THE TRISTATE PAIN INSTITUE

CONSENT TO TREAT AND AUTHORIZATION TO RELEASE INFORMATION

I consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the attending physician. I authorize TriState Medical Specialists, LLC to furnish my Insurance carriers information regarding history, physical findings and treatment rendered as allowed by HIPAA. I further authorize any holder of medical or other Information about me to release such information to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare *I* other insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment or medical insurance benefits to the party who accepts assignment.

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I request and authorize that payments for authorized Medicare / other insurance company benefits be made directly to TriState Medical institute, LLC on my behalf. This includes all services furnished to me by TriState Medical Specialists, LLC, by whomever accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I also understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (Section 11288 of the Social Security Act and 31 USC. 3801-3812 provides penalties for withholding this Information).

PATIENT RESPONSIBILITY

I agree that I am responsible for all charges incurred in this office, if my insurance coverage does not provide full benefits. I will pay any patient responsibility balance due within 30 days unless I have made other arrangements with TriState Medical Specialists, LLC. If cancellation of my appointment becomes necessary, I will contact Tri-State Medical Institute, LLC no later than twenty- four (24) hours prior to my scheduled appointment time. I understand that failure to follow the cancellation of appointment policy, I may be subject to a charge of fifty dollars ($50.00) and such charge is not payable through my insurance. I have read the TriState Medical Specialists, LLC Office Policy Statement and all my financial questions were answered.

ANCILLARY SERVICES

As a convenience to our patients, TriState Medical Specialists, LLC offers direct dispensing of medications, topical creams, durable medical equipment, as well as on site diagnostic testing as recommended. I understand I am under no obligation to obtain these pharmaceuticals, orthotics, or services through TriState Medical Specialists, LLC, and at any time can request a referral to an independent pharmacy, medical supply outlet, imaging center, hospital or another provider.

ASSIGNMENT OF INSURANCE BENEFITS

1 hereby authorize direct payment of all medical / surgical benefits to TriState Medical Specialists, LLC (dba TriState Medical Institute), for services rendered to them in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance. I also authorize my doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize TriState Medical Specialists, LLC (dba TriState Pain Institute) to release any medical of incidental information that may be necessary for either: (1) medical care, or (2) processing applications for financial benefits.

Patient Name: _____

Patient Signature_____Parent/Guardian (if applicable):_____

Date:_____

TRISTATE PAIN INSTITUTE

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

I have been presented with a copy of the NOTICE OF PRIVACY PRACTICES, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Print Patient Name: _____Date: _____

Relationship (if not signed by patient): _____

Please name all of your family/friends we can contact and/or discuss your medical information with:

Name: _____Relationship: _____Phone: _____

Name: _____Relationship: _____Phone: _____

Name: _____Relationship: _____Phone: _____

I wish to place the following restrictions on disclosure of my health information:

I understand that I have the right to revoke this authorization at any time. I must do so in writing and present my written revocation to the medical records department, and I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the rights to consent a claim under my policy.

Patient or Guardian Signature:_____

Date: _____

MY MEDICAL HISTORY

PLEASE CIRCLE ALL THAT:

CVS Hypertension Cholesterol MI Aneurysm Heart Failure PAD Carotid Disease
LE Edema Pacemaker On Blood Thinners Chest Pain Palpitations

LUNGS COPD Asthma Pneumonia Valley Fever Asbestos Bronchitis Shortness of Breath

GI GERD/PUD Irritable Bowel Crohn's Dz Gallbladder Diverticular Dz Constipation
Hemorrhoids Pancreatitis Bowel Obstruction Liver Dz: (Hepatitis / Cirrhosis)

GU/ Renal UTI Kidney Stones Renal: (Dialysis? Y N) Bladder Disease
Males: Prostrate Hypertrophy (BPH) Erectile Dysfunction ***Females:*** Stress Incontinence

ENDO Diabetes: (Insulin / Meds) Osteoporosis Thyroid: (Hypo / Hyper) Low T

NEURO Stroke Seizures Tremor (Essential / Parkinson's) HA/Migraine MS Dementia
Hydrocephalus (Shunt?) Neuropathy ALS RSD/CRPS Restless Leg Syndrome

GYN Periods: (Reg. / Irreg.) Post-Menopause Menopause Pre-Menopause Hysterectomy

CANCER Skin (Melanoma) Lung H/N Stomach/ Intestine/ Colon Blood Lymphoma Brain
Prostrate Ovarian Uterine Bone Kidney Bladder Thyroid
Other:_____ In Treatment _____ In Remission _____ Metastatic Disease _____

RHEUM Arthritis (Osteo / Rheum) Lupus Fibromyalgia Raynaud's

PSYCH Depression Anxiety Bipolar Schizophrenia PTSD Decreased Libido

HEME Anemia Platelets (Low / High) "Bleeder" Hemochromatosis

INFEC +HIV MRSA Chronic Infection (Where? _____)

SENSORY Glasses (Reading Only) Cataracts Glaucoma Hearing Loss Ringing in Ears Legally Blind
Double Vision Loss of Smell

What are you seeing the Doctor for today?

MY MEDICATIONS, ALLERGIES AND FAMILY HISTORY

LIST ALL NON-PAIN RELATED MEDICATIONS: _____ NONE _____ SEE ATTACHED LIST

BLOOD THINNERS (circle): Aspirin (81mg 325mg) Plavix Coumadin Xeralto Other:

OTHER MEDICATIONS (Name, Dose, and how often you take the medication):

I AM ALLERGIC TO: _____ NONE

IODINE RELATED (circle): Shellfish IV Contrast Contrast with Pain Injection

MEDICATION ALLERGIES (List Medication and Reaction):

PLEASE LIST ALL DISEASES THAT RUN IN YOUR FAMILY: _____ I AM ADOPTED

THE TRISTATE PAIN INSTITUE

Pain Treatment with Opioid Medications: Patient Agreement

Please review the information listed here. Do not sign if you have any questions or concerns regarding any of this, and ask a provider or member of the TriState Pain Institute for clarification.

I, _____ , understand and voluntarily agree that:

I will keep the medicine safe, secure and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment, and may not be replaced at all.

I will take my medication as instructed and not change the way I take it without first talking to the doctor or other member of the treatment team.

I understand that prescriptions mayl be filled only during scheduled office visits with the treatment team.

I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.

I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.

I understand, currently prescriptions are prescribed electronically to the pharmacy. There are no written prescriptions.

I agree that if I am under the care of another provider, and that provider prescribes me a benzodiazepine, I could suffer from significant side effects or death as a result of the combination of opioid / benzodiazepines. I understand that TriState Pain my not agree to treat me with opioids if I am taking benzodiazepines without the co-management and cooperation of my care team, especially other prescribing physicians.

Notification of Office Reminders and Related Information:

Phone Message/Call Authorization (means of communication via phone, fax, or email)

"I, the undersigned, hereby authorize the staff of Tri-State Pain to leave messages on my answering machine or cell phone regarding my care or for appointment reminders or transmission of other information via fax, text or e-mail."

IF I HAVE ANY QUESTIONS, I WILL ASK STAFF

Received and Read: _____ Date:_____

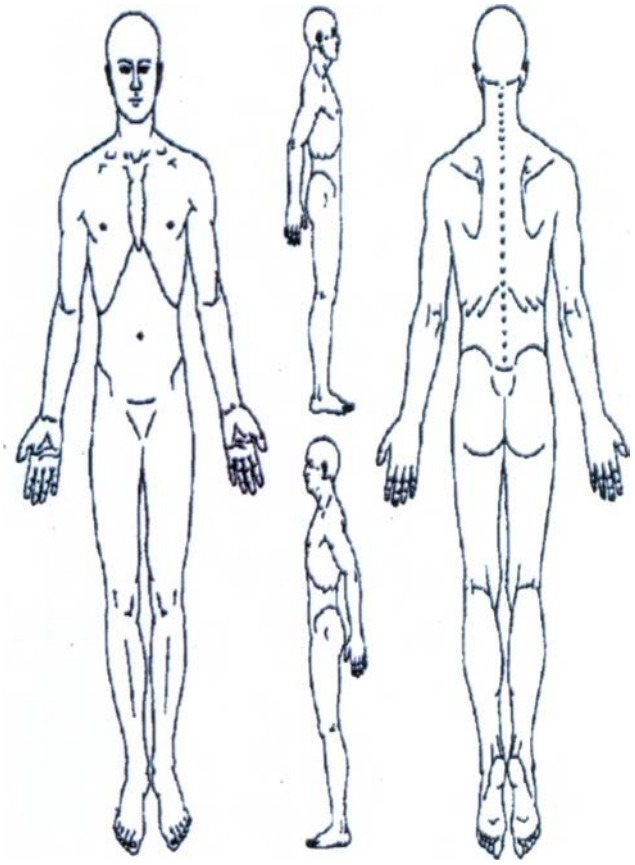
Patient's Signature

Printed Name: _____

Pain Diagram

Please mark the area of injury or discomfort on the chart below using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
----------	o o o o o o o o	^ ^ ^ ^ ^	XXXXXX	●●●●●
----------	o o o o o o o o	^ ^ ^ ^ ^	XXXXXX	●●●●●



Daily Pain Score

PLEASE RATE THE FOLLOWING ON A SCALE OF O - 10

0 = NO PAIN
1-4 = LOW AMOUNTS OF PAIN
5-7 = MODERATE PAIN
8-10 = SEVERE PAIN

Average_____

Best_____

Worse_____

Things that make my pain worse:

Things that make my pain better:

I CURRENTLY TAKE THE FOLLOWING FOR PAIN AND RELATED COMPLAINTS (Please Circle):

Tylenol /Codeine	MS Contin	Suboxone	Naprosyn	Flexeril	Gabapentin
Hydrocodone	Dilaudid	Subutrex	Mobic	Soma	Cymbalta
Zohydro	Methadone	Fentanyl Patch	Celebrex	Valium	Lyrica
Oxycodone	Opana	Butrans Patch	Diclofenac	Zanaflex	Tegretol
OxyContin	Opana ER	Tramadol	Indomethacin	Xanax	Dilantin
Morphine	Kadian	Motrin (Ibu)	Advil /Aleve	Ativan	Topical Cream

Other:

PAIN HISTORY

TRAUMA (Most recent first):

When? _____ What was injured? _____

Treatment: _____

*Additional Prior Trauma (Please explain what happened, what was injured, and how you were treated):

WORK COMP INJURY (Most recent first):

When? _____ What was injured? _____

Treatment: _____

Settlement: _____

*Prior W/C History (Please explain what happened, what was injured, and how you were treated):

PAIN RELATED INTERVENTIONS / OPERATIONS (CIRCLE PLEASE):

HEAD: Trigeminal Injection/Surgery Occipital Nerve Block TMJ Injection Suboccipital Stimulator

Other: _____

NECK: Epidural Facet Injections Trigger Point Injections Radiofrequency ("Nerve Burn")

Stimulator Surgery: (Front / Back / Both) Other: _____

THORACIC: Epidural Facet injections Trigger Point Injections Radiofrequency ("Nerve Burn")

Stimulator Surgery: (Front / Back / Both) Other: _____

BACK: Epidural Facet injections Trigger Point Injections Radiofrequency ("Nerve Burn")

Stimulator Surgery: (Front / Back / Both) Drug Pump Other: _____

JOINT: A = Arthroscopy R = Replacement

Injections: Shoulder Elbow Wrist/Hand Hip Knee Steroid / Collagen Ankle

Surgery: Shoulder (A / R) Elbow (A / R) Wrist/Hand (A / R) Hip (A / R)

Knee (A / R) Ankle (A / R)

OTHER:

TRISTATE PAIN INSTITUTE
PATIENT AGREEMENTS

I agree to take the medication only as prescribed. I understand that these drugs can be very useful, but have a high potential for misuse and are therefore closely controlled by the local, state, and federal government. Because my physician/health care provider is prescribing such medication to help manage my pain, I understand the risks associated with them.

Physical dependence *is common to many drugs such as blood pressure medications, anti-seizure medications, and opioids. It results in biochemical changes such that abruptly stopping these drugs will cause a withdrawal response. It should be noted that physical dependence does not equal addiction. One can be dependent on insulin to treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to the insulin or prednisone.*

Addiction *is a primary, chronic neurobiological disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases one's quality of life. If the patient exhibits such behavior, the drug will be tapered and such a patient is not a candidate for an opioid trial. He/she will be referred to an addiction medicine specialist.*

Tolerance *means a state of adaptation in which exposure to the drug induces changes that result in a lessening of one or more of the drug's effects over time. The dose of the opioid may have to be titrated up or down to a dose that produces maximum function and a realistic decrease of the patient's pain.*

I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from my physician/health care provider at TriState Pain Institute; unless emergency care has been provided, if so please contact our office.

There are side effects with opioid therapy, which may include, but not exclusively; skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, or the possibility of impaired cognitive (mental health} and/or motor ability. Overuse of opioids can cause decreased respiration. It is my responsibility to notify my physician/health care provider of any side effects that continue or are severe (i.e., sedation, confusion}. I am also responsible for notifying my pain physician immediately if I need to visit another physician or need to visit an emergency room due to pain, or if I become pregnant.

Validation of Correct Medication Management is required regularly and randomly as needed, drug test all patients. There are no exceptions. Urine screening is the most common source of specimen, but blood can also be used. TriState Pain Institute reserves the right to observe you while the specimen is obtained. Substituting or tampering with the specimen in a deceptive manner constitutes grounds for termination. Should you be unable to provide a specimen when requested, you are responsible to return no later than 24 hours to do so.

I have been informed and understand the policies regarding the use of controlled substances by TriState Pain Institute, its providers, and staff. I acknowledge that I will only be prescribed controlled substances if they are deemed medically necessary based upon a valid diagnosis.

Received and Read: _____ Date: _____

Printed Name: _____

PATIENT INTAKE WORKSHEET

Patient Name: _____ DOB: _____

Current Address: _____

City: _____ State: _____ Zip: _____

Current Phone #s: Home: _____ Cell: _____ Work: _____

E-Mail Address: _____

Social Security Number (Patient): _____

Employer: _____

Insured (Policyholder) Name: _____

Social Security Number (Insured & Responsible Party): _____

Emergency Contact: _____ Relationship: _____

Home #: _____ Cell #: _____ Work #: _____

WORKER'S COMPENSATION INSURANCE

W/C Carrier: _____

Policy Number: _____ Group Number: _____ Effective Date: _____

Insurance Name: _____

Date of Injury: _____ Body Parts Injured: _____

Attorney: _____ Phone Number: _____

PERSONAL INJURY INFORMATION

Attorney: _____ Phone Number: _____

Office Contact: _____ Date of Injury: _____

PHARMACY INFORMATION

Pharmacy #1: _____ Location: _____

Pharmacy #2: _____ Location: _____

PBM CONSENT- provides the physician with information about medication that you are already prescribed by any provider, to minimize the number of adverse drug events.

Printed Name: _____ Signature:_____

MY PROVIDERS

My primary care provider is: _____

I also see or have seen as consultants / specialists

Cardiologist: _____ Neurologist: _____

Neurosurgeon /Spine Surgeon: _____

Orthopedic Surgeon: _____Prior Pain Doctor: _____

Pulmonologist: _____ Rheumatologist: _____

Oncologist: _____ Podiatrist: _____

Other: _____

I have had Radiology and Imaging at:

_____WARMC _____VVMC _____KRMC _____HRMC _____CRMC

_____Mt. West _____LHC Imaging _____Coast MRI OTHER _____

Electrodiagnostics ("Nerve Test")? _____NO _____ YES By Whom: _____

Sleep Study? _____ NO _____YES By Whom: _____

Recent Cardiac Evaluation? _____NO _____YES By Whom: _____

When: _____ What Was Done: _____ EKG _____Echo _____ Stress Test

Chiropractic or Physical Therapy: _____ NO _____YES When: _____

Where: _____

When was the last time you were hospitalized? _____ Where: _____

Reason:

TRISTATE PAIN INSTITUTE
FORT MOHAVE, AZ – LAKE HAVASU CITY, AZ – LAS VEGAS, NV
PH: 928-788-3333 FAX: 928-788-3555

HIPAA COMPLIANT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

****Entire form must be completed to be considered valid****

PATIENT INFORMATION:

_____ _____ _____
Name of Patient / Previous Names | Birth Date | Phone Number

_____ _____
Street Address | City, State, Zip Code

AUTHORIZES:

_____
Name of Health Care Provider / Plan / Other

_____
Street Address, City, State, Zip Code

_____ _____
Phone | Fax

RELEASE TO:

_____
Name of Health Care Provider / Plan / Other

_____
Street Address, City, State, Zip Code

_____ _____
Phone | Fax

INFORMATION TO BE RELEASED:

☐ **Entire Record**

☐ Office Visits ☐ Procedure Reports ☐ Medications ☐ Other (Specify):_____

☐ Consultations ☐ Laboratory Results ☐ Diagnostic Results _____

DATES OF SERVICE_____ TO _____

Purpose of disclosure: _____

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans, or health care clearinghouses, which must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re0-disclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

1) I understand this consent may be revoked at any time, with the exception and to the extent that disclosure of this information has already occurred prior to the receipt of revocation by the above named provider. 2) I understand if written revocation is not received, this authorization will be considered valid for a period of time not to exceed 12 months from the date signed. To initiate revocation of this authorization, I must submit my request in writing to the "authorizes" entity above. 3) I understand a photocopy of this authorization is to be considered as valid as the original. 4) I understand the information used or disclosed pursuant to this authorization may be transmitted electronically and may be subject to re-disclosure by the recipient and may no longer be protected by Federal Law. 5) I understand that I have the right to refuse to sign this authorization, am signing this authorization voluntarily, and that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining the authorization. 6) I have the right to receive a copy of this authorization and any records obtained with its use. 7) I understand this consent includes disclosure of: Alcohol, Drug Abuse, and/or Psychiatric records, Sexually Transmitted Disease, and HIV/AIDS information. 8) I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information, or obtain copies of my health information, by contacting the Privacy Officer.

Expiration Date: This authorization is good until the following date(s) _____or for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately my wishes.

Signature of Patient or Legal Representative: _____ **Date**: _____

If signed by other than the patient, select authority and provide documentation:

___ Guardian of minor child ___Power of Attorney ___Representative of Decedent's Estate ___Representative of incapacitated Adult ___Other

Witness: _____

TRISTATE PAIN INSTITUTE

CHECKLIST: Review of Systems

- **Constitutional**
  - ☐ Use MMJ on occasion for pain
  - ☐ Certified in AZ for MMJ
  - ☐ Certified or has been certified outside of AZ for MMJ
  - ☐ Sleeping problems
  - ☐ Loss of appetite
  - ☐ Change in appetite
  - ☐ Fever
- **Eyes**
  - ☐ Glasses for reading
  - ☐ Double vision
  - ☐ Eye discomfort
  - ☐ Eye pain
- **HENT**
  - ☐ Acquired hearing loss
  - ☐ Dental problems
  - ☐ Vertigo
  - ☐ Recent head injury
- **Breast**
  - ☐ Breast cancer survivor (remission)
- **Cardiovascular**
  - ☐ Swelling of the feet or ankles
  - ☐ S/P chest pain evaluation
  - ☐ Arrythmia- Pacemaker/ACID
  - ☐ Irregular heart beats
  - ☐ Rapid heart rate
  - ☐ Lower Extremity Edema (swelling)
  - ☐ Cardiac murmurs
  - ☐ Chest pain
  - ☐ Varicosities
- **Respiratory**
  - ☐ O2 use (constant)
  - ☐ O2 use (at night)
  - ☐ Shortness of breath
- **Gastrointestinal**
  - ☐ Hemorrhoids
  - ☐ Nausea
  - ☐ Constipation
- **Genitourinary**
  - ☐ Kidney Stones
  - ☐ Kidney Dialysis
  - ☐ Hematuria
  - ☐ Change in urine color
- **Integument**
  - ☐ Bruising (due to blood thinners)
  - ☐ Bruising (not due to blood thinners)
  - ☐ Rash
  - ☐ Nail changes
- **Neurologic**
  - ☐ Cephalgia
  - ☐ Headache on occasion
  - ☐ Migraines
  - ☐ Radicular pain
  - ☐ Tingling in feet
  - ☐ Tingling in hands
  - ☐ Tremors
  - ☐ Falls
  - ☐ Memory difficulties- mild
  - ☐ Possible dementia
  - ☐ Seizures
  - ☐ Focal seizures
  - ☐ Tingling and Numbness
  - ☐ Acute diffuse muscular weakness
  - ☐ Incoordination
  - ☐ Difficulty concentrating
  - ☐ Speech difficulties
  - ☐ Altered mental status
  - ☐ Change in alertness
  - ☐ Loss of consciousness
  - ☐ Staring spells
  - ☐ Recent head injuries
  - ☐ Black Out Spells

- **Musculoskeletal**
  - ☐ Back pain
  - ☐ Joint swelling
  - ☐ Muscle Pain
  - ☐ Hip pain
  - ☐ Knee pain
  - ☐ Limitation of Motion
  - ☐ Stiffness
  - ☐ Neck pain
  - ☐ Leg cramps
  - ☐ Leg pain
  - ☐ Ankle pain
  - ☐ Congenital muscular disease
  - ☐ Joint pain
  - ☐ Muscle cramps
  - ☐ Shoulder Pain
  - ☐ Wrist pain
  - ☐ Elbow pain
  - ☐ Acute muscular weakness
- **Endocrine**
  - ☐ Able to become pregnant
  - ☐ Tubal Ligation
  - ☐ Heat intolerance
  - ☐ Menopause
  - ☐ Well controlled diabetes
  - ☐ Surgical menopause
  - ☐ Moderately controlled diabetes
- **Psychiatric**
  - ☐ Stable psychiatric illness (on medication)
  - ☐ Eating disorder or illness
  - ☐ Withdrawn
  - ☐ Delusions
  - ☐ Impulsive behaviors
  - ☐ Anxiety
  - ☐ Difficulty sleeping
  - ☐ Inattentiveness
  - ☐ Feeling confused
  - ☐ Suicidal ideation
  - ☐ Depression
  - ☐ Excessive anger
  - ☐ Hallucinations
  - ☐ Compulsive behaviors
  - ☐ Homicidal ideation
- **Heme-Lymph**
  - ☐ Blood thinners – prior or current use
  - ☐ Lymph node enlargement
  - ☐ Purpura (purple colored spots on the skin)
  - ☐ Prior or current diagnosis of anemia
  - ☐ Lightheadedness
  - ☐ Easy bleeding
  - ☐ Easy bruising
- **Allergic-Immunologic**
  - ☐ Sinus allergy symptoms
  - ☐ Hives
  - ☐ Frequent illnesses
  - ☐ Medication allergies

Patient Name:

_____

Patient Signature:

_____

Date:

_____

SOCIAL HISTORY

Circle and Answer All That Apply:

Are You A Snowbird? Y N If so, what is your permanent address?

Marital: Single Married Divorced Separated Co-Habitation Partner

Vocational: Work (F/T or P/T) Unemployed Retired Disabled Not Working by Choice

Children: Biological ____ Ages? Adopted / Stepchildren _____ Ages?

Disability: N/A Applying Receiving Benefits S/S W/C

Abuse: Spousal Physical Verbal Emotional PTS Syndrome

Transportation: Own Auto / Motorcycle Get a Ride Public Transportation /Taxi Other:

Tobacco: **Cigarettes** Age Started? _____ Age / Year Quit? _____ PPD? _____

Pipe Age Started? _____ Age / Year Quit? _____

Cigar Age Started? _____ Age / Year Quit? _____

Alcohol: Beer Wine Spirits How much and how often? _____

Are you an alcoholic? Y N DUI? Y N

Drugs: Rx Meds MJ (Certified? Y N) Meth Cocaine Heroin Other? _____

Arrest Record for Drugs? Y N Attended Rehab? Y N

12 Step Program (AA or NA)? Currently _____ In The Past _____

ANYTHING ELSE YOU WOULD LIKE TO ADD?

MY SURGICAL HISTORY

PLEASE CIRCLE ALL THAT APPLY { If multiple, please write how many on the line }

SPINE: Cervical - Front (ACDF) _____ Back (Laminectomy) _____ Both_____ Fusion Y N

Thoracic - Laminectomy _____ Fusion _____ Scoliosis Surgery _____ Vertebroplasty _____

Lumbar - Laminectomy _____ (Back / Front / Side) Vertebroplasty _____

Stimulator (Spinal / Peripheral) Syrinx Drainage Drug Pump SI Fusion

ORTHO: {A = Arthroscopy R = Replacement}

Right

Shoulder A _____ R _____ Elbow A _____ R _____ Wrist/Hand A _____ R _____

Hip A _____ R _____ Knee A _____ R _____ Ankle/Foot A _____ R _____

Carpal Tunnel _____ Ulnar Nerve Release _____ Fracture Surgery _____

Left

Shoulder A _____ R _____ Elbow A _____ R _____ Wrist/Hand A _____ R _____

Hip A _____ R _____ Knee A _____ R _____ Ankle/Foot A _____ R _____

Carpal Tunnel _____ Ulnar Nerve Release _____ Fracture Surgery _____

HEAD: Craniotomy (Tumor / Aneurysm / Trauma) Aneurysm Coiling Shunt (VP / LP) DBS Pituitary

EYES: Cataracts Glaucoma Surgery Detached Retina Lasik / Vision Surgery

ENT: Thyroid Sinus Surgery Head / Neck Tumor Ear Surgery Vocal Cord Surgery

LUNG: Bronchoscopy Lung Biopsy Lung Resection Drainage of Lung Fluid

CV: Heart Stent _____ Coronary Bypass Surgery _____ Cardiac Ablation _____ Pacemaker

Carotid (Stent / Endarterectomy) LE Stent Aortic Stent Renal Stent Femoral Stent

ABD: Appendectomy Gall Bladder Colon Resection Esophagus Stomach / PUD Trauma

Abdominal Surgery (Trauma / Tumor / Infection / Adhesions) Hemorrhoid Pancreas Surgery

Endoscopy (Upper / Lower) Liver (Biopsy / Resection) Drainage of Fluid Colostomy

GYN: Hysterectomy Tubal Ligation Endometriosis Adhesions C-Section D&C

CANCER: Skin Lung Stomach/ Intestine/ Colon Brain Breast (Biopsy / Mastectomy) Prostate Ovarian

Ovarian Uterine Bone Kidney Bladder Thyroid Head / Neck

GU: BPH Penile Prosthesis Bladder Suspension Uterine Suspension Renal

OTHER SURGERIES:

TRISTATE PAIN INSTITUTE
Policy for Financial Responsibility

Dear Valued Patient,

Medical providers offering discounted fees for services to persons with and without health insurance use a Sliding Fee Schedule (SFS). The SFS determines, based on gross family income, the percentage or portion of billed charges that the uninsured client will be responsible for. SFS must be based on current Federal Poverty Guidelines. They must adhere to A.A.C. R9-1-504 Sliding Fee Schedule submission and content. Federally Qualified Health Centers (FQHCs), FQHC-Look-Alikes (FQHC-LALs), National Health Service Corp sites, Arizona Loan Repayment sites and J-1 visa waiver sites are required to develop and implement a SFS and SFS policy, as well as post a notice about the availability of a SFS in a visible location at their facility. If you have a question or believe you may qualify for a SFS plan because you are uninsured, please ask us.

Thank you for choosing the TriState Pain Institute as one of your healthcare providers. As with all of our services, please bring all questions or concerns to our attention immediately. As always, we strive each day to earn your confidence as your partner for good health.

I have read and understand all of the above.

_____ _____

Patient's Signature Date

THE TRISTATE PAIN INSTITUTE

PAIN MANAGEMENT PHILOSOPHY AND PRACTICE

As a patient of TriState Pain, you can expect the following:

Evaluation of you as a Chronic Pain Patient – Evaluation of your pain will initially include a pain history and assessment of the impact of pain on you, a directed physical examination, a review of previous diagnostic studies, a review of previous interventions, a drug history, and an assessment of coexisting diseases or conditions.

Treatment Plan – Treatment planning will be tailored to both you as an individual and the presenting problem. Consideration will be given to different treatment modalities, such as formal pain rehabilitation program, the use of behavioral strategies, the use of non-invasive techniques, or the use of medications, depending upon the physical and psychosocial impairment related to the pain. An opioid trial will not be initiated in the absence of a complete assessment of the chronic pain complaint. Opioids will not be prescribed on the first patient visit unless there is extreme extenuating or acute care reasons.

Informed Consent – Your physician must discuss the risks and benefits of the use of controlled substances with you, persons you designate or with your surrogate or guardian if as a patient you are without medical decision-making capacity. This discussion will include the risks of addiction/abuse, not alleviating all or your pain, and treatment alternatives including the effects of no treatment.

Agreement for Treatment – There is circumstances in which the use of a documented verbal or written agreement between physician and patient outlining your responsibilities as a patient may be necessary for safe and responsible opioid prescribing. Such an agreement will include urine/serum medication levels and baseline screening when requested; number and frequency of all prescription refills; reasons for which drug therapy may be discontinued (e.g., violation of agreement) requirement that the patient receive all controlled substance prescriptions from one physician and one pharmacy whenever possible. You have received several documents with information regarding opioid / controlled substance treatments and the risks associated. These documents include the rules and terms of such treatment while you are a patient of TriState Pain.

Consultation – Consultation with specialist in addiction, psychiatry or with a psychologist may be warranted, depending on the complexity of the presenting problem. The management of chronic pain in patients with a history of addiction or a co-morbid psychiatric disorder requires special consideration, but does not necessarily contraindicate the use of opioids.

Controlled Substance Prescription Drug Monitoring (PMP) - The Arizona Controlled Substance Prescription Drug Monitoring Program's (PMP) mission is to reduce pharmaceutical drug diversion while promoting legitimate medical practice and patient care. PMP data accumulates Schedule II through IV controlled substance prescription and dispensation information for facilitating diversion awareness and intervention. It is assumed prescribers and pharmacists dedicate their professional skills to identify and assist controlled substance abusers. Prescribing practitioners and dispensers must treat this information in accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and applicable state law. This includes accessing and checking the PMP on each patient for multiple providers prescribing to the patient, or multiple pharmacies being used to fill prescriptions. These can be signs of co-prescribing, diversion or abuse. Law enforcement users must obtain, use and share this information with criminal justice partners only in conjunction with criminal investigative matters. This data shall not be disclosed, sold, or transferred. All of our patients will be monitored through this program on a monthly basis. We also utilize the Nevada PMP Aware and California CURES prescription drug monitoring databases and will be able to see your activity at different pharmacies, as well as prescriptions given by other doctors We may access the PMP of any state. A copy of your PMP will be printed and scanned into your medical records at each visit. If you are in violation of your contract, you may be discharged from our clinic.

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