Patient Demographics

ADVANCED PAIN CONSULTANTS, SC
CENTER FOR INTERVENTIONAL PAIN MANAGEMENT, LLC

Provider: □ Dr. Kondelis □ Dr. Durrani | DATE

Patient Information (please print)

PATIENT NAME (LAST, FIRST, MIDDLE)	SOCIAL SECURITY NUMBER	SEX □ M □ F	DATE OF BIRTH	MAIDEN NAME

ADDRESS	UNIT #	CITY, STATE, ZIP CODE	COUNTY	PRIMARY LANGUAGE

MARITAL STATUS □ SINGLE □ WIDOWED □ MARRIED □ DIVORCED	HOME PHONE # ( )	CELL # ( )	MAY WE CONTACT YOU BY PHONE? □ YES □ NO	EMAIL ADDRESS

EMPLOYER (IF RETIRED, PLEASE INDICATE HERE)	WORK PHONE # ( )	EMPLOYMENT □FULL TIME □ PART TIME	MAY WE CONTACT YOU BY EMAIL? □ YES □ NO

RACE
□ AMERICAN INDIAN OR ALASKA NATIVE □ WHITE □ OTHER
□ NATIVE HAWAIIAN/PACIFIC ISLANDER □ BLACK/AFRICAN AMERICAN

ETHNICITY
□ HISPANIC/LATINO
□ NON-HISPANIC/LATINO

PRIMARY CARE PROVIDER (DR)	Phone	REFERRAL SOURCE (DR / FRIEND/ ?)	Phone
	Fax		Fax

Emergency Contact Information

EMERGENCY CONTACT NAME	HOME PHONE # ( )	RELATIONSHIP □ FATHER □ SISTER □ FRIEND □ MOTHER □ SON □ SPOUSE □ BROTHER □ DAUGHTER □ OTHER _____
CELL PHONE # ( )	WORK PHONE # ( )	

Account Guarantor **If the patient and the Account Guarantor are the same – Please proceed to the Insurance Section**

GUARANTOR OF ACCOUNT (insurance policyholder)	RELATIONSHIP TO PATIENT □ SPOUSE □ PARENT □ OTHER	SOCIAL SECURITY NUMBER

ADDRESS	UNIT #	CITY, STATE, ZIP CODE	COUNTY	DATE OF BIRTH

SEX □ M □ F	EMPLOYER (IF RETIRED, PLEASE INDICATE HERE)	HOME PHONE # ( )	WORK PHONE # ( )	CELL PHONE # ( )

Primary and Secondary Insurances

DOES YOUR INSURANCE REQUIRE A PRIMARY CARE REFERRAL? □ YES □ NO

PRIMARY INSURANCE COMPANY NAME

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

SECONDARY INSURANCE COMPANY NAME

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

I certify that the information provided by me in applying for payment under Title XVIII of the Social Security Act is correct.

Authorization for Release of Information

I authorize ADVANCED PAIN CONSULTANTS, s.c. / CENTER FOR INTERVENTIONAL PAIN MANAGEMENT, LLC to release my medical records for the purpose of treatment and health care operations to those entities who share in my healthcare in addition 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. / CENTER FOR INTERVENTIONAL PAIN MANAGEMENT, LLC in writing of any information I do not want released.

SIGNATURE	DATE

Assignment of Benefits

I authorize the assignment of benefits payable to ADVANCED PAIN CONSULTANTS / CENTER FOR INTERVENTIONAL PAIN MANAGEMENT and/or its designee 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. In the event any lawsuit of action is brought to collect this account or any portion thereof, the patient/guarantor will be responsible for any and all costs, not limited to attorney's fees, court costs, collection fees, interest and any additional cost that this action may incur.

Electronic Prescriptions

Our electronic medical record program accesses your prescription/medication history in order for us to safely prescribe your medication. By signing this, you authorize us to do so.

SIGNATURE	DATE

ADVANCED PAIN CONSULTANTS sc

HEALTH HISTORY FORM

Name: Date:

*What treatment have you already received for your condition? Medications Surgery Physical Therapy Chiropractic Services
None Other_____

*Name and address of other doctor(s) who have treated you for your condition_____
*Current Work Status: Part Time Full Time Disabled Other_____
*Date of last: Physical Exam_____ Spinal X-ray_____ Blood Test_____
Spinal Exam_____ Chest X-ray_____ Urine Test_____
Dental X-ray_____ MRI, CT-Scan, Bone Scan_____

*Place circle "Yes" or "No" to indicate if you have had any of the following:

Shingles	YES	NO	Staphylococcus	YES	NO	MRSA	YES	NO			
AIDS/HIV	YES	NO	Diabetes	YES	NO	Liver Disease	YES	NO	Rheumatic Fever	YES	NO
Alcoholism	YES	NO	Emphysema	YES	NO	Measles	YES	NO	Scarlet Fever	YES	NO
Allergy Shots	YES	NO	Epilepsy	YES	NO	Migraine Headaches	YES	NO	STD	YES	NO
Anorexia	YES	NO	Glaucoma	YES	NO	Mononucleosis	YES	NO	Stroke	YES	NO
Appendicitis	YES	NO	Goiter	YES	NO	Multiple Sclerosis	YES	NO	Suicide Attempt	YES	NO
Arthritis	YES	NO	Gonorrhea	YES	NO	Mumps	YES	NO	Thyroid Problems	YES	NO
Asthma	YES	NO	Gout	YES	NO	Osteoporosis	YES	NO	Tonsillitis	YES	NO
Bleeding Disorders	YES	NO	Heart Disease	YES	NO	Pacemaker	YES	NO	Tuberculosis	YES	NO
Breast Lump	YES	NO	Hepatitis	YES	NO	Parkinson's Disease	YES	NO	Tumors; Growths	YES	NO
Bronchitis	YES	NO	Hernia	YES	NO	Pinched Nerve	YES	NO	Typhoid Fever	YES	NO
Bulimia	YES	NO	Herniated Disk	YES	NO	Pneumonia	YES	NO	Ulcers	YES	NO
Cancer	YES	NO	Herpes	YES	NO	Polio	YES	NO	Vaginal Infections	YES	NO
Cataracts	YES	NO	High Blood Pressure	YES	NO	Prostate Problem	YES	NO	Whooping Cough	YES	NO
Chemical Dependancy	YES	NO	High Cholesterol	YES	NO	Psychiatric Care	YES	NO	Chicken Pox	YES	NO
Kidney Disease	YES	NO	Rheumatoid Arthritis	YES	NO	Other: _____					

*Members	Alive/Deceased/Unknown	Age	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer
Father								
Mother								
Siblings								
Children								
Maternal Grandmother								
Maternal Grandfather								
Paternal Grandmother								
Paternal Grandfather								
Other								

*Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS

*Pharmacy Name_____
*Pharmacy Phone:_____

ALLERGIES

VITAMINS/HERBS/MINERALS

Name:_____ Date:_____

What is your **CHIEF COMPLAINT**?_____

Changes (please circle your answers)
*In Pain: Improved Same Worse *In Activity: Improved Same Less
*ER since last visit? Yes No *New symptoms and pain: Yes No
*In physical therapy? Yes No
*Have you been treated by anyone since your last visit? Yes No If so,who? _____

Is this an Injection follow-up? (please circle your answers)
* Yes No
*Injection Results: Improved by _____%, No change Worse

Medications (please circle your answers)
*Helps pain: Yes No *Decreases pain: Yes No
*Increased quality of life: Yes No *Increased function: Yes No

Side Effects of Medications: (please circle your answers)
*Nausea: Yes No *Dizzy: Yes No
*Dry mouth: Yes No *Constipated: Yes No
*Fatigue: Yes No *Sedation: Yes No
*Sweats: Yes No

Pain (please circle as many choices as needed)
*Frequency: Intermittent Constant. *Severity: Mild Moderate Severe
*What *Increases* your pain: activity, bending, walking, sitting, laying down, standing, working, driving, riding in a car, lifting, moving wrong, change in weather, _____
*What *Decreases* your pain: medication, heat, ice, bed rest, sitting, standing, changing positions, TENS unit, _____.
*What is *Affected* by your pain: appetite, concentration, social interaction, emotions, ADLs, walking, mood, enjoyment of life, housework, work duties, difficulty falling asleep, wake up during night ____ times, daytime drowsiness, _____.

Frequency of : (please circle your answer)
*Alcohol: rare weekly daily Drinks/Week_____ *Illicit drugs: Yes No
*Smoking: Yes No Packs/Day_____ *Possible pregnancy: Yes No

Mankoski Pain Score: (please circle your answer)
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. You can read and converse with effort. 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.

Pain Management Agreement

Opioid (narcotic) treatment for chronic pain is used to reduce pain and improve what you are able to do each day. Along with opioid treatment, other medical care may be prescribed to help you improve your ability to do daily activities. These may include exercise, use of non-narcotic analgesics, physical therapy, psychological counseling, or other therapies or treatment. Vocational counseling may be provided to assist you.

To the doctor: Keep signed originals in your file; give a photocopy to the patient. Renew at least every 6 months.

I, _____, understand that compliance with the following guidelines is important in continuing pain treatment with Dr. Kondelis and Dr. Durrani.

1. I understand that I have the following responsibilities:
   a. I will take medications only at the dose and frequency prescribed.
   b. I will not increase or change medications without the approval of Dr. Kondelis or Dr. Durrani.
   c. I will actively participate in return to work efforts and in any program designed to improve function (including social, physical, psychological and daily or work activities).
   d. I will not request opioids or any other pain medicine from physicians, other than from this doctor. This doctor will approve or prescribed all other mind and mood altering drugs.
   e. I will inform this Doctor of all other medications that I'm taking.
   f. I will obtain all medications from one pharmacy, when possible known to this doctor with full consent to talk with the pharmacist given by signing this agreement.
   g. I will protect my prescriptions and medications. Only one loss prescription or medication will be replaced in a single calendar year. I will keep all medications from children.
   h. I agree to participate in psychiatric or psychological assessment, if necessary.
   i. I agree to random drug testing and pill counts at the discretion of my doctor.
   j. I consent to have my prescription record looked up via the Illinois prescription monitoring program, and view prescription/medication history provided by Advanced Pain Consultants electronic medical records software in order for us to safely prescribe medication.
   k. If I have an addiction problem, I will not use illegal street drugs or alcohol. This doctor may ask me to follow through with the program to address this issue. Such programs may include the following:
      - -12-step program and securing a sponsor
      - Individual counseling
      - Inpatient or outpatient treatment
      - -Other:_____
2. I understand that in the event of an emergency, this doctor should be contacted and the problem will be discussed with the emergency room or other treating physician. I am responsible for signing a consent to request record transfer to this Doctor. No more than three days of medications may be prescribed by the emergency room or other physician without this doctor's approval.
3. I understand that I will consent to random drug screening. A drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking.
4. I will keep my schedule appointments and/or cancel my appointment. A minimum of 24 hours prior to the appointment.
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 #1 above.
   c. I give, sell or misuse the opioid medications.
   d. I develop rapid tolerance or lots of improvement from the treatment.
   e. I obtain opiates from others than this Doctor.
   f. I refuse to cooperate. When asked to get a drug screen.
   g. If an addiction problem is identified as a result of prescribed treatment or any other addictive substance.
   h. If I am unable to keep follow-up appointments.

Nicholas P Kondelis MD

_____ _____

Patient Signature Date

Physician Signature Date

_____

Staff Signature Date

ADVANCED PAIN CONSULTANTS SC

Patient Name: _____

Welcome to Advanced Pain Consultants!

Our mission is to alleviate or adequately manage pain through the most up-to-date interventional pain management treatment options available. Advanced Pain Consultants staff, led by Nicholas Kondelis, MD, is highly experienced and committed to providing excellent and compassionate care to our patients. It is an expectation that the patient's compliance with the Patient Guidelines will contribute to an effective program for the patient.

PATIENT GUIDELINES FOR ADVANCED PAIN CONSULTANTS, S.C. – *please initial on line before each preceding guideline*

_____ **Patient Conduct:** It is the patient's responsibility to be respectful of all the health care providers and staff, as well as other patients.

_____ **Cancellations / Tardiness**: If you are unable to keep an appointment, kindly call our office at least 24 hours prior to your Office Visit and 72 hours prior to your Procedure appointments. We can then reschedule your appointment to a more convenient time. A $50 fee will be applied to all Office Visit appointments not canceled prior to the 24 hour period *or* if you fail to keep your appointment *or* if you arrive 15 minutes past your scheduled appointment time. A $150 fee will be applied to all Procedure appointments not canceled prior to the 72 hour period *or* if you fail to keep your appointment *or* if you arrive 15 minutes past your scheduled procedure time. Cancellation/Late/No Show fees are the sole responsibility of the patient and are not covered under patient's insurance. Late arrivals will need to be rescheduled for a later date, however, if we are able to work you in at the end of the day, late cancellation fees will still apply.

_____ **Repeated Missed Appointments and/or Late Appointments:** We will be unable to schedule future appointments for patients having two (2) missed appointments and/or cancellations without appropriate notice, as missed appointments adversely affect your treatment plan.

_____ **Procedure Appointments:** Patients are required to bring a responsible adult to procedure appointments. The responsible party is to remain in the office for the duration of the procedure, act as the patient's driver post-procedure, and must remain with the patient for twelve (12) hours post-procedure appointments.

_____ **Co-payment and Balance Payment:** Your health insurance card(s) must be presented at every office visit. All co-payments and balance payments must be paid at the front desk at the time of check-in *prior* to seeing the physician. We do not accept checks for the initial consultation. Full payment is due at the time services are rendered unless prior arrangements have been made. We accept Cash, Checks, Visa, MasterCard, Discover and American Express.

_____ **Past Due Accounts:** If your account becomes past due, no appointments or prescription refills will be given to you until your account has been cleared by the Billing Office.

_____ **Pre-authorization and/or Pre-certification**: As a courtesy to our patients, Advanced Pain Consultants, S.C. will obtain any pre-authorization and/or pre-certification required prior to services performed; HOWEVER, it is the *patient's responsibility to ensure these pre- authorization and/or pre-certifications are obtained*. This is not the responsibility of the Provider. The patient also acknowledges that there will be no guarantees given by any employee of the Provider, physician or other party about patient's treatment, including whether it will be paid for by any Insurance carrier and/or whether Provider is in or out of patient's network with the patient's insurance carrier.

PATIENT GUIDELINES FOR ADVANCED PAIN CONSULTANTS, S.C.

_____ **Health Insurance Policy Agreement:** The health insurance policy is an agreement between the patient and the insurance company. *If the insurance company has not paid the patient's bill in full within 60 days of treatment, the patient agrees to contact them to facilitate payment.* The patient is responsible to respond promptly to any requested information from the insurance carrier or billing company. Failure to respond in a timely manner to requests for information which result in non-payment from the insurance carrier will result in the patient being responsible for the entire balance on the affected claims.

_____ **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 (unless there are contractual obligations between Provider and insurance carrier(s) disallowing balance billing).

_____ **Patient Payment Guarantee:** Full cooperation with Providers to assist in their efforts to get claims paid is required of the patient. *It is the patient's sole responsibility to verify the status of healthcare benefits directly from their insurance carrier.* It is the patient's sole responsibility to determine what portion of the care rendered by the Provider will be covered by their insurance carrier and that by receiving said care; the patient agrees to pay any and all charges not paid for by their insurance carrier within 60 days of receiving said care. The patient must unconditionally guarantee payment of these charges.

_____ **Notification of Insurance Changes:** It is the patient's responsibility to give prompt notification to the Provider of any changes in health insurance plan and/or coverage including changes to address and/or phone number, claims adjustor, attorney, primary treating physician, or any other changes to your personal information *within 10 days of the change* so we can keep your records up-to-date. Failure to do so will make the patient fully responsible for the entire bill. In consideration of the services furnished, the patient hereby agrees to pay any balance due within thirty (30) days from presentation of bill and that Providers are not required to honor any limiting notations made on a payment.

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 any and all information required to insurance carriers, WC, etc. to collect and process my claims.

_____ _____

Responsible Party (Please Print) Date

_____

Responsible Party Signature

ADVANCED PAIN CONSULTANTS, S.C.

VERBAL RELEASE OF INFORMATION CONSENT

Patient Name _____ **DOB** _____

Address _____ **City, State & Zip** _____

Please list your preferred numbers:

Home: _____ **Cell:** _____ **Work:** _____

Please **check box** if Advanced Pain Consultants, s.c. may leave detailed messages, including appointment reminders/billing information:

□**Home** □**Cell** □**Work**

Please **check box** if Advanced Pain Consultants, s.c. may leave detailed lab results/test results/medical information:

□**Home** □**Cell** □**Work**

**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
			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** _____

For Office Use Only

We were unable to obtain the acknowledgement for the following reason –

Prepared by _____ **(please initial)**

□ **An emergency existed and a signature was not possible.**
□ **Unable to communicate with patient**
□ **Patient refused to sign**
□ **Other** _____

ADVANCED PAIN CONSULTANTS, S.C.

NO INSURANCE WAIVERS
INSURANCES PROHIBIT WAIVER OF COPAYS, CO-INSURANCE OR DEDUCTIBLES

Beginning September 1, 2014, APC will fully enforce its policy that every patient is required to pay his/her copay in addition to a payment on his/her balance in order to be seen by the doctor. If you have an existing balance on the account, we will work with you to establish a payment plan and help you to achieve and maintain an account in good standing.

Waiving patient out-of-pocket costs for beneficiaries is a violation of contract between the provider and insurance company. Doing so is considered fraud and abuse, which can result in fines and other legal actions for the provider. (42 U.S.C. Section 1320a-7b) (Illinois General Assembly SB 879)

Waiving beneficiary copayments, co-insurances, or deductibles can also mean that the insurance will refuse to pay the claim, the patient will be fully responsible, and may result in removal of the provider from the network and suspension of authorized provider status under that insurance. (42 U.S.C. Section 1320a-7b)

We ask that you understand that the copay, co-insurance, and deductible are a required component of our ability to provide care for you at Advanced Pain Consultants, S.C. It is not an option for our staff to reduce or eliminate these obligations. If you have questions or concerns regarding your insurance plan and benefits we will do our best to help you understand your policy and questions regarding your account at APC and CIPM, however, we may need to redirect you to your insurance carrier to discuss concerns related to your copay, coinsurance, and deductible.

Printed Name: _____

Patient Signature: _____ Date: _____

Advanced Pain Consultants, SC

Patient Portal Consent Form

This form must be completed to provide patients access to their on-line medical records. A new *Advanced Pain Consultants, S.C.* Patient Portal account will be established for those requesting access with the email address provided below.

I agree to the following:

1. I must log into *Advanced Pain Consultants, S.C.* Patient Portal with my own user ID and password.
2. I will abide by the terms and conditions of the *Advanced Pain Consultants, S.C.* Patient Portal site.
3. *Advanced Pain Consultants, S.C.* has the right to revoke on-line access at any time.

I also understand that:

- For medical emergencies, dial 911. *Advanced Pain Consultants, S.C.* Patient Portal is NOT to be used for urgent needs.
- All communication is sent to the nursing staff in the department, not directly to the Provider. The message will be reviewed and responded to or forwarded appropriately.
- I will receive a *Advanced Pain Consultants, S.C.* Patient Portal email notifying me when access is available with login credentials. This is normally sent within 3 business days after the consent form is received by the *Advanced Pain Consultants, S.C.*.

Please enter YOUR information (please print clearly):

Name: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Email Address to web-enable: _____

****

I understand that *Advanced Pain Consultants, S.C.* Patient Portal is intended as a secure online source of confidential medical information. If I share my Patient Portal username and password with another person, that person may be able to view my health information.

I agree that 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 within *Advanced Pain Consultants, S.C.* Patient Portal may be tracked by a computer audit and that entries I make will become part of my medical record.

I understand that access to *Advanced Pain Consultants, S.C.* Patient Portal is provided by *Advanced Pain Consultants, S.C.* as a convenience to its patients and that *Advanced Pain Consultants, S.C.* has the right to deactivate access to *Advanced Pain Consultants, S.C.* Patient Portal at any time for any reason. I understand that use of *Advanced Pain Consultants, S.C.* 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 this Patient Portal Consent Form and agree to its terms.

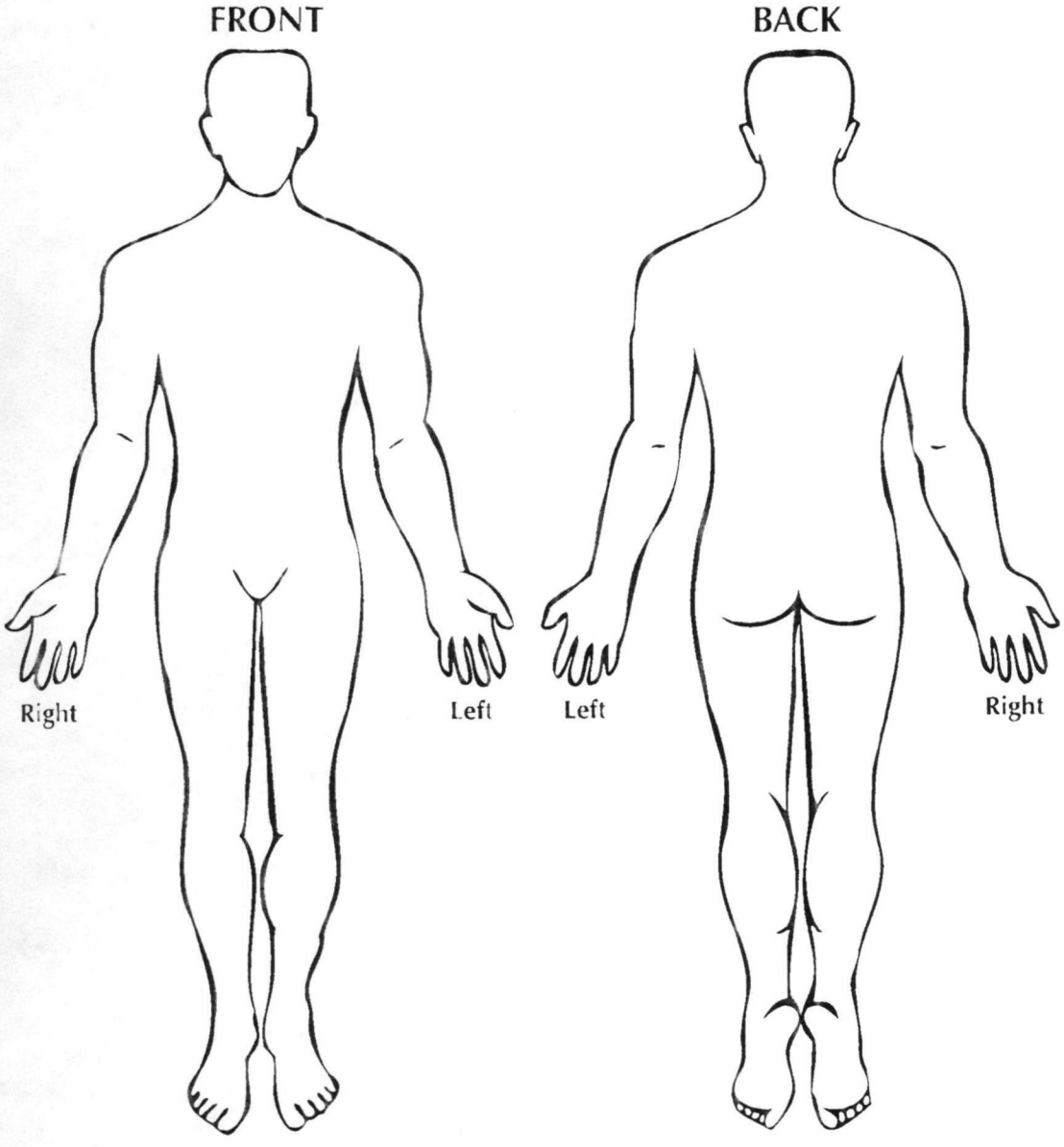
Print Name: _____

Signature: _____ **Date:** _____

PAIN DRAWING

Name _____ Date _____

Be sure to fill this out as accurately as you can. Mark the area(s) on your body where you feel the described sensation. Use the appropriate symbol. Mark any areas of radiation. Include all affected areas.



Symbols

Numbness: ======

Pins & Needles: oooooo

Burning Pain: xxxxxx

Stabbing Pain: //////

Aching Pain: ((((((

On a scale of 1 to 10, please indicate with an "X" the level of pain you are experiencing right now:

(Least Intense) (Most Intense)

0 1 2 3 4 5 6 7 8 9 10

Please indicate the frequency at which you experience this level of pain:

Rarely Once a month Once a week Once a day More than once a day Constant pain

Boston Scientific

PRECISION*Plus*

Nicholas P Kondelis, MD
Zia U Durrani, MD

AUTHORIZATION FOR RELEASE OF INFORMATION TO ADVANCED PAIN CONSULTANTS, S.C.

I authorize

Name _____

Address _____ City _____

State _____ Zip _____ Phone _____ Fax (*required*) _____

To disclose to Advanced Pain Consultants the Protected Health Information of

Patient Name _____ Date of Birth ___ / ___ /_____

Address _____

City _____ State _____ Zip _____ Phone _____

Information Requested

**** Please note that "All Records" will NOT be considered *specific***

The *specific* type of information requested is as follows: (Please check off all appropriate boxes)

☐Progress notes ☐Lab Results ☐Medication list ☐Operative reports/Procedures ☐Radiology reports

☐Treatment Dates Requested _____ ☐Other: _____

Purpose of the use or Disclosure is: (Please check off all appropriate boxes)

☐Attorney/Legal ☐ Social Services Disability ☐Personal Use

☐ Insurance ☐ Continued Patient Care ☐ Other: _____

Rights of the Patient

I acknowledge that the data released may include material that is protected by law. I understand that I may revoke this authorization at anytime; however, the revocation will not apply to information that has already been released in response to this authorization. I also 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. 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. Advanced Pain Consultants will not condition the patient's treatment on receiving my signature on this authorization. Unless otherwise revoked, this authorization will expire automatically 1 year from the date of signature.

Patient Signature _____ Date _____

Witness _____ Date _____

-OR-

Signature of Authorized Representative _____ Date _____

Witness _____ Date _____

****Advanced Pain Consultants 2100 Clearwater Dr. Ste 100 Oak Brook IL 60523 Ph 630-607-1000 Fax 630-834-6429****

ADVANCED PAIN CONSULTANTS, s.c.

MEANINGFUL USE
Race and Ethnicity Guide

At Advanced Pain Consultants, we are united with one common goal – to care for you! As part of this goal, APC is focused on meeting Meaningful Use objectives to improve clinical quality and patient outcomes. "Meaningful Use" is a government program to ensure that healthcare professionals are utilizing their Electronic Medical Record (EMR) system efficiently to improve healthcare quality and patient safety.

A core Meaningful Use objective is to record patient demographics: preferred language, gender, race, ethnicity, and date of birth. The Race and Ethnicity are defined by the Federal Office of Management and Budget (OMB) and the United States Census Bureau.

Advanced Pain Consultants understands that this is very personal and sensitive information. We want to assure you that this information will only be used as part of the Meaningful Use objectives.

INSURANCES PROHIBIT WAIVER OF COPAYS, CO-INSURANCE OR DEDUCTIBLES

Waiving patient out-of-pocket costs for beneficiaries is a violation of contract between the provider and insurance company. Doing so is considered fraud and abuse, which can result in fines and other legal action.

Waiving beneficiary copayments, co-insurances, or deductibles can mean that the insurance will refuse to pay the claim, patient will be fully responsible, and may result in removal of the provider from the network and suspension of authorized provider status under that insurance.

We ask that you understand that the copay, co-insurance and deductible are a *required component* of our ability to provide care for you at Advanced Pain Consultants, s.c.