INTERVENTIONAL PAIN
CONSULTANTS

Welcome to Interventional Pain Consultants!
Please arrive at least 30 minutes early with all your paperwork completed or your appointment will be rescheduled.
Please complete and bring the following:

- O New patient paperwork completed
- O Insurance card and Copay
- O Valid Government Issue Photo ID
- O Current List of Medications
- O Any recent Imaging reports or discs, (XRAY, MRI, CT)

***Please Note:**
* If your paperwork is not completed, we will reschedule your appointment.
* If you do not have a Photo ID, we will reschedule your appointment.
* If you do not have your insurance copay, if applicable, we will reschedule your appointment.
* If you Cancel your appointment in less than 24 hours there will be a fee of $50.00.
* If you No show your appointment there will be a fee of $50.00.

Swansea Location
4972 Benchmark Ctr. Drive Ste 400
Swansea, IL 62226

Alton Location
3 Professional Drive, Ste B
Alton, Illinois 62002

Maryville Location
2023 Vadalabene Dr, STE 300
Maryville Illinois, 62062

Interventional Pain Consultants - Patient Evaluation

Patient Name:	*Date of Birth:*

Please tell us the first and last name of your Referring Provider:_____

Please tell us the first and last name of your Primary Care Provider:_____

If you are a Female, please tell us your pregnancy status: O Hysterectomy O Post-Menopausal O Not able to get pregnant
O Child-Bearing Age-No Contraception O Child-Bearing Age-Birth Control Medication O Child-Bearing Age-Other Contraception

Where is the location of your pain: _____

When did your pain first begin, please tell us month and year if known? mm/yyyy _____

What is the main cause of your pain? O Unknown O Normal aging O Fall O Sporting accident
O Motor vehicle accident O Work injury

What is the frequency of your pain? O Constant O Fluctuating but always present O Fluctuating but usually present
O Fluctuating and rarely present

What best describes your pain? O Aching O Burning O Cramping O Dull O Numb
O Sharp O Stabbing O Stinging O Throbbing O Tingling

What is your pain level most of the time?
O 0- No Pain O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10-Unbearable Pain

What makes your pain worse? O Bending or stooping O Changing from sitting to standing O Sitting
O Lifting or carrying heavy loads O Lifting or carrying small loads O Lying on back
O Lying on side O Nothing

What makes your pain better? O Lying on side O Lying on my back O Sitting O Standing
O Walking O Stretching O Exercise O Nothing

What does your pain interfere with? O Daily chores O Employment O Exercise O Grooming O House Chores
O Mood O Sleep O Relationships O Walking O Nothing

Have you had any of the following Imaging/Tests to assist in the evaluation of your pain?

MRI: O No O Yes Xray: O No O Yes
Ct Scan: O No O Yes EMG/Nerve Conduction: O No O Yes

Have you ever had Genetic Testing done for medication response? O No O Yes

Have you had any of the following to assist in the evaluation of your pain?

O Blood work completed in the past year O Bone Density O Functional Capacity Evaluation
O Drug Screening O Ultrasound O Depression Screening
O Bone Scan O Vascular Studies

Have you had any of the following injections to assist with the treatment of your pain? O Spinal O Joint O Muscle O Botox O None

Have you had any of the following related to your pain? O Back Brace O Neck Brace O Tens Unit O Knee Brace O None

Have you had any of the following Surgeries? O Low Back O Mid Back O Neck O Hip O Knee O Shoulder O None

Have you tried any of the following therapies to assist with treatment of your pain?

O Physical Therapy O Chiropractic Therapy O Aquatic Therapy O Occupational Therapy O None

Have you had or done any of the following to assist with the treatment of your pain?

O Spinal Cord Stimulator O Spinal Traction O Cane O Walker O Exercise Program O Weight loss Program O Intrathecal Pain Pump

Patient Name:	*Date of Birth:*

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (Add additional page if needed):

MEDICATION	DOSAGE	INSTRUCTIONS

If you have tried any of the Anti Inflammatory Medications below, were they helpful or not helpful? or please mark O None tried

Aspirin:	O Helpful	O Not Helpful	Vimovo	O Helpful	O Not Helpful
Celebrex (Celecoxib):	O Helpful	O Not Helpful	Ketroprofen:	O Helpful	O Not Helpful
Diclofenac:	O Helpful	O Not Helpful	Mobic (Meloxicam):	O Helpful	O Not Helpful
Daypro:	O Helpful	O Not Helpful	Naproxen (Aleve/Naprosyn),:	O Helpful	O Not Helpful
Etodalac(Lodine):	O Helpful	O Not Helpful	Relafen:	O Helpful	O Not Helpful
Ibuprofen(Motrin,Advil):	O Helpful	O Not Helpful	Toradol:	O Helpful	O Not Helpful
Indomethacin(Indocin):	O Helpful	O Not Helpful	Duexis:	O Helpful	O Not Helpful

If you have tried any of the Muscle Relaxer Medications below, have they been helpful or not helpful? or please mark O None tried

Baclofen:	O Helpful	O Not Helpful	Norflex:	O Helpful	O Not Helpful
Cyclobenzaprine(Flexeril):	O Helpful	O Not Helpful	Parafon Forte (Lorzone):	O Helpful	O Not Helpful
Carisoprodol(Soma):	O Helpful	O Not Helpful	Skelaxin (Metaxolone):	O Helpful	O Not Helpful
Diazepam(Valium):	O Helpful	O Not Helpful	Tizanidine(Zanaflex):	O Helpful	O Not Helpful
Methocarbamol(Robaxin):	O Helpful	O Not Helpful			

If you have tried any of the Narcotic Medications below, have they been helpful or not helpful? or please mark O None tried

Avinza:	O Helpful	O Not Helpful	Oxycontin:	O Helpful	O Not Helpful
Codeine:	O Helpful	O Not Helpful	Oxycodone (Percocet,Roxicodone,OxyIR):	O Helpful	O Not Helpful
Duragesic:	O Helpful	O Not Helpful	MSIR:	O Helpful	O Not Helpful
Dilaudid(Hydomorphone):	O Helpful	O Not Helpful	Methadone:	O Helpful	O Not Helpful
Hydrocodone (Lortab,Lorcet,Norco):	O Helpful	O Not Helpful	Morphine ER (MS Contin, Avinza, Kadian):	O Helpful	O Not Helpful
Kadian:	O Helpful	O Not Helpful	Tramadol(Ultracet):	O Helpful	O Not Helpful
Opana:	O Helpful	O Not Helpful			

If you have tried any of the "Other" Medications below, have they been helpful or not helpful? or please mark O None tried

Cymbalta:	O Helpful	O Not Helpful	Lyrica:	O Helpful	O Not Helpful
Clonidine:	O Helpful	O Not Helpful	Neurontin:	O Helpful	O Not Helpful
Elavil(Amitriptyline):	O Helpful	O Not Helpful	Savella:	O Helpful	O Not Helpful
Keppra:	O Helpful	O Not Helpful	Topamax:	O Helpful	O Not Helpful
Klonopin:	O Helpful	O Not Helpful	Trileptal:	O Helpful	O Not Helpful
Lidoderm Patch:	O Helpful	O Not Helpful	Zonegran:	O Helpful	O Not Helpful

Allergies/Intolerance: O Penicillin O Sulfa O IV Dye/Contrast O NKDA List other:_____

Have you tried any Over the Counter Medications such as BioFreeze, IcyHot, Bengay, Aspercreme? O No O Yes

Have you ever tried Prescription Creams such as EMLA Cream, Voltaren Gel, etc for your pain? O No O Yes

Patient Name:	*Date of Birth:*

Have you ever tried a Compounded Pain or Scar cream from a specialty pharmacy? O No O Yes

Past Medical History (please check all disease or disorders you have had):

O Migraine headaches	O High blood pressure	O Emphysema	O Cirrhosis	O Kidney disorder	O Cancer
O Head injury	O High cholesterol	O Asthma	O Hepatitis	O Prostate disorder	O Depression
O Stroke	O Coronary artery disease	O Sleep apnea	O Gallbladder dz	O Osteoporosis	O Anxiety
O Seizures	O Heart attack (MI)	O Hiatal hernia	O Pancreatitis	O Spine disorder	O Alcoholism
O Multiple Sclerosis	O Heart arrhythmia	O Reflux	O Diabetes	O Arthritis OA/RA	O Addiction
O Peripheral nerve disease		O Ulcers	O Bowel disease	O Muscle disorder	

Past Surgical History (please list all surgeries you have had):

_____ _____ _____ _____

_____ _____ _____ _____

Family Medical History (please check all disease or disorders your family has had):

O Migraine headaches	O High blood pressure	O Emphysema	O Cirrhosis	O Kidney disorder	O Cancer
O Head injury	O High cholesterol	O Asthma	O Hepatitis	O Prostate disorder	O Depression
O Stroke	O Coronary artery disease	O Sleep apnea	O Gallbladder dz	O Osteoporosis	O Anxiety
O Seizures	O Heart attack (MI)	O Hiatal hernia	O Pancreatitis	O Spine disorder	O Alcoholism
O Multiple Sclerosis	O Heart arrhythmia	O Reflux	O Diabetes	O Arthritis OA/RA	O Addiction
O Peripheral nerve disease		O Ulcers	O Bowel disease	O Muscle disorder	

What is your marital status? O Single O Married O Separated O Divorced O Widowed

Who resides in your same home and or assists in your care if needed? O Alone O Friend O Spouse O Children
O Parents O Skilled Nursing Facility O Hospice Care

What is your employment status? O Employed Full time O Employed Part time O Unemployed O Retired
O Short Term disability O Long Term Disability

Smoking Status: O Current smoker O Former smoker O Nonsmoker O Current every day smoker O Current some day smoker

Alcohol use: O None O Rarely O Occasionally O Regularly

Do you have any street drug use? O Yes O No

Review of Systems: Please mark each of the following symptoms/problems that you currently have (Mark all that apply)

General	**HEENT**	**Respiratory**	**Cardiology**	**Gastroenterology**
O Weight loss	O Headache	O Chronic cough	O Chest pain (angina)	O Appetite loss
O Weight gain	O Facial pain	O Wheezing	O Murmur	O Chronic nausea
O Fever	O Sinusitis	O Shortness of breath	O Congestive failure	O Heartburn
O Night sweats	O Loss of vision	O Sleep apnea	O Abnormal EKG	O Constipation
O Fatigue	O Hearing loss	O Home oxygen use		O Diarrhea
O Many infections	O Teeth/gum problems	O C-PAP		O Bowel control loss
Genitourinary	**Endocrine/Hematological**	**Musculoskeletal**	**Neurology**	**Psychiatric**
O Painful Urination	O Abnormal blood sugars	O Joint pain	O Drowsiness	O Panic attacks
O Blood in urine	O Easy bruising/bleeding	O Muscle spasm	O Dizziness	O Insomnia
O Bladder control loss		O Neck pain	O Blackouts	
O Enlarged prostate	**Vascular**	O Back Pain	O Tremors	**Skin**
O Testicular pain	O Poor circulation		O Numbness	O Rash
O Irregular bleeding	O Current blood clot			
O Pregnancy	O Swelling in legs			

Preventative Medicine: Falls Risk Screening: If you are 65 or older, please check all that apply to you

O No Falls in the past year

O One Fall with injury in the past year

O One Fall without injury in the past year

O Two or more falls with injury in the past year

O Two or More Falls without injury without injury in the past year

Interventional Pain Consultants

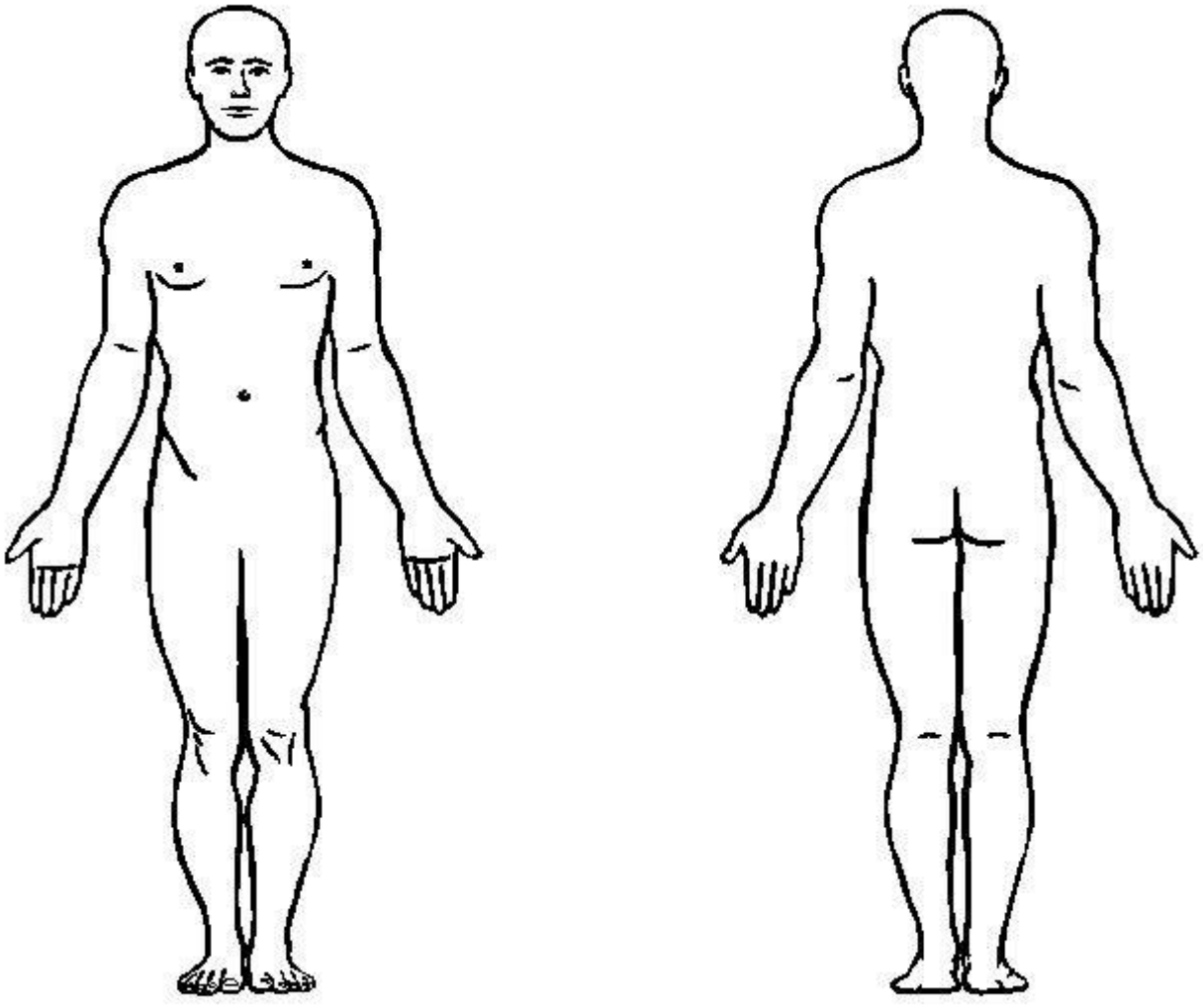
Today's Date: _____

Patient Name:	*Date of Birth:*

Please tell us the location of your pain and any numbness you are currently experiencing.

Draw small X's where your pain is located.

Draw small O's where any numbness is located.



Do you have a pacemaker? Yes or No

PATIENT INFORMATION SHEET

Today' s Date: _____	*Patient Date of Birth:*
Patient First Name:	*Patient Last Name:*
Social Security #:	*Previous Last Name/Nick Name:*
Gender:	*Marital Status:*
Mailing Address:	
Street Address (If different from mailing address):	
If Patient resides in Skilled Nursing Facility, what is the name of the facility?	
If Patient is a Hospice patient, what is the name of the Hospice Service?	
Patient's Primary Care:	*Referring Provider:*
PCP Phone Number:	*Referring Provider Phone #:*

Emergency Contact Information

Contact Name:
Phone Number:
Relationship to Patient:

I wish to be contacted in the Following Manner

Home Telephone:	___ *(Extended) OK to leave message with Detailed information* ___ *(Brief) Leave message with Call back number only*
Cell Phone:	___ *(Extended) OK to leave message with Detailed information* ___ *(Brief) Leave message with Call back number only*
Work Telephone:	___ *(Extended) OK to leave message with Detailed information* ___ *(Brief) Leave message with Call back number only*
Email Address:	
Primary Language: ___ *English* ___ *Spanish* ___ *French* ___ *Japanese* ___ *Chinese* ___ *Other*	

Race: (This is now a requirement for us to have on file and only used for medical purposes)

___American Indian or Alaska Native *___ White/Caucasian*

___Black or African American *___Native American or other Pacific Island*

___Asian *___Refuse to report*

___Hispanic or Latino

Patient Name:	*Date of Birth:*

Employment Information

Employer Name:	*Employer's Phone #:*
Employment status: ___ Full Time ___ Part time ___ Retired	

Is this a worker's comp? ___Yes ____No If yes, please answer the following questions:

Company Name: _____ *Claim Number: _____*

Contact Person: _____ *Contact Person's Phone Number: _____*
Date of Injury: _____

Insurance Information

PRIMARY Insurance:		
Insurance ID:	*Copay:*	
If Policy Holder is other than SELF please complete below information regarding the Policy Holder		
Policy Holders Name:	*DOB:*	*Gender:*
Social Security Number:		
Policy Holders Address:	*City:*	*State:*
Policy Holders Home Number:		
Policy Holders Employer Name:	*Work phone number:*	
Policy Holders Relationship to Patient:		

SECONDARY Insurance:		
Insurance ID:	*Copay:*	
If Policy Holder is other than SELF please complete below information regarding the Policy Holder		
Policy Holders Name:	*DOB:*	*Gender:*
Social Security Number:		
Policy Holders Address:	*City:*	*State:*
Policy Holders Home Number:		
Policy Holders Employer Name:	*Work phone number:*	

Policy Holders Relationship to Patient:

Consent for Insurance Assignment/Payment:
I hereby authorize the assignment of benefits (payments) directly to Interventional Pain Consultants for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-pays, deductibles and non-covered services are due at the time of service. I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Signature of Responsible Party:_____ Date: _____

(Authorization will remain in effect from date signed until revoked in writing by patient or patient representative)

Interventional Pain Consultants

Patient Name:	*Date of Birth:*

Acknowledgement of Receipt of HIPAA Notice

Interventional Pain Consultants is concerned about the privacy of our patient's health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary. I acknowledge that I have received the Notice of Privacy Practices for: Interventional Pain Consultants

_____ _____

Signature of Patient or Legal guardian Date

Authorization To Discuss Your Medical Information

In accordance with the HIPAA guidelines this practice is authorized to discuss my medical information with the following individuals. Please list up to 3 people we may leave messages with in the event we are unable to contact you.

HIPAA Authorized Person's Name	Relationship to patient	Telephone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you utilize a transportation service? Yes_____ No_____

If yes, do you authorize IPC to give information regarding dates/times of appointments to this service? Yes_____ No_____

Do you have a medical Power of Attorney? Yes ____ No ____ If so, please provide a copy for our records

_____ _____

Signature of Patient or Legal guardian Date

_____

Relationship to Patient if Not Patient

INTERVENTIONAL PAIN CONSULTANTS

AUTHORIZATION FOR COMMUNICATION

Patient Name:		*Date of Birth:*
Email Address:	*Cell Phone # :*	*Home Phone # :*

Our goal at IPC is to develop an environment of open communication and shared decision making with our patients. Having the ability to reach you regarding your treatment, your appointments and account, and how we can better serve you is very important to your overall care. In today's busy world, being able to reach patients via text and email allows us to be more agile and reach out more quickly and efficiently. It allows us to personalize our messaging to you and give you information that can help you live well. To make certain that we are using your personal information with your authorization, IPC keeps on file a copy of your written permission. Please take a minute to complete this form.

- I acknowledge and give my expressed consent to IPC to contact me by email to the email(s) I have provided with information that may include, but is not limited to, general health and well-being, changes to, and clarifications regarding company policies, procedures and services, and information, changes and documentation regarding my account. I understand that I have the right to opt-out of future emails at any time. I understand that opting out of emails may affect the timing and scope of content of information I receive from IPC.
- I acknowledge and agree that IPC and any of their affiliates or vendor thereof involved my care or the management of my account, including patient survey partners and billing or collection companies, may contact me by telephone or text message to any telephonic number I have provided to you, and any other telephone number associated with my account, including wireless or mobile telephone numbers. I further agree that you may use any method of contact to these numbers, such as an automated telephone dialing system (ATDS) or prerecorded message. I also agree that I will notify IPC if I have given up ownership or control of any such telephone number.

If the above permissions are given, I understand that:

- This authorization is voluntary. My treatment will not be impacted if I sign this authorization or not.
- Your privacy is very important to us. IPC will abide by all regulations protecting patient health information and will not communicate patient-specific treatment information via unsecured email or text.
- The option to opt-out of any future email is included with any email.
- If I do not sign this authorization, IPC will not disclose my health information as requested.
- This authorization will end only when the use and disclosure of my information is no longer needed for the purposes agreed to above. I may revoke this authorization by mailing or faxing a written request along with a copy of the original authorization to the clinic.

Patient Signature: _____Date: _____

Witness: _____Date: _____

☐ I do not consent – ***If you do not consent to additional information, then we will only communicate with you about your personal medical information via phone, fax, or email***

Medical Records Request

Patient Name:	*Date of Birth:*
Patient's Address:	*Telephone Number:*
Last 4 digits of SS#: _____	

Please "Print" and complete all sections to insure your request is processed in a timely manner

FAX RECORDS TO: Interventional Pain Consultants (IPC)

PURPOSE OF DISCLOSURE: Continuity of Care

I authorize _____to release or disclose to the above-named entity all of my medical records, including any specially protected records, such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle-cell anemia, or HIV infection for the purpose of medical treatment. If you Do Not Want certain portions of your medical records released, please read this section carefully and identify the information you do not want released below:

Please check all that apply: ☐ Past Dates of Service ☐ Present Dates of Service ☐ Future Dates of Service

* I understand that I may revoke the Authorization at any time prior to the expiration date or event, but that my revocation will not have any effect on actions taken by Internvetional Pain Consultants or its physicians, employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to Interventional Pain Consultants.
* I understand that I am not required to sign this Authorization. Interventional Pain Consultants will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this Authorization.
* I understand that my records may be subject to disclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that this Authorization does not limit Interventional Pain Consultants or its physicians', employees' or agents' ability to use or disclose my information for treatment, payment, or health care operations, or as otherwise permitted by law.
* I authorize IPC to request records pertinent to my treatment from providers and other healthcare entities, as needed, within the time this authorization is valid. This Authorization will expire a year from date of signature.

Patient or Authorized Representative's Signature: _____ Date:_____

Relationship to the patient (If not signed by patient):_____

Power of Attorney Provided?_____ Photo ID verified: _____ Scanned by (initials):_____

Specific Records Needed (to be completed by the provider/nurse):

- ☐ MRI of _____
- ☐ Operative Report_____
- ☐ CT of _____
- ☐ Xray of _____
- ☐ Other_____
- ☐ Discharge Letter
- ☐ Recent Progress Notes

Interventional Pain Consultants

Patient Name:	*Date of Birth:*

Financial Policy

Our office can no longer accept cash from self-pay patients per State guidelines

We are pleased that you have chosen our practice for your pain management needs. We are committed to providing you with the highest quality care and achieving desired outcomes through collaborative effort. We would like to take this opportunity to thank you for allowing us to take care of you. In keeping with our philosophy of open communication and education, it is important that you understand the financial policies of the practice. It is equally important that you understand the terms of YOUR medical coverage. Although our staff is very knowledgeable of most insurance plans, it is important that you understand the details and terms of your personal plan. Typically, you will find the insurance company's phone number on the back of your insurance card and we encourage you to contact them with questions specific to YOUR coverage.

If you have Medical Insurance Benefits:

- If you have an insurance plan that requires a referral, you must contact your Primary Care Physician PRIOR to receiving care from a specialty provider. Regretfully, many insurers will not cover specialty services that are rendered without a referral and you may be held responsible for the costs. If we do not have a referral on file, we will not be able to render services.
- We participate in most major health plans and our business office will submit claims for services rendered. It is the patient's responsibility to provide all necessary information to file the claims prior to leaving our office. We will file your primary and secondary insurance claims and work diligently with the carrier to resolve any conflicts that may arise. However, your insurance company may need you to supply certain information directly. It is your responsibility to comply with this request.
- Please bring your insurance cards to **EACH** and **EVERY** visit to our office.
- Your insurance company **REQUIRES** us to collect co-payments at the time services are rendered. Failure to collect or waiver of your co-payment may constitute fraud under state and federal law. Please be prepared to pay your co-payment on the date services are rendered as this is a requirement per your insurance carrier. If you do not have your co-payment, we are not required to see you.
- Additionally, you may have coinsurance and/or deductible amounts required by your insurance carrier. Any outstanding balance on your account following insurance processing will be billed to you.
- It is the policy of the practice to treat **ALL** patients in an equitable fashion related to account balances. The practice will **NOT** waive or fail to collect any co-payments, co-insurance, deductibles, or other patient financial responsibility in accordance with state and federal law as well as participating agreements with payers. Full or partial financial responsibility may only be waived in accordance with the practice's Financial Hardship Policy.
- Your insurance carrier may also pay you directly, if your clinic is out of network, as a patient, you are responsible for bringing in the payment and the Explanation of Benefit (EOB) from your insurance company.

Patient Balances:

- Any patient balances that remain delinquent after 90 days, with no response to requests, payment, may be referred to a collection agency. You will be responsible for any and all costs associated with the collection agency up to and including all legal costs.
- Patients with account balances in excess of 120 days with no payment arrangements or hardship request may be discharged from the practice. If this occurs, you will have 30 days to seek alternative medical care. During the 30-day period our physicians will only be able to treat you on an emergency basis.
- For your convenience, our office accepts the following payment methods:
  Money order --- Check --- Cashier'sCheck —- Cash --- Credit Card
  (Except self—pay patients: Cashier's Check, Check or credit card only can be accepted for payment per state regulations)
- Returned checks will be charged a $40.00 fee.

PLEASE READ THE FINANCIAL POLICY CAREFULLY BEFORE SIGNING

I, the undersigned, understand the financial policies of Interventional Pain Consultants, and agree to abide by the plan I have signed. In addition, I understand and agree to the following.

- To pay the amount charged by Interventional Pain Consultants for all professional treatment and services to the undersigned.
- I understand that I am financially responsible for any and all charges whether or not they are covered by insurance. In the event that I do not pay all costs of collection and reasonable legal fees in addition to the amount originally owed.

If genuine financial difficulties exist, please call our office. We are happy to work with you in resolving your balance and may be able to set up payment arrangements.

_____

(Signature of Patient, or Personal Representative) Date

_____

Relationship to Patient if not signed by Patient ID Verified by Date

Interventional Pain Consultants

Patient Name:	*Date of Birth:*

Treatment Agreement

This agreement must be reviewed and signed in order to proceed with narcotic and/or non-narcotic treatment with Interventional Pain Consultants. The agreement is required to comply with the law regarding controlled pharmaceuticals and to prevent any misunderstandings about any treatments you receive.

Please initial at the bottom of this page and sign page 2 to indicate that you have read and/or have had the information explained to you.

- I agree to submit to a blood, urine or saliva test, if requested by my Provider, to determine compliance with my program of pain medication.
- I understand that my first office visit may be a consultation only and no pain medication given at that time if further investigation and/or testing are deemed necessary.
- I understand that I may be called at any time to bring all prescribed medication for a mandatory pill count within a specified time period (usually 24 hours).
- I understand that I am to bring my medications prescribed by IPC in their original bottles to **EVERY** appointment. I am to bring the bottle even if it is empty.
- I agree that I will use my medications **ONLY** as prescribed by my doctor. I understand that any change to my prescriptions will require an office visit. I understand that self-medicating is not tolerated. No refills will be made during evenings or weekends.
- I will not use any illegal substances, including marijuana, cocaine, etc.
- I understand that lost or stolen medication or unfilled prescriptions **WILL NOT** be replaced, and I will safeguard my medication from theft.
- **I understand that I will follow the guidelines on properly disposing of controlled substances that will be explained to me by clinical staff.**
- I will not share, sell or trade my medications with anyone.
- I will not alter the form of the medication nor will I take the medication in a route other than as prescribed by my provider.
- I will not attempt to obtain controlled medication from any other provider, nor will I borrow or buy medication from any other person.
- In the event of an emergency, if I do obtain controlled substances from another provider, I understand I am required to disclose this information to IPC within 48 hours of discharge or emergency service. I understand it is my responsibility to make sure IPC is notified of any such treatments and that I am to check with IPC before combining any pain medication with the prescriptions IPC provides me.
- I will notify IPC of any change in name, address or phone number. I understand that I must at all times have an updated phone number with my provider. I cannot be on dangerous medications, such as opioids, if my provider cannot reach me in a reasonable period of time (usually considered within 24 hours of the initial attempt). I agree to return any phone call from IPC within 24 business hours.
- I authorize my provider to investigate fully any possible misuse of my pain medication using any city, state or federal law enforcement agency, including this state's Board of Pharmacy.
- I understand that any follow-up appointment may be scheduled with a Licensed Nurse Practitioner or Physician Assistant. Additionally I understand that refusing to see one of IPC providers will likely result in my no longer being able to be treated by the practice.
- Once a prescription has been filled, all questions regarding that prescription should be directed to that pharmacy.
- I understand that IPC does not mail narcotic prescriptions under any circumstances.

Initials_____

Patient Name:	*Date of Birth:*

Treatment Agreement (continued)

- I understand that with any controlled substance that is prescribed to me there are inherent risks, namely
    - loss of efficacy over time, symptoms of withdrawal if abruptly stopped, and addiction;
    - medication taken in excess (this is different for everyone – ranging from the prescribed dose to taking more than prescribed or combining with other controlled substances or even alcohol) may result in respiratory suppression or failure or death;
    - sedation, loss of function, impairment may also occur – I agree not to drive while under the influence of any prescribed controlled substance;
    - constipation, allergic reaction, itching, nausea and dry mouth are also common side effects;
    - my immune system may be suppressed and my hormone levels may decrease over time while being on chronic opioids.
- I understand that the combination of controlled substances and alcohol are contra-indicated; the combination may result in serious harm or even death.
- I understand that non-professional or inappropriate behavior toward any IPC staff, affiliate or provider will not be tolerated. I agree to be respectful to other patients I may encounter in the waiting room, lobby, hallways, etc. I understand that I may not loiter in the parking lot of any IPC location.
- I understand that there may be a medication prescribed or administered to me that is a "compounded" medication – these are compounded by specialty pharmacies and are regulated differently than typical medications found stocked on shelves at commercial pharmacies. If I have questions regarding any of these, IPC is able to provide pharmacy information upon request.
- I understand that IPC providers utilize tests to determine the best option for my care. My unwillingness to complete the tests requested may result in being released from further care with IPC.
- I understand that non-compliance with my pain management treatment plan may result in providers' inability to properly treat my symptoms and could cause symptoms to worsen or become life threatening.
- I understand that I may be released from IPC for missing appointments or cancelling/rescheduling appointments with less than 24 hour notice.
- IPC does not consent to the recording including video or audio of patient visits. If you believe your situation merits additional consideration, please contact management.

I agree that the goals of pain management have been explained to me as to what is considered appropriate and reasonable and that alternative treatment plans, outside of use of controlled pain medications, have been made available to me. I have agreed to proceed with pain management after a full explanation of the risks and benefits. I understand if I break this agreement, it will result in a change in my treatment plan, including safe discontinuation of my opioid medications when applicable or complete termination of the provider/patient relationship.

I understand that I am only to use the pharmacy listed below for all my medication needs with IPC or any other provider and that information will be shared between IPC and my pharmacy to process the prescription:

Pharmacy Name:	*Phone Number:*
Pharmacy Location:	

I have read and/or this information has been explained to me and I understand the terms of this agreement:

Signature of Patient or Legal Representative: _____ Date: _____

Relationship to patient if not signed by patient: _____ Date: _____

Electronic Medical Records Consent

I, _____, authorize Interventional Pain Consultants to send and receive electronic medical records through their EMR system to other practices that might be pertinent to my treatment. This information is only shared with hospitals/clinics with participating EMR systems. I understand that by giving consent to share my electronic medical records, I allow IPC to send and receive records to outside healthcare entities that is related to my treatment. This consent remains valid until the below patient states otherwise.

_____ _____

Patient Signature Date of Birth Date

_____

Employee Initials

O I do not consent.

DATE _____

Opioid Risk Tool

PATIENT NAME _____ DATE OF BIRTH _____

Directions: Please answer these questions by circling the number in the categories that are a "Yes" for you personally. If you are a female, circle the numbers in the female column. If you are a male, circle numbers in the male column.

Mark each box that applies	Female	Male
Does anyone in your family have a history of substance abuse with the following items?		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Do you have a personal history of substance abuse for the following items?		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Are you between the ages of 16-45 years?	1	1
Do you have a history of preadolescent sexual abuse?	3	0
Do you have the following psychological diseases?		
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