AUTHORIZATION AND CONSENT

TO OBTAIN AND RELEASE INFORMATION

Patient Name: ____ **Date of Birth:** __________________

I hereby authorize my Medical Records to be released to/from Michigan Spine & Pain. This information to be released is to be used only for the following authorized purpose:

- **Planning and Management of Medical Care**
- **Payment of Services by a Third Party Payor**

I understand I may withdraw this authorization at any time. Revocation of this authorization will not affect any information already released. I understand in order for a third party payor to pay for services, Michigan Spine & Pain must send reports and proof of services.

I hereby certify that I am:

☐ The parent of a minor child
☐ The legally appointed guardian of the above named individual
☐ The patient and legally empowered to sign this consent

Please list responsible parties who may receive your health information. (Spouse, mother, child, Nurse Case Manager, etc.) Please provide name and relationship below:

____

____

By signing this you also give permission to leave non-specific healthcare messages on a machine or with family (Appointment reminders, messages to call our office, lab results, etc.)

I have read and understand this consent. I am signing this release voluntarily.

____ _________________________
Signature Date

____ _________________________
Witness Date

Information may be withheld if it is not relevant to the authorized purpose claimed. Any subsequent disclosure of medical information by the recipient is prohibited without express written authorization from the above named individual.

Witness is responsible to assure that if the individual signs, he/she was competent to give the informed consent (R330.7003 and R300.6031 (5) (a)-(c) Michigan Department of Mental Health Emergency Rules) or if guardian signs, documentation is on file indicating that the court has empowered the guardian with the authority. If the witness does not feel that the individual is competent, refer to R330.6011 (3)-(4).

Patient's Initials: ______________

TREATMENT AGREEMENT

It is important for you to know **what your insurance policy covers**. Your insurance is a contract between you, your insurance company and/or your employer. Michigan Spine & Pain employs Registered Medical Coders and Certified Professional Coders to bill your insurance.

If you do not have insurance, you will be expected to pay for your appointment in full at the time of your appointment.

In order to comply with your insurance company requirements, **all deductibles and co-pays are due at the time your appointment**.

Our office participates with the following insurance companies:

- Blue Care Network
- Blue Cross and Blue Shield
- Connect Care **- Dr. Bleiberg only**
- County Health Plan
- First Health – **Dr. Ruiz only**
- HAP – **Dr. Bleiberg**
- HCAP
- Health Plus – **Dr. Bleiberg and Dr. Barrett**
- Medicare
- Medicaid
- Physicians Care – **Dr. Bleiberg only**
- Priority Health

We will likely be referring you to physical therapy and/or psychological services. Upon referral, we ask that you seek the first available appointment with these providers. Since these therapies play a very important role in your pain management program, attendance is monitored.

The purpose of this portion of the agreement is to protect your access to controlled substances and to protect our ability to prescribe for you. The long-term use of such substances is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain. Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of our clinic to consider the initial and/or continued prescription of controlled substances to treat your pain.

1. All controlled substances must come from a provider at Michigan Spine & Pain or, in the event of his/her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment).

2. All controlled substances must be obtained at the same pharmacy. The pharmacy you have selected is: ____ Phone: ____

Patient's Initials: _______________

3. You are expected to inform our office of any new medications or medical conditions and, of any adverse effects you experience from any of the medications you take.

4. The prescribing physician has permission to **discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care** for purposes of maintaining accountability. This also allows us to perform a pharmacy "sweep" when we feel it is necessary.

5. You may not share, sell or otherwise permit others to have access to these medications.

6. These drugs should not be stopped abruptly as an abstinence syndrome will likely develop.

7. **UNANNOUNCED URINE SCREENS WILL BE REQUESTED**. You must comply with the request **immediately.** Failure to do so may result in immediate discharge.

8. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected you will take the highest possible degree of care with your medication and prescription. Your medication should not be left where others might see or otherwise have access to them.

9. Medications **WILL NOT** be replaced if they are lost, get wet, are destroyed, left on an airplane, stolen, etc, even if you have a police report.

10. **EARLY REFILLS WILL NOT BE GIVEN.** Do not call for prescriptions after hours or on weekends. Our medication policy states that you must be seen prior to any change in medication and refills may be called in within a 72-hour period.

11. If you fail to comply with **ANY** of the prescribed treatments, lab orders, diagnostic tests, etc, you may be discharged from the clinic. This includes non-compliance with physical therapy or chiropractic (i.e., missing or canceling 3 or more appointments) as well as failure to follow through with appointments with a pain psychologist or for lab/X-ray tests. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substance administration.

12. The risks and potential benefits of these therapies are explained elsewhere (*and you acknowledge that you have received such explanation*).

13. You affirm that you have full right and power to sign and be bound by this agreement and you have read, understand and accept all of its terms.

14. It is understood that any medical treatment is initially a trial and continued prescriptions are contingent on evidence of benefit.

15. You have been advised that you should have a primary care physician while being treated at Michigan Spine & Pain.

Patient's Initials: ______________

At Michigan Spine & Pain, we have adopted a **Zero Tolerance** policy with regard to abuse in the workplace. At no time will foul or abusive language or behavior directed toward our staff be tolerated. These actions are grounds for immediate dismissal from our practice.

Patients will be charged a fee of $35.00 per check for checks returned to our office for non-sufficient funds.

Patients will be charged a fee of $25.50 for failure to cancel their appointment within 24 hours prior to the appointment and/or not showing for their appointment.

If your balance has to be forwarded to our profit recovery center, a $10 fee will be added to your account. In addition, if your balance has to be forwarded to our collection agency, a 25% fee will be added to your account.

In all instances, our office will work with patients having difficulties paying for their care. We understand that extenuating circumstances occur with injuries and accidents and we would like to help you navigate the issues that arise. <u>If you would like to speak with someone regarding payments, please contact our Patient Accounts Department, at 989-772-1609.</u>

I understand that I am responsible for any and all treatments that may not be covered by my insurance.

IT IS UNDERSTOOD THAT FAILURE TO ADHERE TO THESE POLICIES WILL RESULT IN CESSATION OF TREATMENT WITH OUR OFFICE.

I have answered all of the questions in full and to the best of my ability. I certify the information I have provided is true. I do understand any false information or information left out could affect my medical care and rehabilitation. I promise to notify the office of Michigan Spine & Pain immediately should there be any changes or new information. I hereby authorize Michigan Spine & Pain to furnish the requested diagnostic services and or treatment. I authorize payment of insurance benefits be made directly to Michigan Spine & Pain for those services. I authorize the office of Michigan Spine & Pain to release to the insurer such case record documentation about any insured under the below mentioned policy, which may be necessary for any claim to be processed for payment. If female, I am aware that I may be placed on medications or undergo procedures that could be potentially harmful to an unborn baby. If female, I agree to notify the office of Michigan Spine & Pain immediately if I suspect I may be pregnant.

____ _______________
Signature of Patient Date

____
Printed Name of Patient

Patient's Initials: _______________

NEW PATIENT INFORMATION

First: ____________________________ Middle Initial: ______ Last: ___________________________

Date of Birth: _____/_____/_____ Age: _________ Social Security No.: _______/_______/_______

Home Phone No.: ( ) ___________________ Alternative Phone No: ( ) __________________

Home Address: ____

City: _______________________________ State: _______________ Zip Code: ________________

E-mail Address: ____

Height: ___________ Weight: ___________ Sex: ______ Right or Left Handed?: ______________

Emergency Contact Person: _____________________________ Relationship to you: _____________

Home Phone No.: ( ) __________________ Alternative Phone No.: ( ) ____________________

Family Physician / Primary Care Provider: ____

Other physicians you have seen in the past year: ____

Whom can we thank for referring you to Michigan Spine & Pain?_______________________________

INSURANCE INFORMATION

□ **No Insurance, I will privately pay for my treatment.**

Primary Insurance: ____

Name of Subscriber: _________________________ Date of Birth of Subscriber: _____/_____/_____

Subscriber's Social Security No.: ____

Policy No.: _________________________ Group No.: ____________________________________

Secondary Insurance: ____

Name of Subscriber: _________________________ Date of Birth of Subscriber: _____/_____/_____

Subscriber's Social Security No.: ____

Policy No.: _________________________ Group No.: ____________________________________

□ **Workers' Comp** □ **Auto** **Date of Accident / Incident / Injury:** ________________________

Claim No: ____

Name of Adjuster: _____________________________ Phone No.: ( ) ______________________

Insurance Billing Address: ____

 Patient's Initials: ____________

Where is your pain located? On the diagrams below, please shade in the areas where your pain is located. P = Pain T = Tingling N = Numbness

Date of Injury: ______________________________

What makes your pain better? ☐ Rest ☐ Medication ☐ Bending Forward ☐ Sitting

☐ Other: ______________________________

What makes your pain worse? ☐ Activity ☐ Weight Bearing ☐ Other: ______________

Please check the appropriate words that best describe your pain.

☐Aching	☐Severe	☐Constant	☐Tingling
☐Radiating	☐Unbearable	☐Heavy	☐Numbing
☐Intense	☐Dull	☐Stinging	☐Sharp
☐Transient	☐Hot	☐Burning	☐Tight
☐Shooting	☐Sore	☐Annoying	☐Excruciating
☐Cramping	☐Cold	☐Brief	☐Stabbing

On a scale of 0 to 10, with 0 being no pain at all and 10 being the worst possible pain, how would you rate your pain ***right now***?

0 1 2 3 4 5 6 7 8 9 10

no pain at all ... *worst possible pain*

How would you rate your pain, on ***average***, during this ***last week***?

0 1 2 3 4 5 6 7 8 9 10

no pain at all ... *worst possible pain*

 Patient's Initials: ____________

MEDICATIONS – PLEASE FILL OUT COMPLETELY AND ACCURATELY PLEASE REFER TO YOUR MEDICATION BOTTLE(S) IF ADDITIONAL SPACE IS NEEDED – PLEASE USE ADDITIONAL SHEET			
Name of Medication	**Dose (mg)**	**How Often**	**How Many Pills Per Day**

PAST MEDICAL HISTORY

Please check any of the following health problems with which you have been diagnosed:

☐ Alcoholism
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Bleeding Disorder
☐ Blood Clots
☐ Cancer of ___________
☐ Cataracts
☐ Chemical Dependency
☐ Coronary Artery Disease
☐ Depression
☐ Diabetes
☐ Emphysema / COPD
☐ Epilepsy / Seizures
☐ Gastric Reflux Disease
☐ Glaucoma
☐ Gout
☐ Hepatitis
☐ HIV / AIDS
☐ High Cholesterol
☐ Hypertension
☐ Irregular Heartbeat
☐ Kidney Stones
☐ Migraine Headaches
☐ Osteoporosis
☐ Pacemaker
☐ Pneumonia
☐ Prostate Problems
☐ Shingles
☐ Stroke
☐ Suicide Attempt
☐ Thyroid Disease
☐ Tuberculosis
☐ Vascular Disease
☐ History of Pain or,
☐ Injury in Same Area
☐ Other: ____

Medication Allergies: ____
____

Other Allergies: ____

PAST SURGICAL HISTORY

Type of Surgery	Date

Patient's Initials: ____________

FAMILY HISTORY

Are there any diseases that run in your family? ☐ Yes ☐ No If yes, please list below:

____

____

Are there any close family members who are disabled? ☐ Yes ☐ No If yes, please list below:

____

Father: ☐ Alive ☐ Deceased Medical Problems: ____________________

Mother: ☐ Alive ☐ Deceased Medical Problems: ____________________

Grandparents: ☐ Alive ☐ Deceased Medical Problems: ____________________

Your Children: ☐ Alive ☐ Deceased Medical Problems: ____________________

NOTES: ____

____

SOCIAL HISTORY

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

Children: How Many?: ____________ How old are they?: ____________________

Do you smoke cigarettes? ☐ Yes ☐ No How many packs per day? ________ Years? ________
Did you quit smoking? ☐ Yes ☐ No When? ____________________
Do you drink alcohol? ☐ Yes ☐ No How many drinks per day? ________ Years? ________
Did you quit drinking? ☐ Yes ☐ No When? ____________________
Have you used street drugs? ☐ Yes ☐ No What kind? ____________________
Do you currently use drugs? ☐ Yes ☐ No What kind? ____________________

Education: ☐ High School Graduate ☐ College Graduate ☐ GED
Other: ____

Grade Completed (Circle): 6 7 8 9 10 11 12

What are you expecting from today's visit? ____________________________

____

Hobbies/Activities affected by pain: ____________________________

____

Does your pain affect your self-esteem or self-worth?
0 1 2 3 4 5 6 7 8 9 10
not at all *all the time*

How would you rate your feelings of depression?
0 1 2 3 4 5 6 7 8 9 10
not depressed at all *extremely depressed*

 Patient's Initials: ____________

How would you rate your overall energy?

0	1	2	3	4	5	6	7	8	9	10
totally worn out										*most energy ever*

How much do you worry about re-injuring yourself if you are more active?

0	1	2	3	4	5	6	7	8	9	10
not at all										*all the time*

How would you rate your feelings of anxiety?

0	1	2	3	4	5	6	7	8	9	10
not anxious at all										*extremely anxious*

Do you have problems concentrating on things?

0	1	2	3	4	5	6	7	8	9	10
not at all										*all the time*

WORK HISTORY

Are you currently working? ☐ Yes ☐ No ☐ Retired ☐ Homemaker

PLEASE COMPLETE THE FOLLOWING USING YOUR MOST RECENT EMPLOYER – EVEN IF YOU ARE NOT CURRENTLY WORKING

Date Last Worked: ____________________________ Date of Hire: ____________________________
Place of Employment: ____
Job Title: __________________________ Are you currently under work restrictions: ☐ Yes ☐ No
If yes, who placed you on work restrictions?: ____
If yes, please list your restrictions: ____
____

Do you perform repetitive activity? : ☐ Yes ☐ No
If yes, please list these repetitive activities: ____
Maximum number of pounds lifted: _______________ Parts processed per hour: ______________
Hours worked per day: __________ Days worked per week: ___________ Shift: _______________
Describe your job in detail____
____
____

Have you ever been injured at work? ☐ Yes ☐ No If yes, please explain:
Type of injury: ____ Date: _____________________
Type of Injury: ____ Date: _____________________
How many days have you lost from work due to this injury/illness? ☐ None ☐ _________ Days

 Patient's Initials: ____________

HISTORY OF TESTING PREVIOUSLY PERFORMED

Please bring X-ray films and/or CDs with your to your first appointment

Which of the following tests have been done for your condition?

☐ X-Rays ☐ MRI ☐ CT Scan ☐ Myelogram ☐ Bone Scan ☐ Blood Tests ☐ EMG

List all previously performed testing - related to this condition – not mentioned above: ______________

____

____

NOTES: **Please record any questions, comments or concerns you would like to discuss with your provider(s)**

____

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Patient's Initials: _____________

FUNCTION	Please check (✔) the level you are able to complete the following functions
SIT	☐Able to Sit ☐ Able to Sit with Assistance Sit Duration? _______ Minutes / Hours ☐Unable to Sit
STAND	☐Able to Stand ☐Able to Stand with Assistance Stand Duration? _______ Minutes / Hours ☐Unable to Stand
WALK	☐Walks Independently without Assistance or Equipment ☐Walks with Some Help/Assist Device Walk Duration? _______ Minutes / Hours / Blocks / Miles ☐Unable to Walk
LIFT	☐Able to Lift 50+ lbs ☐ Able to Lift 25 – 50 lbs ☐ Able to Lift 10 – 25 lbs ☐Able to Lift < 10 lbs ☐Unable to Lift
PUSH / PULL	☐Able to Push/Pull 50+ lbs ☐ Able to Push/Pull 25 – 50 lbs ☐Able to Push/Pull 10 – 25 lbs ☐Able to Push/Pull < 10 lbs ☐Unable to Push/Pull
BATHES	☐Bathes Self Independently ☐Bathes Self with Some Help ☐Unable to Bathe Self
BEND / TWIST	☐Able to Bend/Twist without Difficulty ☐Able to Bend/Twist with Pain (Direction) ___________________________ ☐Unable to Bend/Twist
CARE FOR FAMILY	☐Able to Care for Family ☐Able to Care for Family with Assistance ☐Unable to Care for Family
CLEAN HOUSE	☐Able to Clean House ☐Able to Clean House with Assistance ☐Unable to Clean House
COOK	☐Able to Cook ☐Able to Cook with Assistance ☐Unable to Cook
DRESS SELF	☐Able to Dress Self ☐Able to Dress Self with Assistance ☐Unable to Dress Self
DRIVE	☐Able to Drive ☐Able to Drive with Assistance ☐Unable to Drive
FEEDS SELF	☐Able to Feed Self ☐Able to Feed Self with Assistance ☐Unable to Feed Self
GROOM	☐Able to Groom Self at Head/Face Level (Brush Teeth/Comb Hair) ☐Able to Groom Self at Head/Face Level (Brush Teeth/Comb Hair) with Assistance ☐Unable to Groom Self at Head/Face Level (Brush Teeth/Comb Hair)
DO LAUNDRY	☐Able to Do Laundry ☐Able to Do Laundry with Assistance ☐Unable to Do Laundry
LAY ON BACK	☐Able to Lay on Back ☐Able to Lay on Back with Assistance or for a Short Period of Time ☐Unable to Lay on Back
LAY ON STOMACH	☐Able to Lay on Stomach ☐Able to Lay on Stomach with Assistance or for a Short Period of Time ☐Unable to Lay on Stomach
SEXUAL ACTIVITY	☐Able to Engage in Sexual Activity ☐Able to Engage with Assistance ☐Unable to Engage in Sexual Activity
TRANSFER SELF	☐Able to Transfer Self ☐Able to Transfer Self with Assistance ☐Unable to Transfer Self
VACUUM	☐Able to Vacuum ☐Able to Vacuum with Assistance ☐Unable to Vacuum
WORK	☐Currently Working ☐Currently Not Working ☐Able to Work ☐Unable to Work ☐Able to Work with Restrictions ☐Currently Working with Restrictions ☐Currently Working without Restrictions

 Patient's Initials: _____________