# Patient Demographics

**ADVANCED PAIN CONSULTANTS, SC**
☐ Oak Brook ☐ Oak Lawn ☐ Orland Park

Provider: □ Dr. Kondelis □ Pauli Gonzales | 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 DOCTOR | Phone / Fax | REFERRAL SOURCE (DR / FRIEND/ ?) | Phone / 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 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. If 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 any and 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

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.

## 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**

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# 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

_____
_____
_____
_____
_____
_____
_____
_____

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# New Patient Health History

1. **CHIEF COMPLAINT:**

_____

_____

_____

**2. Have you received any injections?** (please circle your answers)

1) _____ How many? 1 2 3 more _____
2)_____ How many? 1 2 3 more _____
3)_____ How many? 1 2 3 more _____

**3. Pain** (please circle as many choices as needed)

*Onset/Event: Auto Accident___ Following Surgery____ Work Related____ Fall___
Just Started____Trauma___
*Change of pain since onset? Better Worse Same
*Ability to cope with pain? Better Worse Same
*Total time of pain experience: Years _____ Months _____
*Ambulation Aids: Cane Walker Crutches Wheelchair Scooter
*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, _____.

**4. 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

**5. Had you tried any medications to treat your pain**? (Please list)

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9._____

10._____ 11. _____ 12._____

**6. 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.

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# 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 SC

## PERSONAL INJURY/AUTO ACCIDENT

PATIENT NAME_____ DOB_____

SOCIAL SECURITY #_____ DATE OF ACCIDENT_____

LOCATION_____ ****ATTACH POLICE REPORT****

DESCRIPTION OF ACCIDENT_____

_____

DESCRIPTION OF INJURY / BODILY PARTS INVOLVED_____

PROVIDERS SEEN FOR INJURY (EXAMPLE: ER, HOSPITAL, DR. OFFICE) _____

_____

WAS PATIENT THE OPERATOR OR PASSENGER?_____

WAS PATIENT TICKETED? Y / N OTHER PARTY TICKETED? Y / N WAS IT PATIENT'S VEHICLE? Y / N

IF NOT, WHO OWNS VEHICLE? _____ RELATIONSHIP TO PATIENT_____

WHO WAS THE OPERATOR OF THE OTHER VEHICLE?

NAME_____ PHONE NUMBER_____

INSURANCE COMPANY & ADDRESS_____

_____

ADJUSTER NAME_____ PHONE NUMBER_____

CLAIM #_____ FAX / EMAIL_____

## PERSONAL INJURY/AUTO INSURANCE INFORMATION

PATIENT'S CAR INSURANCE COMPANY & ADDRESS_____

_____

MEDICAL COVERAGE? Y / N COVERAGE AMOUNT_____ UNDERINSURED COVERAGE? Y / N

ADJUSTER NAME_____ PHONE NUMBER_____

CLAIM #_____ FAX NUMBER _____

EMAIL _____

## ATTORNEY INFORMATION

NAME_____ PHONE NUMBER_____FAX NUMBER_____

ADDRESS_____

LAW OFFICE OF_____EMAIL_____

## PATIENT FINANCIAL RESPONSIBILITY

In the event the Personal Injury/Auto Insurance or the Commercial Insurance denies a claim(s), the patient will be fully responsible for all office visits and procedures at the time of the service, and all balances are due in full within 30 days of receipt of a statement.

The information provided on this form is accurate. I understand that I am fully responsible for any and all claims not paid by the Personal Injury/ Auto Insurance.

Signature:_____Date:_____,

ADVANCED PAIN CONSULTANTS SC

## WORKMAN'S COMPENSATION

PATIENT NAME_____ DOB_____

ADDRESS _____PHONE _____

DATE OF INJURY_____WORK STATUS/RESTRICTIONS OR LIMITATIONS_____

DESCRIPTION OF ACCIDENT_____ ___

_____

DESCRIPTION OF INJURY / BODILY PARTS INVOLVED_____

LIST DOCTOR / PROVIDERS SEEN FOR INJURY (EXAMPLE: ER, HOSPITAL, DR. OFFICE)_____

_____

WAS A MOTOR VEHICLE INVOLVED? Y / N ****ATTACH POLICE REPORT, IF APPLICABLE****

IF YES, WHAT KIND OF VEHICLE AND WHO OWNS IT? _____

LOCATION OF ACCIDENT _____

LIST ANY PREVIOUS INJURIES: (DATE, DETAILS ON INJURY, AND WHETHER WORK RELATED) _____

_____

_____

COPY OF REFERRAL ATTACHED? Y/N **(AN INJURED WORKER IN THE STATE OF ILLINOIS IS ALLOWED TO CHOOSE/SEE TWO DOCTORS OF THEIR CHOICE. ALL OTHER DOCTORS MUST BE REFERRED FROM ONE OF THE FIRST TWO DOCTORS.)**

## EMPLOYER INFORMATION

EMPLOYER NAME: _____ PHONE: _____

ADDRESS: _____

## WORKERS COMPENSATION INSURANCE INFORMATION

NAME & ADDRESS_____

_____

ADJUSTER_____ PHONE NUMBER_____

CLAIM / CASE #_____FAX NUMBER _____EMAIL _____

IS THE CLAIM CONTESTED? YES NO

## ATTORNEY INFORMATION

NAME_____ PHONE NUMBER_____FAX NUMBER_____

ADDRESS_____

LAW OFFICE OF_____EMAIL _____

## INSURANCE CARRIER

**CARRIER NAME**: _____ MEMBER ID: _____

GROUP NUMBER: _____

### PATIENT FINANCIAL RESPONSIBILITY

In the event the Workers Compensation Insurance denies a claim and the patient has Commercial insurance, then the Commercial Insurance will be billed. If the patient does not have commercial insurance, or insurance denies the claim(s), the patient will be fully responsible for all office visits and procedures at the time of the service, and all balances are due in full within 30 days of receipt of a statement.

The information provided on this form is accurate. I understand that I am fully responsible for any and all claims not paid by the Workers Compensation or Commercial Insurance.

Signature:_____Date:_____,

ADVANCED PAIN CONSULTANTS SC

**PATIENT FINANCIAL AGREEMENT – Updated 01/01/2020**

1) Present your current/active **insurance card** at each visit. If you do not have insurance, or our office does not participate in your insurance plan, payment will be due at the time of service.

2) Respond promptly to **information requested** from your insurance carrier, including coordination of benefit forms.

3) Notify our office immediately regarding any **changes to your health insurance**

4) Payment of your **co-pay, deductible, and co-insurance** are due upon receipt of your billing statement and on or before your next office visit.

5) **Account balances** must be paid in full or the patient may request a payment plan according to APC's payment guidelines.

6) Failure to make a **payment on the account balance** for two consecutive billing cycles or 60 days will automatically be referred to a collection agency and may result in discharge from the practice.

7) 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:** office visits $50, procedures $150.

8) APC encourages all patients to pay balances due each month and remain at a zero balance. All balances not paid within 30 days of receipt of statement, for procedures and office visits will incur a **finance charge** of 1.5 percent per month. Patients with balances remaining at the end of 2019 will begin to incur the finance charge on the late January statement.

9) **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:** Patient agrees to cooperate fully to assist the office and billing service in their efforts to get claims paid. Please be sure that you are familiar with your insurance benefits and the coverage provided by your insurance plan. We encourage you to contact your insurance directly to verify benefits and coverage of services provided. Our office will assist you in obtaining payment, however, the patient and/or guardian agrees to pay any and all charges not covered by their insurance carrier.

**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.

**I have read and understand the financial and office policies outlined above.**

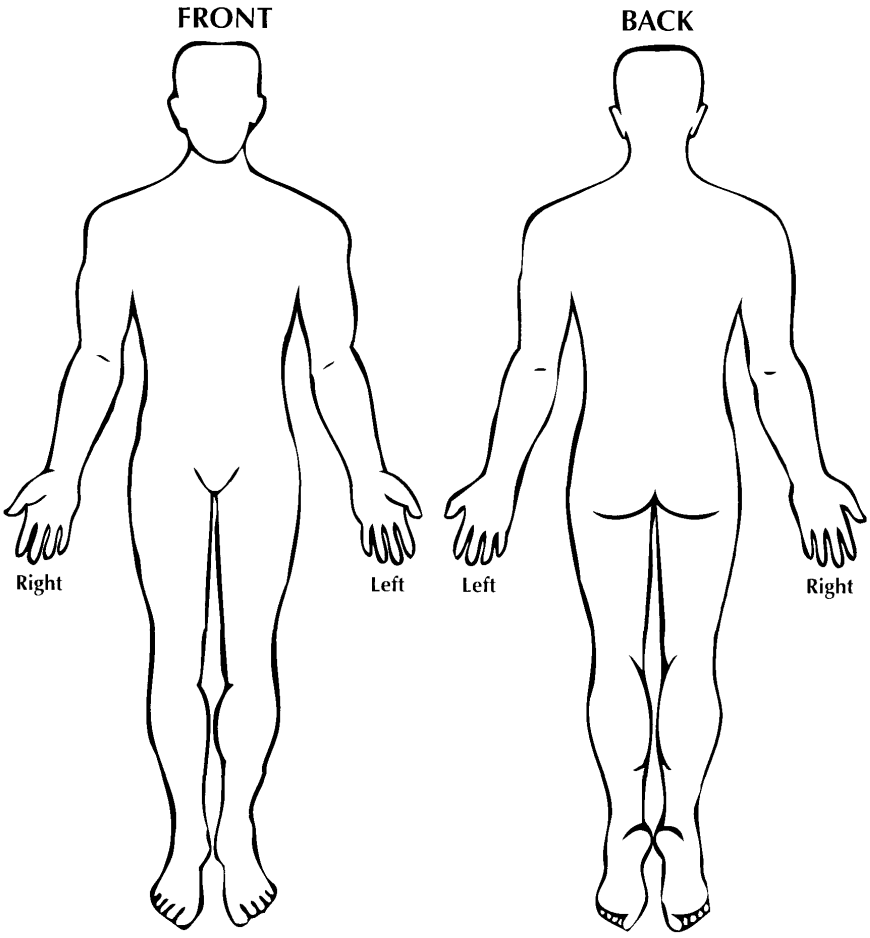
| _____ | _____ | _____ |
|---|---|---|
| Name (please print) | Signature | Date |

ADVANCED PAIN CONSULTANTS SC

# 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:

**Has your insurance changed since your last visit at APC? YES _____ or NO _____**

**Has there has been a change to your home address and or telephone numbers? YES _____ or NO _____**

**Address:**_____

_____

**Phone Number: ( ) _____**

***Please have ID and insurance card present when giving your pain drawing to front desk assistant.**

ADVANCED PAIN CONSULTANTS SC

# ADVANCED PAIN CONSULTANTS, S.C.

Patient Name: _____ **DOB:** _____

## I. VERBAL RELEASE OF INFORMATION

Please **check box** if Advanced Pain Consultants, S.C. may leave detailed messages, including appointment reminders/billing information on your:

☐ **Text** ☐ **Cell** ☐ **Home** ☐ **Work** ☐ **Email**

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

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## II. 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** _____

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## III. ADVANCED PAIN CONSULTANTS PATIENT PORTAL CONSENT

**I understand and agree to the following:**

For medical emergencies, dial 911, the Patient Portal is NOT to be used for urgent needs. All communication is sent to the clinical staff, not directly to the provider. The message will be reviewed and responded to or forwarded appropriately. I will receive an email notifying me when access is available with login credentials. This is normally sent within 3 business days after the consent form is received. The Patient Portal is intended as a secure online source of confidential medical information. 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 anyway. 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. Access to the Patient Portal is provided as a convenience to patients and Advanced Pain Consultants, S.C. 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 Patent Portal Consent Form and agree to its Terms conditions.***

**Signature** _____ **Date** _____