IPI Interventional Pain Institute

Excellence in Pain Management

Dr. Ramis Gheith and Providers

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www.ManageYourPainNow.com

ALL PATIENTS, PLEASE READ

Welcome to our Pain Clinic! Since this is your first appointment, we know you probably have many questions. This letter is to give you a quick overview of the practices of our clinic, and hopefully address some of your concerns.

Depending on your insurance carrier, you will be billed by **Interventional Pain Institute** for **Consults, Follow-up** appointments, and **Procedures.** It is ***advisable*** to contact your insurance carrier to determine what your personal out-of-pocket **(co-pays, co-insurance and deductible)** expense will be. Some insurance companies require authorizations for procedures, which may delay your treatment. Please know that we do everything possible to begin your treatment plan quickly.

In order for your plan of care to be successful, you must be under the care of a Primary Care Physician. Dr. Gheith and Providers can only take care of your Pain Management needs, and we want to communicate with your physician so that your overall health is managed successfully. Dr. Gheith and Providers will not write prescriptions for blood pressure medications, cardiac medications, etc.

You may be required to provide urine sample and sign an Opioid Agreement for our office, especially if Dr. Gheith and Providers write prescriptions for pain medications.

If you need a refill on any medication that we have prescribed, please have your Pharmacy send it electronically or they may fax a refill request to us. Our **fax** number is **636-933-2252**.

If for some reason you need to cancel any upcoming appointments, please give us at least a 24 hour notice, so that we can move another patient into your time slot. If you cancel less than 24 hours, you may incur a fee of **$65.00**.

Lastly, our staff is happy to answer questions/handle your concerns, but usually cannot return calls until late afternoon. We know this can be challenging, but we want to speak to you without interruptions.

Our website is **www.manageyourpainnow.com** . Feel free to browse our site and read about Dr. Gheith and our Providers as well as our available services. Our **office** telephone number is **636-933-2243.**

I read and understand this letter and will ask questions if necessary.

Patient Signature _____ **Date** _____

Staff Signature _____

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Consent for Use of Photographs/Videos

I, _____, give my informed and voluntary consent to Ramis Gheith, M.D. and/or his staff, associates, representatives to take photographs and/or video of me pre-operatively, intra-operatively, and post-operatively. I understand that these photographs and/or videos will be utilized to show the treatment process to the public which includes current and prospective patients. I understand entirely that this authorization is completely voluntary, and that people may recognize my face. I understand that any disclosure of information has the potential of unauthorized disclosure, and that information may or may not be protected by applicable federal and/or state confidentiality rules. Dr. Ramis Gheith or any representative cannot guarantee, nor have liability should you disclose any identifying factors to a third party as they may not be required to maintain your privacy.

Interventional Pain Institute has my permission to share my photos and videos on television and/or online.

Signature: _____

Print Name: _____

Date: _____

We greatly appreciate your participation.

Thank you. Sincerely,

Ramis Gheith, MD
Medical Director, Interventional Pain Institute
Medical Director, Interventional Pain Center of Chesterfield

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PATIENT HISTORY

Patient Name _____ **Date** _____

Date of Birth _____ **Age** _____ **SS#** _____

Marital Status _____ **Height** _____ **Weight** _____ **Email** _____

Telephone Numbers (Home) _____ (Work) _____ (Cell) _____

Home Address _____

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

Primary Care Provider: _____

Phone#: _____ **Fax#:** _____

Referring Provider: _____

Phone#: _____ **Fax#:** _____

INSURANCE

Policy Holder Name _____ **DOB** _____ **SS#** _____

Primary Insurance _____ **Group #** _____ **ID#** _____

Secondary Insurance _____ **Group#** _____ **ID#** _____

PHARMACY

Name of Pharmacy _____ **City** _____

Telephone Number _____ **Fax Number** _____

GENERAL HEALTH REVIEW

Medical History (such as heart disease, stroke, cancer, arthritis, diabetes, hypertension, as well as psychiatric illnesses, heart problems, etc...)

_____

_____

Surgical History unrelated to Pain (example: appendectomy)

_____

_____

Surgical History related to Pain (example: laminectomy)

_____

_____

Allergies (include medication and food allergies)

_____

_____

Intolerances (include side effects from previous medications, such as gastritis, nausea, constipation, etc...)

_____

_____

Current Medications (include vitamins and birth control pills, if applicable)

_____

_____

_____

Do you have any of the following? (Circle all that apply)

Headaches	Stomach Pain	Chest Pain
Vision Problems	Nausea	Shortness of Breath
Hearing Problems	Vomiting	Urinary Problems
Dizziness	Constipation	Rashes

Difficulty Swallowing Diarrhea Swollen Joints

Chronic Fatigue

Have you had any of the following treatments for you current pain? (Circle all that apply)

Physical Therapy Chiropractor Massage Therapy Surgery Medications

DOMESTIC SITUATION

With whom do you live? _____

Are there any substance abuse issues in the household? Yes _____ No _____

If applicable, enter name of caregiver _____

WORK HISTORY

Employment Status: Full Time Part Time Retired None Disability

Job Years Worked Why did you leave?

_____

_____

LEGAL MATTERS

Are you presently involved in a Law Suit? Yes _____ No _____ If yes, please explain.

_____

_____

SUBSTANCE USE

Which of the following drugs or substances, if any, have you used in the **past?** (Circle all that apply). Next to each drug or substance that you've circled, indicate if you used it occasionally ("O), frequently ("F"), or continuously ("C").

Alcohol _____ Barbiturates _____ Cocaine _____

Heroin _____ Amphetamines _____ Marijuana _____

Other _____ Other _____ Other _____

Are you presently using any of the drugs or substances below? (Circle all that apply). Next to each drug or substance that you've circled, indicate if you used it occasionally ("O), frequently ("F"), or continuously ("C").

Alcohol _____ Barbiturates _____ Cocaine _____

Heroin _____ Amphetamines _____ Marijuana _____

Other _____

Do you presently smoke cigarettes or use tobacco in any form? Yes _____ No _____

If yes, what kind? _____

If not, did you ever smoke cigarettes or use tobacco in any form? Yes _____ No _____

How many packs do (did) you smoke a day? _____ For how many years? _____

GENERAL SAFETY INFORMATION ON OPIOIDS

Indications and usage for different opioid analgesics vary and the Full Prescribing Information for the specific products should be consulted.

Examples of Opioids Include

Morphine, Hydrocodone, Oxycodone, Hydromorphone, Methadone, Fentanyl, Duragesic, Levorphanol, Vicodin, Norco, Lortab, Percocet, Oxycontin, Ms IR, Ms Contin, Tylenol #3, Tramadol, Ultram, Demerol, Darvocet, Roxicodone, Roxicet, Actiq, Codeine, Dilaudid, etc...

Please note: Sharing or otherwise diverting your opioids is considered a felony in the State of Missouri and is subject to action(s) by Law Enforcement.

Overdose

Persons who are not prescribed an opioid analgesic can overdose by taking even one dose. Persons who have a prescription for an opioid analgesic can overdose by taking more than the amount prescribed.

Certain doses of specific opioid analgesics may cause fatal respiratory depression if taken by patients who have not developed tolerance to the respiratory depressive effects of opioids.

Manipulation by any means of any opioid analgesic dosage form poses a significant risk to the abuser that could result in overdose and death. The risk of fatal outcome is increased with concurrent use or abuse of alcohol or other CNS depressants.

Opioids should be kept in a secure place out of reach of children and protected from theft or misuse. Accidental consumption especially in children may result in overdose or death.

Respiratory Depression

Respiratory depression is the chief hazard from all opioid agonists, which can result in death.

The risk of respiratory depression is increased in elderly or debilitated patients, usually following large initial doses in persons who have not developed any degree of tolerance to the respiratory depressive effects of opioid, or when opioids are given in conjunction with other agents that depress respiratory drive.

Addiction, Abuse and Diversion

There is potential for drug addiction to develop following exposure to opioids even under appropriate medical use. All patients treated with opioids require careful monitoring for signs of abuse and addiction.

Opioid agonists have the potential for being abused and are subject to criminal diversion.

Physical Dependence and Tolerance

The development of physical dependence and/or tolerance is not unusual during chronic opioid therapy.

When a patient no longer requires therapy with an opioid, the daily dose should be tapered gradually to prevent signs and symptoms of withdrawal syndrome in the physically-dependent patient.

Contraindications

Opioids are contraindicated in any setting with a risk of significant respiratory depression (In unmonitored settings or the absence of resuscitative equipment). In patients who have acute or severe bronchial asthma, in patients who have or are suspected of having paralytic effects, or in patients with known hypersensitivity to any of the opioid product constituents.

Serious Side Effects

Respiratory depression, apnea, respiratory arrest, and to a lesser degree, circulatory depression, hypotension, shock, or cardiac arrest have all been associated with opioid use and abuse.

Common Side Effects

Nausea, vomiting, dizziness, drowsiness, constipation, itching, dry mouth, sweating, weakness, and headache are the most common non-serious side effects of opioid analgesics.

Opioid analgesics may cause drowsiness, dizziness, or lightheadedness and may impair mental and/or physical ability required for the performance of potentially hazardous tasks (examples: driving, operating machinery, etc...). Patients should be cautioned accordingly.

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First Assessment Patient Name _____ Date _____

Age: _____ Gender (circle) Male Female

Please respond to the following questions **for the pain for which you are presenting for assessment today.**

Pain Location: Neck _____ Lower Back _____ Legs _____

Shoulders _____ Hips _____ Foot _____

	No Pain					Moderate Pain					Worst Imaginable
A. How would you rate your pain today?	0	1	2	3	4	5	6	7	8	9	10
How would you rate your worst pain in the past 24 hours?											

B. Please check the **one** descriptor below that best describes your present pain:

(0) No Pain _____ (3) Distressing _____

(1) Mild _____ (4) Horrible _____

(2) Discomforting _____ (5) Excruciating _____

C. Is your pain (check one)? Brief _____ Intermittent _____ Continuous _____

D. Each of the words below describes a quality that pain can have. For each quality, check the number that tells how much of that specific quality your pain has. We are interested in your ***initial impressions;*** please proceed quickly. Please rate every pain quality.

	PAIN QUALITY	NONE	MILD	MODERATE	SEVERE
1.	Throbbing	(0)____	(1)____	(2)____	(3)____
2.	Shooting	(0)____	(1)____	(2)____	(3)____

3.	Stabbing	(0)____	(1)____	(2)____	(3)____
4.	Sharp	(0)____	(1)____	(2)____	(3)____
5.	Cramping	(0)____	(1)____	(2)____	(3)____
6.	Gnawing	(0)____	(1)____	(2)____	(3)____
	PAIN QUALITY	NONE	MILD	MODERATE	SEVERE
7.	Hot-burning	(0)____	(1)____	(2)____	(3)____
8.	Aching	(0)____	(1)____	(2)____	(3)____
9.	Heavy	(0)____	(1)____	(2)____	(3)____
10.	Tender	(0)____	(1)____	(2)____	(3)____
11.	Splitting	(0)____	(1)____	(2)____	(3)____
12.	Tiring-exhausting	(0)____	(1)____	(2)____	(3)____
13.	Sickening	(0)____	(1)____	(2)____	(3)____
14.	Fearful	(0)____	(1)____	(2)____	(3)____
15.	Punishing-cruel	(0)____	(1)____	(2)____	(3)____

E. Please respond to each item by **circling** one box per row.

	Excellent	Very Good	Good	Fair	Poor
1. In general, would you say your health is:	5	4	3	2	1
2. In general, would you say your quality of life is:	5	4	3	2	1
3. In general, how would you rate your physical health?	5	4	3	2	1
4. In general, how would you rate your mental health, including your mood and your ability to think?	5	4	3	2	1
5. In general, how would your rate your satisfaction with your social activities and relationships?	5	4	3	2	1
6. In general, please rate how well you carry out your your usual social activities and roles. (This includes activities at home, at work and in your community,	5	4	3	2	1

and responsibilities as a parent, child, spouse, employee, friend, etc.)

	Completely	Mostly	Moderately	A Little	Not at All
7. To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	5	4	3	2	1

In the past 7 days

	Never	Rarely	Sometime	Often	Always
8. How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	1	2	3	4	5

	None	Mild	Moderate	Severe	Very Severe
9. How would you rate your fatigue on average?	1	2	3	4	5

	No Pain									Worst Imaginable Pain
10. How would you rate your pain on average?	0	1	2	3	4	5	6	7	8	9	10

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OPIOID RISK TOOL

Introduction The Opioid Risk Tool (ORT) is a brief, self-report screening tool designed for use with adult patients in primary care settings to assess risk for opioid abuse among individuals prescribed opioids for treatment of chronic pain. Patients categorized as high-risk are at increased likelihood of future abusive drug-related behavior. The ORT can be administered and scored in less than 1 minute and has been validated in both male and female patients, but not in non-pain populations.

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction.

Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk too. Pain Med. 2005; 6 (6) : 432

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The STOP Bang Questionnaire

Is it possible that you have Obstructive Sleep Apnea? Please answer the following questions to determine if you are at risk.

Snoring ?	**Do you Snore Loudly (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?**	**YES**	**NO**
Tired?	**Do you often feel Tired, Fatigued, or Sleepy during the daytime (such as falling asleep during driving or talking to someone)?**	**YES**	**NO**
Observed?	**Has anyone Observed you Stop Breathing or Choking/Gasping during your sleep ?**	**YES**	**NO**
Pressure?	**Do you have or are being treated for High Blood Pressure ?**	**YES**	**NO**
BMI	**Body Mass Index more than 35 kg/m2?**	**YES**	**NO**
Age	**Age older than 50 ?**	**YES**	**NO**
Neck size	**Neck size / shirt collar 16 inches / 40cm or larger? (Measured around Adams apple)**	**YES**	**NO**
Gender	**Gender = Male ?**	**YES**	**NO**

For general population

OSA - Low Risk: **Yes to 0 - 2 questions**

OSA - Intermediate Risk: **Yes to 3 - 4 questions**

OSA - High Risk: **Yes to 5 - 8 questions**

or Yes to 2 or more of 4 STOP questions + male gender
or Yes to 2 or more of 4 STOP questions + BMI > 35kg/m2
or Yes to 2 or more of 4 STOP questions + neck circumference 16 inches / 40cm

This questionnaire is provided for educational purposes only. The STOP-Bang questionnaire is owned by Dr. Frances Chung and UHN. To license the questionnaire for any other use, including clinical use, visit the official questionnaire website, www.stopbang.ca for more information and an interactive version of the questionnaire.

References:

Chung F, Yegneswaran B, Liao P, et al. STOP questionnaire: a tool to screen patients for obstructive sleep apnea. Anesthesiology 2008; 108:812.

Chung F, Subramanyam R, Liao P, et al. High STOP-Bang score indicates a high probability of obstructive sleep apnoea. Br J Anaesth 2012; 108:768

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Oswestry Low Back Pain Disability Questionnaire

Instructions

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking **ONE** box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just check the box that indicates the statement which most clearly describes your problem.

Section 1 – Pain Intensity	Section 2 Personal Care (washing, dressing, etc)
€ I have no pain at the moment	€ I can look after myself normally without causing extra pain
€ The pain is very mild at the moment	€ I can look after myself normally but it causes extra pain
€ The pain is moderate at the moment	€ It is painful to look after myself and I am slow and careful
€ The pain is fairly severe at the moment	€ I need some help but manage most of my personal care
€ The pain is very severe at the moment	€ I need help every day in most aspects of self-care
€ The pain is the worst imaginable at the moment	€ I do not get dressed, I wash with difficulty and stay in bed

Section 3 – Lifting	Section 4 - Walking
€ I can lift heavy weights without extra pain	€ Pain does not prevent me walking any distance
€ I can lift heavy weights but it gives extra pain	€ Pain prevents me from walking more than 1.2 miles
€ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed; ex: on a table	€ Pain prevents me from walking more than .6 of a mile
€ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if	€ Pain prevents me from walking more than .31 miles

they are conveniently positioned	
€ I can lift very light weights	€ I can only walk using a stick or crutches
€ I cannot lift or carry anything at all	€ I am in bed most of the time
Section 5 – Sitting	**Section 6 - Standing**
€ I can sit in any chair as long as I like	€ I can stand as long as I want without extra pain
€ I can only sit in my favorite chair as long as I like	€ I can stand as long as I want but it gives me extra pain
€ Pain prevents me sitting more than one hour	€ Pain prevents me from standing for more than 1 hour
€ Pain prevents me from sitting more than 30 minutes	€ Pain prevents me from standing for more than 3 minutes
€ Pain prevents me from sitting more than 10 minutes	€ Pain prevents me from standing for more than 10 minutes
€ Pain prevents me from sitting at all	€ Pain prevents me from standing at all

Section 7 – Sleeping	**Section 8 – Sex Life (if applicable)**
€ My sleep is never disturbed by pain	€ My sex life is normal and causes no extra pain
€ My sleep is occasionally disturbed by pain	€ My sex life is normal but causes some extra pain
€ Because of pain I have less than 6 hours sleep	€ My sex life is nearly normal but is very painful
€ Because of pain I have less than 4 hours sleep	€ My sex life is severely restricted by pain
€ Because of pain I have less than 2 hours sleep	€ My sex life is nearly absent because of pain
€ Pain prevents me from sleeping at all	€ Pain prevents any sex life at all

Section 9 – Social Life	**Section 10 - Travelling**
€ My social life is normal and gives me no extra pain	€ I can travel anywhere without pain
€ My social life is normal but increases the degree of pain	€ I can travel anywhere but it gives me extra pain
€ Pain has no significant effect on my social life apart from limiting my more energetic interests, ex: sports	€ Pain is bad but I manage journeys over 2 hours
€ Pain has restricted my social life and I do not go out as often	€ Pain restricts me to journeys of less than 1 hour
€ Pain has restricted my social life to my home	€ Pain restricts me to short necessary journeys under 30 minutes
€ I have no social life because of pain	€ Pain prevents me from travelling except to receive treatment

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○

 The SOAPP®-R was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

PainEDU

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

Please include any additional information you wish about the above answers. Thank you.

PainEDU.org

IPI Interventional Pain Institute

Excellence in Pain Management

Dr. Ramis Gheith and Providers

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www.ManageYourPainNow.com

Controlled Substance Agreement / Understanding

We are committed to doing all we can to treat your chronic pain condition. In some cases, controlled substances are used as a therapeutic option in the management of chronic pain and related anxiety and depression, which is strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and the physician by establishing guidelines, within the laws, for proper controlled substance use. The words "we" and "our" refer to the facility and the words "I", "you", "your", "me", or "my" refer to you, the patient.

1.i.I understand that chronic opioid therapy has been associated with not only addiction and abuse, but also multiple medical problems including the suppression of endocrine function resulting in low hormonal levels in men and women which may affect mood, stamina, sexual desire, and physical and sexual performance.

ii. For female patients, if I plan to become **pregnant** or believe that I have become pregnant while taking this medication, I am aware that, should I carry the baby to delivery while taking these medications; the baby will be physically dependent upon opioids. I will immediately call my obstetrician and this office to inform them of my pregnancy. I am also aware that opioids may cause a birth defect, even though it is extremely rare.

iii. I have been informed that long-term and/or high doses of pain medications may also cause increased levels of pain known as **opioid induced hyperalgesia** (**pain medicine causing more pain**) where simple touch will be predicted as pain and pain gradually increases in intensity and also the location with hurting all over the body. I understand that opioid-induced hyperalgesia is a normal, expected result of using these medicines for a long period of time. **This is only treated with addition of non-steroidal anti-inflammatory drugs such as Advil, Ibuprofen, etc., or by reducing or stopping opioids.**

iv. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if 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 or all of the following: runny nose, yawning, large pupils, goose bumps, 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.

v. 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, reduce the dose, or stop it.**

2. i. All controlled substances must come from the physician whose signature appears below or during his/her absence, by the covering physician, unless specific authorization is obtained for an exception.

ii. I understand that I must tell the physician whose signature appears below or during his/her absence, the covering physician, all drugs that I am taking, have purchased, or have obtained, even over-the-counter medications. Failure to do so may result in drug interactions or overdoses that could result in harm to me, including death.

iii. I will not seek prescriptions for controlled substances from any other physician, health care provider, or dentist. I understand it is unlawful to be prescribed the same controlled medication by more than one physician at a time without each physician's knowledge.

iv. I also understand that it is unlawful to obtain or to attempt to obtain a prescription for a controlled substance by knowingly misrepresenting facts to a physician or his/her staff or knowingly withholding facts from a physician or his/her staff (including failure to inform the physician or his/her staff of all controlled substances that I have been prescribed).

3. All controlled substances must be obtained at the same pharmacy where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is: _____ _____Phone: _____

4. i. You may not share, sell, or otherwise permit others, including your spouse or family members, to have access to any controlled substances that you have been prescribed.

ii. **Early refills will not be given**. Renewals are based upon keeping scheduled appointments. Please do not make excessive phone calls for prescriptions or early refills and do not phone for refills after hours or on weekends. Early refill requests are grounds for dismissal from our pain clinic.

5. **Unannounced pill counts**, **random urine or serum**, or planned drug screening may be requested from you and your cooperation is required. Presence of unauthorized substances in urine or serum toxicology screens may result in your discharge from the facility and its physicians and staff.

6. I will not consume alcohol in conjunction with controlled substances. I will not use, purchase, or otherwise obtain any other legal drugs except as specifically authorized by the physician whose signature appears below or during his/her absence, by the covering physician, as set forth in Section 2 above. I will not use, purchase, or otherwise obtain any illegal drugs, including marijuana, cocaine, etc. I understand that driving while under the influence of any substance, including a prescribed controlled substance or any combination of substances (e.g., alcohol and prescription drugs), which impairs my driving ability, may result in DUI charges.

7. **Medications or written prescriptions may not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen, it will not be replaced unless explicit proof is provided with direct evidence from authorities. A report narrating what you told the authorities is not enough.**

8. In the event you are arrested or incarcerated related to legal or illegal drugs (including alcohol), refills on controlled substances will not be given.

9. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribed by this physician and other physicians at the facility and that law enforcement officials may be contacted.

10. **I also understand that the prescribing physician has permission to discuss all diagnostic and treatment details,including medications, with dispensing pharmacists, other professionals who provide your health care, or appropriate drug and law enforcement agencies for the purpose of maintaining accountability.**

11. I give permission to Interventional Pain Institute to obtain a list of my medication history from my insurance company.

12. I affirm that I have full right and power to sign and to be bound by this agreement, **that I have read it**, and understand and accept all of its terms. A copy of this document has been given to me.

_____
Patient's full name

_____ _____
Patient's signature Date

_____ _____
Physician's Signature Date

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT RECEIPT

I have received the Notice of Privacy Practices on this visit or a previous one. I understand I can request another copy at any time.

First Name MI Last Name Date of Birth

Signature of Patient/Parent or Legal Guardian Date

PATIENT RECORD OF DISCLOSURES

IN GENERAL, THE HIPAA PRIVACY RULE GIVES INDIVIDUALS THE RIGHT TO REQUEST RESTRICTION ON DISCLOSURES OF THEIR PROTECTED HEALTH INFORMATION (PHI). THE INDIVIDUAL IS ALSO PROVIDED THE RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS OR THAT A COMMUNICATION OF PHI MAY BE MADE BY ALTERNATIVE MEANS SUCH AS SENDING CORRESPONDENCE TO THE INDIVIDUAL'S OFFICE OR CELL PHONE, INSTEAD OF THE INDIVIDUAL'S HOME PHONE.

PLEASE CHECK ALL THAT APPLY:

HOME TELEPHONE:

___Leave message with detailed information

___Leave message with call back number only

WORK TELEPHONE:

WRITTEN COMMUNICATION:

___OK to mail to:

___OK to fax to:

CELL PHONE:

___Leave message with detailed information

___Leave message with call back number only

___Leave message with detailed information

___Leave message with call back number only

I GIVE CONSENT TO THIS OFFICE TO RELEASE ANY AND ALL

RESULTS TO THE PERSONS LISTED BELOW:

NAME	RELATIONSHIP	PHONE NUMBER

THIS DOCUMENT WILL BE A PART OF YOUR MEDICAL RECORD

FOR OFFICE USE ONLY: _____

Entered into system by Date

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INTERVENTIONAL PAIN INSTITUTE FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you anytime. Your clear understanding of our Financial Agreement is important to our professional relationship. Please ask if you have any questions about our fees, financial agreement or your financial responsibility. Please initial on each line to confirm your understanding.

1. ___ **APPOINTMENTS** – This practice requires at least **24** hours advance notice for appointment cancellations. A **$65.00 fee** will be charged to patient's account if a patient fails to give advanced notice and does not show for their scheduled appointment.
2. ___ **REFFERALS –** If your plan requires a referral from your primary care physician, it is **YOUR** responsibility to obtain a referral prior to your appointment. Referrals must be received in our office prior to your appointment. If no referral is received by the time of service, you will be responsible for the charges.
3. ___ **CO-PAYMENTS** – By contract with your insurance carrier, we **MUST** collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. Should you not pay at the time of service and we subsequently send you a statement, an administrative fee of $10.00 may be added to your account.
4. ___ **ADMINISTRATIVE FEES –** are charged to the following – **FMLA: $75.00; SHORT TERM DISABILITY: $75.00; HANDICAP PARKING PERMIT: $35.00; HUNTING: $35.00; HEALTH FORMS: $3.00 each, DETAILED BILLING STATEMENTS: $1.00 per page, MEDICAL RECORDS:** Fees according to MO Department of Health and Senior Service. We require 3-business days for processing of these forms. Patient must be current on check-up appointments.
5. ___ **SELF-PAY PATIENTS** – Payment is expected at the time of service.
6. ___ **INSUFFICIENT FUND CHECKS** – a **$50.00** fee will be charged to patient's account for checks returned due to non-sufficient funds.
7. ___ **BALANCE ON ACCOUNT** – Accounts with balances for 31+ days or more will be subject to a 2% late fee.
8. ___ **NON-PAYMENT** – Accounts with an outstanding balance for 90+ days will be charged collection fees and forwarded to a third party for collections. All collection fees are the patient's responsibility. **NO ADDITIONAL CONTACT WILL BE MADE BY OUR OFFICE AT THAT POINT.**
9. ___ **PRIVACY POLICY** – I have received and had time to review the Notice of Privacy Practices.
10. ___ **CONTROLLED SUBSTANCE AGREEMENT/UNDERSTANDING –** I have received and had time to review the Controlled Substance Agreement/Understanding. I have received and reviewed the opioid fact sheets and understand the risks associated with using controlled substances including risk of dependence and/or addiction, withdrawal, overdose, respiratory depression and/or death.
11. ___ I have been informed and fully understand that **Interventional Pain Institute** has partnership and investment interests in the Interventional Pain Center of Chesterfield.
12. ___ All my questions have been addressed and answered to my satisfaction.
13. ___ I have received and understand the instruction form regarding the importance of stopping my blood thinners for any spinal procedure(s) and the consequences associated with stopping the medication for any spinal procedure(s).
14. ___ I have received the Patient Counseling Guide regarding opioid analgesics.
15. ___ The physicians in this medical practice in partnership with DxTx Pain and Spine, have a financial interest in Interventional Pain Center of Chesterfield, ambulatory surgical center.

ALL FEES STATED IN THIS FINANCIAL AGREEMENT ARE NOT BILLED TO INSURANCE. FEES ARE THE PATIENT'S FINANCIAL RESPONSIBILITY.

I have read and understand the practice's patient financial agreement and agree to be bound by its terms. I also understand and agree that such terms may be periodically amended by the practice.

Print Patient Name **Patient Signature** **Date**

Signature of Person Authorized to Consent **Relationship to Patient** **Patient's Date of Birth**