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### New Patient Intake Information

Name	DOB/Age	Date
Referring Physician/Address	Primary Care Physician/Address	

**Chief Complaints (if multiple, circle the worst):**

Does the pain radiate (into arm/leg)?

When did it start (Date)?  
 How long has it been going on (months, years)?

Do you recall a specific cause for your pain (Injury, etc.)?

Intensity (VAS): (no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe)  
 Range: On a good day: \_\_\_/10 On a bad day: \_\_\_/10

Timing of the Pain: Rarely / Sometimes / Always / Constant / Waxes & Wanes (Good Days & Bad Days)

Describe the Pain (circle): Dull / Achy / Throbbing / Sharp / Stabbing / Burning / Lancinating / Gnawing / Numbness / Pins & Needles / Tingling / Other:

Aggravating Factors: Resting / Activity / Laying / Sitting / Standing / Walking / Positional changes / Bending / Twisting / Pushing / Pulling / Lifting / Exercise / Work  
 Other:

Improving Factors: Resting / Laying down / Activity / Sitting / Standing / Walking / Positional changes / Bending / Twisting / Exercise / Medication / Heat / Cold / TENS / Injections / Surgery  
 Other:

<p><b>Low Back Pain (Circle):</b> Left Right Middle          % of Pain:</p> <p>Radiates into leg(s)? Yes No          Side: Left Right Both          How far down leg? Buttock Mid-thigh Knee          Calf Ankle Foot          Other:</p> <p>Side of leg? Front Back Outside Inside</p>	<p><b>Neck Pain (Circle):</b> Left Right Middle          % of Pain:</p> <p>Radiates into arm(s)? Yes No          Side: Left Right Both          How far down arm? Shoulder Upper Arm Elbow          Forearm Wrist Hand          Other:</p> <p>Side of arm? Front Back Outside Inside</p>
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## PAIN DIAGRAM

Please mark the area of injury or discomfort using the appropriate symbols:

Numbness

+++++++

Burning

XXXXXX

Aching

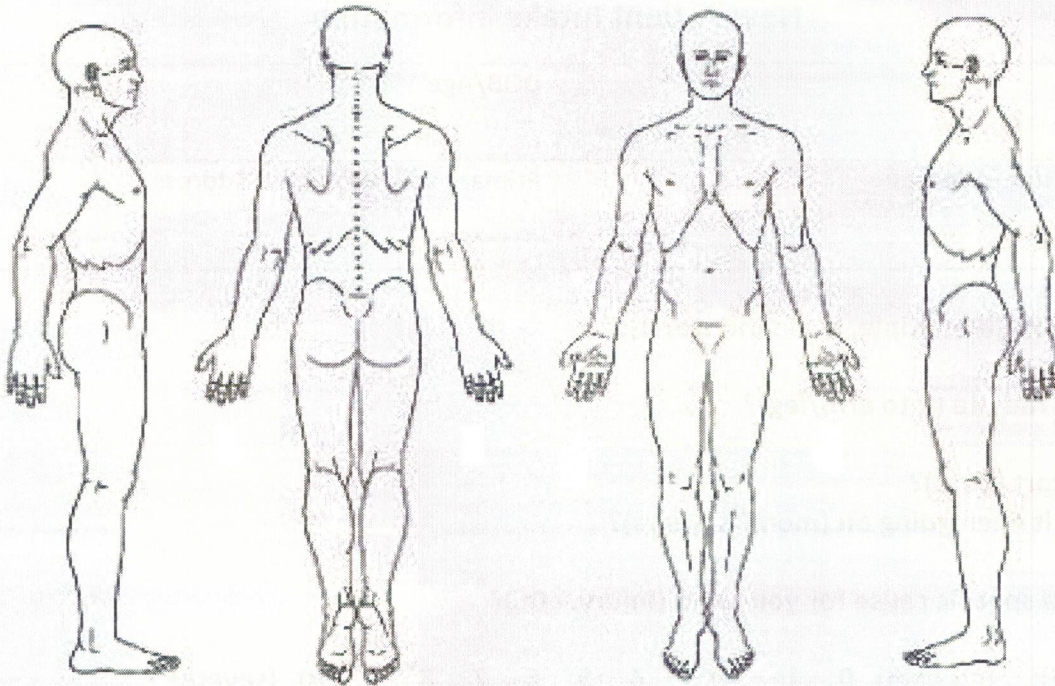
OOOOO

Stabbing

^^^^^^

Pins & Needles

////////



## TREATMENTS

(Circle if Treatment effective, Mark a line through it if not effective)

**General:** Rest / Exercise / Physical Therapy / Occupational Therapy / Aquatic Therapy / TENS Unit / Heat Cold / Chiropractor / Massage / Acupuncture / Counselling / Biofeedback / Behavioral Therapy  
Other:

**Injections/Procedures:** Epidural Injections / Facet Joint Injections / Intercostal Nerve Block  
Joint Injections / Peripheral Nerve Blocks / Radiofrequency Ablation / Sacroiliac Joint Injection  
Spinal Cord Stimulator / Spine Surgery / Sympathetic Nerve Blocks / Trigger Point Injections  
Other:

**Anti-Inflammatories (NSAIDs):** Arthrotec / Celebrex / Daypro / Flector / Ibuprofen / Maloxicam / Mobic /  
Motrin / Naprosyn / Naproxen / Relafen / Other:

**Muscle Relaxers:** Baclofen / Flexeril / Norflex / Robaxin / Skelaxin / Soma / Valium / Zanaflex

**Membrane Stabilizers (Anti-seizure):** Depakote / Dilantin / Gabapentin / Lyrica / Neurontin / Tegretol /  
Topamax / Zonegran / Other:

(continued...)



**Treatments (cont.)**

**Opiates:** Dilaudid / Duragesic / Fentanyl / Hydrocodone / Hydromorphone / Methadone / Morphine (Avinza, Kadian, MS Contin) / Norco / Nucynta / Oxycodone / Oxycontin / Percocet / Percodan / Tramadol / Vicodin / Vicoprofen / Xtampza / Other:

**Sleep Aid:** Amitriptyline / Elavil / Nortriptyline / Trazadone

**Antidepressant:** Cymbalta / Paxil / Prozac / Zoloft

**Topical:** Capsaicin / Compound / Flector / Lidoderm / Voltaren gel

**Other:** Tylenol / Herbal Medications / Ativan / Valium / Xanax / Other:

**Physical Therapy:**

Where?  
When?  
What was done?

**Injections:**

Who did them?  
When?  
What was done?

**Surgery:**

Surgeon?  
When?  
What was done?

**Medications:**

**NSAIDs** (Ibuprofen, Naproxen, Motrin, Mobic, Voltaren), Others: \_\_\_\_\_  
**Muscle Relaxers** (Flexeril, Norflex, Zanaflex, Baclofen, Soma), Others: \_\_\_\_\_  
**Gabapentin /Lyrica**  
**Pain Meds** (Norco, Percocet, Morphine, Dilaudid, Fentanyl), Others: \_\_\_\_\_  
**Others:**

**IMAGING**

**X-ray:**

Body part?  
  
Where?  
  
When?

**MRI:**

Body part?  
  
Where?  
  
When?

**CT:**

Body part?  
  
Where?  
  
When?

**WORKMANS COMP / INSURANCE**

**Work injury?** Yes No **Date:**

BWC Claim #:

**Car Accident?** Yes No **Date:**

Attorney & Phone:

**Current Medications:**

**Allergies:**

**Past Medical History:** Diabetes Cancer Heart Disease Peptic Ulcers GERD Kidney Disease  
Bleeding Disorder Liver Disease Other:

**Past Surgical History:** Spinal surgery Abdominal CABG Heart Valve Peripheral Bypass  
Amputation Brain Surgery Other:

**Family Medical History (Alive/Deceased; Age; Medical Condition):**

Grandparents

Parents

Siblings

Children

**Social History:**

Marital Status: Single Married Separated Divorced # of Children: \_\_\_\_\_

Living Arrangements: Residence: Home Apartment Assisted Living Other: \_\_\_\_\_

With self Spouse/Partner Caregiver Other: \_\_\_\_\_

Tobacco: Never Former user Cigarettes Cigar Chew Snuff Packs/day: \_\_\_\_\_

Recreational/Street Drugs: Never Yes Former user Rehab How often? \_\_\_\_\_  
What? Marijuana Cocaine Meth Other: \_\_\_\_\_



## Review of Systems

Circle any symptoms you're currently experiencing or have had in the past 3 years:

**Constitutional**

Fever  
Weight Loss  
Excessive Fatigue  
Night Sweats

**HEENT**

Double Vision  
Blurred Vision  
Hearing Loss  
Vertigo

**Cardiovascular**

High Blood Pressure  
Palpitations  
Chest Pain

**Respiratory**

Shortness of Breath  
Coughing  
Wheezing

**Gastrointestinal**

Loss of Appetite  
Nausea  
Vomiting  
Abdominal Pain  
Heartburn/Reflux

Diarrhea

Constipation

**Genitourinary**

Loss of Bladder Control  
Difficult Urination  
Frequent Urination

**Neurological**

Numbness  
Lack of Coordination  
Confusion  
Memory Problems  
Tremors  
Fainting  
Headaches  
Dizziness

**Hematological**

Blood Clots  
Anemia  
Bleeding Tendency  
Swollen Glands

**Psychiatric**

Anxiety  
Depression  
Insomnia

**Skin**

Rashes  
Easy Bruising  
Redness  
Discoloration

**Musculoskeletal**

Spasms  
Cramps  
Arm Weakness  
Leg Weakness  
Joint Pain  
Joint Swelling

Vital Signs (Clinic Staff to Fill This Out)					
Height:	Weight:	BP:	/	Temp:	°F
				Pulse:	Resp:

The information provided above is accurate to the best of my knowledge.

Patient Signature:

Date:

Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

### **Modified Oswestry Low Back Pain Questionnaire**

This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. We realize that you may feel that more than one statement may relate to you, but please just circle the **one** number that most closely describes your problem.

1. Pain Intensity

- 0 The pain comes and goes, and is very mild.
- 1 The pain is mild and does not vary much.
- 2 The pain comes and goes and is moderate.
- 3 The pain is moderate and does not vary much.
- 4 The pain comes and goes and is severe.
- 5 The pain is severe and does not vary much.

2. Personal Care

- 0 I do not have to change my way of washing or dressing to avoid pain.
- 1 I do not normally change my way of washing or dressing, even though it causes me pain.
- 2 Washing and dressing increase the pain, but I manage not to change my way of doing it.
- 3 Washing and dressing increases the pain, and I find it necessary to change my way of doing it.
- 4 Because of the pain, I am unable to do some washing and dressing without help.
- 5 Because of the pain, I am unable to do any washing and dressing without help.

3. Lifting (skip if you have not attempted lifting since the onset of your low back pain)

- 0 I can lift heavy weights without extra low back pain.
- 1 I can lift heavy weights but it causes extra pain.
- 2 Pain prevents me from lifting heavy weights off the floor.
- 3 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (ex: on a table).
- 4 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- 5 I can only lift light weights at the most.

4. Walking

- 0 I have no pain walking.
- 1 I have some pain on walking, but I can still walk my required to normal distances.
- 2 Pain prevents me from walking long distances.
- 3 Pain prevents me from walking intermediate distances.
- 4 Pain prevents me from walking even short distances.
- 5 Pain prevents me from walking at all.

5. Sitting

- 0 Sitting does not cause me any pain.
- 1 I can sit as long as I need, provided I have my choices of sitting surfaces.
- 2 Pain prevents me from sitting more than 1 hour.
- 3 Pain prevents me from sitting more than ½ hour.
- 4 Pain prevents me from sitting more than 10 minutes.
- 5 Pain prevents me from sitting at all.

Name \_\_\_\_\_

6. Standing

- 0 I can stand as long as I want without pain.
- 1 I have some pain while standing, but it does not increase with time.
- 2 I cannot stand for longer than 1 hour without increasing pain.
- 3 I cannot stand for longer than ½ hour without increasing pain.
- 4 I cannot stand for longer than 10 minutes without increasing pain.
- 5 I avoid standing because it increases the pain immediately.

7. Sleeping

- 0 I have no pain while in bed.
- 1 I have pain in bed, but it does not prevent me from sleeping well.
- 2 Because of pain, I sleep only ¾ of normal time.
- 3 Because of pain, I sleep only ½ of normal time.
- 4 Because of pain, I sleep only ¼ of normal time.
- 5 Pain prevents me from sleeping at all.

8. Social Life

- 0 My social life is normal and gives me no pain.
- 1 My social life is normal, but increases the degree of pain.
- 2 Pain prevents me from participating in more energetic activities (ex: sports, dancing, etc).
- 3 Pain prevents me from going out very often.
- 4 Pain has restricted my social life to my home.
- 5 I hardly have any social life because of pain.

9. Traveling

- 0 I get no pain while traveling.
- 1 I get some pain while traveling, but none of my usual forms of travel make it any worse.
- 2 I get some pain while traveling, but it does not compel me to seek alternative forms of travel.
- 3 I get extra pain while traveling that requires me to seek alternative forms of travel.
- 4 Pain restricts all forms of travel.
- 5 Pain prevents all forms of travel, except that done lying down.

10. Employment/Homemaking

- 0 My normal job/homemaking duties do not cause pain.
- 1 My normal job/homemaking duties cause me extra pain, but I can still perform all that is required of me.
- 2 I can perform most of my job/homemaking duties, but pain prevents me from performing more physically stressful activities (ex: lifting, vacuuming, etc).
- 3 Pain prevents me from doing anything but light duties.
- 4 Pain prevents me from doing even light duties.
- 5 Pain prevents me from performing any job or homemaking chore.

**To be completed by provider:** Score \_\_\_\_\_ (points/possible score [max 50] x 100 = %)





## OPIOID RISK TOOL

Name: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_

	Mark each box that applies		For Female Patients	For Male Patients
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Rx Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Rx Drugs	[ ]	5	5
3. Age (Mark box if 16-45 yo)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder Obsessive Compulsive Bipolar Disease Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
			_____	_____

**TOTAL:**

**Total Score Risk Category: (circle)**

**Low Risk      0 - 3**

**Moderate Risk   4 - 7**

**High Risk        ≥ 8**

Reference: Webster, LR. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. Pain Medicine. 2005; 6(6):432-442.

**Spine Muscles Nerves**  
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**Confidential Patient Information**

Referred By (location/phone): \_\_\_\_\_

Primary Physician (location/phone):  
 (if different) \_\_\_\_\_

Pharmacy (location/phone): \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address of Insured:  Same as above \_\_\_\_\_

SS#: \_\_\_\_\_

Sex:  Female  Male Marital Status:  Single  Married  Divorced  Widowed  Separated

Occupation: \_\_\_\_\_ Employer/School: \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact Phone #: \_\_\_\_\_

**Insurance Information**

Insurance Company: \_\_\_\_\_ Insur. Phone #: \_\_\_\_\_

ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Employer: \_\_\_\_\_ SS#: \_\_\_\_\_

Patient's Relationship to Policy Holder:  Self  Spouse  Child  Significant Other

Secondary Insur. Company: \_\_\_\_\_ Insur. Phone #: \_\_\_\_\_

ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ SS#: \_\_\_\_\_

**LEGAL ASSIGNMENT AND RELEASE**

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the captioned, and hereby assign at clinic's request, and convey directly to Spine Muscles Nerves all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefits payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care, including but not limited to, my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

**I understand I may be billed \$50 for missed or cancelled appointments when I do not provide 24 hours notice.**

**I have read and fully understand this agreement.**

Signature of Insured/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



## Agreement for Chronic Opioid Therapy

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

*Spine Muscles Nerves (SMN)* may consider prescribing opioid medications for chronic pain. This decision was made because my condition is serious or other more conservative have not helped.

It is understood that us of opioid medications have risks associated with them, including: drowsiness, constipation, nausea, vomiting, itching, dizziness, allergic reactions, slowed breathing, slowed reflexes or reaction time, physical dependency, tolerance, addiction, and that the medicine may not provide complete relief. I am aware of the possible risks and benefits other types of treatments that may be used for my benefit.

I will tell my doctor about all other medicines and treatments that I am receiving.

I will not involve myself in any activity that may be dangerous to me or someone else if I feel drowsy or I am not thinking clearly, and if my reflexes and reaction time might be slowed. I will avoid activities that may put me or others in danger, such as: using heavy equipment or machinery, operate a motor vehicle, working at dangerous heights, or being responsible for another individual who depends on me for his or her care.

I am aware that other medications, such as Naloxone (Narcan), Naltrexone (Vivitrol), Buprenorphine (Subutex), Buprenorphine/Naloxone (Suboxone, Zubsolv) may reverse the action of the medicine I am using for pain control. Taking any of these other medicines while I am taking my pain medicines can cause symptoms that will make me feel like I have the flu, called **Withdrawal Syndrome**. I agree not to take any of these medicines and to tell any other doctors that I am taking an opioid for pain control and cannot take any of the medicines listed above.

I am aware that **Addiction** is defined as the use of medicine even if it causes harm, having cravings for a drug, feeling the need to obtain and use a drug to control those cravings, even with the risk of decreased quality of life. I am aware that the chance of becoming addicted to pain medicine is low. I am aware that the development of addiction has been reported in medical journals and is much more common in a person who has a family member or personal history of addiction. To the best of my ability, I agree to tell my doctor my complete and honest personal and family drug history.

I understand that **Physical Dependency** is a normal and expected result of using these medicines over a long period of time. I understand that physical dependency is not the same as addiction. I am aware that physical dependency means that if my pain medicine use is markedly decreased or stopped, I will experience Withdrawal Syndrome, which tends to present with any of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, nausea, vomiting, diarrhea, irritability, body aches, and flu-like symptoms. I am aware that opioid withdrawal is uncomfortable but not life threatening.



## **Agreement for Chronic Opioid Therapy (continued)**

**The following pertains to receiving opioid medicines from SMN:**

- Changes to opioid medications require an office visit before a new prescription may be given. It will be required for you to bring in unused medications to the office before a new prescription will be given.
- Opioid medications may not be refilled early.
- If medication is lost or stolen, a new prescription will not be given until your next scheduled refill date.
- I will need to protect my medications from being lost/stolen, which may require use of a lock box.
- If prescribed by SMN, I agree to receive opioid medications from **only** this practice.
- To avoid possession of multiple opioid prescriptions, I will discard all previously prescribed opioid medications, because if future testing shows old prescriptions in my system, then that will be deemed a failed screen.
- **Urine Drug Screens** will be done as part of an evaluation of compliance. If a urine sample cannot be given, then a cheek swab may be done.
- **Random Pill Counts** may be requested to ensure compliance with medication prescribed.

**I understand that I may be dismissed due to any of the following:**

- Use of illegal drugs/substances.
- Taking medication that is not part of the SMN treatment plan.
- Obtaining medications from other providers. If you do not notify other practices you are receiving opiates and subsequently receive opiates from them, then that will be a violation of your Agreement.
- Refusal to provide a drug screen sample.
- Pill counts being refused, or not done on the requested date/time.
- Pill counts resulting in having overtaken, thus having less medication than should be present.

**I understand that I will:**

- **NOT** adjust the dose or frequency of my medication(s) without consulting the provider **FIRST**.
- **NOT** give my medications to others.
- **NOT** take pain medications for any other purpose than pain relief.
- **NOT** alter my medication in any way and I will only consume my medications as directed and in the form received from my pharmacy.

**I have read this form or it has been read to me. I understand my responsibilities as outlined above. I understand that violating any of the above policies in the Agreement may lead to my dismissal from the practice. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give my consent for the treatment of my pain with opioid pain medicines. This Agreement will remain in effect as long as I am being prescribed controlled substances (ex, pain medication) by my provider at Spine Muscles Nerves.**

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_



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## FINANCIAL POLICY

### *Welcome to Spine Muscles Nerves!*

We are dedicated to you, our patient, with our goal to give you the best care available. We know that dealing with the financial side of your care may be confusing and stressful.

Like all businesses, our practice must collect payments for our services in order to remain financially viable. However, unlike other businesses, medical practices typically receive payment from businesses (health insurance carriers) other than the individuals to whom they provide services, which can take up to 30 days or more to receive after those services are rendered. In order to provide patients with high standards of care and expertise they come to expect, it is important that we work together to ensure accurate billing and timely payments for the services we provide.

### **Patient Demographic and Insurance Information**

It is critical that we have correct demographic (personal) information about you and your health insurance coverage in order for us to bill accurately for the services we provide to you. This information includes:

- Your complete name, address, social security number, and phone number.
- If different, the subscriber's complete name, address, social security number, and phone number.
- The name of your insurance company, the group and subscriber number, or other identifying numbers.
- A copy of your insurance card, which also shows important information about your plan.
- The name, address and phone number of the physician (usually your primary care physician, or other specialist) who is referring you to our office.

Please bring a valid I.D. to each visit so we can verify and update your demographic information, and for patients with insurance, please bring your current insurance card for your primary and (if applicable) secondary insurance. This is to ensure accurate billing information and to protect you by confirming that we are providing services to the correct individual. This is no different than when you check into a hospital or urgent care center. Please understand that our staff will ask for this information and these documents even if you have recently been seen in our office. We rely on the information you provide in order to bill third parties for your medical services. Please be sure to report all potential third party sources of payment (auto, work comp, supplements, etc). If you do not provide us with the needed information in a timely manner, you may be responsible for payment for services rendered. ***Balances that are not paid due to errors or omissions in the information you provide may result in the entire balance becoming your responsibility.***





## Insurance Payment & Patient Responsibility

It is your responsibility to understand your insurance plan benefits and your responsibility for copayments, co-insurance, and any deductible amount for services you receive. **See chart below.** If you have questions on your insurance benefits coverage, you can call the Member Services Department listed on your insurance card regarding your coverage.

Please keep in mind, your insurance policy is a contract between you and your insurance. As a courtesy, we will file your claim.

There are several responsibility components that may apply to an insurance payment.

- **Deductible** – a set annual amount that the patient is responsible for paying prior to their insurance making a payment. It is your responsibility to know if **Spine Muscles Nerves** is an IN network or OUT of network provider under your insurance plan/coverage. There are normally separate deductibles for IN vs OUT of network providers, and they do not combine.
- **Co-Pay** – a set dollar amount per office visit that is the patient's responsibility. You are required to pay your office visit co-pay when you check in for your appointment. **If you do not have your co-pay, you will be re-scheduled.**
- **Co-Insurance** – a percentage of the charge that is the patient's responsibility. We may ask for payment up front.

Because of the contract you have with your insurance company, we are obligated to collect payment from you for your portion of the balance.

If you have a high deductible plan (\$1000 or more) and your insurance company reports a large amount of that deductible is unmet, then a down payment will be required at each visit until your deductible has been met. If you are unable to pay the down payment, then your appointment will be rescheduled.

Your insurance company will send you an Explanation of Benefits (EOB) to provide you with a summary of how your insurance company administered your benefits. This statement will also indicate what your responsibility is on a particular claim. If you disagree with how your benefits were administered, you need to direct your inquiries to your insurance company.

Please remember that it is up to you to understand the requirement of your individual insurance plan and that if a visit is not approved, your insurance company may not cover the service and you will be responsible for the bill. If you're not sure if a service is covered by your plan, we will be glad to call your insurance company in advance to see if you are going to be responsible for the bill. We must emphasize that as your healthcare provider, our relationship and concern is with you and your health, not with your insurance company.

As a courtesy, we will work with your insurance company to ensure that you receive all benefits due to you. However, most insurance plans do not pay 100% of the claims and any unpaid balance will become your responsibility.

We will be glad to work with you on payment plans for denied and non-covered services. Please contact the office at (614) 918-9808 to make arrangements.





## **Non-Covered Services**

We follow current Pain Management standards of care and appropriate-use guidelines in recommending interventional treatments as part of your care. Please be aware that some parts of your treatments recommended to you may be determined to be non-covered services or may be considered “not medically necessary” based on the benefits provided by your specific insurance plan. You will be financially responsible for the costs of non-covered services and services that your insurance carrier declines to cover as “not medically necessary.” In the event that our information indicates that a specific service or services may not be covered by your plan, you will be asked to sign an ABN, or Advanced Beneficiary Notice, outlining the services that we have determined may not be covered by your plan, and for which you agree to be responsible for payment, before we will provide those services to you. Please understand that even for insurance plans with which we participate, covered benefits may vary from one person’s or employer’s plan to another, and it is impossible for us to know what is covered under every plan. You are responsible for knowing the covered and non-covered benefits available under your plan. We will be happy to provide, upon request, the billing codes for your planned surgery. If you have questions, contact your employer’s personnel department or your plan directly.

## **Verification of Insurance Coverage**

We will verify your insurance coverage, including Medicare, at the time your visit or surgery is scheduled, and again shortly before your scheduled appointment or surgery. If your insurance coverage changes after you schedule your appointment or surgery, please notify us as soon as possible, before your visit. If we are able to confirm active coverage, you will be considered “self-pay.” It may be necessary to reschedule your visit or surgery, depending on the service requested, whether or not we are able to verify your new coverage (and whether we participate with your new carrier), and whether or not you are able to make payments at the time of the visit.

## **Payment Methods**

We accept a variety of payment methods, including: cash, check, money order, or credit/debit cards.

We understand that there may be times and circumstances that come up where you are unable to pay your entire bill. In these situations, it is VERY important that you contact us at (614) 918-9808, so a representative can assist you in setting up a reasonable plan and to keep your account from being sent to a collection agency.

## **Surgery**

If your physician recommends surgery, your surgery will be scheduled by the medical assistant. The medical assistant will answer specific questions about the surgery scheduling process, discuss the paperwork and tests involved, and complete all pre-certification/authorization if your insurance company requires it.

We will require a pre-surgical deposit to go towards your surgery co-payment, deductible or any other amount deemed the patient’s responsibility by your insurance carrier. After your insurance company has processed your claims, any amount remaining as a credit balance will be refunded to you.



## Referrals

If your plan requires a prior authorization from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If your plan requires a prior authorization and you do not obtain one, you will be held responsible for the visit charges in full at the time of service.

## Cancellation/Missed Appointment Policy

We understand that on rare occasions, issues may arise causing you to miss your appointment without the ability to notify our office prior to your appointment. Should you experience any unforeseen circumstance that causes you to miss your appointment, please call our office to have it rescheduled.

We are committed to your wellbeing and have reserved your time just for you. Patients that miss more than one appointment without notifying our office prior to the scheduled appointment are subject to a **\$50.00 missed appointment fee**. This must be paid in-full before the appointment is rescheduled.

The cancellation of a scheduled surgery results in the failure to serve other patients as well as the disruption of the schedules for the Operating Room and other Healthcare Professionals.

We, therefore, respectfully request your understanding and cooperation with our Cancellation Policy.

Cancellation within 7 days prior to your procedure date will result in the loss of your deposit. Cancellations made because of a death or illness in the family will be exempt from this policy, and a full refund will be made.

## Failure to Pay for Services Rendered

**Returned Checks** – For checks returned to us for non-sufficient funds, we will charge a \$50 fee. In addition, check privileges will be denied after the first returned check.

**Multiple Statements** – Spine Muscles Nerves will send you three monthly statements. If you fail to make payments or set up a payment plan, then your account will be referred to the collection agency and your ability to schedule appointments will be suspended. If you have been set up on a payment plan and fail to make two consecutive payments, then your account will be referred to collections. Due to the costs associated with sending out multiple statements, we reserve the right to assess any account with balances older than 90 days a monthly interest rate of 2%. Spine Muscles Nerves does not assess interest if the patient is on a payment plan and making timely payments.

**Past Due Accounts** – If your account has to be sent to the collection agency, additional fees will be charged. Due to the cost associated with setting up your account at the collection agency, we will add an additional fee of \$100 to your account. These charges along with your balance will be your responsibility. You will not be able to schedule visits until your account has been cleared.





## Refunds

Overpayments will be refunded to the appropriate party. Patient refunds will not be processed until all pending insurance claims have been paid in full. Refunds of \$5 or less will not be issued unless specifically requested. If your spouse or dependents have a past due balance with *Spine Muscles Nerves*, your credit will be automatically applied to that account. If you, your spouse or dependents have a past due balance with *Spine Muscles Nerves*, your credit with *Spine Muscles Nerves* will automatically be transferred and applied as well.

## Completion of Forms

There may be times when you request that we complete forms of various types. Examples may include: medical histories for life insurance applications, disability forms, FMLA, etc. There will be a charge (below), payable in advance, for completion of each form. Please understand that completion of such forms requires time by our providers and staff in order to ensure that they are completed accurately. Please allow for 7 business days for the forms to be completed.

- 1-2 pages: \$30
- 3+ pages: \$60
- Forms filled out by physician: \$60

## Patient Acknowledgement

I authorize the release of medical information necessary to process claims for my insurance either by mail or electronic submission. I authorize payment of medical benefits to Spine Muscles Nerves for services rendered. I certify the information provided on this form is correct to the best of my knowledge. I understand that I am financially responsible for all charges whether they are covered by insurance or not and will be charged a service fee if sent to a collection agency.

I agree, in order for the practice or third party agency to service my account or to collect any amounts I may owe, they may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. The practice or agency may also contact me by sending text messages or emails, using any email address provided by me. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I have read and agree to the above policies.

I have received and understand the Financial Policy of Spine Muscles Nerves.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

**A COPY OF THIS FORM WILL BE PROVIDED AT YOUR REQUEST. PLEASE INFORM THE RECEPTIONIST.**





450 Alkyre Run Drive, Suite 360, Westerville, OH 43082

Phone: (614) 918-9808 Fax: (614) 918-9807

**PATIENT ACKNOWLEDGEMENT FORM, NOTICE OF PRIVACY PRACTICES AND CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**NOTICE OF PRIVACY PRACTICES:** I have received a copy of the Spine Muscles Nerves Privacy Practices.

**CONSENT OF HEALTH INFORMATION:** This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

**I hereby give my consent to *Spine Muscles Nerves* to use and disclose my protected health information for the purposes of treatment, payment and operations of my health care with this practice.**

**CONSENT FOR TREATMENT:** I, with my signature, authorize this practice and any employee working under the direction of the physician, to provide medical care for me, or to this patient which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but limited to) preventive, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing drugs, devices, equipment or other items required and in accordance with prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

**CONSENT TO RELEASE OF INFORMATION FOR PAYMENT AND OPERATION:** I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the privacy practice notice.

**CONSENT RELATED TO THE PRIVACY NOTICE:** I have had a chance to review the Privacy Practice Notice as part of this registration process. I understand that the terms of the Privacy Practice Notice may change and I may obtain these revisions by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on the use, it is bound by the agreement.

**If we are able to reach you personally, do we have your permission to leave a message on your voicemail or answering machine? (Initial here for YES) \_\_\_\_\_ Phone #: \_\_\_\_\_**

**I AUTHORIZE THE RELEASE OF MY MEDICAL INFORMATION TO THE FOLLOWING:**

- 1. \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_
- 2. \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_
- 3. \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

PATIENT PRINTED NAME: \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_ Date \_\_\_\_\_

PATIENT'S PERSONAL REPRESENTATIVE: \_\_\_\_\_ Date \_\_\_\_\_

OFFICE REPRESENTATIVE: \_\_\_\_\_

REPRESENTATIVE SIGNATURE: \_\_\_\_\_ Date \_\_\_\_\_



## Privacy Notice

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Privacy Notice is being provided to you as a requirement of the federal law, the Health Insurance Portability and Accountability Act (HIPAA). This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations, and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. Your “protected health information” means any written or oral information about you, including demographics data that can be used to identify you, created or received by your health care provider, which relates to your past, present, or future physical or mental health or conditions.

### **Uses and Disclosures of Protected Health Information for Treatment, Payment, and Health Care Operations.**

We may use your protected health information for the purposes of providing treatments, obtaining payment for treatment, and conduction health care operations. Your protected health information may be used or disclosed only for these purposes, unless we have obtained your authorization, or the use or disclosure is permitted or required by the HIPAA regulations or other law. Disclosures of your protected health information for the purposes described in this Privacy Notice may be made in writing, orally, or by electronic means.

1. **Treatment.** We will use and disclose your protected healthcare information to provide, coordinate, or manage your healthcare and related services, including coordination and management with third parties for treatment purposes. Here are some examples of how we may use or disclose your protected health information for treatment:
  - a. To a laboratory to order tests.
  - b. To other physicians who may be treating you or consulting with us regarding your care.
  - c. To those who may be involved in your care after you leave here, such as family members or other personal representatives.
2. **Payment.** We will use your protected health information to obtain payment for the services we provide to you. We may also disclose your protected health information to another provider involved in your care for their payment activities. Here are some examples of how we may use or disclose your protected health information for payment:
  - a. To communicate with your health insurance company to get approval for the services we render, to verify your health insurance coverage, to verify that particular services are covered under your insurance plan, and to demonstrate medical necessity.
  - b. To anesthesia care providers involved in your care so they can obtain payment for their services.
3. **Healthcare Operations.** We may use and disclose your protected health information to facilitate our own healthcare operations and to provide quality care to all of our patients. Healthcare operations include such activities as: quality assessment and improvement; employee review activities; conduction or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection, and compliance reviews; business planning and development; and business management and general administrative activities. In certain situations, we may also disclose your protected health information to another provider or health plan for their healthcare operations. Here are some examples of how we may use or disclose your protected health information for healthcare operations:
  - a. To review our treatment and services, and to evaluate the performance of our staff in caring for you.
  - b. We may combine protected health information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective.
  - c. We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes.
  - d. In the course of maintenance and management of your electronic health information systems.



## Uses and Disclosures of Protected Health Information Permitted without Authorization or Opportunity for the Individual to Object.

The federal privacy rules allow us to use or disclose your protected health information without your authorization and without your having the opportunity to object to such use or disclosure in certain circumstances, including:

1. **When Required By Law.** We may disclose your protected health information when we are required to do so by federal, state, local law.
2. **For Public Health Reasons.** We may disclose your protected health information as permitted or required by law for the following public health reasons:
  - a. For the prevention, control, or reporting of disease, injury or disability;
  - b. For the reporting of vital events such as birth or death;
  - c. For public health surveillance, investigations, or interventions;
  - d. For purposes related to the quality, safety, or effectiveness of FDA-regulated products or activities, including:
    - Collecting and reporting of adverse events, product defects or problems, or biological product deviation.
    - Tracking of FDA-regulated products.
    - Product recalls, repairs, or lookback.
    - Post-marketing surveillance.
  - e. To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease or condition;
  - f. Under certain limited circumstances, to report to an employer information about an individual who is a member for the employer's workforce.
3. **To Report Abuse, Neglect, or Domestic Violence.** We may notify government authorities if we believe a patient is a victim of abuse, neglect, or domestic violence. We will make this disclosure only when specifically authorized or required by law, or when the patient agrees to the disclosure.
4. **For Health Oversight Activities.** We may disclose your protected health information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight.
5. **For Judicial or Administrative Proceedings.** We may disclose your protected health information in the course of any judicial or administrative proceedings in response to an order of a court or administrative tribunal as expressly authorized by such order. We may disclose your protected health information in response to a subpoena, discovery request, or other lawful process that is not accompanied by an order of a court or administrative tribunal if we have received satisfactory assurances that you have been notified of the request or that an effort has been made to secure a protective order.
6. **For Law Enforcement Purposes.** We may disclose your protected health information to a law enforcement official for law enforcement purposes, including:
  - a. Wound or physical injury reporting, as required by law.
  - b. In compliance with, and as limited by the relevant requirements of a court order or court-ordered warrant, a subpoena, summons, or similar process.
  - c. Identification or location of a suspect, fugitive, material witness, or missing person.
  - d. Under certain limited circumstances when you are the victim of a crime.
  - e. Alerting law enforcement of the death of an individual where there is suspicion that the death may have resulted from criminal conduct.
  - f. Reporting criminal conduct that occurred on the premises of the provider.
  - g. In an emergency to report a crime.
7. **To Coroners, Medical Examiners, and Funeral Directors.** We may disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. We may disclose protected health information to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent. In some cases, such disclosures may occur prior to, and in reasonable anticipation of, the individual's death.
8. **For Organ or Tissue Donation.** We may use or disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating donation and transplant.
9. **For Research Purposes.** We may use or disclose your protected health information for research purposes when an institutional review board that has reviewed the research proposal and protocols to safeguard the privacy of your protected health information has approved such use or disclosure.



10. **To Avert a Serious Threat to Health or Safety.** We may, consistent with applicable law and standards of ethical conduct, use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health and safety or that of the public.
11. **For Specialized Government Functions.** We may use or disclose your protected health information, as authorized or required by law, to facilitate specified government functions related to military and veterans' activities; national security and intelligence activities; protective services for the President and others; medical suitability determinations; correctional institutions and other law enforcement custodial situations.
12. **For Worker's Compensation.** We may use and disclose your protected health information, as necessary, to comply with worker's compensation laws or similar programs.

### **Uses and Disclosures of Protected Health Information Permitted without Authorization but with an Opportunity for the Individual to Object.**

We may use your protected health information to maintain a directory of patients in our facility. The information included in the directory will be limited to your name, your location in our facility, and your condition described in general terms.

We may disclose your protected health information to a friend or family member who is involved in your medical care payment for care. In addition, if applicable, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

You may object to these disclosures. If you do not object to these disclosures, or we determine in the exercise of our professional judgement that it is in your best interest for us to disclose information that is directly relevant to the person's involvement with your care, we may disclose your protected health information.

### **Uses and Disclosures of Protected Health Information Which You Authorize**

Other than the uses and disclosures described above, we will not use or disclose your protected health information without your written authorization. We require your written authorization in order to use or disclose your protected health information for:

- Marketing, except if the communication is in the form of a face-to-face communication made by us to you, or a promotional gift of nominal value that we provide to you, and
- Any sale of your protected health information.

Authorizations are for specific uses of your protected health information, and once you give us authorization, any disclosures we make will be limited to those consistent with the terms of the authorization. You may revoke your authorization, by submitting a revocation in writing, at any time, except to the extent that we have already taken action in reliance upon your authorization.

### **Your Rights Regarding Your Protected Health Information**

You have the following rights regarding your protected health information:

1. **The Right to Request Restriction of Uses and Disclosures.** You have the right to request that we not use or disclose certain parts of your protected health information for the purposes of treatment, payment, or healthcare operations. You also have the right to request that we do not disclose your protected health information to friends or family members who may be involved in your care, or for notification purposes as described earlier in this notice. Your request must be made in writing and must state the specific restriction requested and the individuals to whom the restriction applies.

We must agree to your request to restrict disclosure of your protected health information to a health plan if:

- The disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law; and
- The protected health information pertains solely to a healthcare item or services for which you or someone else has paid out-of-pocket in full.

Otherwise, we are not required to agree to a restriction you may request.

We will notify you if we do not agree to your restriction request. If we do agree to the restriction request, we will not use or disclose your protected health information in violation of the agreed upon restrictions, unless necessary for the provision of emergency treatment.

We may terminate our agreement to a restriction if you agree to the termination in writing; if you agree to the termination orally and the oral agreement is documented, or if we notify you of termination of the agreement and the termination applies only to protected health information created or received by us after you receive the notice of termination of the restriction.

Request for restrictions must be made in writing to the Privacy Officer.

2. **The Right to Request Confidential Communications.** You have the right to request that you receive communications of



protected health information from us by alternative means or at alternative locations. We must accommodate any reasonable request of this nature. We may condition the provision or accommodation by requesting information from you describing how payment will be handled, or by requesting specification of an alternative address or alternative form of contact.

Requests for confidential communications must be made in writing to the Privacy Officer.

**3. The Right to Inspect and Copy Protected Health Information.** You have the right to inspect and obtain a copy of your protected health information that is maintained in a designated record set for as long as we maintain the protected health information. The designated record set is a collection of records maintained by us, which contains medical and billing information used in the course of your care, and any other information used to make decisions about you.

By law, you do not have a right to access psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative proceeding; and protected health information which is subject to a law which prohibits access to protected health information. Depending on the circumstance of your request, you may have the right to have a decision to deny access reviewed.

We may deny your request to inspect or copy your protected health information if, in our professional judgement, we determine that the access requested is likely to endanger you or another person, or is likely to cause substantial harm to another person referenced within the protected health information. You have a right to request a review of a denial of access.

If you request a copy of your information, we may charge you a fee for the costs of copying, mailing, or other costs incurred by us as a result of complying with your request.

Request for access to your protected health information must be made in writing to the Privacy Officer.

**4. The Right to Amend Protected Health Information.** You have the right to request that we amend your protected health information in a designated record set for as long as we maintain that information. In certain cases, we may deny your request. If we deny your request, you will be notified in writing, and you will have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement of disagreement and if we do so, we will provide a copy of our rebuttal to you.

Requests for amendment of protected health information must be made in writing to the Privacy Officer, and must include a reason to support the requested amendment.

**5. The Right to Receive an Accounting of Disclosures of Protected Health Information.** You have the right to request an accounting of disclosures of your protected health information made by us. This right applies to disclosures made by us, except for disclosures: to carry out treatment, payment, or healthcare operations as described in this Notice or incidental to such use; to you or your personal representatives; pursuant to your authorization; for our directory, or other notification purposes, or to persons involved in your care; or for certain other disclosures we are permitted to make without your authorization.

Requests for disclosure of accounting must specify a time period sought for the accounting, with the maximum time period being six years prior to the date of the request. We are not required to provide accounting for disclosures made before April 13, 2003. We will provide the first disclosure accounting you request during any 12-month period without charge. Subsequent disclosure accounting request will be subject to a reasonable cost-based fee.

**6. The Right to Obtain Paper Copy of this Notice.** Upon request, we will provide a paper copy of this notice.

### **Your Right Regarding Your Protected Health Information**

We are required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our legal duties and privacy practices with respect to protected health information. We are required by law to notify you if a breach of your unsecured protected health information occurs. We are required to abide by the terms of the Notice currently in effect. We reserve the rights to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. If we change the Notice, we will provide a copy of the revised notice through in-person contact.

### **Your Rights Regarding Your Protected Health Information**

You have the right to express complaints to us and to the Secretary of the Department of Health and Human Services, if you believe that your privacy rights have been violated.

If you wish to complain to us, please do so in writing, and direct your complaint to the Privacy Officer. **You will not be penalized for filing a complaint.**

### **Contact Information.**

For further information about this Notice, privacy issues, or if you believe that your privacy right have been violated, please contact: Administrator or CEO.

Patient Name: \_\_\_\_\_ Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Release of Medical Information**

I hereby authorize the release of any and all medical records pertaining to my care to:

Robert E. Gould, DO

Spine Muscles Nerves

450 Alkyre Run Drive, Suite 360, Westerville, OH 43082

Phone: (614) 918-9808

Fax: (614) 918-9807

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Signature: \_\_\_\_\_





Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ cell / home / work

Secondary Phone: \_\_\_\_\_ cell / home / work

Email: \_\_\_\_\_ PCP: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

### **PATIENT CONSENT FOR TREATMENT**

I have requested a consult and/or treatment from Spine Muscles Nerves (SMN) and consent to treatment discussed with the provider.

### **OFFICE RELATED COMMUNICATIONS**

It is a policy of SMN to obtain authorization to leave messages on telephone answering services, cell phone voicemail, or send messages via email regarding confirmation of your appointments or pertinent medical information regarding your treatment.

I authorize SMN personnel to leave information regarding my appointments/treatments on answering services, voicemail, or via email at the current phone number(s) and/or email provided above.

### **APPOINTMENT CANCELLATIONS**

Due to the limited availability, we must enforce a "No Call / No Show" policy. If you fail to give **24 hours'** notice without sufficient reason, then you may be billed **\$50.00** for that time slot you occupied.

I have read (or have been read to) the above, understand and agree to these policies.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

### **CONSENT TO BILL INSURANCE**

I consent for Spine Muscles Nerves (SMN) to bill my insurance(s) for services rendered with a SMN's provider. I understand that any service requested and delivered that is not covered by my insurance plan will be my responsibility. I am aware that it is my responsibility to know what benefits I have and I agree to pay any charges that are not covered by my insurance (Copay, Deductible, Out-of-Pocket).

I have verified my copay amount with my insurance company and understand that I have to pay this amount at the time of service. Other amounts will be billed to my insurance(s). Amount applied to my Deductible and Out-of-Pocket will be my responsibility to pay.

I understand that there are additional charges for services not covered by insurance (completion of form, some procedures, etc.) and I will be asked to pay these prior to completion of the service. I also understand that returned checks may incur additional fees to my account.

Balances are due once the Explanation of Benefits are received by the office and payment will be requested at any office visit. If you are not able to pay, payment plans are available. Unpaid bills may lead to the account being sent to collections, and your dismissal from the practice. Once a balance is sent to collections, you will not be able to reschedule or have medication prescribed until the balance is paid in-full.

I have read (or have been read to) the above, understand and agree to this Consent.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_





## GENERAL HEALTH INFORMATION

Please place your initials at the beginning of each paragraph that's applicable to you:

\_\_\_\_\_ I am aware that *Tolerance* to analgesia means that I may required more medicine to get the same amount of pain relief. I am aware that *Tolerance* to analgesia does not seem to be a big problem for most patients with chronic pain, however, it has been seen and may occur to me. If it occurs, increasing doses may not always help and may contribute to side effects. *Tolerance* or failure to respond well to opioids may cause my doctor to choose another form of treatment.

\_\_\_\_\_ Males Only: I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

\_\_\_\_\_ Females Only: If I plan to become pregnant or believe that I have become pregnant while taking pain medicine, I will immediately call my obstetrician and this office to inform them. I am aware that should I carry a baby to delivery while taking these medicines, the baby will be physically dependent on opioids, and could result in neonatal opioid withdrawal syndrome which can be a life-threatening condition to the newborn. I am also aware that opioid use is generally not associated with a risk for birth defects. However, birth defects can occur whether or not the mother is on medications, and there is always the possibility that my child could have a birth defect while I am taking the opioid during pregnancy.

I have read (or have been read to) the above statements, and understand potential health risks. I have had a chance to have all of my questions answered to my satisfaction. By signing this form voluntarily, I give my consent for the treatment of my pain with opioid pain medicines. This Agreement will remain in effect as long as I am being prescribed controlled substances (ex: pain medicines) by a provider at Spine Muscles Nerves.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_