Please review and update the information below to the best of your ability.

Patient Registration

Current Patient Information – Please Print

Last Name:

First Name:

Middle Name:

Date of Birth:

Sex (please circle): **M** or **F**

Address:

City: State: Zip:

Home Phone:

Mobile Phone:

Work Phone:

Patient email:

Required by Government Mandate (optional)

Language:

Race:

Ethnicity:

Marital Status:

Guarantor Information (to whom statements are sent)

Name:

Address:

Relationship to patient: _____

Phone: ( ) _____ - _____

Emergency Contact Information

Name:

Relationship to Patient:

Home Phone: ( ) _____ - _____

Mobile Phone: ( ) _____ - _____

Pharmacy Information

Name:

Crossroads:

Phone: ( ) _____ - _____

Other

Patient Referred by:

Primary Care Provider:

Primary Insurance Information

Plan Name

Policy Holder:
Date of Birth:
Sex (please circle): **M** or **F**
Address:
City: **MD** Zip:
Relationship to patient:

Secondary Insurance Information

Plan Name

Policy Holder:
Date of Birth:
Sex (please circle): **M** or **F**
Address:
City: State: Zip:
Relationship to patient:

To the best of my knowledge the above information is complete and accurate.

Signed_____ **Date:**_____

Please sign and date each item below

ACKNOWLEDGEMENT AND AUTHORIZATION:

- **I have read and understand the HIPAA/Privacy Policy for PAIN AND SPINE SPECIALISTS OF MARYLAND LLC DBA PAIN & SPINE SPECIALISTS OF**

Signed_____ **Date:**_____

- **I hereby assign my insurance benefits to be paid directly to the healthcare provider**

Signed_____ **Date:**_____

- **I authorize PAIN AND SPINE SPECIALISTS OF MARYLAND LLC DBA PAIN & SPINE SPECIALISTS OF to release medical information required to process my claim**

Signed_____ **Date:**_____

- **I have read and understand the Financial Policy for PAIN AND SPINE SPECIALISTS OF MARYLAND LLC DBA PAIN & SPINE SPECIALISTS OF**

Signed_____ **Date:**_____

- **I authorize PAIN AND SPINE SPECIALISTS OF MARYLAND LLC DBA PAIN & SPINE SPECIALISTS OF to obtain/have access to my medication history**

Signed_____ **Date:**_____

- **I authorize my provider's office to contact me by mobile phone**

Signed_____ **Date:**_____

Patient Intake Form

Date: _____

Patient's Name: _____

D.O.B.: _____ Age: _____ Circle: Male or Female

Address: _____
Street Apt# City State Zip

Home Phone #: ( )_____

Work Phone #: ( )_____ Ext. #: _____

Mobile Phone #: ( )_____

Social Security #:_____

Marital Status: □ Single □ Divorced □ Separated □ Married □ Widow

Email Address: _____

Employer: _____ Occupation: _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Other Physicians involved in my care: _____

Emergency Contact Name: _____ Phone:_____

Relationship to Patient: _____

Current or Past Medical Conditions:

- ☐ Asthma/Respiratory Problems
- ☐ Hypertension (high blood pressure)
- ☐ Head Trauma
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Kidney Disease
- ☐ Anemia (low blood count)
- ☐ Pancreatitis
- ☐ Diabetes
- ☐ Gastrointestinal Disease
- ☐ Cancer _____
- ☐ Heart Disease (heart attack, cholesterol, angina)
- ☐ Tuberculosis
- ☐ Gallbladder Disease
- ☐ Peptic Ulcer Disease
- ☐ Arthritis
- ☐ Seizures/Epilepsy
- ☐ Thyroid Disease
- ☐ STDs _____
- ☐ Nutritional Deficiency
- ☐ HIV/AIDS
- ☐ Hepatitis

Other (please describe):

_____

_____

_____

Have you had any blood transfusions?	☐ Yes	☐ No
Any reactions?	☐ Yes	☐ No
Do you require any antibiotics prior to procedures?	☐ Yes	☐ No

Allergies and Sensitivities to Drugs:

Name:	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies and Sensitivities to Foods:

Name:	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Current Medications:

Prescribed:

Non-Prescribed Medications:
(Pain meds, aspirin, laxatives, vitamins, supplements)

Past Surgeries/Procedures:

Date:

Family History:

Has your appetite changed? ☐ Increased ☐ Decreased ☐ Stayed the same

Has your weight changed? ☐ Increased ☐ Decreased ☐ Stayed the same

Overall, would you say your health is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Social History

Do you smoke? ☐ Yes ☐ No

Have you ever smoked? ☐ Yes ☐ No

If yes, when did you quit? _____

Do you drink coffee, tea or soda? ☐ Yes ☐ No

If yes, how many per day? _____

Do you consume beer, wine or liquor? ☐ Yes ☐ No

If yes, how many per day? _____ How many per week? _____

Do you think you should cut down on alcohol consumption? ☐ Yes ☐ No

Has anyone complained about you drinking? ☐ Yes ☐ No

Have you ever been sexually or physically abused? ☐ Yes ☐ No

Please answer the following questions:

1. Who lives with you? _____

2. At what age did you use opiates/opioids for the first time? _____

3. During how many time of the last 30 days did you use opiates/opioids? _____/30 days

4. What opiates/opioids due you primarily use (e.g. heroin, oxycodone, etc..)

   _____

5. How do you use opiates/opioids? (please check all that apply)
   ☐ Orally/Pills ☐ Snorted/Intranasal ☐ Smoked ☐ I.V. ☐ Other _____

6. How much do you use in one day? _____

7. Have you used intravenously (i.e. "shot up"), even once? ☐ Yes ☐ No

8. Do you experience physical withdrawal when not using opioids? ☐ Yes ☐ No
   If yes, What symptoms do you usually have? _____

9. Have you previously been treated with Suboxone? ☐ Yes ☐ No
   If so, from which doctor(s) or clinic(s)? _____
   Why did you stop Suboxone? _____

10. Have you been treated in the past through a methadone treatment program? ☐ Yes ☐ No
    Name of clinic(s) and when? _____
    Why did you stop methadone treatment? _____

11. Do you use alcohol or any other drugs in addition to opiates/opioids? ☐ Yes ☐ No
    If so, which ones? _____

12. What are your major triggers to relapse?

_____

_____

13. What coping methods have you developed to manage the triggers, without resorting to using?

_____

_____

14. What psychiatric diagnosis have you received (e.g. depression, anxiety, personality disorder)?

_____

15. Have you ever been hospitalized for psychiatric response? ☐ Yes ☐ No

If yes, please explain

_____

16. Do you see a psychiatrist, psychologist, counselor or social worker regularly? ☐ Yes ☐ No

If yes, please indicate:

Name: _____ Phone: _____

Last Visit: _____ Next visit: _____

17. Have you ever attempted suicide, or engaged in self-injurious behavior (cutting or burning)?

☐ Yes ☐ No

18. As a result of your drug use, have you had any medical or psychiatric problems such as:

☐ Depression ☐ Sexual Function ☐ Sleep Disorders

☐ Anything not mentioned above: _____ ☐ No problems

19. As a result of your drug use, have you had any interpersonal and family consequences such as:

☐ Separation or Divorce from your spouse

☐ Your parents, siblings or children staying away from you

☐ Anything not mentioned: _____ ☐ No Problems

20. As a result of your drug use, have you had any financial or employment consequences such as:

☐ Bankruptcy ☐ Loss of job ☐ Loss of professional license

☐ Spending all your money to get drugs

☐ Anything not mentioned: _____ ☐ No problems

21. As a result of your drug use, have you had any legal consequences such as:

☐DUI/DWI ☐Being in prison or jail ☐Parole or probation

☐Loss of custody of children

☐Anything not mentioned: _____ ☐No problems

Previous Treatments and Recovery Efforts:

Have you gone through detoxification by:

- ☐ Going Cold Turkey
- ☐ Using over-the-counter aids
- ☐ Inpatient hospital admissions
- ☐ Outpatient community-based programs

  How severe and how long were the withdrawal symptoms?

  _____

- ☐ No Prior Detoxification

Substance Use History

Have you found:

- ☐ That you need markedly increased amounts of the narcotic to achieve your desired effect?
- ☐ A markedly diminished effect with continued use of the same amount of the narcotic?

Have you had:

- ☐ Withdrawal symptoms when you stop using narcotics such as:

  Racing pulse, sweating, restlessness, diffuse aching in muscles or joints, runny nose or eye tearing, diarrhea, vomiting, stomach cramps, tremors, yawning, anxiety or irritability, gooseflesh.
- ☐ To take the same or similar narcotic to relieve or avoid withdrawal symptoms?

Have you been on long-term medications such as:

- ☐ Methadone
- ☐ Suboxone
- ☐ Naltrexone
- ☐ No prior long-term medications

Since you have recognized that you were dependent on narcotic medications,

What has been the longest period of time that you could go without using them? _____

How did you do it, and what worked? _____

_____

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

*The educational pamphlet entitled **"Notice of Privacy Practices"** provides information about how Pain and Spine Specialists of Maryland may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).
*Our **Notice of Privacy Practices** states that we reserve the right to change the terms described. Should this happen, you will receive a revised copy either by mail, or in person.
*You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are required to agree to your restrictions, but if we do, we are bound by our agreement with you.
*By signing below, you acknowledge receipt of our **Notice of Privacy Practices**.*

RELEASE OF MEDICAL INFORMATION FOR COORDINATION OF CARE

I, hereby authorize Pain and Spine Specialists of Maryland to release medical information to my referring physician, primary care doctor, case manager and any other individual involved in my medical care for the sole purpose of facilitating my treatment. I understand that my medical information is confidential and that I have a choice to request that my physician not share my medical records with any of the above individuals. Should I choose to exercise this right, I will provide in writing to my physician any of the individuals involved in my care whom I do not wish to receive my medical records. I agree that a copy of this release may be used in place of the original. I am aware that I may request this Release of Medical Information may be revoked at any time by providing the physician's office with a dated and signed letter. I have read and agree to those terms.

MISSED APPOINTMENT POLICY

Please be aware that by scheduling an initial consultation with our physicians, you are agreeing to abide by the billing policies of our service. To better serve all of our patients, we require a 24 hour notification should you need to cancel or reschedule your appointment. Should you miss, or reschedule your appointment with less than a 24 hour notice, you will be charged $75, and payment will be due at the time of your next appointment. Your insurance company does not cover fees for missed appointments.

AUTHORIZATION TO DISCUSS INFORMATION WITH DESIGNATED PERSON

It is often difficult to reach a patient to discuss appointments, medications and other information pertinent to our patients' care. In this event with your signed authorization we would discuss such information to a person you designate. Please complete the section below:
I hereby authorize Pain and Spine Specialists of Maryland to discuss any information required in the course of my examination or treatment (when I cannot be reached by phone) to the following designated person(s)

Name of Designee: _____ Phone Number: _____
Relationship to Patient: _____

Name of Designee: _____ Phone Number: _____
Relationship to Patient: _____

☐ NONE

I agree to all of the above

_____ _____
Patient or Legal Guardian Signature **Date**

_____
Print Name

This form shall expire one year from the date of signature

REALEASE OF MEDICAL INFORMATION FOR BILLING PURPOSES

I, hereby authorize Pain and Spine Specialists of Maryland to release medical information to Medicare, my employer's Benefits Department, or my other insurance company for the sole purpose of obtaining payment for my medical care. Although medical information is confidential, many carriers require medical documentation prior to payment for services. I understand that only information pertaining to obtaining payment form my care will be released. I agree that a copy of this release may be used in place of the original. I am aware that I may request the Release of Medical Information to be revoked at any time by providing the physician's office with a dated and signed letter. I have read and agree to these terms.

NOTICE OF FINANCIAL INTEREST

Federal regulations require that we inform you that the physician below has a 100% financial interest Pain and Spine Specialists of Maryland. An interest in this facility enables them to have a voice in the administrative and medical policy of this healthcare institution. This involvement helps us ensure the finest quality surgical care for their patients.

PAYMENT FOR MEDICAL SERVICES

I hereby assume financial responsibility for all charges incurred for services rendered. I understand that I will be requires to pay co-payments, amounts applied to deductibles, and balances of bills not paid in accordance with the benefits of my current insurance policy. If I am unable to make payment in full for my medical treatment within 30 days, I agree to call the business office and make payment arrangements. I hereby authorize payment for all medical insurance benefits which are payable under the terms of my insurance policy, to be paid directly to Pain and Spine Specialists of Maryland, or designates for services rendered. I certify that the information I have reported regarding my insurance coverage is correct. I authorize the doctor's office to verify insurance coverage and benefits allowed in accordance with my insurance company's policy. I understand that it is my full responsibility that any third party which I direct Pain and Spine Specialists of Maryland, to bill, in the event of non-payment for whatever reason in accordance with the benefit of my current insurance policy, I will pay immediately. It is further agreed that in the event I fail to pay upon demand, should my account be referred to an outside collection agency and or attorney, I accept full responsibility to pay the full balance due to PASS as well as the collection costs not to exceed 30% of the total charged by the collection agency to PASS, and interest of 1.5% per month on the total amount due, not to exceed 18% per annum and reasonable court costs.

I have received information on Bill Of Rights and agree to all of the above.

_____ _____

Patient or Legal Guardian Signature **Date**

Please circle if you have ever executed an Advanced Directive: Yes / No

_____ _____

Patient or Legal Guardian Signature **Date**

Consent for Treatment with Buprenorphine

Buprenorphine is a medication approved by the Food and Drug Administration (FDA) for treatment of opioid dependence. Buprenorphine can be used for detoxification or for maintenance therapy. Maintenance therapy can continue as long as medically necessary.

Buprenorphine itself is an opioid, but it is not as strong an opioid as heroin or morphine. Buprenorphine treatment can result in physical dependence of the opiate type. Buprenorphine withdrawal is generally less intense than with heroin or methadone. If buprenorphine is suddenly discontinued, some patients have no withdrawal symptoms; others have symptoms such as muscle aches, stomach cramps, or diarrhea lasting several days. To minimize the possibility of opiate withdrawal, buprenorphine should be discontinued gradually, usually over several weeks or more, under a healthcare provider's supervision.

If you are dependent on opiates, you should be in as much withdrawal as possible when you take the first dose of buprenorphine. It you are not in withdrawal, buprenorphine may cause significant opioid withdrawal.

Some patients find that it takes several days to get used to the transition from the opioid they had been using to buprenorphine. During that time, any use of other opioids may cause an increase in symptoms. After you become stabilized on buprenorphine, it is expected that other opioids will have less effect. Attempts to override the buprenorphine by taking more opioids could result in an opioid overdose. You should not take any other medication without discussing it with your healthcare provider first.

Combining buprenorphine with alcohol or some other medications may also be hazardous. The combination of buprenorphine with medication such as Valium, Librium, Ativan has resulted in deaths.

The form of buprenorphine (Suboxone/Zubsolv) you will be taking is a combination of buprenorphine with a short-acting opiate blocker (Naloxone). If the Suboxone tablet were dissolved and injected by someone taking heroin or another strong opioid, it could cause severe opiate withdrawal.

Buprenorphine tables must be held under the tongue until they dissolve completely. Buprenorphine is then absorbed over the next 30 to 120 minutes from the tissue under the tongue. Buprenorphine will not be absorbed from the stomach if it is swallowed.

Buprenorphine will cost $10+/day just for the medication. If you have medical insurance, you should find out whether or not buprenorphine is a benefit.

Alternatives to buprenorphine

Some hospitals that have specialized drug abuse treatment units can provide detoxification and intensive counseling for drug abuse. Some outpatient drug abuse treatment services also provide individual and group therapy, which may emphasize treatment that does not include maintenance on buprenorphine or other opiate like medications. Some opioid treatment programs use naltrexone, a medication that blocks the effects of opioids, but has no opioid effects of its own.

I agree to the following office policies:

1. Keep, be on time, or give 24 hour notice of cancelation for all scheduled appointments.
2. Adhere to payment policy including but not limited to missed appointment fees.
3. Conduct myself in a professional manner in the practice.
4. Not to sell, share, or give any of my medications to another person. I understand that any mishandling of my medication is a serious violation if this agreement and would result in cessation of continued treatment with the office.
5. Not to deal, steal, or conduct any illegal or disruptive activities in the office.
6. I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my medication is filled, that the behavior will be reported to my Provider's office and may result in cessation of continued treatment with the office.
7. My medication/prescription can only be given to me at my regularly scheduled office visits. A missed visit may result in my not being able to get my medication/prescription until the next scheduled visit.
8. My medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of why it was lost.
9. Not to obtain medications from any healthcare providers, pharmacies, or other sources without telling my treating provider.
10. I understand that mixing this medicine with other medications, especially benzodiazepines (for example, Valium, Klonopin, or Xanax), can be dangerous. I also recognize that several deaths have occurred among persons mixing buprenorphine and benzodiazepines (especially if taken outside of a healthcare provider, using routes of administration other than sublingual or in higher than recommended therapeutic doses).
11. To read the Medication Guide and consult my healthcare provider should I have any questions or experience any adverse events.
12. To take my medication as my healthcare provider has instructed and not to alter the way I take my medication without first consulting my provider.
13. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my provider and specified in my treatment plan.
14. To abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (except nicotine).
15. Provide random urine samples and have my provider test my blood alcohol level.
16. Violations of the above may be grounds for termination of treatment.
17. I cannot receive Suboxone treatment if I am pregnant.
18. If I become pregnant during my treatment, I will notify my provider as soon as possible.
19. I will not take Methadone or Benzodiazepine while I am being treated with Suboxone.
20. My provider will formulate a safe and regulated wean schedule for my Buprenorphine treatment.

_____

Signature

_____

Print Name

_____

Date

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with **MD** State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. PAIN AND SPINE SPECIALISTS OF MARYLAND LLCuses SureScripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized to PAIN AND SPINE SPECIALISTS OF MARYLAND LLC.
2. This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts, Inc. to PAIN AND SPINE SPECIALISTS OF MARYLAND LLC
3. I have the right to revoke this authorization at any time by writing to PAIN AND SPINE SPECIALISTS OF MARYLAND LLC. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law.
6. This authorization expires one year from the date of my signature below.
7. THIS AUTHORIZATION DOES NOT AUTHORIZE PAIN AND SPINE SPECIALISTS OF MARYLAND LLC TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.

Signature of patient or representative authorized by law	Date
Relationship to Patient	Interpreter, if utilized
Witness Signature	

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information to the facility listed below.

Facility Name: Pain and Spine Specialists or Maryland

Address: 2702 Back Acre Circle Suite 290B

Mt. Airy, MD 21771

Phone: (301) 703-8767 Fax: (301) 703-8766

Patient Name: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____

Phone #: _____

The information you may release subject to this signed release form is as follows:

- o Complete copy of my medical records
- o Copy of any radiology reports

Patient Signature: _____ Date: _____

This Form will expire one year from the date of signature

Pain and Spine Specialists 2020 Notification

Please be mindful that it is the patient's responsibility to contact our office and notify us of any changes to your insurance, prior to your appointment. Waiting until the day of your appointment will result in a delay of your appointment. As a courtesy, our office assists in tracking referrals and checking eligibility, but it is ultimately the patient's responsibility to be aware and track this information.

You will be required to provide your **most recent insurance card(s)** and **current photo ID** at every appointment.

Please arrive **15 minutes prior** to every appointment.

COPAY'S

ALL copays will be due at check in on the day of your appointments. **Note:** copay amounts may vary depending on appointment type. Secondary insurances may also require a copay.

URINES DRUG SCREENS

All patients receiving medications are subject to random urine drug screens. Patients will be responsible for all copays, deductibles and/or coinsurance for this service. The urine drug screen is sent to a specialty lab to obtain quantitative results after we obtain qualitative results in office. This means we run an initial screening in our office and then send the urine drug screen to a specialty lab to obtain a confirmatory report. Patients may receive a bill from our office as well as the outside lab, as they are two separate tests.

REFERRALS

Some insurances require an insurance referral from your Primary Care Physician in order to be seen by a specialist. It is the patient's responsibility to be aware if this is a requirement for their plan. As a courtesy, our office assists in tracking these referrals, but ultimately is the patient's responsibility to track and contact their PCP when an updated one is required. Referrals must be provided at the time of your appointment or before your appointment.

AUTHORIZATIONS

Select insurance companies require prior authorizations for procedures and/or medications. We start prior authorizations for procedures once they are scheduled. We start prior authorizations for medications once the pharmacy advises us it is required. Procedure authorizations may take up to 10 business days depending on the type of insurance. If a procedure authorization is pending or denied, patients will be notified no later than two business days prior to their scheduled appointment.

Please note that Physical therapy documentation may be required for procedure, imaging and medication authorizations. Failure to comply with recommended treatment plan could result in denials of appointment and medication request.

Pain And Spine Specialists of Maryland places significant importance on assessing all aspects of our patient's health which includes behavioral, mental and cognitive health. NeuroFlow and Cambridge Brain Sciences offer diagnostic tests which play a pivotal role in providing ongoing treatment.

Updated imaging is a requirement of the practice. Current imaging is needed for injections and to prescribe medication.

Please schedule your next appointment at check-out, before leaving the office. Failure to do so may prevent you from obtaining an appointment that works best for your schedule or complies with your medication schedule.

We see patients based on appointment times not arrival times.

_____ _____

Signature of Patient **Date**

_____ _____

Print Name **Date**