MUSCULOSKELETAL PAIN INTERVENTION

Patient Registration

Name: _____
(Last) (First) (MI)

Date of Birth: _____

Sex: Male_____ Female_____ Age _____

Occupation: _____

Home Address: _____
(Street) (Apt)

_____
(City) (State) (Zip)

Home Phone: _____

Cell Phone: _____

Social Security #: _____

Referred by Doctor _____

Employer: _____

Work Address: _____

Work Phone: _____

Spouse's Name: _____

Spouse's Work Phone: _____

Name of the nearest relative not living with you:

_____

Relationship: _____

Address: _____

Phone Number: _____

BILLING INFORMATION

Person responsible for your account:

_____

Relationship to the patient:

_____

Mailing Address: _____

_____

Phone Number: _____

Occupation/Title: _____

Employer: _____

Work Address: _____

_____

Work Phone: _____

INSURANCE INFORMATION

Primary Insurance Company: _____

_____

Subscriber: _____

Policy Number: _____

Coverage Code: _____

Effective Date: _____

Secondary Insurance Company: _____

_____

Subscriber: _____

Policy Number: _____

Coverage Code: _____

Effective Date: _____

In the event that a delinquent account is placed in the hands of a collection agency, or an attorney for collection, or suit instituted on this account, I agree to pay, in addition to the amount to the delinquent account plus interest, reasonable collector's or attorney's fee.

Date: ____/____/____ Signed: _____

MUSCULOSKELETAL PAIN INTERVENTION
Patient Questionnaire – Initial Visit

Date: ___/___/___ Patient's Name: _____ Age: ____ Date of Birth: ___/___/___

1. Name: _____
(Last) (First) (MI)
Sex: Male/Female Occupation: _____

2. Referred by: a) Doctor: _____ b) Hospital: _____ c) Friend or Relative: _____

3. Are you: a) Right-handed _____ b) Left-handed _____ c) Ambidextrous _____

4. What is your biggest complaint now? (**Choose ONLY One**)
a) Pain b) Numbness c) Stiffness d) Weakness e) Other _____

5. Is this problem caused by: (**Choose ONLY One**)
a) Auto accident b) Work accident c) Auto accident while on the job
d) Sports injury: name of sport _____ e) other _____
f) I know of no incident, accident or other occurrence that may have caused this current problem
g) No Incident, but symptoms began at work

If you circled f or g, answer the following three questions:

1. What were you doing when you noticed your first symptoms?
a) Can't recall b) Describe _____

2. Were you doing anything strenuous or out of the ordinary a few hours prior to the onset of your symptoms?
a) Can't recall b) No c) Yes d) Describe: _____

3. Were you involved in any strenuous activities a day or so prior to the onset of your symptoms?
a) Can't recall b) No c) Yes d) Describe: _____

6. Describe the incident: _____

7. Date of incident: ____/____/____ Estimated: Yes ____ No____

8. Was this the very first symptom you felt just as this episode began? Yes ___ No ___ If not, then: _____
What was the first symptom? (Pain, Numbness, etc.): _____
Where on your body was that felt? _____
When did this very first symptom begin? ____/____/____ Estimated: Yes ___ No: ___
Is this first symptom still present? Yes__ No__ If not, when did it stop? __/__/__ Estimated: Yes__ No__

9. How did your symptoms begin? (**Choose ONLY One**)
a) Suddenly, with a jolt b) Gradually c) suddenly, then gradually worsened d) Unsure

10. Was it worse a few hours later? Yes ____ No ____ Unsure ____

11. The next morning was this problem: (**Choose ONLY One**)
a) Better b) Same c) Worse d) Unsure

Continued…..

12. In addition to your biggest complaint, have you felt any pain sometimes run into your arms, legs, head or

elsewhere? Yes ____ No ____

If yes, where? _____

When did this radiating pain begin? ____/____/____ Estimated: Yes____ No____

Is it still present? Yes___ No___ If not, when did it stop? ___/___/___ Estimated: Yes___ No___

13. In addition to your biggest complaint, have you also noticed and numbness, pins and needles, tingling, or other unusual sensation in your arms, legs, head or elsewhere? Yes ____ No ____

If yes, where? _____

When did this numbness begin? ___/___/___ Estimated: Yes ____ No ____

Is this numbness still present? Yes ____ No ____

If not, when did this numbness stop? ___/___/___ Estimated: Yes ____ No ____

14. Currently, how would you describe your current pain? (**Circle ALL that apply**)

a) a dull ache b) sharp c) a cramp d) a deep boring pain e) shock-like f) other_____

15. Rate this problem, when it is most severe, on a scale of 1 to 10 (**10 being the absolute worst pain possible**):

1 2 3 4 5 6 7 8 9 10

16. How often does this problem become this severe? (**Choose ONLY One**)

a) constantly b) many times a day c) daily d) a few times a week

e) once or twice a month f) a few times a year g) almost never

17. Does this problem see related to a certain time of day: Yes____ No____
If no please skip to question #22

18. When is this problem generally the least? (**Circle ALL that apply**)

a) in the morning b) around noon c) in the afternoon d) in the evening e) during the night

19. When is this problem generally the least? (**Circle ALL that apply**)

a) in the morning b) around noon c) in the afternoon d) in the evening e) during the night

20. Which of the following describes your sleep as it relates to this problem? (**Circle ALL that apply**)

a) difficulty getting to sleep b) wake up during the night because of the pain

c) wake up with pain when lying on the painful side d) have no difficulty when sleeping

21. Which of the following increases this problem? (**Check ALL that apply**)

a) coughing b) sneezing c) deep breathing

d) holding breath and pushing down (as when having a bowel movement) e) none of the above

22. Overall, for this episode, are you now: (**Choose ONLY One**)

a) improving b) worsening d) neither improving nor worsening

23. Are you having any symptoms now? Yes____ No____

24. Have you seen other physicians for the same complaint? Yes____ No____

Continued…..

25. List their names and specialties:

1. _____
2. _____
3. _____
4. _____
5. _____

26. Are you involved in a legal process regarding this case? Yes____ No____

27. Are you currently: (**Circle ALL that apply**)
    a) working a regular job b) off work c) working light duty d) working part-time e) retired
    f) a student g) unemployed-for reasons unrelated to this problem

28. How much time off work have you had because of this episode of pain? (**Circle the BEST choice**)
    a) not missed work because of this episode b) been off work since onset of pain
    c) missed some work because of this episode

    If c), then answer the following:
    1. List dates of **total off work** status:
       ___/___/___ through ___/___/___ Estimated: Yes___ No___
       ___/___/___ through ___/___/___ Estimated: Yes___ No___
    2. List dates of **light-duty, full-time** work status:
       ___/___/___ through ___/___/___ Estimated: Yes___ No___
       ___/___/___ through ___/___/___ Estimated: Yes___ No___
    3. List dates of **light-duty, part-time** work status:
       ___/___/___ through ___/___/___ Estimated: Yes___ No___
       ___/___/___ through ___/___/___ Estimated: Yes___ No___
    4. List dates of **regular duty, part time** work status:
       ___/___/___ through ___/___/___ Estimated: Yes___ No___
       ___/___/___ through ___/___/___ Estimated: Yes___ No___
    5. List dates of **regular work** duty status:
       ___/___/___ through ___/___/___ Estimated: Yes___ No___
       ___/___/___ through ___/___/___ Estimated: Yes___ No___

29. Have you had similar symptoms in the past? Yes____ No____
    If yes, fill out additional form and attach to packet

GENERAL MEDICAL HISTORY

30. Have you noticed any of the following symptoms recently? (**Circle ALL that apply**)

    a) Fever, Chills, or Sweats
    b) Weight Loss or Weight Gain
    c) Chest Pain or Rapid Heart Beat
    d) Shortness of Breath
    e) Hoarseness
    f) Cough or Wheezing
    g) Joint Pains, Where_____
    h) Anxiety or Depression
    i) Problems with Concentration or Memory
    j) Leg or Arm Swelling
    k) Eye Problems
    l) Dizziness
    m) Nausea
    n) Swelling of Lymph Nodes
    o) Rash or Skin Discoloration
    p) Heel Pain or Foot Pain
    q) Arm or Leg Weakness
    r) Heartburn/Acid Stomach
    s) Headache
    t) Other (Please Explain) _____

Continued…..

31. Do you have difficulty with your urine? Yes No

If YES, explain:

_____

32. Do you have difficulty with your bowels? Yes____ No____

If YES, explain: _____

33. (**MALES ONLY**) Do you have difficulty with your erections? Yes____ No____

If YES, explain: _____

34. (**FEMALES ONLY**) Are you pregnant? Yes____ No____

If YES, what month are you in? _____

35. Do you have any of the following medical problems: (Circle ALL that apply)

a) Allergies
b) Angina
c) Asthma
d) Heart Disease/Prior MI
e) Stroke
f) High Blood Pressure
g) Diabetes
h) Kidney Disease
i) Liver Disease
j) Thyroid Problem
k) Lung Disease
l) Epilepsy or Seizures
m) Osteoporosis
n) Arthritis
o) Gastritis
p) Ulcers
q) Bowel Disease
r) Shingles
s) Sexually Transmitted Diseases:
1. HIV
2. Hepatitis C
3. Genital Herpes
t) Other (Please Explain)
_____

36. Do you drink alcohol? Yes____ No____

If YES, how many drinks per day? _____ How many per week? _____

37. Do you smoke cigarettes? Yes____ No____

If YES, how many packs per day? _____ How long have you been smoking? _____ years.

38. Have you ever had, or do you now have cancer? Yes____ No____

If YES, what type: _____ Year when it was diagnosed: _____

39. Have you ever had any operation (unrelated to this problem)? Yes____ No____

If YES please list and give dates:

Operation	**Year**
_____	_____
_____	_____
_____	_____

40. Are you taking any medication? Yes____ No____ If YES, please list:

_____ _____
_____ _____
_____ _____

41. Are you allergic to any medications? Yes____ No____ If YES, please list:

_____ _____
_____ _____

Continued…..

42. Do any of your immediate family members have any serious medical or musculoskeletal problems?

    Yes____ No____ Unsure____

    If Yes, please explain: _____

43. Additional comments: _____

    _____

    _____

VITAL SIGNS- BP: _____ WEIGHT: _____ HEIGHT: _____

Signature: _____ Date: ____/____/____

Patient Name: _____

Continued…..

Sherif Roushdy, M.D.

MUSCULOSKELETAL PAIN INTERVENTION

SIGNATURE ON FILE

( ) I authorize the use of this form on all my insurance submissions.

( ) I authorize release of information to my Insurance Companies.

( ) I understand that I am responsible for my bill.

( ) I authorize Advanced Spine Associates to act as my agent in helping me obtain payment from my Insurance Companies.

( ) I authorize payment directly to Advanced Spine Associates.

( ) I permit a copy of this authorization to be used in place of the original.

Signature: _____ Date: _____

Sherif A. Roushdy, M.D.
Danielle L. Black, CNP

Financial Agreement and Authorization for Treatment

Patients Name: _____

I authorize treatment of the person named above. I agree to pay all charges for me and members of my family promptly after receipt of statement thereof, unless credit arrangements are agreed up on in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty (30) days of billing date. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to my family or me, I agree to pay all reasonable attorney fees or other such costs as the Court determines proper.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or any claims still pending insurance and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as valid as original.)

In compliance with the Federal Consumer Protection Act, Advanced Spine Associates, P.A. wishes to notify you of its policies regarding the financial responsibilities associated with services rendered to you or a member or your household/family.

- Uninsured patients will be required to pay for their visit by cash or credit card at the time of the service.
- If applicable, we will furnish you with a monthly statement of your account showing both the amounts billed to you and the payments or credits to your account. The monthly statement will also provide you with a detailed aging of unpaid balance. You will not receive a statement before insurance has paid or denied your claims.
- We will file your claims to your insurance company. However, you are required to notify us of any changes in your insurance. If we encounter problems with your insurance company, your assistance is required.
- Please remember that your insurance policy is a contract between you and your insurance company. If your insurance does not pay your claim within 30 days after it is mailed, we ask that you contact your insurance company regarding settlement. We will assist you in processing your claim; however, our account is billed to you and you are personally responsible for payment of your account.
- If for some reason you are having a personal financial crisis, you should contact our business office to discuss a payment schedule.

We may accept late payments, partial payments, or any payments marked as being paid in full or as being in settlement of any dispute without losing any rights under the law.

A $30.00 FEE will be charged for each insufficient funds check returned and payable to Advanced Spine Associates, P.A. (Your bank may also charge you a fee).

In case of errors or inquiries about your bill:

If you think your bill is wrong, or if you need more information about a transaction on your bill, write or call us at Advanced Spine Associates, P.A., 1545 Northway Drive, Suite 140, St. Cloud, MN 56303, 320-253-8500, or 1-800-774-2417, as soon as possible. We must hear from you no later than thirty (30) days after we sent you the first bill on which the error or problem appeared.

In your letter, please give us the following information:

- Your name and account number.
- The dollar amount of the suspected error.
- Describe the error and explain why you believe there is an error. If you need more information, describe the item you are unsure about.

The undersigned hereby acknowledges to have read and agrees to the above financial credit payment policies of Advanced Spine Associates P.A.

Signature_____ Date_____
(Patient or Authorized Representative)

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Advanced Spine Associates, P.A. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Advanced Spine Associates, P.A. Notice of Privacy Practice provides a more complete description of such uses and disclosures).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Advanced Spine Associates, P.A. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Advanced Spine Associates, P.A at 1545 Northway Drive, Suite 140, St. Cloud, MN 56303.

With this consent, Advanced Spine Associates, P.A. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Advanced Spine Associates, P.A. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Advanced Spine Associates, P.A. may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards or patient statements. I have the right to request that Advanced Spine Associates, P.A. restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does it is bound by this agreement.

By signing this form, I am consenting to Advanced Spine Associates, P.A. use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Advanced Spine Associates, P.A. may decline to provide treatment to me.

_____

Signature of patient or Legal Guardian

_____ _____

Patient Name Date

_____

Print Name of patient or Legal Guardian

MUSCULOSKELETAL PAIN INTERVENTION

PATIENT RESPONSIBILITY FOR CHRONIC OPIOID (NARCOTIC) THERAPY

This document represents patient expectations regarding the use of Opioid (narcotic) pain medications for treating pain. Opioid medications are only part of an overall treatment plan; therefore I will regularly attend and participate in all prescribed therapies. By signing this, I understand and agree to the following risk and conditions, which may be associated with long-term use of Opioid medications.

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, 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 and controlled substance use. The words "we" and "our" refer to the facility and the words "I", "you", "me", or "my" refer to you, the patient.

RISKS:

1. Constipation (which may be severe enough to require medical treatment)
2. Urinary retention (difficulty with urination)
3. Change in appetite and/or weight
4. Drowsiness or confusion, which may affect thinking abilities or emotions
5. Itching
6. Nausea
7. Problems with coordination or balance that may make it unsafe to operate motor vehicles or heavy equipment
8. Depressed respiration (breathing too slowly, overdose can lead to respiratory arrest, coma, or death)
9. Physical dependence (which means that quickly stopping Opioids may lead to withdrawal symptoms)
10. Psychological dependence (which means that quickly stopping Opioids may lead to drug cravings)
11. Sexual difficulties
12. If I become pregnant, my baby might be born physically dependent on Opioids. This can be treated successfully. There may be other, unknown risks to unborn children. (Female patients only)
13. Other, rare side effects may occur

OPIOID GUIDELINES & CONDITIONS

1. All controlled substances must come from the physician whose signature appears below unless specific authorization is obtained for an exception. I understand that I must tell the physician whose signature appear below 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. I will not seek prescriptions for controlled substance from any other physician, healthcare provider, or dentist. I understand 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 (including failure to inform the physician or his/her staff of all controlled substances that I have been prescribed). If an emergency occurs and Opioids are prescribed from another doctor, I will notify the physician as soon as possible.

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

3. Prescriptions will not be mailed.

4. I will not consume excessive amount of 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, as set forth in Section One above. I will not use, purchase or otherwise obtain illegal drugs, marijuana, cocaine, etc. I understand that driving while under the influence of any substances, 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.

5. I will take Opioids only as prescribed by my physician and under no circumstances will I share, sell, or otherwise permit others, including spouse or family members, to have access to any controlled substances that you have been prescribed.

6. The use of Opioids medications will be strictly monitored. Medications or written prescriptions may not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, etc. If 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 authorities is not enough.

7. No unplanned or emergency refills will be allowed. Early refills (less than 30 days) will not be given. Renewals are based upon keeping scheduled monthly appointments. Any calls for prescriptions received after 2pm on weekdays may be not addressed until the next business day. Our clinic is closed on all major holidays. Patients needing refills must call at least one week (seven days) before current supply of medication runs out. Furthermore, prescriptions and refills WILL NOT be called into pharmacies and must be picked up by patients.

8. Unannounced urine or serum toxicology specimens 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 this facility.

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

10. 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.

11. Due to known and unknown risks to unborn children, which include physical dependence, I will notify my physician if I am pregnant in the future (female patients only).

12. I understand that Opioid medications will be slowly reduced and safely stopped if I violate any aspect of this patient responsibility form, or if my physician feels that Opioids are not effective in controlling my pain. It may be necessary for me to enter a chemical dependency program in order to completely stop the medications.

13. I must see my physician every 4-6 weeks for monitoring any medications.

14. I give my physician permission to communicate with any of my other physicians regarding my use of controlled substances.

15. I affirm that I have full right and power to sign and be bound by this agreement, and that I have read it and understand and accept all of its terms.

16. Other conditions:_____

    _____

Patient: _____ Date: _____

Physician: _____ Date: _____

Witness: _____ Date: _____

INTERPRETER'S STATEMENT: I have translated the information and advice presented orally to the individual consented by the person obtaining this consent. To the best of my knowledge and belief, he/she understood this explanation.

Interpreter: _____ Date: _____