ADVANCED PAIN CONSULTANTS SC

NAME:

DOB:

Annual Patient Consents and Acknowledgments

- **General 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 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 provide any information asked of me in a timely manner and to the best of my knowledge. That includes insurance, financial, family, and medical history information. I also agree that the information I have already provided is true, correct, and complete.

- **Billing your insurance:** I give consent to the practice to bill my insurance company according to the most recent insurance information that I have provided, including Medicare and Medicaid Advantage Plan cards. I am aware that my copays, deductibles, and co-insurances, are my responsibility and are based on the insurance plan I chose. I understand copays and balances are expected to be paid PRIOR to seeing a physician. My deductible is my responsibility to review, understand, and pay prior to my insurance covering any services. A co-insurance is the percentage I owe for medical services per my insurance after it has been billed (often 20%) unless I have secondary insurance. I understand if claims are denied by my insurance for any reason, I am responsible for the balance due.

- **Assignment of Benefits:** I authorize the assignment of benefits to Advanced Pain Consultants and/or Center for Interventional Pain Management, for physician services, supplies, and facility fees by government and/or other third-party insurance carriers, workers compensation and attorneys working on a personal injury claim on my behalf.

- **Insurance network coverage:** I understand it is my responsibility to make sure the practice is in network with my insurance. If I have an HMO, I must provide a referral for office visits and treatments from my primary care doctor Care will not be provided unless an active referral is on file with our office. I understand if claims are denied due to an out of network status or no referral on file, I will be required to pay the self-pay rate for the services rendered.

- **Routine lab testing:** I understand that urine drug tests are expected as a new patient and routinely after to verify consistency of the medications prescribed from all providers, review potential for drug interactions and to ensure medications are within acceptable guidelines. I authorize the practice to obtain my prescription history via the Illinois Prescription Monitoring Program to ensure accuracy for my treatment plan. I understand Advanced Pain Consultants (APC) utilizes **National Labs** for their lab testing and that National Labs will be processing a separate bill. If my insurance requires me to use a different laboratory, I will notify the office prior to testing, and request an order be printed/faxed to my designated lab. It is my responsibility to have the tests done and faxed to APC by my next visit. I understand having consistent lab results on file is necessary and required for my provider to continue with my treatment plan.

ADVANCED PAIN CONSULTANTS SC

NAME:

DOB:

- **Financial expectations and policy:** I understand that I must notify the office of cancellations at least 24 hours prior to an office visit and at least72 hours prior to a scheduled procedure. I understand there is a grace period of 15 minutes for late arrival. The office charges No Show/Late Cancel Fees of $**75** for an office visit and: **$200 per procedure**. The office requires that a credit card be kept on file in a secured, encrypted, and legally compliant EMR gateway. By saving a card on file, I authorize automatic payments for copays when telehealth services are rendered, or when a balance remains unpaid thirty days after a statement has been sent. I am aware that APC uses a collections agency to collect on unpaid accounts. If my account is sent to collections, I will be responsible for an additional 20% collection agency fee or 40% if my account is referred to an attorney. If my account is sent to collections, the office may discharge me from care.

- **Telehealth:** APC may offer telehealth visits when a provider determines it is appropriate to do so, and it is covered by my insurance. I understand I have the right to an in person visit and may request that a telehealth visit be changed to an in-person exam. I understand that it is my responsibility to verify that I have telehealth coverage with my insurance and that my benefits cover telehealth with this office. I give consent to APC to send the claim to my insurance; if it is not covered, I will have to pay the self-pay rate of $165 after an insurance denial is received.

- **Medical scribe (AI) acknowledgement** I understand the office uses a remote medical scribe and/or Artificial Intelligence (AI) to transcribe information during my office appointment. I am aware these scribe services are HIPAA compliant, and my medical information remains confidential.

- **Local and IV sedation**: I am aware that during procedures the physician office typically uses local anesthetic to numb the area being treated. Recently insurances have deemed IV sedation to be "not medically necessary" for many procedures. Some patients find IV sedation to help ease anxiety and reduce movement during these procedures. In these cases, our office offers IV sedation for a fee of $95. I have two options if I want IV Sedation:
  - A. I can call my insurance ahead of time and verify IV Sedation is a covered benefit for my specific procedure. I understand that in billing my insurance for an uncovered service, may result in them denying payment for the entire procedure. If this occurs, I will be responsible for any portion not covered by my insurance.
  - B. Pay $95 when I arrive for my procedure and bill the insurance after if the office deems that IV sedation is typically covered for this service. If not typically covered for this procedure, I understand my insurance will not be billed.

- **Verbal Release of Information Consent:** I understand the office uses voice and text messages to send appointment reminders and other notifications regarding my appointments. I consent to receiving text messages because it has proven to be the most effective method in relaying valuable and time sensitive information. I also consent to voicemails that leave detailed information regarding my patient care. I am aware I can revoke these reminders but run the risk of losing appointment slots without proper communication with staff.
  - **Patient Portal - Healow:** I understand my patient portal will be activated when I provide an email address. I will receive an email notifying me when Patient Portal access is available with my login credentials. The Patient Portal is intended as a secure online source of confidential medical information and allows me to view my patient chart, statements, and payment methods etc. I understand that the portal is not to be used for medical emergencies. All portal communication is sent to the office staff, not directly to the provider. Portal messages will be reviewed and responded to in a timely manner by the office. I understand that use of the Patient Portal is voluntary, and I am not required to utilize it.

ADVANCED PAIN CONSULTANTS SC

NAME:

DOB:

- **Prohibited Behavior:** I understand the following behavior will not be tolerated and may result in immediate discharge from the practice:
  - Intimidating or harassing staff or other patients: which includes making verbal threats to harm another or destroy property.
  - Making any racial or cultural slurs or derogatory remarks.
  - Making menacing or offensive gestures or yelling at staff.

My signature means I have read and understood the details outlined above. All my questions have been answered, and I feel comfortable signing my consent that I have acknowledged all practice policies.

Signature: _____ Date: _____

Emergency Contact:

Person:	Relationship:	Cell:

Primary Care Doctor:

Person:	Office Location:	Phone:

ADVANCED PAIN CONSULTANTS SC

NAME:

DOB:

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.

- I will inform my physician of all medications that I'm taking.
- 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.
- 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.
- I will not request opioids or any other pain medicine from other physicians.
- 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.
- I will obtain all medications from one pharmacy, when possible, with full consent for an APC physician to talk with the pharmacist.
- 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.
- I agree to travel only with enough medications for the duration of my trip keeping them in an appropriately labeled prescription bottle.
- 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.
- I consent to have my prescription history reviewed, including Illinois and other states prescription monitoring programs.
- 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.
- 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.
- 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.
- 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.
- I 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.
- I understand that this doctor may stop prescribing opioids, or change the treatment plan if:
  - I do not show any improvement in pain from opioids, or my physical activity has not improved.
  - My behavior is inconsistent with the responsibilities outlined in this agreement.
  - I give, sell, or misuse opioid medications. I obtain opiates from anyone other than this doctor.
  - I develop rapid tolerance from the treatment.
  - I refuse to cooperate when asked to submit to a drug screen.
  - If an addiction problem is identified as a result of prescribed treatment or any other addictive substance.
  - If I repeatedly miss appointments, procedures or other treatments.

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. 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.

Signature: Date:

ADVANCED PAIN CONSULTANTS SC

NAME:

DOB:

HIPAA AUTHORIZATION FORM

- I authorize the use or disclosure of Protected Health Information as described above for the purpose indicated until such event or time as specified in Section 4.
- I have the right to revoke this authorization. To do so I understand I must submit my revocation in writing to the party specified in Section 2. The revocation will prevent further disclosure of my health information by the party specified in Section 2 from the date of receipt. I understand a delay may exist if the party specified in Section 2 is not the covered entity authorized to disclose Protected Health Information to the party specified in Section 2. I also understand that a written revocation is not effective with respect to actions the covered entity or party specified in Section 2 took in reliance on a valid Authorization, or where the Authorization was obtained as a condition of obtaining insurance coverage.
- I am signing this authorization voluntarily and understand my entitlement to treatment, payment, enrollment, or eligibility for health plan benefits will not be affected if I do not sign this HIPAA Authorization Form.
- If the party specified in Section 3 is not a HIPAA Covered Entity or Business Associate as defined in 45 CFR §160.103, the disclosed health information may no longer be protected by federal and state privacy regulations.
- I have a right to receive a copy of this HIPAA Authorization Form.
- (If applicable) My substance abuse disorder records are protected under the federal regulations governing the Confidentiality of Substance Use Disorder Patient Records and cannot be redisclosed without my written authorization

Consent for release of 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.

Person:	Relationship:	Cell:	Release SHI?:
			Yes
			Yes
			Yes

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 sign-ing this authorization. I understand that I have the right to refuse to sign this authorization.

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, 6046

Phone: 630-607-1000
Fax: 630-607-1002
Email: Info@APCNoPain.com

MEDICAL RECORD REQUEST

☐ STAT 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: _____

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**:_____

ADVANCED PAIN CONSULTANTS sc

Name:

DOB:

1.What doctors/ facilities have you seen to help treat your pain?

Chiropractor, Neurologist, Orthopaedic Surgeon, Physical therapy, Aqua therapy etc

2.What medications or remedies have you tried to treat your pain?

Gabapentin, Pregabalin, Duloxetine, Meloxicam, Tylenol, etc

2A.Which doctor prescribed the medicationand when did you last see them?

3.What surgeries or injections have you done to treat pain?

3A.Were they successful? If so, for how long?

4. How would you prefer we help treat your pain?

☐ ONLY Injections ☐ ONLY Medication ☐ Both Injections/Medication

5. Any past medical history we should be aware of?

Date:

ADVANCED PAIN CONSULTANTS sc

Name:

DOB:

Brief description and location of your pain:

- When did your pain start? Select...
- How did this happen? Select...
- What is the frequency of your pain? Select...
- How would you rate the severity of the pain? Select...
- Describe your pain since it started: Select...
- Describe your ability to deal with the pain since it started: Select...
- How long have you been dealing with this pain? ____ years ____ months
- Does your pain affect your sleep: ☐ Daytime drowsiness ☐ Trouble sleeping
  - Wakes me up ___ times during the night
- How would you rate your average pain from 1-10?
  Select...

List all current ambulation aids: ☐ Cane ☐ Walker ☐ Crutches ☐ Wheelchair ☐ Scooter

What **INCREASES** your pain: ☐ Activity ☐ Bending ☐ Walking ☐ Sitting ☐ Standing

☐ Driving ☐ Lifting ☐ Changes in weather ☐ Other:

What **RELIEVES** your pain: ☐ Medication ☐ Heat ☐ Ice ☐ Bed Rest ☐ Switching positions

Other:

Social history review:

Frequency of alcohol: Select...

Any history of illicit drugs: Select...

Frequency of smoking: Select...

Any possibility of pregnancy: Select...

Date: