CHICAGO
SPORTS & SPINE
PAIN MANAGEMENT PHYSICIANS

Patient Information

Patient Name_____ Date of Birth ____/____/_____

Street Address _____ City, State _____ Zip _____

Home Phone ( ) _____ Work ( )_____ Cell ( )_____

Email Address _____

Social Security Number _____ - _____ - _____

Patient Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

In case of emergency, please contact:

Name _____ Phone ( ) _____

Relationship to Patient _____

Occupation _____ Name of Employer _____

Referring Physician _____ Phone ( )_____

Primary Care Physician _____ Phone ( )_____

How did you hear about Chicago Sports and Spine?

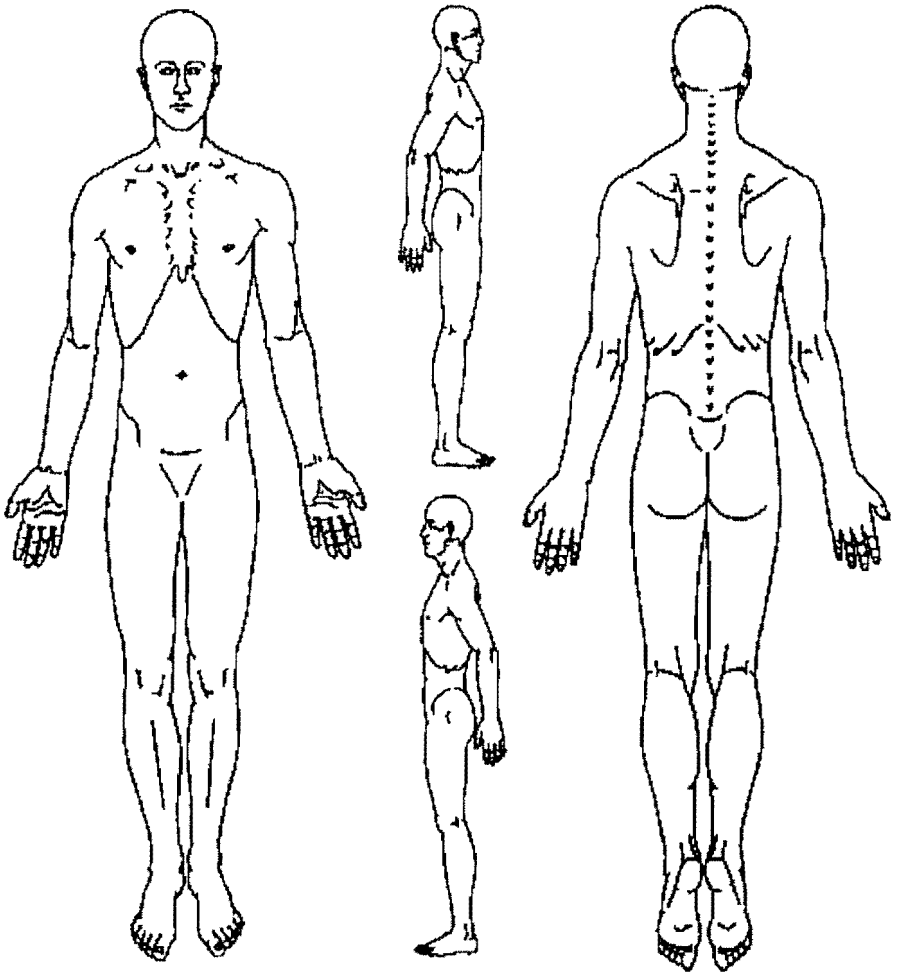
☐ Family/Friend _____ ☐ Physician _____

☐ Insurance ☐ Website _____

☐ Yellow Pages ☐ Other _____

Pain Clinic Initial Evaluation Form

On the picture below, mark the areas on your body where you are currently experiencing pain or other symptoms.



How would you describe your pain?

☐ Aching ☐ Numbness ☐ Pins and Needles ☐ Burning Stabbing

☐ Other: _____

Approximately when did your pain start? _____

Is your pain the result of an injury? ☐ **Yes** ☐ **No** If yes, what was the date of injury? ___/___/___

Please explain:_____

_____

Pain is: ☐ constant ☐ intermittent

What increases your pain? _____

What decreases your pain? _____

How has this pain affected your daily living activities, work and life? _____

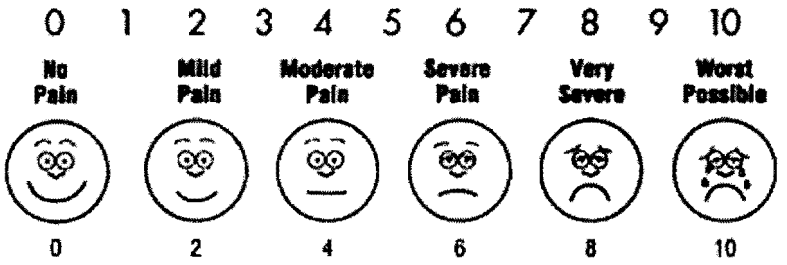
_____

Has your pain gotten worse with time? ☐ **Yes** ☐ **No**

Do you have difficulty sleeping because of the pain? ☐ **Yes** ☐ **No**

Do you have any bowel or bladder problems? ☐ **Yes** ☐ **No**

Using the pain scale below, **rate your pain.**



As of today, what have you done to help relieve your pain? (Check all that apply.)

☐ Physical Therapy
☐ Chiropractor
☐ Massage Therapy
☐ Medications
☐ Ice
☐ Heat
☐ TENS Unit
☐ Other:

Have you seen any pain physicians for this problem in the past? ☐ **Yes** ☐ **No**

Name: _____

Have you ever had spine surgery? ☐ **Yes** ☐ **No**

If yes what is the name of the surgery? _____

Have you ever had an epidural steroid injection? ☐ **Yes** ☐ **No**

If yes, did it help? ☐ **Yes** ☐ **No** What physician did the injection? _____

Are you currently taking any blood thinners? ☐ **Yes** ☐ **No**

What are your expectations regarding your pain? _____

_____

Medical History

Do you have any of the following medical conditions? Please check all that apply.

☐ Any contagious disease	☐ Kidney disease	☐ Suppressed immune system
☐ High blood pressure	☐ Liver disease	☐ Cancer
☐ Diabetes	☐ Thyroid disease	☐ Stomach ulcers
☐ Heart disease	☐ Bleeding problems	☐ Seizure disorder
☐ Chest pain	☐ Rheumatiod Arthritis	☐ Other:
☐ Asthma	☐ COPD	

Please explain any of the above yes, or any other medical problems you may have:

_____

Please list all drug ***allergies***:_____

Please list ***all surgeries*** since childhood:

Sugery	Date (MM/YY)
_____	_____
_____	_____
_____	_____
_____	_____

Please list ***all pain medications*** you are currently taking:	Please list ***all other medications*** you are currently taking:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY

Do you smoke? ☐ **Yes** ☐ **No**

If yes, how long have you smoked? _____ How much do you smoke per week? _____

Do you drink alcohol? ☐ **None** ☐ **Rarely** ☐ **Socially** ☐ **Other:**_____ **drinks/wk**

Do you have a history of drug or alcohol abuse? ☐ **Yes** ☐ **No**
If yes, please explain: _____

With whom do you live?: ☐ **Alone** ☐ **With Spouse** ☐ **With children**
☐ **With roommates** ☐ **With spouse and children**
☐ **Other:** _____

What is your current occupation? _____

VERIFICATION OF INFORMATION

I verify that the above information is true and accurate to the best of my knowledge.

_____ _____
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE DATE

_____
RELATIONSHIP TO PATIENT

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understand Chicago Sports & Spine, LLC's *Notice of Privacy Practices* containing a description of the uses and disclosures of my health information. I further understand that Chicago Sports & Spine, LLC may update its *Notice of Privacy Practices* at any time and that I may receive an updated copy of Chicago Sports & Spine, LLC's *Notice of Privacy Practices* by submitting a request in writing for a current copy of Chicago Sports & Spine, LLC's *Notice of Privacy Practices*.

_____
Printed Patient Name

_____ _____
Patient Signature Date

If completed by patient's personal representative, please print name and sign below.

_____ _____
Printed Patient Personal Representative Name Relationship to Patient

_____ _____
Patient Personal Representative Signature Date

For Chicago Sports & Spine, LLC Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative.

Chicago Sports & Spine

Authorization of Treatment
and
Patient Financial Responsibility Policy

Financial responsibility for all services rendered by our physician lies with the patient. Chicago Sports & Spine will aid our patients by submitting claims to their insurance. It is the patient who is responsible for assuring we have current and complete information.

When registering, you will be asked to present proof of your insurance and a completed demographic form. If any changes occur during your treatment you must notify us.

Any procedure that the Physician orders for you will be evaluated by our billing coordinator. We will determine your out of pocket expense for that particular procedure and notify you prior to the scheduled appointment. Should you choose to move forward with the procedure, we will expect your patient responsibility portion to be paid at the time of service.

Any office visit or procedure will still be sent to your insurance provider(s) and any patient balance will be collected as claims are paid as per the explanation of benefits. Co-pays must be collected at each visit and cannot be billed.

Your signature below indicates that you are authorizing treatment from our facility and understand that you are financially responsible for all charges whether or not they are covered by insurance. We cannot change information on an insurance claim just so the claim will be paid. Please be advised that if your account becomes delinquent and has to be sent to an outside collection agency, a collection processing fee will be assessed.

Thank you for your understanding that the changes in healthcare have affected both the patient and the provider. As always, thank you for choosing Chicago Sports & Spine for your pain management needs. Your medical care is our priority and your good will is important to us.

_____ _____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE DATE

_____

RELATIONSHIP TO PATIENT

_____ _____

WITNESS DATE

PAIN MEDICATION POLICY AGREEMENT
CHICAGO SPORTS AND SPINE, LLC

Before any pain medications are prescribed for your pain, you will need to be aware and familiar with the Pain Medication Policy ("Policy") of Chicago Sports and Spine, LLC (CSS) pertaining to use and risk of these medications, and agree to the Policy and the terms of this Pain Medication Policy Agreement ("Agreement").

Please carefully read each provision of this Agreement. Check the box next to each item to indicate that you have read, understood and verify the information. If you have any questions or concerns, please speak with your CSS physician.

Initial patient evaluation. Controlled substances may not be prescribed on your first visit to the office. By law we are required to gather a comprehensive medication history before beginning the prescription of these substances. It is also our policy not to write prescriptions for controlled substances before this contract is signed. The law requires that there be a patient-physician relationship established before treatment is undertaken. Prescriptions will not be written for any non-patients.

Illinois Prescription Monitoring Program. You agree that before any drugs are prescribed and regularly thereafter we will check the program to see what drugs you are being prescribed.

Telephone calls. No Schedule II (opiate) prescriptions will be *refilled, called-in,* or *faxed* to your pharmacy over the phone. In addition, no medication changes will be made by telephone or fax. This policy applies to refilling prescriptions and any new medications, except for non-Scheduled II drugs in the event of emergency only.

After business hours, holidays and weekends. No prescriptions will be written at these times. Prescriptions will be written only during regular business office hours at your appointment. Therefore, it is your responsibility to closely monitor your supply of medications. If you are traveling, you must schedule an earlier appointment to see your CSS Physician. No prescriptions will be provided to accommodate your travel plans.

Appointments: Office hours are: Monday through Friday 9:00 am and 5:00 pm.

Cancellations: Any appointment cancellation must be made **at least 24 hours in advance** to avoid a cancellation charge of $50.00.

Drug screening tests and follow-up. We require documentation of your use of controlled substances. Therefore, you will be required to provide a urine sample for the purpose of monthly screening tests. It is unethical and illegal to prescribe medications without adequate medical follow-up. Therefore, not keeping your regular appointments constitutes a violation of this Agreement, jeopardizing the continuation of your medication(s).

Sharing medications is strictly prohibited. Medications are only to be used by you as prescribed.

State and Federal laws strictly prohibit selling or distributing. This is an illegal practice and could result in criminal drug charges.

Lost medications or prescriptions will not be replaced under any circumstances. Stolen medications or prescriptions may be replaced one-time only upon evidence of a timely-filed police report. More than one instance of stolen and/or lost medication will lead to you being terminated from the CSS pain treatment program.

Obtaining pain medications from more than one physician is called *doctor shopping* and State Law strictly prohibits it. This is an illegal practice and could result in criminal drug charges. If you have received drugs from another physician, you must tell your CSS doctor immediately, even if the drugs were provided by a dentist or at the Emergency Room. If this occurs one time, you will be warned. If this occurs a second time, you will be terminated from CSS.

Obtaining pain medications from any other sources is strictly prohibited. You are not to obtain any pain medications from friends, family members, street drug dealers or Internet pharmacies.

Picking-up prescriptions without an appointment is not permitted by you or your designee. You must attend office appointments in order to be assessed for the need to continue taking the medication(s). Prescriptions will only be given to whom they were prescribed, and only during regular office visits.

Identification. You are required to have a current, valid Photo I.D. on file in the office, and you will be asked for identification before receiving your prescription for a controlled substance or other medications.

Driving or operating heavy machinery is prohibited when taking controlled substances.

Handling firearms or other weapons is strictly prohibited when taking controlled substances.

Pregnancy or lactation. Taking controlled substances while pregnant may cause fetal abnormalities as well as fetal addiction and prenatal withdrawal syndrome. I certify that I am not pregnant and do not intend to become pregnant during the period for which I am receiving pain medication treatment. I agree to notify my CSS physician immediately if I become pregnant.

Use of alcohol is strictly prohibited when taking controlled substances. Combining alcohol and pain medications may result in serious illness or death.

Illegal drug use is strictly prohibited. If your monthly drug test shows the use of illegal drugs, you will be required to see a drug/addiction specialist within thirty (30) days before returning for your next appointment. Upon the finding of illegal drugs a second time, your physician has the option to terminate you from CSS. Upon a third finding, you will be terminated as a patient from CSS and you will be discharged from the pain program for use of illegal drugs or abuse of medications. I certify that I am not in treatment for substance dependence or abuse, and that I am not currently using any illicit drugs including marijuana, cocaine, etc.

Using suicide as a threat will result in immediate and complete discontinuation of all pain medications and mandatory (possibly involuntary) institutionalization in an inpatient psychiatric facility.

Suicidal attempts will result in immediate and complete discontinuation of all medications with the potential for self-harm. Furthermore, your clinical care will be transferred to a psychiatric program. Go immediately to a hospital ER if you feel suicidal.

Discontinued medications should be taken to your appointments for the purpose of being discarded with adequate documentation and in front of witnesses. A sample may be sent out for analysis and identification. We will not accept video recordings as proof of disposal.

Medication prescriptions will be issued only in the office, during regular business hours. No prescriptions will be called in, faxed or mailed to your pharmacy. This is necessary for maintaining strict control and documentation on the distribution of these controlled substances.

I authorize CSS and my pharmacy to cooperate fully with any investigation by city, state or federal law enforcement agency, including, but not limited to, this State's Board of Pharmacy, in the possible misuse, sale or other diversion of my pain medication. I authorize my CSS physician to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy of confidentiality with respect to these authorizations.

Comprehensive pain management may include collaboration with a pain management psychologist, since it is well understood that psychosocial, cognitive and behavioral factors contribute to the maintenance or exacerbation of your pain experience. Stress management, cognitive-behavioral treatment and relaxation training may be provided in conjunction with medical and pharmacological treatment.

Sharing and obtaining information. I agree to allow my CSS physician to share and/or obtain medication-related information with/from my other treating physicians. This is essential if adverse medication interactions are to be avoided. I agree to allow my CSS physician to freely discuss my case with any other physician or psychologist currently or previously involved in my medical care.

Appointments. I understand the importance of following a prescribed treatment plan and I agree to keep all my office appointments (medical, behavioral and/or follow-up, etc.). My failure to attend scheduled office appointments may result in the discontinuation of my narcotic/opioid prescriptions and treatment program.

Character and intensity of pain. I will communicate fully with my CSS physician about the character and intensity of my pain, the effect of the pain on my daily life and how well the medication(s) are helping to relieve my pain.

Pain treatment goals. I understand that my CSS physician will discuss the use of narcotic medications with me, including the issues of appropriate realistic goals, side effects and specific issues of developing tolerance, dependence, habitation, addiction and withdrawal. I will have an opportunity to ask questions regarding the use of narcotic/opioid medications. Your participation in the CSS program requires your understanding that it is the goal of CSS to find another resolution to your pain. It is CSS' goal to prevent long-term use of narcotic medications and to help find a better solution for you.

Anti-anxiety medications will not be prescribed. I understand that benzodiazepines medications such as Valium (Diazepam), Xanax (Alprazolam), or Ativan (Lorazepam) are unlikely to be prescribed and depend on your doctor. If you are currently taking these medications, they must continue to be prescribed by your physician that initiated the psychotropic medication therapy or a licensed psychiatrist We will not prescribe any drugs that are not related to the condition for which you are being treated by CSS.

Periodic Clinical Review. I understand that the benefit of the narcotic/opioid pain medication will be evaluated periodically using the following criteria: degree of pain relief; increase in general functioning; increase in exercise activities, behavioral adjustment, completion of rehabilitation program; and, maintenance or return to employment.

Disruptive or unacceptable behavior patterns may result in discontinuing your narcotic/opioid medications.

Follow-up appointments. I understand that I must keep monthly office appointments as recommended by my physician and that failure to comply may cause discontinuation of my narcotic/opioid prescriptions.

Multiple pharmacies are not permitted. I agree to use a single in-state pharmacy, of my own choosing, to obtain my pain medication. If for whatever reason I decide to change my pharmacy, I will immediately provide the name, location and telephone number of my new pharmacy. The name, location and telephone number of my pharmacy is given below:

I agree to ONLY use the following pharmacy:

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: (____) _____

RECOMMENDED CARE OF YOUR PAIN MEDICATIONS

- You may be asked to bring your medications to your office appointments.
- Keep all of your medications away from children. It is best to keep them under lock and key, even if you live alone.
- Always open your bottles over a counter or table, so that if the pills fall out you may be able to collect and use them. Never open the bottle over the commode. We will not replace damaged medications.
- Do not discuss with others the types of medicines that you take. Be aware of scams where persons look for people willing to make their medication information available, often while sitting at a pharmacy or even the physician's waiting room. The unsuspecting patient is then either assaulted and the medications taken, or followed home where they wait for an opportunity to break in and steal the medications.
- Never carry more medicine then what you will consume during that day. If your medication is lost or stolen, you will be out of it for only one day. Remember, we will not replace lost or stolen medications.

- Always keep your medications under lock and key, even if you live alone. We have had cases of visiting friends who may come with someone else, unknown to the owner of the house, who have stolen the medications on an innocent trip to the bathroom.
- Always know how much medicine you have left and if you need a refill.
- Never take more medicine than the prescribed amount. If you run out of medicine early, we won't give you more.
- Taking less medication is perfectly acceptable, especially if you feel that you do not need as much.
- If you have a problem (side-effect) with your medication stop taking it immediately. If the side-effect seems serious go to your nearest hospital emergency room. Otherwise, stop the medication and call our office to request an earlier appointment to discuss the problem. Do not ask to have the mediation changed over the phone. No medications are prescribed or changed via telephone.

I am in full agreement with the terms of the Pain Medication Policy Agreement. I have read and understand all of the information in the Pain Medication Policy and all of my questions and concerns regarding treatment have been adequately answered.

I understand that the purpose of this Agreement is to prevent misunderstandings about certain medications I will be taking for pain management. This is to achieve compliance with the laws related to the prescribed use of controlled pharmaceuticals.

I understand that if I violate any term of this Agreement, my CSS physician may stop prescribing all pain control medications and CSS has the right to discharge me from the care of its physicians. In this case, I may be provided with a thirty (30) day prescription of medicine(s), able to attend any scheduled appointments or emergency appointments during that thirty (30) day period and provided with contact telephone number(s) to assist in my selection of a new physician.

I understand that this Agreement is essential to the trust and confidence necessary in the physician-patient relationship and that my CSS physician undertakes to treat me based on my pledge to act in accordance with all terms of this Agreement. I have received a copy of this document for my records.

This Agreement is entered into on this _____ day of _____, _____.

Patient Signature: _____

Printed Patient Name: _____

Physician Signature: _____

Witnessed By: _____