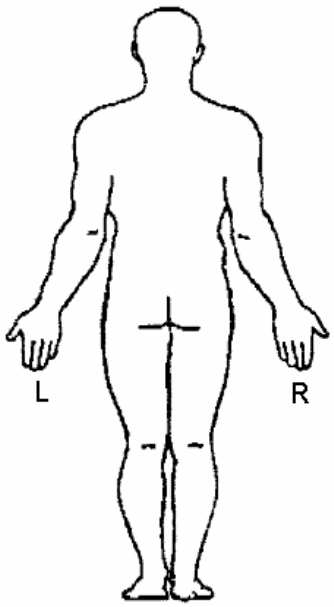
_____

____Following an illness: Date:_____ Describe what happened:_____

____Other (specify): Date:_____ Describe what happened:_____

Below, please shade in all the areas where you have pain, AND put an "X" over the area that hurts the most.





What BEST describes <u>your current pain</u>? (Circle all that apply)

Sharp Stabbing Throbbing Cramping Stinging Aching Squeezing Burning Piercing Tingling Dull Shooting Splitting

Rate your pain by placing "X" on the line to describe your <u>AVERAGE</u> pain in the past month:

(NO PAIN) I----------I----------I----------I----------I----------I----------I----------I----------I----------I----------I (Worst Pain Ever)
0 1 2 3 4 5 6 7 8 9 10

How <u>often</u> do you have your pain? (Circle one)

Constantly Most of the time Occasionally Rarely

In general, when is <u>your pain worse</u>? (Circle one)

Morning Afternoon Evening Bedtime At no specific time

Which of the following *<u>increase your pain</u>*****? (Circle all that apply)

Standing Walking Bending Twisting Lifting Heat Cold Stress Bright Lights Alcohol Meals Menstruation Poor Sleep
Weather Changes Loud Noise Other: _____

Which of the following *makes your pain better?* (Circle all that apply)

Rest Laying down Warm Shower Relaxation Cold Heat Distraction Pain Medications Other:_____

Are there any other symptoms *<u>associated with your pain</u>*****? (Circle all that apply)**

Numbness Weakness Tenderness Vomiting Nausea Bowel Incontinence Urinary Incontinence Fatigue
Swelling Blurred Vision Night time movements Sexual Dysfunction Anger Other (specify):_____

Has your pain affected your mood? No Yes: (describe):_____

Does your pain ***<u>awaken</u>*** you during the night? (Circle one) Usually Never Rarely Occasionally

Place an "X" on the lines below to describe how pain has interfered with you:

<u>Normal Daily Activity</u>
Does NOT interfere_____Completely Interferes
<u>Normal Work</u> (inside and outside home)
Does NOT interfere_____Completely Interferes

<u>PREVIOUS TREATMENTS</u>:

PHYSICAL THERAPY

Have you done any **<u>physical therapy</u>** in the past? No Yes

If yes: when was the last time?_____ For how long did you do it?_____ How many times a week did you do it?_____
How much did your pain improve? (circle one) NONE MINIMAL MODERATE SIGNIFICANT PAIN GOT WORSE

PAIN INTERVENTIONAL PROCEDURES

Have you had any pain injection(s) in the past? No Yes If yes: How many injections? _____ When was the last time? _____
What type of injections you had?_____
How much did your pain improve? (Circle one) NONE MINIMAL MODERATE SIGNIFICANT PAIN GOT WORSE

OTHER PAIN TREATMENTS

Which of the following **<u>other treatments</u>** have you tried in the past? (Circle all that apply)

Bed Rest Exercising Chiropractor therapy:_____ Acupuncture TENS Unit Psychotherapy other (specify):_____

IMAGING

Do you have any MRI (s) done in the past? No Yes If yes, Specify: _____ Did you bring it with you today? No Yes
Do you have any CT (s) done in the past? No Yes If yes, Specify: _____ Did you bring it with you today? No Yes

Please CIRCLE ALL <u>current and past medications</u> that you have taken for your current pain condition.

OPOIDS: Fentanyl patch Vicodin Norco Lortab Dilaudid Demerol MSContin Morphine Avinza Kadian Methadone Oxycontin Oxycodone Percocet Tylenol with Codeine Tramadol Suboxone Opana Other (specify):_____

NSAIDS: Ibuprofen Naproxen Toradol Meloxicam Lodine Celebrex Voltaren Feldene Indomethacin Other (specify):_____

ANTIDEPRESSANTS: Elavil Cymbalta Wellbutrin Prozac Paxil Zoloft Effexor Lexapro Other (specify):_____

ANTICONVULSANTS: Neurontin Lyrica Topamax Keppra Other (specify):_____

MUSCLE RELAXANT: Flexeril Skelaxin Zanaflex Robaxin Soma Baclofen Other (specify):_____

OTHER: Xanax Ativan Valium Ambien Buspar Lunesta Haldol Atarax Restoril Seroquel

Please list below ***<u>any other PAIN medications</u>*** that you have taken in the past if not listed above:

_____

<u>MEDICAL HISTORY</u>:

Do you <u>have</u> any of the following? (Please check all that apply) ___NO PROBLEMS

__High Blood Pressure	___Asthma	___ Multiple Sclerosis	___HIV
___Heart Attack	___Chronic Lung Disease	___Hepatitis (A B C)	___Fibromyalgia
___Heart Failure	___COPD/Chronic Bronchitis	___Crohn's Disease	___Arthritis
___Coronary artery disease	___Obesity	___ Ulcerative Colitis	___Peripheral Neuropathy
___A-Fib	___Diabetes/On Insulin	___ Stomach Ulcer	___Depression
___Pacemaker/Defibrillator	___Diabetes/NOT on Insulin	___ Kidney Disease	___Bipolar disorder
___Peripheral Vascular dz	___HYPO (Low) Thyroid	___Dialysis	___Anxiety
___Stroke	___HYPER (High) Thyroid	___Migraines	___Insomnia
___Seizure	___Glaucoma	___Prostate Enlargement	___Blood Clots
___Carotid Stenosis	___Gout	___GERD	___On Blood Thinner
___ High Cholesterol	___Cancer (Specify):_____		
___Other (Specify):_____			

<u>SURGICAL HISTORY</u>

Please list all ***<u>Surgeries</u>*** you had in the past below:

Procedure: _____	Date:_____	Procedure: _____	Date: _____
Procedure: _____	Date: _____	Procedure: _____	Date:_____
Procedure: _____	Date: _____	Procedure: _____	Date:_____
Procedure: _____	Date: _____	Procedure: _____	Date:_____
Procedure: _____	Date: _____	Procedure: _____	Date:_____

<u>MENTAL HEALTH HISTORY:</u>

Have you ever <u>had</u> mental health treatment? ___No ___Yes (specify): _____

Are you in <u>current</u> mental health treatment? (Psychiatrist, Psychologist, Counselor) ___No ___Yes:_____
(Name of Provider)

Do you think about hurting yourself or hurting anyone else? ___No ___Yes (specify): _____

Do you hear voices? ___No ___Yes (Specify): _____

Have you ever been hospitalized for psychiatric reasons? ___No ___Yes (specify):_____

ALLERGIES:

Are you allergic to any medications or other agents? ___ NO ___Yes (fill list below)

YES	NO	MEDICATION *I* AGENT	TYPE OF REACTION (Rash, Swelling, Shortness of breath, Itching, etc…)	SEVERITY (Mild, Moderate, Severe)
		LATEX		
		PENICILLIN		
		SULFA (Specify):		
		IV DYE		
		SHELLFISH (Lobster, shrimp, clams, etc)		
		IODINE		
		OTHER:_____ _____ _____		

SOCIAL HISTORY:

Marital Status: (Circle one) Single Married Divorced Separated Widowed

Are you pregnant or planning to become pregnant? ___Not Applicable ____No ___Yes (Due date):_____

Do you have children? ___Yes ___ No If yes, how many?_____What are the ages of your children?_____

Who lives with you in your household? _____

EDUCATION:

What is your **Highest** level of education? (Circle one)

High School GED Vocational School College Masters PhD Nursing Pharmacist Other Degree (specify): _____

None of the above (Specify):_____

EMPLOYMENT:

Present employment status: (Circle one)

Full-time Part Time Unemployed Disability Workers Compensation Leave of absence Retired Student

If not working, when was your last day of work?_____

CURRENT Occupation or LAST Occupation you held:_____

List all previous occupations: _____

LIFE STYLE AND HABITS:

How much caffeine (coffee, tea, pop/soda) do you consume in a day?_____Cups

Do you smoke? ____Never ____Yes: Number of packs per day:_____ ____Ex-Smoker-Quit: When?_____

Do you drink alcohol? (Wine, beer, liquor)

___None ____Rarely (once per month) _____Occasionally(less or equal to once per week)

___Daily ____Regularly (2-3 per week)

Have you ever been recommended to a drug or alcohol rehab program? __Never __Yes (Indicate when) _____

Have you ever participated in a drug or alcohol rehab program? __ Never __Yes (Indicate when) _____

Have you ever used recreational (street) drugs? ___Never ___Yes **LIST BELOW:**

YES	NO	NAME OF DRUG	When was the last time?	How did you take it? (Snort-Inject-Smoke-Swallow)
		Cocaine (Crack)		
		Heroin		
		Marijuana		
		LSD		
		Other (specify):		

FAMILY HISTORY:

Does your ***immediate familv*** have a history of? (Circle No or Yes for each item below)

		Who? *(Father,Mother,brother,sister)*			**Who?** *(Father,Mother,brother,sister)*
High Blood Pressure	No Yes	_____	Migraines	No Yes	_____
Heart disease	No Yes	_____	Seizures	No Yes	_____
Strokes	No Yes	_____	High Cholesterol	No Yes	_____
Thyroid Disease	No Yes	_____	Diabetes	No Yes	_____
Cancer	No Yes	_____	(Specify what type of cancer): _____		
Other	No Yes	_____	(Specify):		

_____

___Adopted __Unknown Family History

PLEASE LIST ALL CURRENT MEDICATIONS

NAME OF MEDICATION	**DOSE**	**FREQUENCY**

REVIEW OF SYSTEMS: Please check all CURRENT

CONSTITUTIONAL __ NO PROBLEMS
__Lack of energy __Fevers __Yellow skin
__Trouble Sleeping __Chills __Weight Loss
__Poor appetite __Night Sweats __Weight Gain

EAR. NOSE. THROAT __NO PROBLEMS
__Hearing Loss: __Left __ Right __Dizziness __Ringing in ears
__Decreased Hearing __Hoarseness __Discharge from nose
__Frequent Sore Throat __Snoring __Other (specify):_____

VISION __NO PROBLEMS
__ Decreased Vision: __ right __left __Double Vision ___Other (specify):_____
__Blurred Vision: __ right __left __Glasses /Contacts

RESPIRATORY __ NO PROBLEMS
__Shortness of Breath __Chronic Cough __Wheezing
__Home Oxygen: @ __ Liters (circle) Day/Night / Continuous

CARDIOVASCULAR __NO PROBLEMS
__Chest pain __Swelling in legs and feet
__Palpitations __Irregular Heart Beats
__Blue color changes in hands and feet __Red color changes in hands and feet
__Cold hands & feet __Other: _____

GASTROINTESTINAL __NO PROBLEMS
__Difficulty chewing __ Diarrhea __Constipation
__ Difficulty swallowing __Nausea __Vomiting
__Abdominal Cramps Bloating __Incontinence of Stool __Dark or tarry stools
__Abdominal pain __Blood in stool __Other (specify):_____

HEMATOLOGIC __NO PROBLEMS
__Painful veins __Painful arteries __Trouble with blood clotting __Easy Bruising

ENDOCRINE __NO PROBLEMS
__Cold Intolerance __Heat Intolerance __Other (specify):

MUSCULOSKELETAL __NO PROBLEMS
__Muscle Pain __Joint Pain __Muscle Loss __Weakness __Stiffness
__Cramps __ __Bone pain __Other (specify): _____

NEUROLOGICAL __ NO PROBLEMS
__Headache __Fainting __Difficulty finding words when thinking
__Poor Memory __Poor Concentration __Difficulty walking
__Falls __Numbness or tingling of: ___arms ___legs
__Other (specify): _____

PSYCHIATRIC __NO PROBLEMS
__Frequent sadness/ feeling unhappy __Panic __Excessive worry __Problems in relationships with others
__Unusually high energy/ excitability __Anger __Other (specify):
_____

GENITOURINARY __ NO PROBLEMS
__Urinary Frequency __Incontinence of Urine __Pain during sex __Other (specify):_____

GYNECOLOGIC __NO PROBLEMS ___ Not applicable
__Period Irregularity __Hot Flashes __Heavy Periods __Painful Periods
__Currently breast feeding ___Absence of periods ___PMS symptoms __Other (specify): _____