Michigan Pain Specialists

(734) 995-7246
3520 Green Court, Suite 100
Ann Arbor, MI 48105

Patient Name:
DOB:
Age:
Gender:

Patient Demographic

Date: Referral:

Patient Name: ______________________ Date of Birth: ______________

Address ______________ City ______________ State ________ Zip ________

Home Phone ______________ Social Security Number ______________

***** Do you live in a nursing home? Yes / No If you live in a nursing home or other assisted living facility, please notify our staff.*****

Marital Status (please circle one) Single Married Divorced Widowed Committed/ Engaged

Work Status (please circle one): Full-Time Part-time Student Retired Unemployed Sick-Leave Disability

Employer/School ______________________ Work Phone No. ______________

Work Address ______________ City ______________ State ________ Zip ________

Full Name of Referring Physician ______________________ Phone No. ______________

Full Name of Primary Physician ______________________ Phone No. ______________

Emergency Contact ______________ Relationship ______________ Phone No. ______________

*Please list an emergency contact that lives outside of your home. If you list a spouse below, we will attempt to contact them first.

Spouse's/ Partner's Name ______________________ Date of Birth ______________

Employer ______________________ Work Phone No. ______________

Work Address ______________ City ______________ State ________ Zip ________

Primary Insurance ______________ ID Number ______________ Group ________

Policy Holder Name ______________ Relationship ______________ DOB ________

Secondary Insurance ______________ ID Number ______________ Group ________

Policy Holder Name ______________ Relationship ______________ DOB ________

Is your pain related to an accident? NO YES If yes, Date of Injury ______________

Please circle one: Worker's Comp Auto Accident Other ______________

DO YOU STILL HAVE AN ACTIVE WORK COMP OR AUTO CLAIM? NO YES If yes:

Case Mgr/Claim Adjuster Name ______________________ Phone No ______________

Insurance Company ______________________ Claim No. ______________

Claims Address ______________ City ______________ State ________ Zip ________

Is there a good number for us to leave messages reminding you of upcoming appointments? (please circle)

Home Phone Work Phone Other ______________ Please DO NOT make reminder calls to me

Is there someone we should contact who handles your billing information for you? NO YES If yes:

Billing Contact ______________ Relationship ______________ Phone No. ______________

______________________ ______________________

Signature of Patient Date Signed

______________________ ______________ ______________

Advocate/Authorized Signature (if Patient is a minor) Relationship Date Signed

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Patient Name:
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HIPAA Acknowledgement

Referral:

Date:

I understand that I have the right to review Michigan Pain Specialists, P.L.L.C. Notice of Privacy Practices prior to signing this consent. I understand that Michigan Pain Specialists, P.L.L.C. reserves the right to change their notice and practices, and I will be given new notification if this occurs. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations, and the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I understand that I am authorizing the release of all or any part of my medical record for the purposes of treatment, payment, or practice operations. This release may include records containing information regarding the diagnosis and/or treatment of HIV or AIDS, mental illness, and/or drug and/or alcohol addiction or abuse to any person or corporation which is or may be liable under a contract for all or part of the medical charges, including but not limited to: Medicare, Medicaid, or other private or public health insurance programs, reviewing agencies, worker's compensation carriers, welfare agencies or patient's employer. The records may be needed in order to process a claim for medical services. I authorize Michigan Pain Specialists, P.L.L.C. to release information needed for billing purposes to entities that may provide services pertaining to my physician visit, such as reference laboratories.

Signature of Patient or Legal Representative ____________________ Date ____________

Printed Name of Patient ____________________ Witness ____________

Release of Medical Information to Family Members
During the course of your treatment it may become necessary to discuss your condition with a family member or family friend. Below, please indicate to whom we may discuss your condition and/or treatment with:

Spouse Name: ____________________

Family Member Name(s): ____________________

Friend(s) Name(s): ____________________

Restrictions
Please do not discuss my treatment with: ____________________

Documentation of Failure to Obtain Signed Acknowledgement
I presented this Acknowledgement to the patient. The patient refused to provide a signature when requested.

Staff Member Signature ____________________ Date ____________

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Patient Name:

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Financial Policy

Date:

Thank you for choosing Michigan Pain Specialists, P.L.L.C. as your health care provider. The following is our Financial Policy. If you have any questions or concerns about our payment policies please do not hesitate to ask our business office personnel. We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Forms prior to seeing the doctor.

Patient's portion of payment, as well as any past due balances, are due at the time services are rendered unless prior arrangements have been made with the billing department. We accept cash, personal checks, and all major credit cards for payment.

We accept assignment with most major insurance companies and participating provider plans (Blue Cross/Blue Shiled, Medicare, Aetna, Care Choices, Preferred Choices, Health Alliance Plan). However, you must understand that:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance carrier.

2. All charges are your responsibility whether your insurance company pays or not.

3. Fees for services, along with unpaid deductibles and co-payments, are due at the time of treatment.

4. If the insurance company does not pay your balance in full within 30 days we ask that you contact the carrier to request prompt payment. Please inform our office of the carrier's response.

5. Returned checks will be subject to a $30.00 collection charge. We will notify you by mail. If the check is not picked up within 10 days the check may be turned over to law enforcement.

6. Balances over 90 days may be charged a handling fee.

7. Unpaid balances over 60 days are subject to collections via small claims court, attorney, and/or collection agency with applicable collection fees.

8. Failure to cancel an appointment may result in a cancellation fee/No show fee charge of $100.00 for new patients and $50.00 for return patients.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Authorization to Release and Assign Insurance Benefits: I authorize release of any information required to act on any insurance claim and permit photographic or other facsimile reproduction of this authorization to be used in place of the original assignment. I here by assign to Michigan Pain Specialists, P.L.L.C. the medical and/or surgical benefits I am entitled from my insurance company and/or Medicare.

This authorization is in effect for all future claims, until I choose to revoke it in writing.

I, the undersigned, understand and agree to the above Financial Policy. I understand that I am financially responsible for all charges incurred for my medical treatment.

____________________ Patient's Signature

__________ Date

____________________ Printed Name of Patient

____________________ Relationship to Patient if not patient

____________________ Authorized Witness

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Gender:

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New Patient Questionnaire

Date:

Welcome to Michigan Pain Specialists. Please carefully answer these questions so that we can help you decrease pain and increase function.

Please correct any misspellings or incorrect information below.

Name ______________________________ Birthdate ____________

Height ______________ Weight ______________

Where do you hurt? ______________________________

Please provide the names of people who you wish to receive information about your visits.

Primary Care Physician

Name ______________________________

Address ______________________________ City ______________

State ______________ Phone (   )   -   Fax (   )   -

Referring Physician

Name ______________________________

Address ______________________________ City ______________

State ______________ Phone (   )   -   Fax (   )   -

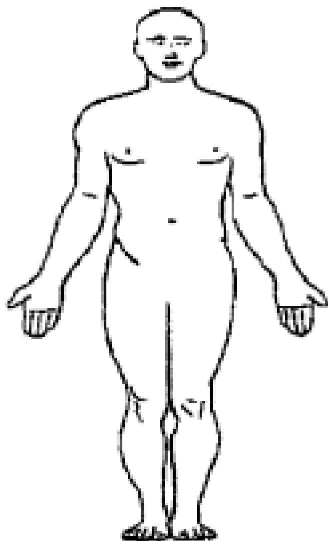
Others

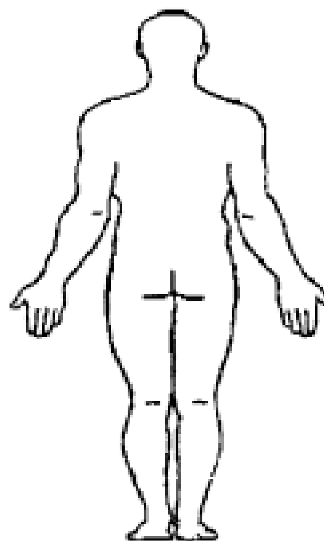
Name ______________________________

Address ______________________________ City ______________

State ______________ Phone (   )   -   Fax (   )   -

Please show the location of your pain by drawing on the figures below:





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New Patient Questionnaire

Date:

When did your pain start? ______________________________

Do you know what specific date your pain started? NO YES ________/__________/_________

Do you know what caused your pain? NO YES Explain: ______________________________

Have you ever had pain like this before? NO YES (If yes, how did you treat the pain?) ______________________________

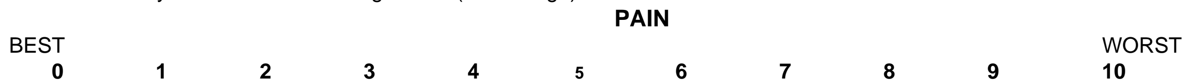
How often does your pain occur? Hourly Daily Weekly Occasionally Constant

Has your pain changed over time? NO YES Explain: ______________________________

Describe in your own words what your pain feels like:

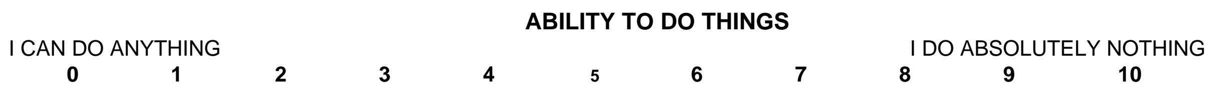
Please mark where you are on the following scales (on average):

PAIN



BEST **0 1 2 3 4** 5 **6 7 8 9 10** WORST

ABILITY TO DO THINGS



I CAN DO ANYTHING **0 1 2 3 4** 5 **6 7 8 9 10** I DO ABSOLUTELY NOTHING

Check any symptoms you are experiencing

- ☐ Burning
- ☐ Cold
- ☐ Hot
- ☐ Tingling
- ☐ Electric
- ☐ Pounding
- ☐ Sharp
- ☐ Dull
- ☐ Pressure
- ☐ Squeezing
- ☐ Throbbing
- ☐ Spasms
- ☐ Aching
- ☐ Cramping
- ☐ Shooting
- ☐ Numbness
- ☐ Weakness

Do you notice any of the following physical changes with your pain?

_______ Hair growth _________ Swelling _______ Nail bed changes

_______ Vision Changes _________ Sweating _______ Loss of consciousness

_______ Muscle Spasms _________ Weakness _______ Loss of bowel/Bladder control

_______ Skin color changes _________ Temperature changes

What relieves your pain?

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New Patient Questionnaire

Date:

What makes your pain worse?

Please circle all other modalities tried for pain relief:

Steroid injections	Surgery	Aqua Therapy	Traction	Massage
Acupuncture	TENS	Biofeedback	Other:	

Who have you seen to help you with your pain? (Please circle and give names)

Primary Care Doctor
Surgeon
Orthopedic Surgeon
PM&R Doctor
Neurosurgeon
Neurologist
Emergency Room
Pain Clinic
Physical Therapist
Chiropractor
Naturopath
Psychologist
Psychiatrist
Other

What tests have been done to diagnose your pain? (Please circle and give dates)

Xrays
MRI Scan
CAT Scan
Bone Scan
EMG
Myelogram
Thermography
MMPI-2 Test
Nerve Blocks
Other

List all **Allergies,** and list the reaction:

IF YOU ARE TAKING ANY OF THE FOLLOWING MEDICINES, **NOTIFY THE DOCTOR**

- ☐ Coumadin (warfarin)
- ☐ Plavix (clopidogrel)
- ☐ Ticlid (ticlodipine)
- ☐ Lovenox (enoxaparin)
- ☐ Innohep (tinzaparin)
- ☐ Fragmin (dalteparin)
- ☐ Trental (pentoxifylline)
- ☐ Aggrenox
- ☐ NSAIDS
- ☐ Aspirin
- ☐ Pletal (cilostazol)

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New Patient Questionnaire

Date:

List ALL medicines, vitamins, herbs, nutritional supplements you take:

Drug	Dose	How often do you take it?	Physician Who Ordered

Please circle which medicines you have tried for pain relief:

NSAIDS:	Celebrex, Vioxx, Bextra, Motrin/ Ibuprofen, Aleve/ Naprosyn, Tylenol, Aspirin
Narcotics:	Morphine, Oxycontin, Methadone, Duragesic Patch, Vicodin, Lorcet, Norco, Hydrocodone, Darvocet, Percocet, Oxycodone, Ultram
Antidepressants:	Paxil, Prozac, Celexa, Elavil/ Amitriptyline, Zoloft, Lexapro, Effexor, Desyrel/Trazadone, Pamelor/Nortrptyline, Sinequan/Doxepin
Anticonvulsants:	Neurontin, Lamotrigine, Dilantin, Tegretol
Muscle Relaxants:	Soma, Flexeril Skelaxin, Diazepam/Valium, Klonopin/ Clonazepam, Zanafle, Baclofen
Other Medicines	Lidoderm Patch, Capsaicin, Catapress Patch

Please List ALL surgeries and give dates:

SURGERY	DATE

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New Patient Questionnaire

Date:

What type of work do you do? ______________________________

If you are retired, what type of work did you do? ______________________________

What is your favorite hobby or leisure activity? ______________________________

How does your pain affect your work? ______________________________

Does your pain affect your hobbies or family/personal life? ______________________________

Many factors exacerbate pain symptoms. Please circle Yes or No:

Yes / No Missing work because of pain
Yes / No Workman's Comp case
Yes / No Receiving disability
Yes / No Use of alcohol
Yes / No Involved in a lawsuit
Yes / No Use of drugs
Yes / No Use of tobacco
Yes / No Under psychiatric care
Yes / No Sexually active
Yes / No Use of illegal drugs
Yes / No DUI/DWI

Please circle your highest completed level of education:

Post Graduate (PhD/Masters/Professional) College High School Elementary

Please circle all that apply:

Married Divorced Remarried Committed Single #of children_______

If female, are you pregnant? YES NO Don't Know

What pain score is needed to get you back to work?

BEST										WORST
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

What pain score is needed to get you back into performing hobbies or leisure activities?

BEST										WORST
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Do your parents, siblings or children have chronic pain? YES NO

Explain: ______________________________

Do your parents, siblings or children have depression? YES NO

Explain: ______________________________

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Referral:

New Patient Questionnaire

Date:

Please circle all medical conditions that affect you:		Treating physician:
General Health	Fever, unintentional weight loss, HIV, Cancer Type____________________________	
ENT	Cold symptoms, sinusitis, sore throat, hearing loss	
Eyes	Glaucoma, cataracts, macular degeneration, blindness	
Heart	Heart attack, heart failure, irregular rhythm, palpitations, chest pain, poor circulation, valve disease, high blood pressure	
Lung	Cough, Asthma, COPD, Emphysema, Chronic Bronchitis, shortness of breath, Home oxygen use	
Intestinal, stomach	Nausea/ vomiting, diarrhea, ulcers, constipation, reflux, liver cirrhosis, hepatitis, loss of bowel control	
Renal	Renal failure, UTI, kidney stones, blood in urine, loss of bladder control, impotence	
Hormonal	Diabetes, thyroid disease, calcium imbalance	
Lymph node	Enlarged lymph nodes in neck, arm pits, or groin areas	
Muscle/bones	Arthritis, osteoporosis, lupus, rheumatoid arthritis, spinal stenosis, disc disease, neck pain, back pain, sciatica, radiculopathy	
Skin	Rash, infection, blisters, psoriasis, dermatitis, eczema, Any skin infections or ulcers now or in the past	
Brain/ Neurological	Stroke, seizures, paralysis, TIA, mini-stokes, facial drooping, slurred speech, neuropathy	
Blood Disorders	Bleeding history, blood clots, Von Willebrand's Disease, Sickle Cell Anemia, Hemophilia, excessive bleeding when cut, easy bruising	
Sleep/ Psychological	Insomnia, excessive tiredness, anxiety, depression	

How did you hear about MPS? ____

____
Patient signature

Thank you, you finished!

Yes / No All other systems negative except those noted above.

Yes / No Imaging **films** available and reviewed.

Yes / No Imaging **report** available and reviewed.

I have personally reviewed this entire document.

____
Physician signature

Total time spent with patient: __________

Percent of time spent in counseling/ coordinating care: _________

99202-20 min	99242-30 min
99203-30 min	99243-40 min
99204-45 min	99244-60 min
99205-60 min	99245-80 min