Michigan Pain Specialists

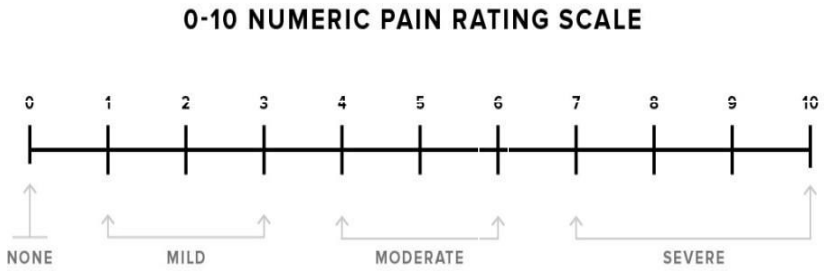
Patient Name:
DOB:
MR#:
Date:

Intracept Patient Intake Form

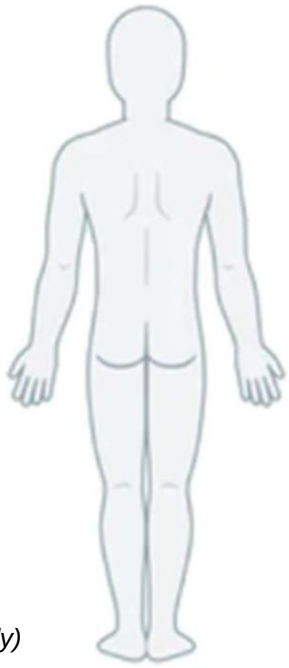
Duration of low back pain: (place 'x' next to response)

__ > 6 months __ > 1 year __ > 2 years __ > 3 years __ > 5 years

Complete the remainder of the form considering your pain and function over the last 30 days



Drag 'X' to location of pain.



Average Pain: _____ Back Pain (%): _____

Worst Pain: _____ Leg Pain (%) _____

Does bending forward/lifting increase your back pain? ___ Yes __ No

Does sitting for long periods (ex. driving) increase your back pain? ___ Yes __ No

Does walking and/or standing improve your back pain? ___ Yes __ No

Does your pain negatively affect your activities of daily living? *(place 'x' next to all that apply)*

___ Sleep ___ Work ___ Leisure Activities

____ Household Chores ___ Other: _____

What medications have you taken for your low back pain: _____

Which treatments have your tried to relieve your low back pain? *(place 'x' next to all that apply)*

_ _ Physical Therapy __ Home Exercise Program __ Chiropractic Care

_ _ Massage Therapy __ Acupuncture __ Other: _____

__ Injections: __ Epidural Injections __ Facet Injections __ SI Joint Injections __ Facet Ablations

Pertinent surgical/medical history:

_____

intracept by relievant

Office Use Only:

MRI Report Included? Yes ☐ No ☐

Signer has reviewed imaging? Yes ☐ No ☐

Modic changes noted at:

Vertebral Body	Location	Modic Type 1	Modic Type 2
☐ **L3**	☐ Superior ☐ Inferior	☐	☐
☐ **L4**	☐ Superior ☐ Inferior	—	—
☐ **L5**	☐ Superior ☐ Inferior	—	—
☐ **S1**	☐ Superior ☐ Inferior	—	—

Diagnosis:

☐ **M54.51** Vertebrogenic low back pain; low back pain vertebral endplate pain	☐ **M54.50** Low Back Pain	☐ **M47.816** Spondylosis w/o myelopathy or radiculopathy, lumbar region
☐ **M47.817** Spondylosis w/o myelopathy or radiculopathy, lumbosacral region	☐ **M51.36** Other intervertebral disc degeneration, lumbar region	☐ **M51.37** Other intervertebral disc degeneration, lumbosacral region

Treatment Plan:

Intracept	☐ **L3**	☐ **L4**	☐ **L5**	☐ **S1**

Additional comments (why Intracept is the best treatment option):

REIMBURSEMENT SERVICES POLICY

PATIENT AUTHORIZATION FORM FOR THE INTRACEPT® PROCEDURE

Your physician has determined that the Intracept® System is medically necessary to treat your condition. In order to facilitate your access to this treatment, the manufacturer of the medical technology, Relievant Medsystems, Inc. ("Relievant"), is able to provide certain assistance to you regarding insurance coverage and reimbursement.

In order to provide this assistance, Relievant will need to use your Protected Health Information (as defined below). This Authorization will allow your healthcare providers, health plans, and health insurers to disclose this information to Relievant and its representatives.

Authorization and Signature

I authorize my physician, physician's practice, any other health care provider, my health plans and health insurers to disclose my Protected Health Information to Relievant Medsystems Inc. and its agents and representatives as they request. Protected Health Information includes but is not limited to information relating to my medical condition, treatment, care management, health insurance, and medical record. The information will be used for the following purposes:

- To help establish my eligibility for benefits
- To communicate with me and my healthcare providers, my health plans and my health insurers about my medical care and coverage; and
- To facilitate coverage and reimbursement by my health insurer

I also authorize Relievant and its representatives to contact me directly about these issues.

I understand that information disclosed pursuant to this Authorization is subject to re-disclosure by Relievant for the purposes set forth above and will no longer be protected by federal privacy laws (the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations).

I understand that my treatment, payment, enrollment, or eligibility for benefits are not conditioned on my signing this Authorization and that I am signing it voluntarily.

I understand that I am entitled to a copy of this Authorization.

I understand that I may revoke this Authorization at any time by mailing my written request to: Relievant Medsystems, Inc.,
Attn: VP Health Economics and Reimbursement
8500 Normandale Lake Blvd. Suite 2150
Minneapolis, MN 55437
but that any revocation will not apply to any information already used or disclosed pursuant to this Authorization.

I understand that this Authorization automatically expires five (5) years from the date signed below.

I understand that Relievant Medsystems Inc. does not guarantee that insurance coverage, reimbursement or any other payment will be made and that I am ultimately responsible for the cost of my care.

I agree that a copy of this form may be treated as a signed original.

Signature: _____ Date: _____

Employer providing insurance coverage (if applicable): _____

Relievant Medsystems, Inc. would like to periodically update you regarding the status of your insurance request via email. Your email address will not be used for any other purpose other than Intracept Patient Access Program activities.

Patient Email: _____