Medical Pain Management Services, LTD

815-397-8400

Patient Questionnaire

Patient Name:_____Date:_____

General History

Please comment on your general health status. Check any items that are presently a problem or list any conditions you have that are not seen below.

Height_____ **Weight**_____

Heart: ☐ Arrhythmia ☐ Heart attack ☐ Coronary artery disease ☐ Angina ☐ Bypass
☐ Pacemaker ☐ Blockage ☐ Valve repair/replacement ☐ Stents
☐ Congestive Heart failure ☐ Other:_____

Lungs: ☐ Asthma ☐ Pneumonia ☐ Chronic bronchitis ☐ Emphysema ☐ COPD
☐ Smoker # of yrs.____ ☐ Other:_____

Liver: ☐ Hepatitis ☐ Cirrhosis ☐ Fatty liver ☐ Enlarged Liver
☐ Other:_____

Kidney: ☐ Renal failure ☐ Kidney stones ☐ Frequent infections ☐ Other:_____

Diabetes: ☐ Non insulin ☐ Insulin dependent ☐ Diet controlled

Hypertension: ☐ Medicated ☐ Diet controlled

Bleeding disorder: ☐ Blood thinners ☐ Hemophilia ☐ Clotting disorder ☐ Anemia
☐ Other:_____

Other Conditions: ☐ Peripheral vascular disease ☐ Neuropathy ☐ Stroke ☐ TIA
☐ Seizure disorder ☐ Cancer where?_____

Conditions note mentioned, or comments:_____

_____

_____

List **all medications** you take and what you take them for. Include drug name, dose, and frequency.

_____

_____

_____

_____

_____

_____

_____

_____

List allergies to medication. Include drug and your reaction:

_____

_____

_____

_____

_____

Patient History

When did your pain start?_____

_____

What were you doing at the time?_____

_____

Is your pain: ☐ Getting better ☐ Constant ☐ Sporadic ☐ Getting worse ☐ Staying the same

What makes your pain worse? ☐ Walking ☐ Standing ☐ Sitting ☐ Bending forward ☐ Twisting
☐ Lying down ☐ Other:_____

What makes your pain better? ☐ Walking ☐ Standing ☐ Sitting ☐ Lying down ☐ Other_____

_____

Where is your pain now?_____

_____

Check the quality of your pain: ☐ Shooting ☐ Dull Ache ☐ Cramping ☐ Sharp ☐ Burning
☐ Severe Ache ☐ Pressure ☐ Throbbing ☐ Other:_____

Comment further if you choose: _____

_____

_____

On a scale of 0 – 10 (0 being no pain, 10 being bad enough to go to the ER) your pain level is: (circle)
0 1 2 3 4 5 6 7 8 9 10

Answer the questions below that apply to your condition:

Do you have shooting or radiating pain? ☐ Yes ☐ No Where? _____

_____

Do you have any numbness or tingling in any extremities? ☐ Yes ☐ No Where? _____

Does the pain inhibit your activity? ☐ Yes ☐ No ☐ Sometimes

Does the pain awaken you? ☐ Yes ☐ No ☐ Sometimes

How often do you take pain medication? (amount of time between does) _____

_____

What type of work do you do? _____

_____

Which would best describe your work? ☐ Retired ☐ Homemaker ☐ Office ☐ Sales ☐ Construction ☐ Industrial ☐ Other _____

Did your injury happen at work? ☐ Yes ☐ No

Have you been off work due to your present condition? ☐ Yes ☐ No If yes, for how long?_____

Have you applied for Workman's Compensation? ☐ Yes ☐ No

Do you have an attorney involved with your case? ☐ Yes ☐ No Attorney's name, address, and phone:_____

_____

Have you had back or neck surgery? ☐ Yes ☐ No How many?_____

How long did you get acceptable relief from your **last** back/neck surgery?_____

Did you return to work after surgery? ☐ Yes ☐ No If yes, for how long?_____

Please list **all** surgeries you have had in the past: _____

_____

_____

_____

_____

_____

_____

_____

List any treatments or medications you have tried in the past for your current pain: _____

_____

_____

_____

What pharmacy do you use? _____

Primary Care Physicians name, phone and address: _____

_____

Please return this form to our office when you come for you appointment.
If you have any further questions, the physician will answer them in full at the time of your appointment.

Signature:_____Date:_____

Medical Pain Management Services, Ltd.

Patient_____

Date_____

"Review of Systems"-To be completed by the patient.

		Current Health Problem	Explanation
YES	NO	**CONSTITUTIONAL**	
		Elevated Blood Pressure	
		Change in energy	
		Change in weight	
		Fever, chills or sweats	

YES	NO	**HEENT**	
		Problems with eyes, ears, nose, mouth, or throat	
		Double vision, blurry vision, temporary loss of vision	
		Difficulty swallowing	

YES	NO	**CARDIOVASCULAR SYSTEM**	
		History of heart attack, angina, chest pain	
		Rapid or slowed pulse	
		Cold extremities, claudication (pain in legs when walking)	

YES	NO	**RESPIRATORY SYSTEM**	
		Bronchitis, asthma, shortness of breath	
		Tuberculosis	
		Pneumonia	
		Wheezing	
		Frequent cough	
		Coughing up blood	
		Productive cough	

YES	NO	**GASTROINTESTINAL SYSTEM**	
		Nutrition or dietary problems	
		Change in appetite (increased or decreased)	
		Recent weight loss or weight gain	
		GERD (stomach reflux disease)	
		Peptic ulcers, bleeding ulcers	
		Nausea, vomiting, blood when vomiting	
		Diarrhea/Constipation/Loss of stools, incontinence	
		Blood in stools or black tarry stools	

YES	NO	**GENITOURINARY SYSTEM**	
		Loss of urine, incontinence, urgency	
		Difficulty starting to urinate/Pain with urination	
		Blood in the urine	
		Issues related to sexual intercourse, libido	
		Impotence (Sexual dysfunction)	
		For Women: Problems/Changes with menstruation	
		History of venereal disease, herpes	
		Up to urinate more than once during the night	

YES	NO	**INTEGUMENTARY/SKIN/INFECTION**	
		Skin problems: wounds, scars, excessive perspiration	
		Excessive itchiness of the skin	
		MRSA (methicillin resistant Staphylococcus aureus)	

Medical Pain Management Services, Ltd.

Patient_____

Date_____

"Review of Systems"-To be completed by the patient.

YES	NO	Current Health Problem	Explanation
		MUSCULOSKELETAL	
		Neck pain, recent injury	
		Back pain, recent injury	
		Weakness of arms, dropping items	
		Weakness of legs, legs "giving out"	
		Uncontrolled muscle movements	
		Night cramps	
		Muscle Aches/Pain, Swelling or Stiffness	
		Arthritis	
		History of Fractures	
		Change in temperature of extremities, swelling	

YES	NO		
		NERVOUS SYSTEM	
		History of Stroke or TIA ("mini stroke")	
		Frequent headaches: migraines, sinus headaches	
		Seizure disorder (convulsions, fits)	
		Mental status: confusion, fatigue, memory loss	
		Loss of Balance, problems with coordination	
		Feeling of numbness or "pins and needles"	
		Disturbance of taste/smell, hearing	
		Focal weakness, a muscle "not working right"	

YES	NO		
		HEMATOLOGIC/LYMPHATIC/IMMUNOLOGIC	
		History of blood clots	
		Blood thinners: Coumadin, Plavix, Aspirin	
		Liver problems: hepatitis, cirrhosis, jaundice	
		Anemia	
		History of bleeding (w/ minor injury) or bruising easily	
		Fever, chills, night sweats	

YES	NO		
		ENDOCRINE	
		Diabetes or excessive thirst, frequent urination	
		Thyroid problems	
		Hot or cold intolerance	

YES	NO		
		PSYCHIATRIC HISTORY	
		Depression, tearfulness, hopelessness/Mood swings	
		Feeling suicidal or past suicide attempts	
		Sleep disturbances, insomnia	

YES	NO		
		SOCIAL HISTORY	
		Use of tobacco: smoke cigarettes, cigar, chew	
		Alcohol Use (list usage in right hand column)	
		Use of recreational or street drugs	
		Caffeine use (coffee, tea, pop, Excedrin)	
		Living Will	

YES	NO		
		ALLERGIES/INTOLERANCES	
		Environmental allergies, hay fever, ragweed, dust, etc.	
		Any allergies to Medications or Foods-LIST ALL	

Patient_____

Date_____

Oswestry Low Back Pain Disability Questionnaire

Instructions

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem.

Section 1 – Pain intensity

- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

Section 2 – Personal care (washing, dressing etc)

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but manage most of my personal care
- ☐ I need help every day in most aspects of self-care
- ☐ I do not get dressed, I wash with difficulty and stay in bed

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed eg. on a table
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift very light weights
- ☐ I cannot lift or carry anything at all

Section 4 – Walking*

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me from walking more than 1 mile
- ☐ Pain prevents me from walking more than 1/2 mile
- ☐ Pain prevents me from walking more than 100 yards
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time

Section 5 – Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favourite chair as long as I like
- ☐ Pain prevents me sitting more than one hour
- ☐ Pain prevents me from sitting more than 30 minutes
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

Section 6 – Standing

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than 1 hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

Section 7 – Sleeping

- ☐ My sleep is never disturbed by pain
- ☐ My sleep is occasionally disturbed by pain
- ☐ Because of pain I have less than 6 hours sleep
- ☐ Because of pain I have less than 4 hours sleep
- ☐ Because of pain I have less than 2 hours sleep
- ☐ Pain prevents me from sleeping at all

Section 8 – Sex life (if applicable)

- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life is normal but causes some extra pain
- ☐ My sex life is nearly normal but is very painful
- ☐ My sex life is severely restricted by pain
- ☐ My sex life is nearly absent because of pain
- ☐ Pain prevents any sex life at all

Section 9 – Social life

- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests eg, sport
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

Section 10 – Travelling

- ☐ I can travel anywhere without pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad but I manage journeys over two hours
- ☐ Pain restricts me to journeys of less than one hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from travelling except to receive treatment

References

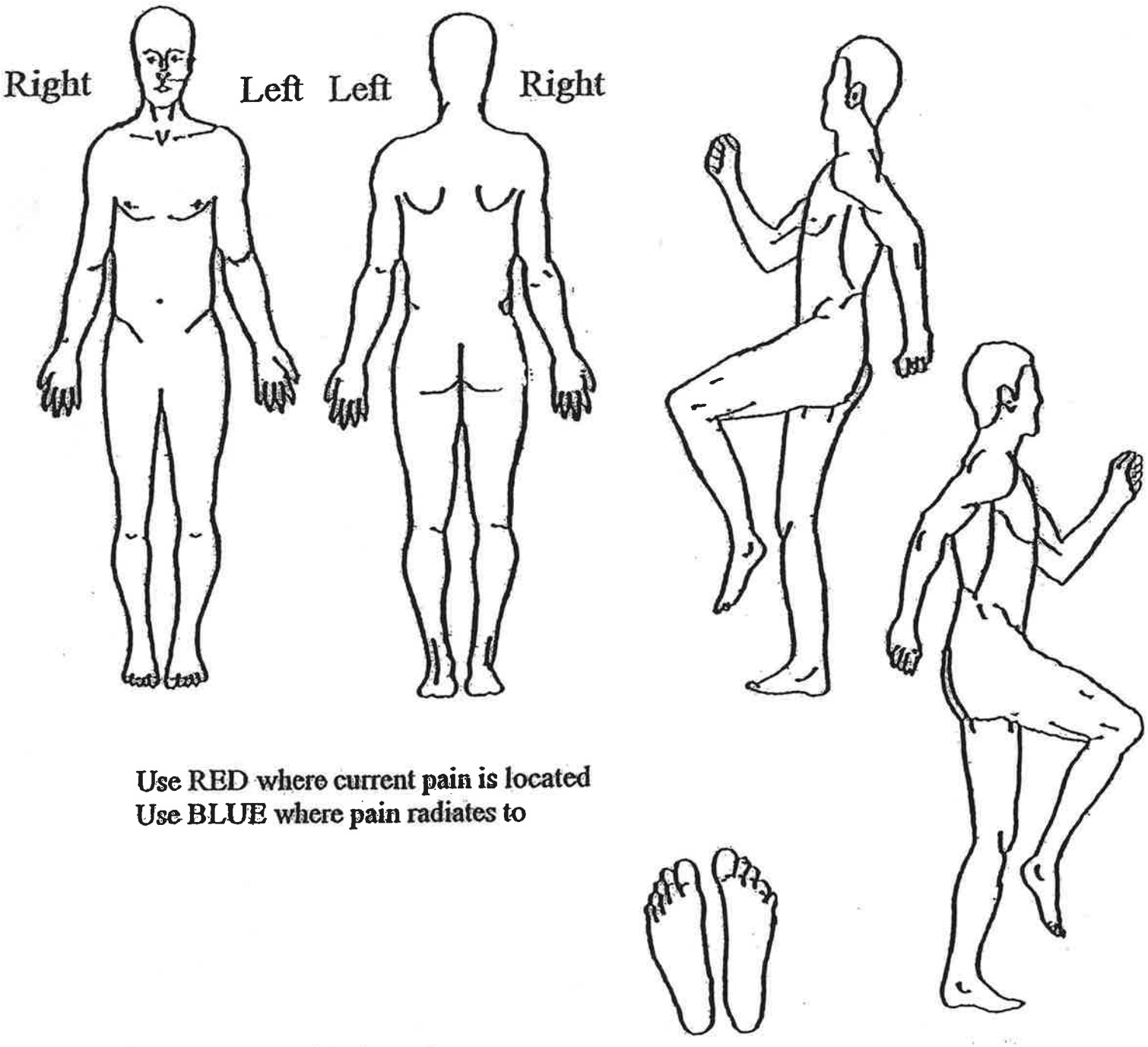
1. Fairbank JC, Pynsent PB. The Oswestry Disability Index. Spine 2000 Nov 15;25(22):2940-52; discussion 52.

Patient_____

Date_____

Pain Distribution Form

To Be Completed By Patient



Use RED where current pain is located
Use BLUE where pain radiates to

My pain level is (circle one)

0	1	2	3	4	5	6	7	8	9	10
none		slight		moderate		severe		extreme		couldn't be worse

Medical Pain Management Services, LTD

Patient Name_____ _____ _____
(Last) (First) (MI) (Date)

Social Security#_____-_____-_____ Sex: M____F____ Date of Birth: _____/_____/_____

Address: _____ City: _____

State: _____ Zip: _____ Marital Status: ____Single ____Married ____Other

Home Phone: _____ Work Phone: _____

E-Mail Address_____ Cell Phone: _____

Primary Physician: _____ Office Phone: _____

EMPLOYMENT INFORMATION

Occupation: _____ Status: _____Full _____Part _____Retired _____Unemployed

Employer Name: _____

Employer Address: _____

INSURANCE INFORMATION

Primary Insurance Name: _____

Claim Mailing Address: _____

City: _____ State _____ Zip_____ Phone#_____

Group# _____ Policy # _____

Insured Name: _____ Date of Birth_____/_____/_____
(Month/Day/Year)

Address: _____

Secondary Insurance Name: _____

Claim Mailing Address: _____

City: _____ State _____ Zip_____ Phone#_____

Group# _____ Policy # _____

Insured Name: _____ Date of Birth_____/_____/_____
(Month/Day/Year)

Address: _____

SERVICES ARE DUE TO:

☐ Worker's Compensation ☐ Auto Accident ☐ Personal Injury

IF SERVICES ARE DUE TO WORK COMP OR AUTO ACCIDENT

Send Claims to: _____ Mailing Address _____

City: _____ State _____ Zip _____ Phone# _____

Adjustor's Name: _____

Date of Injury: _____ Claim # _____

Insured Name _____ Address _____

City: _____ State _____ Zip _____

ATTORNEY INFORMATION

Name: _____ Phone _____

Address _____ City _____ State _____ Zip _____

GUARANTOR INFORMATION

(Individual Responsible for payment, if different than patient)

Patient Relationship to Guarantor: _____ Self _____ Spouse _____ Child _____ Other

Name: _____ _____ SSN: _____/_____/_____
(Last) (First) (MI)

Address: _____ City & State _____

Zip: _____ Home Phone: _____ Work Phone: _____

Guarantor's Employer: _____

Employer Address: _____

Employment Status: _____ Full Time _____ Part Time _____ Retired _____Unemployed

REVISED 7-10-12 AKC REVISED: 5/14 CP

NOTICE OF PRIVACY PRACTICES

Medical Pain Management Services, LTD

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your health information. We are also required by law to give you this notice of our duties and privacy practices and your rights. This notice describes the uses and disclosures we may make with your protected health information, as well as your rights to access and control your protected health information including demographic information that may identify you and that relates to your past, present, or future physical or mental health condition and related health care services.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make and maintain records of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly.

If you have any questions about this Notice, please contact our Privacy Officer listed in Section E.

A. How We May Use or Disclose Your Health Information

We collect health information about you and store it on paper as well as electronically. This information comprises your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide and coordinate your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we may contact your insurer to verify benefits for which you are eligible, obtain prior authorization, or give them details they need about your treatment to make sure they will pay for your care. We will also use or disclose your medical information to bill directly and to obtain payment from third parties that may be responsible for payment, such as family members.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our independent contractors known as "business associates" that perform administrative services for us. We have a written contract with

each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

4. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

5. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization. In addition, we will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

6. Required by Law. We will use and disclose your health information when we are required to do so by law, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirements set forth below concerning those activities.

7. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or

disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

8. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

9. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

10. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

11. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

12. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

13. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

14. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

15. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

16. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

17. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

18. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances, our business associate may provide the notification. We may also provide notification by other methods as appropriate.

19. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When We May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about our denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information

at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in the paragraphs describing treatment, payment, health care operations, notification and communication with family and specialized government functions or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, please contact our Privacy Officer listed below. The Notice of Privacy Practices is also available at our web site: http://www.medicalpain.com.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment We will also post the current notice on our website.

E. Contact and Complaints

To exercise any of the rights described above, or if you have any questions about this Notice, please contact our Privacy Officer at (815) 397-8400 or mail questions to us at Medical Pain Management Services, 1235 N. Mulford Road, Suite 222 Rockford, IL 61107 Attention: Privacy Officer.

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer. If you are not satisfied with the manner in which we handle your complaint, you may submit a formal complaint to: the Secretary of the Department of Health and Human Services, Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue. S.W., Room 509F, HHH Building, Washington, D.C. 20201. There will be no retaliation for filing a complaint.

F. Effective Date

The effective date of this Notice of Privacy Practices is September 23, 2013.

NOTICE OF PRIVACY PRACTICES

Medical Pain Management Services

THE NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

MY SIGNATURE BELOW ACKNOWLEDGES THAT I HAVE RECEIVED AND REVIEWED THE MEDICAL PAIN MANAGEMENT NOTICE OF PRIVACY PRACTICES.

Signature_____Date:_____

Signature page should be retain in individuals record

Verbal Release of Information

Phone (815) 397-8400

Medical Pain Management Services is committed to keeping our patients' private health information confidential. However, we realize there may be circumstances when you would like to have a spouse or close relative make appointments, request prescriptions, or have other communication with our office. If you wish others to have the right to call our office regarding you care at Medical Pain Management Services, please list the name and relationship below.

Name	Phone	Relationship
Name	Phone	Relationship
Name	Phone	Relationship
Name	Phone	Relationship

Patient Signature

Date

MEDICAL PAIN MANAGEMENT SERVICES, LTD
FINANCIAL POLICY & PATIENT RESPONSIBILITIES

Medical Pain Management Services (MPMS) firmly believes that a good physician/patient relationship is based upon understanding and good communication. We realize the billing and financial aspects of healthcare can be complicated and it is our goal to simplify this process as much as possible by keeping you informed of your financial responsibility in statement form and through our secure web portal. Please read this carefully and if you have any questions, please do not hesitate to ask.

PAYMENT:

1. All applicable co-payments, co-insurance and personal balances, both current and prior are due at the time of service unless other payment arrangements have been made. In some cases, you may be asked to pay the balance of your account or make payment arrangements prior to making your next appointment.
2. If you fail to meet the financial obligations agreed upon in this financial policy or other payment arrangements made, your outstanding balance will be sent to a collection agency and you will be required to pay the entire balance and any collection agency fees, up to 30%, before being scheduled for any further appointments.
3. Accounts over 30 days old from billed date are subject to an interest rate of 1.5% monthly.
4. If after billing your insurance plan the claim is denied for any reason, the charges then become your responsibility.
5. There is a $25.00 service charge for returned checks.
6. If you have questions regarding your charges/bill please contact Tenzing Billing at 815-636-6192.
7. Medical Pain Management Services accepts the following forms of payment: cash, checks, Visa, Master Card, or Discover Card.
8. Over payments will be refunded after all charges have been processed and paid by your insurance company.

INSURANCE:

1. Our office participates with a variety of insurance plans. MPMS accepts assignment of insurance benefits. This means your insurance plan will pay MPMS directly the amount due based on your plan coverage.

   It is your responsibility to:

   - Bring your insurance card to each visit and notify MPMS of any changes to your coverage and personal information
   - Know and understand your benefit plan
   - If MPMS physicians do not participate in your insurance plan or you are a self-pay patient, payment in full is expected at the time of the services unless prior arrangements have been agreed upon.
2. Be aware that MPMS physicians may provide services at the MPMS Pain Clinic, Rockford Ambulatory Surgery Center, OSF Outpatient Services, SwedishAmerican Hospital, Rochelle Community Hospital, & KSB Hospital. Your insurance coverage may be different for each facility.

3. We will work with your insurance plan to obtain payment. Your assistance in collection from your insurance plan may be required.

AUTO & PERSONAL INJURY CASES:

1. Our policy regarding injury cases is to require a minimum monthly payment in order to keep your account current.
2. MPMS requires both your health insurance plan information as well as the accident insurance plan information at the initial visit in order to file claims to both potential responsible parties. This eliminates possible denied claims at a later date due to timely filing issues imposed by insurance companies.

RELEASE OF PROTECTED HEALTH INFORMATION

By signing this form, you are authorizing Medical Pain Management Services, LTD or its designee (s) to release and disclose protected health information as may be necessary to process insurance claims and obtain payment on your behalf. This information is acquired during the course of your examination and treatment. This includes any alcohol or drug abuse information that may be protected by federal Regulations-42CFR Part 2.

AUTHORIZATION TO ACCESS MEDICATION HISTORY

By signing this form, you are authorizing Medical Pain Management Services, LTD or its staff to view medication history obtained from external sources.

- **A note regarding Medication Refills:**
  You must be seen by your provider every 3 months (90 days) in order to obtain a refill on your medications.

- **Please notify MPMS at least 24 hours in advance if you cannot keep your appointment. Missed appointments are subject to $50.00 charge which you will be held responsible for payment.**

I have read Medical Pain Management Financial Policy. I understand and agree to this policy.

_____/_____

Signature of Patient or Responsible Party **Date**

_____/_____

Signature of Co-Responsible Party **Date**