Patient Registration

PLEASE SELECT THE FOLLOWING TYPE OF COVERAGE:
☐ WORK-COMP ☐ PERSONAL INJURY ☐ AUTO ☐ INSURANCE

Patient Information

NAME:	SOCIAL SECURITY NUMBER:	DATE OF BIRTH	SEX □ M □ F
ADDRESS UNIT #	CITY, STATE, ZIP CODE		
MARITAL STATUS □ SINGLE □ WIDOWED □ MARRIED □ DIVORCED	CELL PHONE # ( )	EMAIL	
EMPLOYER + ADDRESS:	CURRENT WORK STATUS: □ FULL-TIME □ PART-TIME □ DISABLED □ RETIRED		

PRIMARY CARE DR.	**PHONE #** ( )	**FAX #** ( )	**REFERRING DR.**	**PHONE #** ( )	**FAX #** ( )

Emergency Contact Information

NAME + RELATIONSHIP	PHONE # ( )

Insurance information

□ PPO □ HMO
REFERRAL #: _____

PRIMARY INSURANCE COMPANY NAME

MEMBER POLICY #	GROUP #	RELATIONSHIP TO PATIENT □ SPOUSE □ SELF □ PARENT □ OTHER

SECONDARY INSURANCE COMPANY NAME

MEMBER POLICY #	GROUP #	RELATIONSHIP TO PATIENT □ SPOUSE □ SELF □ PARENT □ OTHER

Authorization for Release of Information

I authorize Advanced Pain Consultants, S.C. / Center for Interventional Pain Management, LLC to release to my insurance carrier or its designated agents any information concerning medical care (physical and/or psychological), advice, treatment or supplies provided to me for the purposes of administration, review, investigation or evaluation of claim coverage and utilization of services. I authorize a copy of this information to be as valid as the original. I will notify Advanced Pain Consultants, S.C. in writing of any information I do not want released. I authorize Advanced Pain Consultants, S.C. / Center for Interventional Pain Management, LLC to release to my insurance carrier or its designated agents any information concerning medical care (physical and/or psychological), advice, treatment or supplies provided to me for the purposes of administration, review, investigation or evaluation of claim coverage and utilization of services. I authorize a copy of this information to be as valid as the original. I will notify Advanced Pain Consultants, S.C. in writing of any information I do not want released. We share medical records electronically with other health care providers to allow and promote continuity of care among providers. If you visit another who also participates in an electronic medical record system, they may have access to your medical record. If you do not want your medical records shared with other providers, please request, and complete a Medical Record Opt-Out form.

Assignment of Benefits

I authorize the assignment of benefits payable to Advanced Pain Consultants/Center for Interventional Pain Management, for physician services and supplies, by government and/or any other third party. I understand that I will be held responsible for payment of all co-payments, co-insurance, deductibles, and non-covered services. If the account or any portion thereof is sent to collections, in addition to the amount owed, I will be responsible for the collection's fees. In the event any lawsuit of action is brought to collect this account or any portion thereof, and I (patient/guarantor) am legally found at fault, I will be responsible for all costs, not limited to attorney's fees, court costs, collection fees, interest, and any additional cost that this action may incur.

Authorization for Treatment

I voluntarily present myself for medical care and consent to such medical care and treatment. I am aware that medicine and surgery are not exact sciences and understand that no guarantee has been or will be made about the results of the services I will receive. This includes the results of any diagnosis, treatment, surgery, te or exam. I am aware that I will be asked to sign another consent for any procedures performed by the physician and/or nurse practitioner. I am aware that I can refu treatment. I agree to give any information asked of me to the best of my knowledge. That includes financial, family, and medical history information. I also agree that the information I have already given is true, correct, and complete.

Electronic Prescriptions

I authorize use of e-prescribing for prescriptions, which allows health care providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medication dispensing history if a physician/patient relationship exists.

Notice of Privacy Practices: *I have read and understand the Notice of Privacy Practices.*

PATIENT SIGNATURE: **DATE:**

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HEALTH HISTORY FORM

Name: Date:

What treatment have you already received for your condition:
☐Medications ☐Surgery ☐Physical Therapy ☐Other_____

List ALL treating providers + phone number:

1._____ ( ) - **3.** _____ ( ) -
2._____ ( ) - **4.** _____ ( ) -

List ALL recent diagnostic images: *Month/year @ facility – Type of test.*
_____/_____ @ _____ Type: _____
_____/_____ @ _____ Type: _____
_____/_____ @ _____ Type: _____

List ALL medical conditions: *Year - Condition*

_____- _____
_____- _____
_____- _____
_____- _____
_____- _____
_____- _____

ALLERGIES:

- _____
- _____
- _____
- _____

☐ NKDA

List ALL surgery/procedure dates and descriptions: *Month/year- procedure.*
_____/_____ Type: _____ _____/_____ Type: _____
_____/_____ Type: _____ _____/_____ Type: _____
_____/_____ Type: _____ _____/_____ Type: _____

CURRENT MEDICATIONS:	**DATE:**	**DIRECTIONS:**
• _____	_____/____	_____
• _____	_____/_____	_____
• _____	_____/_____	_____
• _____	_____/_____	_____
• _____	____/_____	_____
• _____	____/_____	_____
• _____	____/_____	_____

☐ MEDICATION LIST WAS PROVIDED BY PATIENT WITH ACCURATE INFORMATION

Family Medical History: *Fill diagnosis box with an "x"*

Relative	Alive/Deceased/Unknown	Age	Diabetes	Cancer	Stroke	Hypertension	Mental Illness	Heart Disease
Father								
Mother								
Siblings								

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Name: _____

New Patient Health History

1. Brief description of primary complaint:

_____

_____

_____

2. Pain *(please "X" as many choices as needed)*

I. Event: ☐Auto Accident ☐Work Related ☐Fall ☐Following Surgery
Onset: ☐Just Started ☐Trauma

II. Frequency: ☐Intermittent ☐Constant

III. Severity: ☐Mild ☐Moderate ☐Severe

IV. Change of pain since onset: ☐Better ☐Worse ☐Same

V. Ability to cope with pain: ☐Better ☐Worse ☐Same

VI. Total time of pain experience: (___) Years (___) Months

VII. What ***increases*** your pain: ☐Activity ☐Bending ☐Walking ☐Sitting ☐Laying down ☐Standing ☐Working ☐Driving ☐Lifting ☐Moving wrong ☐Change in weather

VIII. What ***decreases*** your pain: ☐Medication ☐Heat ☐Ice ☐Bed rest ☐Sitting ☐Standing ☐Changing positions ☐TENS unit

IX. What is ***affected*** by your pain: ☐Appetite ☐Concentration ☐Social interaction ☐Emotions ☐Walking ☐Mood ☐Housework ☐Work duties

X. Ambulation Aids: ☐Cane ☐Walker ☐Crutches ☐Wheelchair ☐Scooter

XI. Sleeping Habits: ☐Difficulty falling asleep ☐Waking up (__) during night ☐Daytime drowsiness

3. Frequency of:

Alcohol: ☐Rare ☐Weekly ☐Daily (___) Drinks/Week Illicit drugs: ☐Yes ☐No

Smoking: ☐Yes (___) Packs/Day ☐No Possible pregnancy: ☐Yes ☐No

4. Mankoski Pain Score: (please "x" your CURRENT pain)

☐ 0 - Pain free
☐ 1 - Very minor annoyance - occasional minor twinges.
☐ 2 - Minor annoyance - occasional strong twinges.
☐ 3 - Annoying enough to be distracting.
☐ 4 - Can be ignored if you are really involved in your work, but still distracting.
☐ 5 - Can't be ignored for more than 30 minutes.
☐ 6 - Can't be ignored for any length of time, but you can still go to work and participate in social activities.
☐ 7 - Makes it difficult to concentrate, interferes with sleep. You can still function with effort.
☐ 8 - Physical activity severely limited. Nausea and dizziness set in as factors of pain.
☐ 9 - Unable to speak. Crying out or moaning uncontrollably - near delirium.
☐ 10 - Unconscious. Pain makes you pass out.

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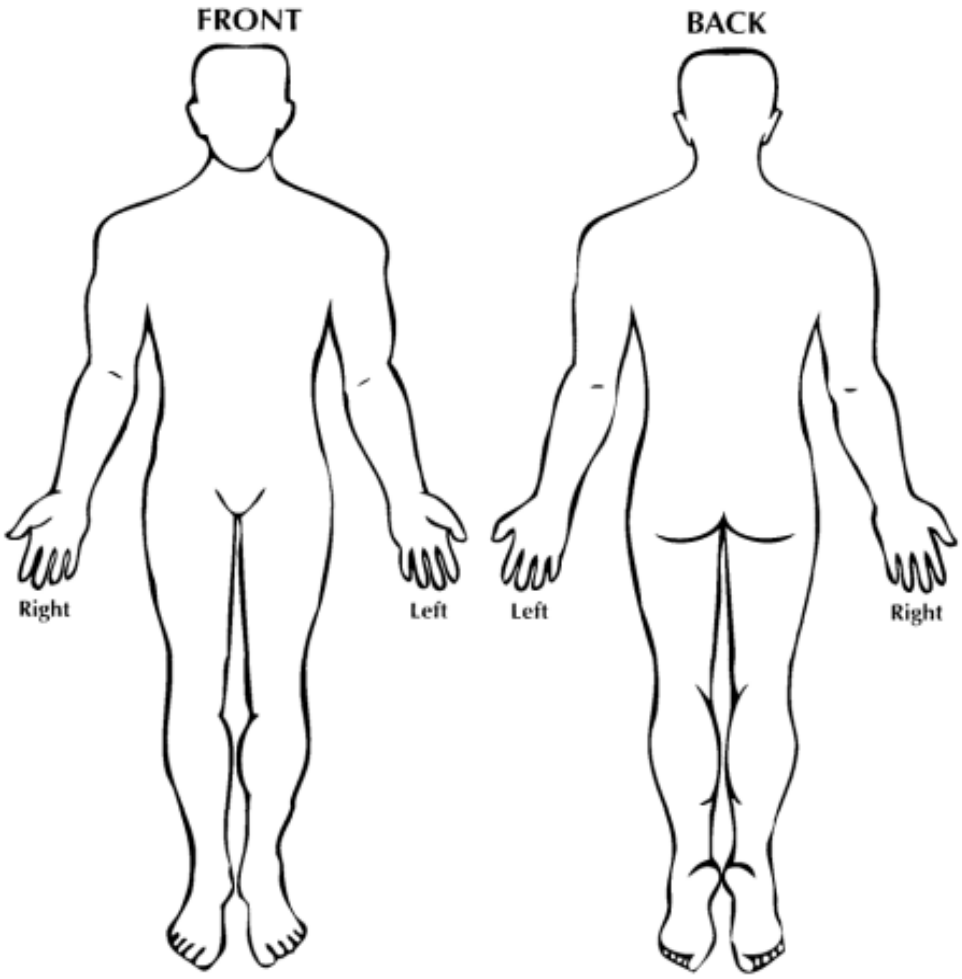
□WC	□PI	□AUTO	□INSURANCE

DATE:_____ /_____ /_____ **NAME:**

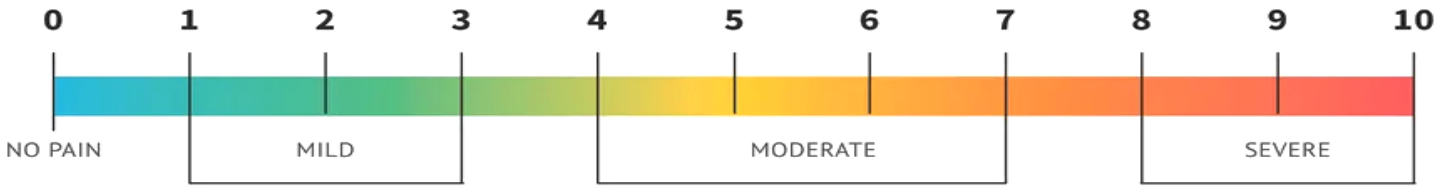
DOB:_____ /_____ /_____



SYMBOLS:

Numbness:	**========**
Pins & Needles:	**0000000000**
Burning:	**XXXXXXXX**
Stabbing:	**/////////**
Aching:	**(((((((**

Please indicate with an "X" the level of pain you are experiencing right now:



ADVANCED PAIN CONSULTANTS sc

2024 Credit Card Authorization Form

MANDATORY: Patients being seen at any of our offices are now REQUIRED to place a credit card on file in our safe and secure electronic system and provide authorization for credit card payments. Maintaining a card on file allows our office to automatically process your copay at the time of service, your coinsurance, and/or deductible that your insurance states are patient responsibility once insurance has processed the claim. Services may not be rendered without a valid credit card on file. Patients WILL NOT be permitted to maintain a balance beyond **60 DAYS** of the statement date unless a detailed payment plan with automatic payments is on file.

Credit/Debit Card Information
Card Type: ___ Mastercard ____ Visa ____ Discover ____Am Ex
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date: _____/_____ CVV (security code on back of card): _____
Cardholder Zip code (for credit card billing address) _____

NOTE: THE CREDIT/DEBIT CARD ON FILE MUST BE PRESENTED AND VERIFIED

I **authorize** Advanced Pain Consultants, SC to maintain my credit card on file and to charge my credit card for all amounts owed to the practice for medical visits, procedures, or supplies, including amounts agreed as part of a payment plan, copayments, coinsurance, and/or deductible, for amounts not covered by insurance, and fees charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation. My credit card will be automatically charged for outstanding patient balances remaining on my account 30 days after a patient statement is generated. The patient statement will be sent electronically via patient portal with notification of statement availability sent to my email and or cell phone; a hard copy statement will be mailed if payment is not received upon receipt of electronic statement. I understand that my credit card information will be stored safely and security in an encrypted electronic medical record system for future transactions. This authorization will remain in effect until the patient balance on the account is satisfied. I may cancel this authorization at any time by submitting a request to cancel in writing, however I understand that the office may decline to provide services without an authorized card on file and will take all necessary actions to collect amounts due including use of a collection agency or legal action.

Signature: _____ Date: _____

PAIN MANAGEMENT AGREEMENT

The use of controlled substances to treat pain conditions is a serious consideration. It is necessary for both you and your physician to comply with applicable state and federal laws regarding the use and prescribing of controlled substances. In order to receive a prescription for controlled substances from this practice, you must adhere to the conditions listed below.

1. **I understand that I have the following responsibilities:**
    a. I will inform my physician of all medications that I'm taking.
    b. I will take medications only at the dose and frequency prescribed and will not take any medications prescribed for other people. I will not increase, stop, or change medications without the approval of my physician. If I take more medication than what is prescribed, a dangerous situation could result, such as organ damage, or even death. I understand that if I run out of my medication too soon, or if my medication is stopped suddenly, I could have narcotic withdrawal symptoms which can be very uncomfortable or dangerous.
    c. I will actively participate in return-to-work efforts and in any program designed to improve function including exercise, use of non-narcotic analgesics, physical therapy, psychological counseling, or other therapies or treatment.
    d. I will not request opioids or any other pain medicine from other physicians.
    e. I will not be involved in the sale, illegal possession, or diversion of controlled substances. I will not use illegal substances, street drugs, or abuse alcohol while taking controlled substance medications.
    f. I will obtain all medications from one pharmacy, when possible, with full consent for an APC physician to talk with the pharmacist.
    g. I am personally responsible for securing my medications. I acknowledge that Advanced Pain Consultants recommends securing my medications in a lockbox or safe, removing only one day of medications at a time.
    h. I agree to travel only with enough medications for the duration of my trip keeping them in an appropriately labeled prescription bottle.
    i. If my medications are lost or stolen, I understand that the physician may replace the missing medications, one time only, if a copy of the police report of the theft is submitted to the office.
    j. I consent to have my prescription history reviewed, including Illinois and other states prescription monitoring programs.
    k. I understand the possible complications of chronic narcotic therapy include chemical dependence (addiction), constipation severe enough to require medical treatment, difficulty with urination, drowsiness, nausea, itching, slowed respiration, and reduced sexual function.
    l. I certify that I am not pregnant and will notify my physician if I become pregnant. I recognize that being pregnant, there are risks to the unborn child which include narcotic addiction and the possibility of the baby experiencing narcotic withdrawal at birth.
    m. In the event of an emergency, I agree to request the emergency room or other treating physician contact my doctor to discuss any pain or opiate related issues; no more than three days of medications may be prescribed by the emergency room or other physician without this doctor's approval; contact the practice within 24 hours if an unavoidable emergency occurs requiring a prescription for controlled substances, ER visit, or hospital admission; sign a consent to request record transfer to this doctor.
2. I consent to random drug testing and pill counts at the discretion of my doctor. I understand that the drug test is a two-step process, with the initial drug screen completed in the office, and a second more conclusive test performed by an outside laboratory. This two-step process allows my doctor to prescribe medications at the time of my appointment.
3. I will keep my scheduled appointments and/or cancel my appointment a minimum of 24 hours prior to the appointment.
4. Understand that the benefits of narcotic medications will be evaluated regularly using criteria for pain relief including but not limited to increased functionality, increased general function, improvement in pain levels, feedback from family and friends, absence of side effects, and if possible, return to work.
5. I understand that this doctor may stop prescribing opioids, or change the treatment plan if:
    a. I do not show any improvement in pain from opioids or my physical activity has not improved.
    b. My behavior is inconsistent with the responsibilities outlined in this agreement.
    c. I give, sell, or misuse the opioid medications.
    d. I develop rapid tolerance from the treatment.
    e. I obtain opiates from anyone other than this doctor.
    f. I refuse to cooperate when asked to submit to a drug screen.
    g. If an addiction problem is identified as a result of prescribed treatment or any other addictive substance.
    h. If I repeatedly miss appointments, procedures or other treatments.
6. I will under no circumstances hold Advanced Pain Consultants nor its physicians liable for any sequelae of discontinuance of controlled substances provided 30-day notice of termination is given.
7. **I have read this agreement, understand it, and have had any questions answered satisfactorily. I agree to comply with the terms of this agreement.** I understand that if I do not comply, I may not receive further prescriptions for controlled substances, my doctor will taper off the medication, and a drug dependence treatment program may be recommended. I have received a copy of this agreement.

_____ _____ _____

Patient Printed Name **Patient Signature** **Date**

ADVANCED PAIN CONSULTANTS, S.C.

Patient Name: _____ **DOB:** _____

VERBAL RELEASE OF INFORMATION

Advanced Pain Consultants uses voice and text messages to send appointment reminders and other notifications from our office. Our system defaults to sending text messages: It has proven to be the most effective method in relaying valuable and time sensitive information. By signing below and providing your cellular phone number in the patient demographics you consent to receiving voice and text messages.

Initials: _____

**Answering machines and voice mail must have an identifying message to confirm these are your numbers.*
For example: "You have reached John Doe"

CONSENT FOR PERSONS WITH WHOM WE MAY SHARE VERBAL INFORMATION

Please list any persons with whom we MAY share details about your health care. Indicate below whether this may include **sensitive health information (SHI)** such as mental health, developmental disabilities, AIDS/HIV or other STD treatment and/or diagnosis, Drug/Alcohol abuse diagnostics, treatment and /or referral and Genetic Testing.

NAME	PHONE NUMBER	RELATIONSHIP	RELEASE SHI?
			Yes No
			Yes No

I understand that I have the right to revoke this authorization at any time by sending a written notification. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by state or federal law. I understand I have the right to inspect or copy the protected health information to be used or disclosed as described in this document, and that I may do this by written notification. ***I understand my treatment will not be conditioned on signing this authorization. I understand that I have the right to refuse to sign this authorization.***

Signature _____ **Date** _____

PATIENT PORTAL CONSENT

I understand that Advanced Pain Consultants offers a patient portal to allow an easy and convenient way for our team and the patient to share information. In providing my email on the demographics form, I understand my patient portal will be activated. I will receive an email notifying me when access is available with my login credentials. The Patient Portal is intended as a secure online source of confidential medical information. The Patient Portal allows me to view my patient chart, statements, and payment methods etc. If I share my username and password with another person, that person may be able to view my health information. It is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way. I understand that my activities on the portal may be tracked by a computer audit and that entries I make will become part of my medical record. I understand that the portal is not to be used for medical emergencies. All portal communication is sent to the clinical staff, not directly to the provider. Portal messages will be reviewed and responded to in a timely manner by our team. Access to the Patient Portal is provided as a convenience to patients and Advanced Pain Consultants (APC). APC has the right to deactivate access at any time for any reason. I understand that use of the Patient Portal is voluntary, and I am not required to use Advanced Pain Consultants, S.C. Patient Portal. By signing below, I acknowledge that I have read and understand the Patient Portal Consent Form and agree to its Terms conditions.

Signature _____ **Date** _____

ADVANCED PAIN CONSULTANTS SC

Point of Care Urine Drug Testing & Laboratory Confirmation Testing

Patient safety is our priority. Identifying the cause of your pain and providing an effective treatment plan is our purpose. Helping patients to control patients pain often requires use of medications, and sometimes chronic pain medications (narcotics). It is our responsibility in prescribing these medications to ensure your safety. We do this by verifying the medications you are prescribed from all providers, reviewing potential for drug interactions, managing levels all medications and ensuring they are within acceptable guidelines, and testing for consistency through urine drug testing,

Our office utilizes a contracted laboratory service, **National Labs**, to process definitive urine drug testing. This is in addition to the immediate point of care urine drug-screen performed by the office at the time of your visit.

The point of care urine drug screen provides instant results for our office to determine minimum levels of consistency for us to prescribe your medications at the time of service instead of having you wait for definitive results from the lab. This is an inexpensive test, typically covered by insurance.

Definitive Testing performed by an outside lab – your urine is then sent to an outside lab to perform testing that details the specific medications and concentrations that are in the urine.

National Labs will process all bills through your insurance. You may receive a bill from National Labs with the portion not covered by your insurance, amounts falling under your deductible or co-insurance. Since National Labs is a separate company from Advanced Pain Consultants, we are not able to see these bills or resolve any of your billing questions. We can only facilitate discussions between you and the lab. All billing questions must be addressed directly to National Labs.

If your insurance has better coverage with a specific lab, we will work with you to send the urine to your lab or you may go to your lab for testing. You must go to your lab within 48 hours of our request for testing, and we will not be able to prescribe medications until we receive receiving test results from your lab.

Attestation: I understand that I will be required to provide urine samples that will be sent to National Labs. I may not receive prescription medications unless a drug test is performed upon request. I further understand that I am responsible for the bills associated with the laboratory testing from this outside lab and will discuss any questions or concerns with the laboratory. Any requests for special laboratory considerations must be based on insurance requirements and must be made in writing.

_____ _____

Patient Signature Date

ADVANCED PAIN CONSULTANTS sc

2024 Procedure and IV Sedation Policy

Medicare and many other insurance carriers are now considering IV Sedation a luxury during pain procedures and will not cover charges related to sedation. APC does not require IV sedation to perform these procedures; however, many patients feel having sedation relieves their anxiety, makes the procedure more tolerable, and helps the patient to minimize movement during the procedure.

Many insurance plans are denying authorization, and denying payment for IV Sedation, therefore APC will provide sedation at the patient's request, for a fee of $85. This applies to patients under all insurances. This fee is payable at the time of service. For insurance carriers that have not yet explicitly stated they will not cover IV sedation, we will attempt to bill for this service and if payment is received from insurance, we will apply your payment to any outstanding balance on your account or will provide a refund.

Keep in mind, we make every effort to work with your insurance to get 100% of charges covered. Your specific insurance plan and their medical policies dictate what will be authorized and paid for. If your insurance does not cover all or part of your procedure, IV sedation, or office visits before or after the procedure, these charges will become patient responsibility.

I have read and understood the IV sedation and procedure policy.

_____

Patient printed name

_____

Patient Signature

_____

Date

ADVANCED PAIN CONSULTANTS SC

PATIENT FINANCIAL AGREEMENT

As a patient of Advanced Pain Consultants, you must agree to:

1. Present your current/active **insurance card** at each visit. If our office is unable to verify active insurance at the time of your visit, or our office does not participate in your insurance plan, a self-pay fee of $150 will be due at the time of service. Notify our office immediately regarding any **changes to your health insurance.** Notify our office immediately regarding any **changes to your health insurance.**
2. Understand your insurance plan. Patients will be responsible for contacting your insurance and verifying that our provider is in your specific plan, that your benefits cover the services being provided at our offices, and that your insurance will authorize and pay for care provided by our physicians. Before your appointments, patients in HMO insurance plans MUST provide a written referral from your primary care physician specifying referral to our offices. You must also contact your insurance to obtain authorization to receive treatment outside of your specific HMO medical group and verify that your treatment will be paid by the insurance carrier. Our office will also verify your benefits and eligibility; however, your insurance is your selected plan, and we expect you to participate in getting your bills paid timely.
3. Notify our office of cancellations at least 24 hours prior to your office visit and 72 hours prior to your scheduled procedure. **No show, late cancellation, and late arrival fees of more than 15 minutes:** office visits $50, procedures $150.
4. Respond promptly to **information requested** from your insurance carrier, including coordination of benefit forms. Failure to respond to the insurance carrier within 30 days will result in non-payment and the balance will be dropped to the patient.
5. Payment of your copay is due at each appointment **PRIOR** to seeing the physician. Payment of your copay, deductible and coinsurances are required by your insurance plan. If you do not pay your copay at the time of service, you will be asked to reschedule your appointment. A late reschedule fee of $50 will apply.
6. Payment of your **deductible and coinsurance** are due upon receipt of your billing statement and on or before your next office visit. Our staff will request payment on unpaid balances at each office visit. Accounts with an outstanding balance must be paid in full prior to scheduling your next appointment or have a written payment plan with a credit or debit card on file for auto payment of the agreed upon amount. All balances not paid within 30 days of receipt of statement, may be charged to the credit card on file and/or may incur a **finance charge** of 1.5 percent per month.
7. Failure to make a **payment on the account balance** for two consecutive billing cycles or 60 days will cause the account to be referred to a collection agency and may result in discharge from the practice. If the account or any portion thereof is sent to collections, in addition to the amount owed, you will be responsible for the collection's fees. In the event any lawsuit is brought to collect this account or any portion thereof, and I (patient/guarantor) am legally found at fault, you will be responsible for all costs, not limited to attorney's fees, court costs, collection fees, interest, and any additional cost that this action may incur.
8. **Direct Insurance Payments**: Any payments sent directly to the patient are the property of the Provider. The patient agrees to immediately forward to Provider all payments, explanation of benefits and correspondence sent directly to the patient from all insurance carriers related to the care rendered by the Provider. Failure to do so will make the patient responsible for the entire billed charge.
9. **Patient Payment Guarantee:** Patient agrees to cooperate fully and to contact your insurance prior to office visits and procedures to validate coverage and to assist our office and billing service in your efforts to get claims paid. Please be sure that you are familiar with your insurance benefits and the coverage provided by your insurance plan. Call your insurance if you have questions regarding your benefits, coverage, deductibles, copays, or coinsurance. Our office will assist you in obtaining payment, however, the patient and/or guardian agrees to pay all charges not covered by your insurance carrier.
10. **Assignment and Release:** I authorize payment to be made directly to Advanced Pain Consultants, S.C., and fully understand that I am the responsible party for all charges incurred by me or my dependents at this facility. I also authorize the release of all information required to insurance carriers, WC, etc. to collect and process my claims.

I have read and understood each of the financial and office policies outlined above.

Patient Signature _____ Date _____

ADVANCED PAIN CONSULTANTS sc

GENERAL CONSENT FOR TREATMENT

Consent for Treatment: I voluntarily present myself for medical care and consent to such medical care and treatment. I am aware that medicine and surgery are not exact sciences and understand that no guarantee has been or will be made about the results of the services I will receive. This includes the results of any diagnosis, treatment, surgery, test or exam.

I am aware that I will be asked to sign another consent for any procedures performed by the physician and/or nurse practitioner. I am aware that I can refuse treatment.

I agree to give any information asked of me to the best of my knowledge. That includes financial, family, and medical history information. I also agree that the information I have already given is true, correct, and complete.

Electronic Medical Records: We share medical records electronically with other health care providers to allow and promote continuity of care among providers. If you visit another who also participates in an electronic medical record system, they may have access to your medical record. If you do not want your medical records shared with other providers, please request, and complete a Medical Record Opt-Out form.

Electronic Prescriptions: I authorize use of e-prescribing for prescriptions, which allows health care providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medication dispensing history as long as a physician/patient relationship exists.

Authorization For Release of Information: I authorize Advanced Pain Consultants, S.C. / Center for Interventional Pain Management, LLC to release to my insurance carrier or its designated agents any information concerning medical care (physical and/or psychological), advice, treatment or supplies provided to me for the purposes of administration, review, investigation or evaluation of claim coverage and utilization of services. I authorize that a copy of this information to be as valid as the original. I will notify Advanced Pain Consultants, S.C. in writing of any information I do not want released.

Assignment of Benefits: I authorize the assignment of benefits payable to Advanced Pain Consultants/Center for Interventional Pain Management, for physician services and supplies, by government and/or any other third party. I understand that I will be held responsible for payment of all co-payments, co-insurance, deductibles, and non-covered services. If the account or any portion thereof is sent to collections, in addition to the amount owed, I will be responsible for the collection's fees. In the event any lawsuit of action is brought to collect this account or any portion thereof, and I (patient/guarantor) am legally found at fault, I will be responsible for all costs, not limited to attorney's fees, court costs, collection fees, interest, and any additional cost that this action may incur.

Notice of Privacy Practices: I have read and understand the Notice of Privacy Practices.

Patient Signature _____ Date _____

ADVANCED PAIN CONSULTANTS SC

☐2100 Clearwater Dr Oak Brook IL, 60523
☐5851 W 95th St #300 Oak Lawn IL, 60453
☐10719 160th St Orland Park IL, 60467

MEDICAL RECORD REQUEST

Name:_____ **Date of Birth:** ____/_____ /_____

I authorize **ADVANCED PAIN CONSULTANTS SC** to request my protected health information below.

Specific description of information requested:

☐Progress / Consultation notes (medication list included)
☐Lab reports
☐Operative reports / procedures
☐EMG/NCV
☐Radiology / Diagnostic imaging
☐Mental Health records
☐ALL treatment dates
☐Treatment dates: ____/_____/_____-_____/_____/_____
☐Other: _____

Purpose of use and disclosure:

☐Continuity of care
☐Personal request
☐Attorney/Legal purposes
☐Other: _____

This information is being requested from the following organization/physician:

Facility/Physician name: _____P: _____F: _____
Facility/Physician name: _____P: _____F: _____
Facility/Physician name: _____P: _____F: _____

I acknowledge that the data released may include material that is protected by law. I understand that I may revoke this authorization at any time; however the revocation will not apply to information that has already been released in response to this authorization. I understand that in order to revoke this authorization, I must do so in writing. The procedure for revoking this authorization is to present my written revocation to Advanced Pain Consultants SC. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information will no longer be protected under Federal Privacy Rule. I understand that I may refuse to sign this authorization. Unless otherwise revoked, this authorization will expire automatically 12 months from the date of signature.

Patient signature: _____ **Date**: _____