NeuSpine Institute | Diagnostic Pain

PATIENT INFORMATION

Today's Date: _____

Name:_____Middle Initial: _____ Date of Birth: _____

Address: _____

STREET CITY STATE ZIP CODE

Gender: ☐Male ☐ Female Social Security #: _____

Home Phone: _____ Cell Phone _____E-mail: _____

Race/Ethnicity: ☐ American Indian ☐ Hispanic/Latino ☐ Asian ☐African American ☐ White ☐ Other

Is your visit related to an Auto Accident? ☐ **Yes** ☐ **No** Open Claim ? ☐ **Yes** ☐ **No**

Is your visit related to a Work Accident? ☐ **Yes** ☐ **No** Open Claim ? ☐ **Yes** ☐ **No**

Is your visit related to a Slip & Fall? ☐ **Yes** ☐ **No** Open Claim ? ☐ **Yes** ☐ **No**

How were you referred? ☐Primary ☐ Specialty ☐Friend/Family ☐ Advertising ☐Other (please specify)

Referring Physician (if applicable): _____

Primary Care Physician:

Name: _____Phone Number: _____ Fax: _____

EMERGENCY CONTACT INFORMATION:

1. Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

2. Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

PROVIDER HISTORY:

Primary Care Physician:

Name: _____Phone Number: _____ Fax: _____

INSURANCE INFORMATION:

Primary Insurance

Person Responsible: ☐ Self ☐ Other Relationship to Patient: _____Name:_____

Insurance Company: _____ ID Number: _____

Insurance Phone: _____ Group #: _____

Secondary Insurance (IF ANY)

Person Responsible: ☐ Self ☐Other Relationship to Patient: _____Name: _____

Insurance Company: _____ ID Number: _____

Insurance Phone: _____ Group #: _____

PHARMACY INFORMATION:

Local Pharmacy
Name: _____
Address: _____
_____
Phone Number: _____

Mail Order Pharmacy
Name: _____
Address: _____
_____
Phone Number: _____

FINANCIAL AND CONSENT AGREEMENT:

ALL PROFESSIONAL FEES ARE DUE AT THE TIME OF SERVICE UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE.

PATIENT INFORMATION FORM – FINANCIAL AGREEMENT

1) Services are rendered to the patient not the insurance company. Our office will file your insurance if proper information is received.
   a) You are responsible for Copays, Deductibles, Non-Covered Services, Co-Insurance and items considered "not medically necessary" by insurance.
   b) For unpaid claims, over 45 days,it is your responsibility to follow up with your insurance company and the balance may be considered due and payable.
2) It is your responsibility to notify our front desk of any insurance or address changes.
3) You will be responsible for any changes that occur if your current insurance is not communicated at the time of service.
4) Expenses incurred to collect patient-responsible debt may be charged to the patient or guarantor.

_____ _____ _____
Patient/Legal Guardian Printed Name | Patient/Legal Guardian Signature | Date

ACKNOWLEDGEMENT AND CONSENT FOR NOTICE OF PRIVACY

Acknowledgement of Receipt:

I have reviewed NeuSpine Institute Notice of Privacy, which explained how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document at no cost to me.

Patient requested copy: ☐ Yes ☐ No

_____ _____ _____
Name of Patient *(Please Print* | Signature of Patient of Legal Guardian | Date

Consent to Release Medical Information to Personal Representative

I, _____, hereby consent to have my information released to the following individuals. This consent will remain in effect until otherwise notified by me in writing.

☐ Appointment times ☐ Medical Information ☐ Billing/Demographic Info

Do NOT release my information, except to health care providers and…

_____ _____ , _____ _____
Name | Relationship | Name | Relationship

_____ _____ , _____ _____
Name | Relationship | Name | Relationship

_____ _____
Signature of Patient of Legal Guardian | Date

PATIENT AUTHORIZATION & CONSENT

I hereby voluntarily consent to medical treatment, including diagnostic procedures, surgical and other medical services, provided by NeuSpine Institute or their authorized designees, as they may in their professional judgment be necessary to provide appropriate medical, surgical or emergency care. I agree to reimburse the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, all costs, and expenses, including but not limited to reasonable attorney's fees that may incur in such collection efforts.

I authorize NeuSpine Institute physicians to submit claims to my insurance for services rendered by my medical providers. I authorize the release of any medical information necessary to process this assignment on the claim. I authorize payment to be made to NeuSpine Institute physicians for services provided by them.

TO ALL PATIENTS:

In order to provide you with good service, it is of great importance we have your current address and phone number on file. Please be sure to contact us if your phone number and/or address changes. This information will be utilized to remind you of your appointment date and time.

Cancellation/No Show Policy:

Any Follow-up appointment cancellation or no-show in which a 24-hour notice is not provided, will result in a $50 charge.

Any Injection appointment cancellation or no show in which a 24-hour notice is not provided, will result in a $75 charge.

After three occurrences you will be terminated from NeuSpine Institute. If we terminate our service with you, we will be happy to transfer a copy of your medical records to your new physician upon receipt of a signed authorization to release records.

Late Policy:

The clinic has limited waiting time for your appointment. If you are more than 15 minutes late your appointment will be rescheduled.

_____ _____

Signature of Patient of Legal Guardian Date

NEUSPINE INSTITUTE
HIPAA Privacy Authorization Form
Authorization for Use of Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

I authorize **NEUSPINE INSTITUTE.** to use and disclose the protected health information described below.

By signing,

1. I authorize the release of my complete health record (including records related to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
2. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
3. This authorization shall be in force and effect during my entire care at NeuSpine Institute LLC.
4. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on the authorization or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
5. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
6. I may inspect and receive a copy of the information being used and disclosed pursuant to this Authorization form.
7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____	_____	_____
Printed Patient Name & DOB	Patient Signature	Date

Assignment of benefits, liens, direct payment authorization, authorization to release insurance information, and authorization to escrow unpaid medical & PIP benefits
NEUSPINE ANCILLARY LLC

Insurance Carrier_____

For and consideration of NEUSPINE INSTITUTE LLC agreeing to pursue the responsible insurance carrier for payment of benefits due and not requiring prepayment for services, I hereby irrevocably assign all rights and benefits to NEUSPINE INSTITUTE LLC for Medical Payment Coverage, and other benefits which I may have accordance with Florida Statute § 627.736. This includes any benefits from my insurance company and any other entity may be responsible for medical expenses incurred. I further authorize NEUSPINE INSTITUTE LLC to collect payments & prosecute any necessary actions to collect payments for services as they see fit and allowable by law and contract. THIS DOCUMENT CONSTITUTES AN ASSIGNMENT OF RIGHTS AND BENEFITS.

This assignment concerns only the bills for NEUSPINE INSTITUTE LLC and those costs including, but not limited to,attorney's fees other costs, and interest necessary in procuring payment from the above-names insurance company and/or other entities. This assignment is not intended to assign any other causes of action that may belong to the undersigned patient. I agree to pay any applicable deductible or copayment not covered by any policy of insurance cited above . I understand that as a benefit and convenience to me, NEUSPINE INSTITUTE LLC will bill any pursue collection against the insurance company or other responsible entity on my behalf. I hereby instruct and direct my insurance company to pay my benefits directly to NEUSPINE INSTITUTE LLC on the address provided on the bill. If my current policy prohibits direct payment to doctors, then I hereby instruct and direct my insurance company or other responsible entity to make the check payable to me and mail it to NEUSPINE INSTITUTE LLC at the address on the bill. NEUSPINE INSTITUTE LLC medical care is being provided for a reasonable fee for treatment that I have sought out for under my above mentioned insurance carrier and is medically necessary. I instruct my insurance carrier or other responsible entity to pay these bills to the full extent of my available benefits under the insurance policy and Florida law. If any portion of the charge for these services is either reduced or denied in whole or in part,my insurance company or other entity is to place funds equal to the amount of the reduced or denied charges into escrow and hold the escrowed funds until agreement or resolution of legal action by NEUSPINE INSTITUTE LLC. I further instruct my insurance company to make payment for charges submitted NEUSPINE INSTITUTE LLC in priority to any other request to escrow benefits,including a request by myself to reserve benefits for pending disability claims . I hereby give NEUSPINE INSTITUTE LLC limited power of attorney to endorse and sign my name on any draft for payment to either NEUSPINE INSTITUTE LLC or myself if said draft represents payment for charges related to services rendered by NEUSPINE INSTITUTE LLC.

I further direct my insurance carrier ir responsible other entity to provide information to NEUSPINE INSTITUTE LLC which is otherwise available to me including but not limited to a copay of any applicable insurance policy, declaration page,all applicable endorsements, transcripts and/or copies of any recorded statements,examinations under oath and request for same,independent medical evaluations and requests for same, and peer review reports, this request includes the name of other medical providers to whom payments have been under my policy of insurance in favor of NEUSPINE INSTITUTE LLC. If any language within this agreement has the effect of invalidating this agreement , that language shall be deemed void and the remainder of the assignment shall maintain full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original .

Patient Signature	Patient Name	Date

INFORMED CONSENT AND CONTROLLED SUBSTANCE AGREEMENT

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used, so that you may make an informed decision whether or not to take the drug after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so you may give or withhold your consent to the drug(s) recommended to you by me, as your physician.

CONSENT TO TREATMENT AND/OR DRUG THERAPY voluntarily request Dr. Juan Egas, Dr. Kamal Patel, Dr. Armen Deukmedjian, Dr. Amir Ahmadian, and Dr. Jason Paluzzi as my physician, and such associates, technical assistants, nurses and other health care providers as it may deem necessary or advisable, to treat my condition which has been explained to me as: chronic pain. I hereby authorize and give my voluntary consent to administer or follow prescribed prescription(s), controlled substance(s), or narcotic medication(s) as an element in the treatment of my chronic pain.

It has been explained to me that these medication(s) include narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) are addictive and may, like other drugs used in the practice of medicine, produce adverse effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

I understand that I will undergo medical tests and examinations before and during my treatment at NeuSpine Institute. Those tests include random unannounced urine and/or blood test for drugs and I hereby give permission to perform the tests or my refusal may lead to termination of treatment with controlled substances. Presence of unauthorized substances may result in my discharge from NeuSpine Institute.

For Female patients only: To the best of my knowledge,

_____I am pregnant _____I am not pregnant

If I am not pregnant, I will use appropriate contraception during my course of treatment. I promise to inform my doctor and/or his/her appropriately authorized assistant(s) immediately if I become pregnant during the course of treatment.

If I am pregnant, in addition to the possible risks involved with the long-term use of narcotic(s) and controlled substance(s), I further understand that information on the effects of narcotic(s) and controlled substance(s) on pregnant women and their unborn children is at present inadequate to guarantee that I may not produce significant or serious side effect(s) to my unborn child.

It has been explained to me and I understand that narcotic(s) and controlled substance(s) are transmitted to the unborn child and will cause physical dependence. Thus, if I am pregnant and suddenly stop taking narcotic(s) and controlled substance(s), I or the unborn child may show signs of withdrawal, which may adversely affect my pregnancy or the child. I shall use no other drugs without approval, since these drugs particularly as they might interact with narcotic(s) and controlled substance(s), may harm me or my unborn child.

I shall inform any other doctor who sees me during my present or any future pregnancy or who sees the child after birth, of my current or past participation in a chronic, intractable pain program in order that he may properly care for my child and I.

It has been explained to me that after the birth of my child I should not nurse the baby because narcotic(s) and controlled substance(s) are transmitted through the milk to the baby and this may cause physical dependence on narcotic(s) and controlled substance(s) in the child. I understand that for a brief period following birth, the child may show temporary irritability or other ill effects due to my use of narcotic(s) and controlled substance(s). It is essential for the child's physician to know of my participation in a narcotic(s) and controlled substance(s) treatment program so that he may provide appropriate medical treatment for the child.

All of the above possible effects of narcotic(s) and controlled substance(s) have been fully explained to me and I understand that at present, there have not been enough studies conducted on the long-term use of the drug to assure complete safety to my child. With full knowledge of this, I consent to its use and hold NeuSpine Institute and its physicians and all staff harmless for injuries to the embryo / fetus / baby.

MOST COMMON SIDE EFFECTS: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention, insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to

medication(s), physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive narcotic(s) for the treatment of my chronic, intractable pain.

The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and active life. I realize that the goal of taking narcotic(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. An appropriate treatment goal may even mean the eventual withdrawal from the use of all narcotic(s). I realize that the treatment for some will require prolonged or continuous use of controlled medication(s) and that my condition will be evaluated on an individual basis.

I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time, and I will be afforded detoxification under medical supervision.

The drug therapy that my physician may prescribe for me may involve using a drug that the Federal Food and Drug Administration may not have been asked by the manufacturer to review for safety or effectiveness for your condition. Current medical literature shows that such “off label” use may be beneficial to some patients and I understand that recommended dosages for treating intractable pain are often exceeded in order to balance the benefit and risk to the patient.

I understand that no warranty or guarantee has been made to me as to the result of any drug therapy or cure of any condition. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

I am aware that certain other medicines such as nalbuphine (Nubain), pentazocine (Talwin), buprenorphine (Buprenex), and butorphanol (Stadol), 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 like a bad flu, called a withdrawal syndrome. I agree not to take any of these medicines and to tell any other doctors that I am taking an opioid as my pain medicine and cannot take any of these medicines listed above. I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life.

I am aware that the chance of becoming addicted to my pain medicine even if I follow the assigned protocol. I am aware that the development of addiction has been rarely noted in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge.

I understand that physical dependence is a normal, expected result of using these medicines for a long time. I understand that physical dependence is not the same as addiction. I am aware that physical dependence means that is my pain medicine use is markedly decreased, stopped or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any of the following: runny nose, yawning, large pupils, goosebumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening.

I am aware that tolerance to analgesia means that I may require 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 cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment.

CONTROLLED SUBSTANCES AGREEMENT:
This informed consent also contains the following important requirements that I must fulfill in order to participate in the Chronic Pain Treatment Program.

This agreement relates to my use of any controlled substance(s) (i.e., Narcotics, painkillers, prescription medications) for chronic pain prescribed by NeuSpine Institute’s Doctors and/or any appropriately authorized ancillary personnel at its office(s). I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). The Florida Department of Health has specific requirements for the use of controlled substance(s) for the treatment of chronic pain.

Therefore, controlled substance(s) will only be provided so long as I am actively participating in NeuSpine Institute Treatment Program and adhere to the rules specified in this Agreement.

My doctor and/or any appropriately authorized ancillary personnel may at any time discontinue the narcotic prescription(s) at his/her discretion. My progress will be periodically reviewed and, if the narcotics are not improving my quality of life, the narcotics will be discontinued. I will disclose to NeuSpine Institute drugs I take at any time, prescribed by any physician.

In the event that my doctor and/or any appropriately authorized ancillary personnel discontinue my medication and start me on another medication, the discontinued medication will need to be turned into my local police department and a copy of the receipt from the police department will need to be turned into NeuSpine Institute prior to receiving any new medications.

The therapies necessary to treat my chronic pain have been explained to me and I understand that the therapies will involve my taking daily dosage(s) or narcotic(s), which will help to control my chronic, intractable pain.

I will use the medication(s) exactly as directed by my doctor and/or his appropriately authorized ancillary personnel. I agree not to share, sell or otherwise permit others, including my family and friends, to have access to these medications. I will not participate in the diversion of my medications for illegal use; nor will I give or sell them to anyone else.

All controlled substances must be obtained at the same pharmacy, when possible. Should the need arise to change pharmacies, I agree to inform NeuSpine Institute. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement.

I authorize my doctor, and his/her appropriately authorized ancillary personnel to release my medical records to my pharmacist at his/her discretion. I also authorize any pharmacy that I am receiving medications from to release my medical records to NeuSpine Institute.

Pharmacy Name:_____Pharmacy Phone: _____

Pharmacy Address: _____ Patient's Initials _____

I understand that my medication(s) will be refilled on a regular basis. **I understand that my prescription(s) and my medication(s) are exactly like money. If either are lost or stolen, they WILL NOT BE REPLACED. I FURTHER UNDERSTAND THAT ANY REPLACEMENT OF LOST OR STOLEN MEDICATIONS IS COMPLETELY AT THE DISCRETION OF MY TREATING PHYSICIAN**. Otherwise, I will need to wait until my next scheduled refill. I will not seek the same or similar medications from any other source, whether professional or otherwise and if I am prescribed them by another practitioner, I will notify the physician here. In the event that I am arrested or incarcerated related to legal or illegal drugs, refills on controlled substances will not be given.

Refill(s) will not be ordered before the scheduled refill date. I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out. I agree that refills of my prescription(s) for pain medicine will be given only at the time of an office visit or during regular office hours. No refills will be available during evening hours and/or weekends. The patient or authorized person must be present in person at the office in order to be able to pick up medication script(s). I am aware of the fact that my physician will not call in any pain medication(s) to the pharmacy by phone and/or fax.

I will receive a controlled substance(s) or medication(s) only from NeuSpine Institute Doctors and/or their appropriately authorized ancillary personnel unless it is for an emergency or the controlled substance(s) that are being prescribed by another physician are approved by NeuSpine Institute Doctors.

Information that I have been receiving medication(s) prescribed by other doctors, that has not been approved previously by NeuSpine Institute doctors may lead to a discontinuation of medication(s) and treatment.

Until NeuSpine Institute and/or their appropriately authorized ancillary personnel have gotten to know me and my medical history well, I understand that prescription(s) for larger quantities of medication(s) to cover me while I am out of town will not be given. Later, depending on my compliance, NeuSpine Institute and/or their appropriately authorized ancillary personnel may modify this, at the sole discretion of the physicians.

If it appears to my doctor and/or his appropriately authorized ancillary personnel that there are no demonstrable benefits to my daily function or quality of life from the controlled substance(s), then my doctor and/or his appropriately authorized ancillary

personnel may try alternative medication(s) and/or his appropriately authorized ancillary personnel, may taper me off of all narcotic(s). I will not hold my doctor and/or any other member of NeuSpine Institute staff liable for problems caused by the discontinuance of controlled substance(s).

I agree to submit to urine and blood screens to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s) the treatment for chronic pain will be terminated and can only be restarted if I am evaluated and treated by an Addictionologist and the Addictionologist recommends continued treatment for chronic pain.

I recognize that my chronic pain represents a complex problem, which may benefit from physical therapy, psychotherapy, behavioral medicine strategies, and surgery. I also recognize that my active participation in the management of my pain is extremely important. I agree to actively participate in all aspects of the pain management program to secure increased function and improved coping with my condition.

I agree that I shall inform any doctor who may treat me for any medical problem that I am enrolled in a narcotic(s) and controlled substance(s) treatment program, since the use of other drug(s) in conjunction with same may cause me harm.

I hereby give my doctor and/or his appropriately authorized assistant(s) permission to communicate with the referring physician(s) and any pharmacist(s) regarding my use of controlled substance(s).

I must take the narcotic medication(s) as instructed by my doctor and/or his appropriately authorized assistant(s) or in smaller doses. Any unauthorized ***increase*** in the dose of narcotic medication(s) may be viewed as a cause for discontinuation of the treatment with narcotic medication (s).

All opiate medications prescribed must be brought to each visit. This means you must bring your opiate medication bottles with you to each visit in order for the physician to refill your medication. The medication will then be counted by an authorized NeuSpine Institute staff member in a sterile manner to ensure that medications are being taken as prescribed and will document those findings in your chart.

If I demonstrate unacceptable behavior patterns, my doctor and /or his appropriately authorized assistant(s) may discontinue prescribing the narcotic medication(s) for me.

I must keep all regular follow up appointments as recommended by my doctor and/or his appropriately authorized assistant(s).

I agree to be seen/re-evaluated at a minimum of every three months, while receiving controlled substances prescriptions from NeuSpine Institute.

Evidence of medication hoarding; increasing the amount of medication without communication to my doctor and/or his/her appropriately authorized assistant(s); refilling my prescription too frequently; getting the medication from multiple physicians; increasing the amount of the medication despite significant side effects; altering prescriptions; selling, trading, or giving away medication; un-approved use of other drugs (alcohol, sedatives, or using non-prescription medications inconsistent with drug labeling) during narcotic analgesic treatment; or other unacceptable behavior will result in tapering and discontinuing of narcotic maintenance therapy.

Failure to comply with any of the foregoing conditions may cause discontinuation of narcotic prescription(s) and/or your discharge from the care and treatment by NeuSpine Institute. Discharge may be immediate for alleged criminal behavior.

I certify and agree to the following:

I am not currently abusing illicit or prescription drug(s) and I am not undergoing treatment for substance dependence or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

I have never been involved in the sale, illegal possession, diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.). No guarantee or assurance has been made as to the

results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that I would otherwise continue to have chronic pain.

I have reviewed the Narcotic Side Effect Information, on pages 6, 7, 8 and 9 that may be used in the treatment of my chronic pain. I fully understand the explanations regarding the benefits and the risks of this method. I agree to the use of narcotic medication(s) in the treatment of my chronic pain.

_____ _____

Patient Signature Patient Full Name

_____

Physician (or Appropriately Authorized Ancillary Personnel) Signature

Dr. Armen Deukmedjian, MD, FAANS

Dr. Amir Ahmadian, MD, FAANS

Dr. Jason Paluzzi, MD

Dr. Juan Egas, MD

Dr. Kamal Patel, MD

Social History:

Occupation: _____ When was the last time you worked? _____

___ Temporary Disability ___ Permanent Disability ___ Retired ___ Unemployed

Alcohol Use:

___ Social Use ___ Daily use of alcohol ___ Never ___ History of alcoholism ___ Current alcoholism

Tobacco Use:

___ Current user ___ Former user ___ How long has it been since you stopped smoking: _____
___ Packs per day: _____ ___ How many years: _____

Illegal Drug Use:

___ Denies any illegal drug use ___ Currently uses illegal drugs ___ Formerly used illegal drugs

Have you ever abused narcotic or prescription medications: ___ Yes ___ No

Family History:

Mark all appropriate diagnoses as they pertain to your parents and siblings:

___ Arthritis ___Diabetes ___Cancer ___Headaches/Migraines

___ High Blood Pressure ___Kidney Problems ___Liver Problems ___Osteoporosis

___ Rheumatoid arthritis ___Seizures ___Stroke Other Medical Problems: _____
___I have no significant family medical history

Past Medical History/Treatment:

LIST OF SURGERIES AND HOSPITALIZATIONS

Hospital Name	Reason	Date

____ I have NEVER had any surgical procedures performed.

Mark the following conditions/diseases that you have been treated for in the past

Cancer/Oncology:
Cancer-Type: _____ Cancer-Type: _____ Cancer-Type:_____

Cardiovascular/Hematologic:

___ Anemia
___ Heart Attack
___ Coronary Artery Disease
___ Stroke/TIA
___Heart Valve Disorder
___ Peripheral Vascular Disease
___ Presence of stent/pacemaker/ defibrillator
___ High Blood Pressure

Gastrointestinal:

___ GERD (Acid Reflux)
___ IBS
___ Gastrointestinal Bleeding
___ Crohn's's Disease
___ Stomach Ulcers

Neurological:

___ Multiple Sclerosis
___ Seizures
___ Balance Disorder
___ Peripheral Neuropathy
___ Head Injury
___ Headaches
___ Migraine

Urological:

___ Chronic Kidney Disease
___ Kidney Stones
___ Urinary Incontinence
___ Dialysis

ENT:

___ Glaucoma
___ Vertigo
___ Hearing Problems
___ Nosebleeds

Respiratory:

___ Asthma
___ Bronchitis/Pneumonia
___ Emphysema/COPD

Musculoskeletal/Rheumatologic:

___ Bursitis
___ Osteoarthritis
___ Osteoporosis
___ Fibromyalgia
___ Carpal Tunnel Syndrome
___ Rheumatoid Arthritis
___ Chronic Joint Pains

Endocrinology:

___ Diabetes - Type: _____
____ Hyperthyroidism
___ Hypothyroidism

Psychological:

___ Depression
___ Anxiety
___ ADD/ADHD
___ Schizophrenia
___ PTSD
___ Bipolar Disorder
___ Other- Type: _____

Other Diagnosed Conditions:

_____
_____
_____
_____
_____

_____

MEDICATION HISTORY:

Are you currently taking any blood thinners or anti-coagulants? Yes No

If YES, Which ones? Aspirin Plavix Coumadin Lovenox Other: _____

Please list all medications you are CURRENTLY taking. Attach additional sheet if required:
(Include all over the counter medications)

Name	Dosage	Directions	Reason for Medication

Do you have any drug/medication allergies? ____ Yes ____ No

If so, please list all allergies and symptoms if known:

Medication Name:	Symptom:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Topical Allergies: ____ Latex ____ Iodine ____Tape ____ IV Contrast

Please list all past pain medications that you have been on at any point for your current pain complaints.
(Include all over the counter medications)

Name	Dosage	Directions	Did this help you? Y/N

ONLY if your medications cause constipation, please answer the following questions. If not, skip this section.
On average, how often do you have a bowel movement?
(Please check one)

____ More than 3 times per day **____ 2 to 3 times per day**

____ Once per day **____ 2 to 3 times per week** **____ Less than once per week**

Review of Systems:

Mark the following symptoms that you **currently** suffer from:

Constitutional:
__Fevers
__Chills
__Sweats
__Weakness
__Fatigue
__Decreased Activity
__Malaise
__Unexplained Weight Loss
__Unexplained Weight Gain
__Low Sex Drive
__Difficulty Sleeping

Eyes:
__Blurriness
__Double Vision
__Pain
__Visual Disturbance

Respiratory:
__Sputum Production
__Shortness of Breath
__Cough
__Wheezing

Ears/Nose/Throat/Neck:
__Hearing Problems
__Ear Pain
__Sore Throat
__Sinus Problems
__Nose Bleeds

Integumentary:
__Rash
__Itching
__Lesion
__Bruising

Musculoskeletal:
__Back Pain
__Neck Pain
__Joint Pain
__Muscle Pain
__Muscle Cramp
__Muscle Spasm
__Gait Disturbances
__Joint Stiffness
__Joing Swelling
__Trauma

Neurological:
__Abnormal Balance
__Confusion
__Numbness
__Tingling
__Dizziness
__Headaches
__Loss of Coordination
__Memory Loss
__Seizures
__Tinnitus
__Tremors
__Vertigo

Cardiovascular:
__Chest Pain
__Palpitations
__Swelling in Feet
__Bleeding Disorder
__Blood Clots
__Fainting
__Shortness of Breath during sleep

Psychiatric:
__Feeling Anxious
__Depressed Mood
__Suicidal Thoughts
__Hallucination
__Stress Problems
__Suicidal Planning
__Thoughts of harming others

Gastrointestinal:
__Nausea
__Vomiting
__Diarrhea
__Constipation
__Heartburn
__Abdonminal Pain

Genitourinary/Nephrology:
__Painful Urination
__Blood in Urine
__Change in Urine Stream
__Unusual Discharge
__Flank Pain
__Urinary Incontinence

Pain History:

Chief complaint (Reason for your visit today): _____

Does the pain radiate? If so, where? _____

Please list any additional areas of pain: _____

Onset of Symptoms:

Approximately, when did this pain begin? _____

What caused your current pain episode? _____

How did your current pain episode begin? _____ Gradually _____ Suddenly

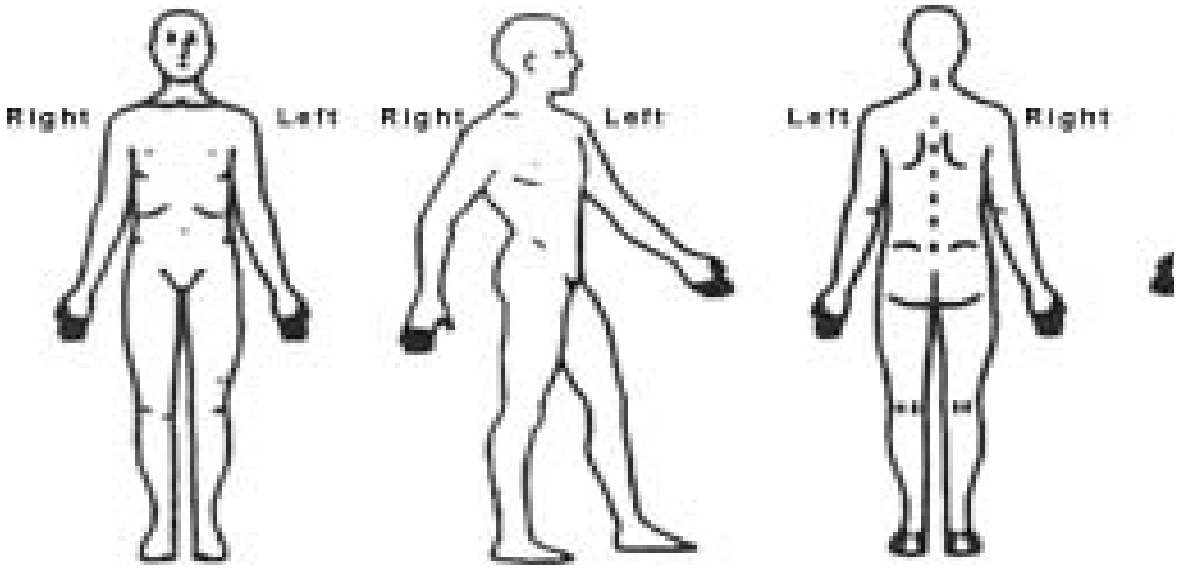
Since your pain began, how has it changed? _____ Improved _____ Worsened _____ Stayed the same

Pain Description:

Please mark with an "x" the nature of your pain: ___ Dull ___ Achy ___ Burning ___ Numbness ___ Tingling ___ Sharp

___Stabbing ___ Shooting ___ Stabbing ___ Electrical ___ Radiating ___ Weakness Other: _____

Use this diagram to indicate the area of your pain. Mark the location with an "X" and please write the type of pain you described next to that "x".



What time of day is your pain at its worst? _____

How often does the pain occur? ___ Constant ___ Changes in severity but always present ___ Intermittent

If "0" is no pain and "10" is the worst pain, how would you rate your pain?

Current pain level _____ On your best day: _____ On your worst day: _____

Please mark with an "x" what your pain is aggravated by: ___ Sitting ___ Standing ___ Bending ___Twisiting ___ Lifting
___ Stretching ___ Walking ___ Exercise ___ Daily Activities ___ Working ___ Sneezing Other: _____

Please mark with an "x" how your pain is relieved: ___ Sitting ___ Elevating legs ___ Lying down flat ___ Exercise ___ Massage

___ Stretching ___ Topical Meds ___ Oral Meds Other: _____

Are there any other symptoms? (example: numbness, tingling, weakness, etc.) _____

_____

What are your goals with Pain Management? _____

_____

Interventional Pain Treatment History:

___ Epidural Steroid Injection - Please circle: Cervical Thoracic Lumbar
___ Joint Injection - Joint(s) : _____
___ Medial Branch Blocks/Facet Injections - Please circle: Cervical Thoracic Lumbar
___ Nerve Blocks - Area/Nerve(s) : _____
___ Radiofrequency Nerve Ablation - Please circle: Cervical Thoracic Lumbar
___ Spinal Cord Stimulator - Trial Only/Permanent Implant: _____
___ Trigger Point Injections - Where? _____
___ Vertebroplasty/Kyphoplasty - Level(s): _____
___ Other: _____

Which of these procedures listed above have helped with your pain? _____

_____

Which of the following physicians or specialist have you consulted for your current pain?

___ Acupuncturist ___ Chiropractor ___ Orthopedic Surgeon
___ Neurosurgeon ___ Neurologist ___ Physical Therapist
___ Psychiatrist/Psychologist ___ Rheumatologist ___ Other Pain Management: _____

Other: _____

Please mark all of the following treatments you have had for pain relief: (Please "x" in boxes)

Treatment:	No Change	Worsened Pain	Helped Pain:	Comments:
Spine Surgery				
Physical Therapy				
Chiropractic Care				
Psychological Therapy				
Brace Therapy				
Acupuncture				
Hot/Cold Packs				
Massage therapy				
TENS Unit				