ISSP: Integrative Sports Spine and Pain and MPSA
Maryland Pain and Spine Associates New Patient Forms

Full Name:	Date of Birth:
Street Address:	Social Security #: Marital Status:
City: State: Zip:	Employer:
Preferred Phone: _____ Is it ok to leave a message? Yes____ No____	Occupation:
Secondary Phone: _____	Work Phone

Gender Identity:
- o Male
- o Female
- o Transgender Male/Trans Man/ Female-to-Male (FTM)
- o Transgender Female/Trans Woman/ Male-to-Female (MTF)
- o Non-Binary
- o Choose not to disclose

Sex Assigned at Birth
- o Male
- o Female
- o Choose not to disclose

Race:
- o Hispanic or Latino
- o Native American
- o Asian or Pacific Islander
- o Black
- o White
- o Choose not to disclose

Who is your primary care physician? _____ Who can we thank for referring you to our clinic? _____	Primary Care Provider or referring provider: _____ Phone: _____

Primary Insurance Information	**Secondary Insurance Information**
Name of Insurance Company and Plan:	Name of Insurance Company and Plan:
Address:	Address:
City: State: Zip:	City: State: Zip:
Member ID: Group ID:	Member ID: Group ID:

Policyholder:
- o Self
- o Spouse
- o Child
- o Other

Policyholder:
- o Self
- o Spouse
- o Child
- o Other

Fill out this information if you are NOT the policyholder for your **primary insurance**

Policy Holder Name: _____ DOB: _____ SSN#: _____-_____-_____ Phone: _____ Address: _____

City/State/Zip: _____

Policy Holder Gender: _____

Fill out this information if you are NOT the policyholder for your **secondary insurance**

Policy Holder Name: _____ DOB: _____ SSN#: _____-_____-_____ Phone: _____ Address: _____

City/State/Zip: _____

Police Holder Gender: _____

Complete this section only if your visit is related to a Worker's Compensation claim or Motor Vehicle Accident

Workers Compensation Motor Vehicle Information	
Employer: _____ Employer Address:_____ Phone:_____ Employer Insurance Carrier: _____ Insurance Address:_____ Phone:_____ Claim #: Date/Time of injury: Adjuster Name: Adjuster Name:	Name of Insurance: Address: State where accident occurred: Claim #: Date/Time of injury:
Adjuster Phone: Adjuster Fax: Attorney: Phone #:	Adjuster Phone: Adjuster Fax: Attorney: Phone #:

Consent For Treatment

I certify that the above information is accurate, complete, and true.

I authorize Integrative Sports Spine and Pain and its associates, assistants, and other health care providers it may deem necessary to treat my condition. I understand that no warrant or guarantee has been made of a specific result or cure. I agree to actively participate in all aspects of my care to maximize its effectiveness.

Patient Signature: _____ Date: _____

Financial Policy

Patient Name:_____ DOB: _____ Date: _____

Insurance Co-payments

In accordance with my insurance contract, I understand that all **co-payments are due at the time of service.**

Deductible

If my insurance deductible has not been met, I understand that outstanding deductible amounts will be collected at the time of service and at the time interventional procedures are scheduled. **Co-Insurance**

I understand that co-insurance amounts will be collected at the time of service and at the time the interventional procedures are scheduled.

Private Pay Patient

If I have no coverage, or if ISSP is unable to verify current insurance coverage, I understand that full payment is expected at time of service and at the time of interventional procedures. If a patient does obtain insurance, it is the patient's responsibility to supply that insurance card to the office at time of service. **Motor Vehicle Accident Accounts**

It is the policy of this office to bill your MVA carrier until your Personal Injury Protection is expired or exhausted whichever comes first. Once PIP Coverage is no longer available your account will be switched to your private insurance and all balances will become your responsibility. We will not accept a letter of protection from your attorney in lieu of billing your insurance. If you do not have medical insurance, you will become a private pay patient.

Workers Compensation

It is the policy of this office for you to provide written documentation of workers compensation coverage. We will bill your employer until it is expired or exhausted whichever comes first. We will not accept a letter of protection from your attorney in lieu of billing your insurance. If you do not have medical insurance, you will become a private pay patient.

Secondary Insurance

I understand that ISSP will file a claim with my secondary insurance as a courtesy, but I am fully responsible for all secondary insurance amounts left unpaid by my secondary insurance.

Refund Policy

Refunds will be issued as soon as a complete insurance reimbursement for all medical services on the account has been received

Verification of Benefits and Non-covered Services.

Insurance policies are individualized per patient plan. I understand that some services may not be covered by my insurance policy. ISSP will attempt to assist me in verifying if services are covered by my plan, however if the carrier denies my services as non-covered, I understand that I am financially responsible for the denied services.

Payment Agreements

Payment Agreements will be on an as needed basis, based on balance and patient requirements. All payment agreements must be approved through the billing manager. If a patient refuses to sign a payment agreement, then they will not be seen and will be considered discharged from the practice.

Financial Policy Continued

Collections

I understand that once an account has been referred to an outside agency for collections no further appointments may be scheduled with a provider until my balance is paid in full, I will be responsible for all collection and interest costs.

Cancellations and No Show Appointments

Please provide at least 24 hours' notice for appointments that need cancelled or rescheduled. If you no-show more than 3 times for an appointment you may be discharged from the practice.

Cancellation/ No Show Policy for Interventional Procedures

Due to the longer block of time needed for interventional procedures, last minute cancellations can cause problems for both our clinical and administrative staff. Many insurance plans require prior authorizations for interventional procedures. Once they are approved you only have a window of time to schedule your procedure. If you must cancel your appointment, please contact the interventional procedure coordinator at least 5 business days or sooner to cancel and reschedule your appointment.

Returned Checks

Returned checks will be subject to a $50.00 returned check fee.

Authorization for Treatment and Financial Agreement

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment, promptly upon presentation of statement, unless prior credit agreements have been agreed upon in writing. Although this office may assist me in filing an insurance claim, I understand that I am fully responsible for the balance and agree that payment will not be delayed because of any pending insurance claim. In the event legal action should become necessary to collect an unpaid balance, I agree to pay all reasonable attorney's fees or other costs that the court may determine proper.

_____

Patient/Responsibility Party Signature Relationship to Patient Date

Informed Consent for Opioid Treatment for Chronic Pain

ISSP understands that your pain is a significant hindrance to the quality of life you desire. To help you achieve your goals we may recommend interventional procedures, non-opiate medications, physical medicine and rehabilitation and low dose opiates or abuse deterrent opiates as part of your treatment plan. If opiates are prescribed in your treatment plan, they can be helpful in managing your pain symptoms. However, you must be aware that these pain medications carry significant risks when used for a long period of time. The purpose of this agreement is to provide you information about medications that are used in the treatment of chronic pain and to assure that you and your provider will comply with both Federal and State Guidelines in the prescribing of controlled substances.

I have agreed to use opioids as part of my treatment plan for chronic pain. I understand that these drugs can be very useful but have a high potential for misuse and are therefore closely controlled by the local, state, and federal government. Because my physician/ health care provider is prescribing such medication to help manage my pain, I agree to the following conditions:

Please initial each page of the informed consent document in addition to your full signature on the last page

⇒ I understand the purpose of this agreement is to prevent misunderstandings about certain medications that I will be taking for pain management. This is to help me, and my doctor comply with the law regarding controlled medications.

⇒ I agree that I will not mix alcohol with pain medication.

⇒ I agree that I will not use illegal substances

⇒ I agree that driving or operating any type of machinery will not be allowed while I am prescribed opioid medications as this could be considered “driving under the influence” by law. ⇒ I agree to take my medication as prescribed. If my pain level increases, I will call to request an appointment to discuss with my prescribing provider. I will not increase or decrease the dosage of my medication without the consent of the prescribing provider.

⇒ If given narcotic medication I consent to receive these medications **only** from ISSP for the duration of my care. If, for any reason I am given a prescription for a controlled medication from another provider, I will not fill the medication until I discuss the matter with my prescribing provider.

⇒ I agree to receive my prescriptions only from one pharmacy, to be recorded in my medical chart. I agree to update the clinic if I plan to switch pharmacies.

⇒ I understand the risks associated with the use of pain medications such as, but not limited to the following: addiction to narcotics, drug interactions when combined with other prescribed medications such as: respiratory depression, bowel and bladder dysfunction, sexual dysfunction, change of appetite (weight gain/loss), change of coordination and other serious side effects-including risk of accidental overdose including death.

⇒ I will report any changes to my mental state, as well as possible side effects from my medications.

Initials:_____

⇒ I understand that I will inform my provider of my use of anti-anxiety medications such as Benzodiazepines (Ativan, Xanax)or Soma. I understand taking these anti-anxiety medications with opioids can led to respiratory depression and accidental overdose

⇒ It is my responsibility to keep my scheduled appointment. If I need to cancel an appointment, I will give 72 hours' notice.

⇒ I understand all narcotic medications refills must be accompanied by either an in-person office visit or telehealth visit. I understand that my controlled medications will not be mailed to me. ⇒ I understand all ineffective medications must be returned and may not be discarded in the trash or flushed down the toilet.

⇒ I will not share or sell my medications with anyone, nor will I take another person's pain medication as it is against the law.

⇒ I agree to submit to random urine drug testing and/or pill counts at the request or the need of the providers

⇒ I understand that sudden stopping of pain medications can lead to rebound pain, withdrawal symptoms, seizures, and other symptoms. I have been informed and understand not to stop any pain medications suddenly unless under the supervision of my pain provider.

⇒ I will communicate fully with my provider to the best of my ability at the initial and all follow-up visits my pain level and functional activity along with any side effects of the medications. This information allows my provider to adjust my treatment plan accordingly

⇒ I agree that any contact with providers, staff, management, must be respectful. I understand ISSP follows a strict code of conduct and does not tolerate rude, aggressive, profane or any disruptive behavior to any member of the staff or to other patients.

⇒ I agree to allow my physician/health care provider to contact any health care professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about my care or actions *if the provider feels it is necessary*.

⇒ I agree to a family conference or a conference with a close friend or significant other *if the physician feels it is necessary*

⇒ If it appears to the physician/health care provider that there is no improvement in my daily function or quality of life from the controlled substance, my opioids may be discontinued. I will gradually taper my medication as prescribed by the physician.

⇒ I am responsible for my pain medications. I understand that:

Initials:_____

- Refill prescriptions can be written for a maximum of one month supply and will be filled at the **same pharmacy.**
- Pharmacy: _____ Phone number: _____ ● **It is my responsibility to schedule appointments for the next opioid refill before I leave the clinic OR within 3 days of the last clinic visit**
- I am responsible for keeping my pain medications in a safe and secure place, such as a locked cabinet or safe. I am expected to protect my medications from loss or theft. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. If my medication is stolen, I will report this to my local police department and obtain a stolen item report. I will then report the stolen medication to my provider and provide a copy of the police report. If my medications are lost, misplaced, or stolen my provider may choose not to replace the medications or to taper and discontinue the medications.
- Refills will not be made as an "emergency", such as on Friday afternoon because I suddenly realize I will "run out tomorrow".
- Prescriptions for pain medicine or any other prescriptions will be done only during an office visit, (telehealth while under PHE) and during regular office hours. **No** refills of any medications will be done during the evening or on weekends.

1. You agree to let our provider or designated staff look up available PDMP (Prescription Drug Monitoring Program) aka CRISP in Maryland, which reports regarding your prescriptions. 2. If you are not a Maryland resident you allow our staff to contact your home pharmacy to see when your prescriptions have been picked up.

⇒ **You must bring back all opioid medications and adjunctive medications prescribed by your physician in the original containers/bottles at every visit.**

⇒ Prescriptions will not be written in advance due to vacations, meetings, or other commitments. ⇒ If an appointment for a prescription refill is *missed*, another appointment will be made as soon as possible. *Immediate* or *emergency* appointments will not be granted.

⇒ No "walk-in" appointments for opioid refills will be granted.

I have read and understand the information listed above. I agree that any non-compliance with the above will result in formal discharge with notification to my primary care physician and other treating providers. This agreement will remain in effect for the duration of my care.

Patient name (Print): _____ DOB: _____ Signature:

_____ Date: _____

AUTHORIZATION FOR RELEASING HEALTH INFORMATION HEALTHCARE PROVIDERS, FACILITIES, HOSPITAL, SKILLED NURSING FACILITY, BEHAVIORAL HEALTH SERVICES

Patient Name: Date:
Social Security No: Phone Number:
Purpose or need for information: _____ __ _____ __

I hereby authorize ISSP to obtain protected health information regarding the above-named person to be used in treatment and diagnosis.

For ISSP Staff ONLY
Person/Institution Date:
Fax Number: Phone Number:
Address:

I understand that records are protected under the federal confidentiality regulations and cannot be disclosed without my written authorization unless otherwise provided for in the regulations.

PROHIBITION OF DISCLOSURE: Alcohol and drug abuse information, if present, have been disclosed from records that are protected by federal law. Federal regulation, 42 CFR Part 2, prohibits recipients from making any further disclosure of this information except with specific written consent to the patient. DIV testing, ARC and or AIDS related diagnosis is further prohibited from disclosure by state regulations without a specific written consent of the patient. A general authorization for release of information if held by another party is not sufficient for this purpose.

RE-DISCLOSURE: Notice is hereby given to the patient of the legal representative signing this authorization that ISSP cannot guarantee that the recipient receiving the requested health information will not re-disclose it to others. Notice is hereby given to the recipient that law prohibits the re-disclosure of any health information regarding drug and/or alcohol abuse, DIV, and mental health treatment.

Patient Signature: _____ Date: _____

HIPAAAuthorization for Release of Information to Personal Representative
(Family members, spouse, caregiver, friend)

Patient Name: _____ Patient Date of Birth: _____

Signature of Patient: _____ Date of Signature: _____

Request for Confidential Communication of your Protected Health Information

Representative's Relationship to Patient:

Specific Request:

Printed Name of Patient Representative: Representative's Date of Birth:

Signature of Representative: Date of Signature

Date:

Signature: Initial:

Please write the e-mail for which you would like to receive communications_____

Please Circle the Following

May we leave messages concerning your appointments with whomever answers your calls? Yes	No	N/A
May we leave messages on a voicemail? Yes	No	N/A
May we discuss your appointment/treatment with your spouse/significant other? Yes	No	N/A
If you are over the age of 18 and still living at home, may we discuss your appointment/treatment with your parent(s)? Yes	No	N/A
If you are over the age of 18, may we discuss your appointment and/or treatment with your children? Yes	No	N/A
May we e-mail messages to you on the e-mail you provide? Yes	No	N/A
May we text you on the number provided? Yes	No	N/A

May we take your picture for identification and documentation purposes only? Yes No N/A

Please list family/friends for whom you have deemed we can disclose your Protected Health Information:

Name: Relationship:

Name: Relationship:

Patient Name:_____ DOB:_____ Date:_____

Right or Left Hand Dominant:_____

Where is the worst area of the pain?_____

Does your pain radiate? If so, where?_____

Please list any other areas of Pain :_____

_____

Details of your pain:

How did your current episode begin? ( ) Suddenly ( ) Gradually

When did your current pain episode begin?_____

Describe how the injury occurred: _____

_____

Have you ever had similar pain? Please Explain._____

_____

What does your pain feel like?

( ) Dull ( ) Shooting ( )Hot/Burning ( ) Throbbing ( ) Aching ( ) Tingling ( ) Sharp ( )

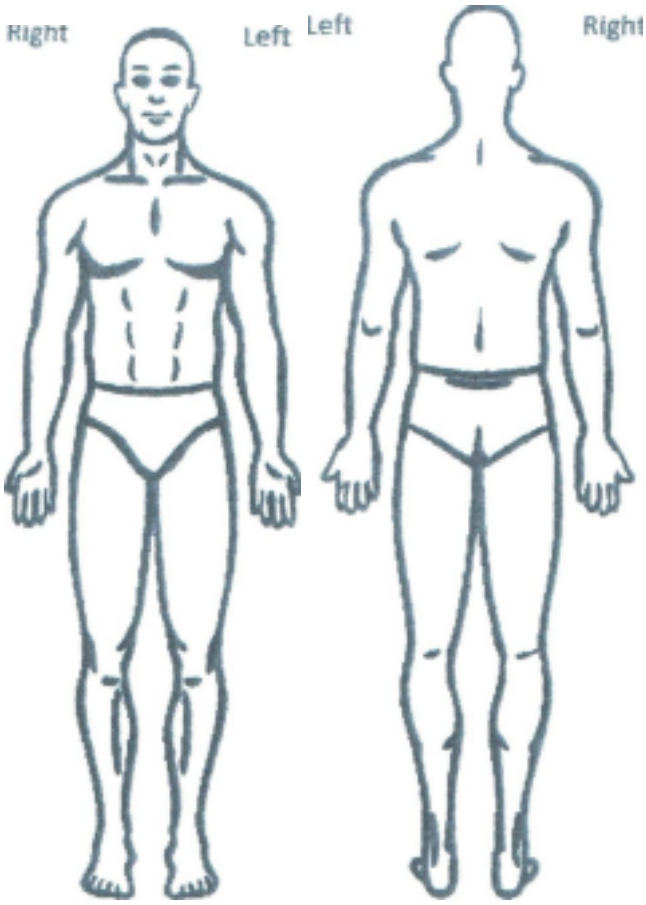
Stabbing ( ) Numb ( ) Cramping ( ) Tiring/Exhausting ( )

Other:_____

How does your pain change over time? ( ) Continuous ( ) Intermittent

How many hours per day do you have pain?_____

When severe pain occurs, how long does it last?_____



Use the diagram to indicate the location of pain. Mark the drawings with the following letters to indicate your symptoms.

"N" = Numbness

"S' = Stabbing Pain

"B" = Burning Pain

"P" = Pins and Needles

"A" = Aching pain

What is your pain level today? Please rate your pain using the scale provided below

Which number (0 — 10) describes your pain right now?

Which number (0 — 10) describes your worst pain?

Which number (0 — 10) describes your least pain?

Which number (0 — 10) describes your average pain over the past week?

0 = pain free

1 = very minor annoyance, occasional minor twinge

2 = minor annoyance, occasional strong twinges

3 = annoying enough to be distracting

4 = can be ignored if you are really involved in your work

5 = can't be ignored for more than 30 minutes

6 = can't be ignored for and length of time

7 = makes it difficult to concentrate, interferes with your sleep

8 = physical activity severely limited, you can read and converse with effort, nausea and dizziness set in as factors of pain

9 = unable to speak, crying or moaning uncontrollably, near delirium

10 = unconscious and pain makes you pass out

Past Medical History --- Have you had any of these conditions? Mark all the apply.

( ) Headaches ( ) Heart Disease ( ) Increased Cholesterol ( ) Diabetes ( ) High Blood Pressure ( ) Kidney Problems ( ) Arthritis ( ) Rheumatoid Arthritis ( ) Osteoporosis
( ) Liver Problems ( ) Fibromyalgia ( ) Hepatitis
( ) Emphysema/COPD ( ) Mitral Valve Prolapse ( ) Cirrhosis
( ) Seizures ( ) Asthma ( ) Irritable Bowel Syndrome ( ) Bursitis ( ) Stroke/TIA ( ) ADHD
( ) Carpal Tunnel ( ) Autism ( ) Tinnitus
( ) Other Medical Problems _____

Have you had any hospital stays other than for surgery? ( ) Yes ( ) No

Do you have a history of psychiatric admission(s)? ( ) Yes ( ) No

Do you have a history of suicidal or homicidal ideations? ( ) Yes ( ) No

Family History: Please indicate which family members have had the following medical problemsSocial History

Headaches _____
Heart Disease _____

Stroke _____
High Blood Pressure _____
Increase Cholesterol _____
Arthritis _____
Rheumatoid Arthritis _____
Diabetes _____
Kidney Problems _____
Liver Problems _____
Osteoporosis _____
Seizures _____
Cancer _____
Fibromyalgia _____
Substance abuse _____
Alcohol abuse _____

Social History

( ) Married/Living with Significant Other

( ) Divorced

( ) Widowed

( ) Single

What kind of work do you do?_____

Do you have any children at home? ( ) Yes ( ) No

Do you ever drink alcohol? ( ) Yes ( ) No If yes, how often do you drink?_____

Were you a heavy drinker? ( ) Yes ( ) No If yes, when did you quit?_____

Have you ever had a DUI/DWI? ( ) Yes ( ) No

Are you currently a smoker? ( ) Yes ( ) No If no, are you a former smoker? ( ) Yes ( ) No

Tobacco or Chew? _____ How much?_____

Did you or do you use any street drugs? ( ) Yes ( ) No

Have you ever OVER used narcotics or prescription medications? ( ) Yes ( ) No

Have you ever used narcotic or prescription medication for conditions other than pain or what they are intended for? ( ) Yes ( ) No

Do you currently or have you recently experienced any of the following?

General

( ) Insomnia ( ) Low Sex Drive ( ) Fatigue ( ) Weakness ( ) Unintentional weight loss ( )

Other _____

Eyes

( ) Eye Pain ( ) Vision Changes ( ) Light Sensitivity ( ) Other _____ **Ears,**

Nose, Throat, Neck:

( ) Ringing in ears ( ) Hearing loss ( ) Earache ( ) Nose bleed ( ) Sinus Congestion ( ) Dental Problems ( ) Sore Throat

( ) Other _____

Respiratory

( ) Wheezing ( ) Chest Congestion ( ) Cough ( ) Shortness of breath/Dyspnea ( ) Cough ( ) Other _____

Cardiovascular

( ) Chest Pain/Pressure ( ) Irregular Heartbeats ( ) Swelling of feet ( ) Other _____

Digestive

( ) Abdominal Pain ( ) Nausea ( ) Vomiting ( ) Constipation ( ) Diarrhea ( ) Heartburn ( ) Upset Stomach

( ) Other _____

Urinary/Kidney

( ) Pain while urinating ( ) Urinary retention/hesitancy or feeling of incomplete emptying

Musculoskeletal

( ) Neck Pain ( ) Back Pain ( ) Muscle weakness ( ) Joint Pain ( ) Other _____

Dermatologic/Skin

( ) Bruises easily ( ) Itching ( ) Rash ( ) Sores ( ) Other _____

Neurologic

( ) Headache ( ) Seizures ( ) Dizziness ( ) Dizziness ( ) Fainting ( ) Disturbance of thinking ( ) Excessive Sleepiness

( ) Other _____

Psychiatric

( ) Alcohol Abuse ( ) Drug Abuse ( ) Depression ( ) Anxiety ( ) Bipolar ( ) Stress ( ) Suicide

Attempts

( ) Other _____

Reproductive System

Could you be pregnant? ( ) Yes ( ) No

If you are unsure, would you like a test to be sure you are not pregnant before you have a procedure?

( ) Yes ( ) No

Are there other details of your pain or medical conditions we should know about?

( ) Weakness in the legs or arms? If yes,
where?_____ ( ) Bladder

incontinence? ( ) Bowel incontinence ( ) Chills ( ) Night Sweats ( ) Fever ( ) Difficulty writing ( )

Genital numbness ( ) Other_____

Mark the effect of each of the following on your pain

	Decreases my pain Increases my pain	No change
Sitting		
Standing		
Rising from sitting		
Bending forward		
Bending backward		
Walking		
Climbing stairs		
Lying on your back		
Lying on your stomach Driving		
Coughing/Sneezing Lifting objects		

Mark all of the following treatments you have used for pain relief

	Decreases my pain Increases my pain	No change

Acupuncture		
Biofeedback		
Brace Support		
Chiropractic		
Hot or cold packs		
Injection Therapy		
Massage Therapy		
Medications		
Osteopathic		
Physical Therapy		
Psychological Counseling		
Surgery		
TENS unit Traction		

Please mark physicians/specialists you have seen only for pain relief for the current problem.

( ) Acupuncturist ( ) General Physician ( ) Orthopedic Surgeon
( ) Anesthesiologist ( ) Hypnotist ( ) Pain Clinic
( ) Chiropractor ( ) internist ( ) Physical Therapist
( ) Dentist ( ) Naturopathic Doctor ( ) Plastic Surgeon
( ) ENT Physician ( ) Neurologist ( ) Podiatrist
( ) Endocrinologist ( ) Neurosurgeon ( )Psychiatrist/Psychologist ( ) Faith Healer ( )
Ophthalmologist ( ) Rheumatologist
( ) Other _____

Which Pain Clinics have you been to in the past?

_____

Goals/Limitations

What are your treatment goals?_____

_____

What three activities are limited by your condition?

1. _____
2. _____
3. _____

Have you had a recent MRI/CT of the current painful area? ( ) Yes ( ) No

If yes, please list the date and facility of the MRI/CT _____

Have you ever had an EMG or Nerve Conduction Study? ( ) Yes ( ) No

Location on the body and what side?_____

When? _____

What was the purpose?_____

Medications : Dosages/Frequency Per Day – You may attach a separate sheet with all this information

Please include any over the counter medications (Vitamins, Supplements, etc)

Medication	**Dose Frequency Per Day**

Allergies & Reactions?

_____

_____

Do you take blood thinners (Coumadin, Plavix, Etc)? ( ) Yes ( ) No

Please list and past surgery's you have had & approximate date of surgery:

_____

_____

_____

_____

_____