NEUROSPINE INSTITUTE

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Patient: Last_____First:_____MI: _____

Birth Date: /__/_____ Sex: M / F Soc. Security Number: _____

Address:_____City:_____Zip Code: _____

Cell Phone Number:_____Home Phone Number: _____

Email Address:_____CDL No: _____

Primary Care Provider:
Name:_____Office: _____

Address:_____City:_____Zip Code: _____

Telephone Number:_____Fax Number: _____

Emergency Contact's Name:_____
Address:_____City:_____Zip Code: _____

Telephone number to best reach them:_____Relationship: _____

Insurance Information: Name of Insurance: _____

Primary Holder of Insurance: _____

Insurance ID #:_____Group #: _____

Address:_____City:_____Zip Code: _____

Telephone Number:_____Fax Number: _____

The Above information is true to the best of my knowledge. I authorize my Insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Neurospine Institute or Insurance company to release any information required to process my claims. I acknowledge I have received Neurospine notice of privacy practices.

Patient/Guarantor Signature: _____

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient Name: Last First MI

Today's Date: Reason for Visit:

Previous or referring doctor: | Patient sex : ☐ M ☐ F | DOB:

REASON FOR VISIT (MAIN REASON FOR DOCTOR'S APPOINTMENT): _____

HISTORY OF PRESENT PAIN PROBLEM

DATE OF ONSET: _____ HOW DID IT START? _____

WHAT MAKES THE PAIN WORSE? ☐Sitting ☐Standing ☐Lying Flat ☐Walking ☐Twisting ☐Exercise ☐Sneezing ☐Work ☐Meds ☐Other _____

WHAT MAKES THE PAIN BETTER? ☐Sitting ☐Standing ☐Lying Flat ☐Walking ☐Twisting ☐Exercise ☐Sneezing ☐Work ☐Meds ☐Other _____

DESCRIBE YOUR PAIN: _____

IS THIS RELATED TO AN AUTO INJURY? ☐Yes ☐No IS THERE A LEGAL CASE/LITIGATION? ☐Yes ☐No

IS THIS A WORKMAN'S COMPENSATION CASE? ☐Yes ☐No

PAIN (CHECK ONE): ☐Continuous ☐Intermitent (Comes and goes) How long does it last? _____

HOW MANY TIMES PER DAY DO YOU EXPERIENCE THIS PAIN? _____ RATE THE LEVEL OF PAIN AT PRESENT:

☐No pain ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

RATE YOUR PAIN WITH ACTIVITY: ☐No pain ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

CHECK THE WORDS THAT DESCRIBE YOUR PAIN AND INDICATE THE AREA WHERE YOUR PAIN IS WORSE AND SECOND:

☐Aching - Worst _____ Second _____
☐Dull - Worst _____ Second _____
☐Electrical - Worst _____ Second _____
☐Radiating - Worst _____ Second _____
☐Tender - Worst _____ Second _____
☐Throbbing - Worst _____ Second _____
☐Burning - Worst _____ Second _____
☐Deep - Worst _____ Second _____
☐Sharp - Worst _____ Second _____
☐Shooting - Worst _____ Second _____
☐ Stabbing - Worst _____ Second _____
☐ Tingling - Worst _____ Second _____

DOES YOUR PAIN INTERFERE WITH YOUR SLEEP? ☐Yes ☐No

HOW MANY WORK DAYS DID YOU MISS IN THE LAST MONTH DUE TO PAIN? _____

PLEASE LIST OTHER PHYSICIANS YOU HAVE SEEN FOR PAIN:

NAME: _____ RECOMMENDATION: _____ SPECIALTY: _____ DATE: _____
NAME: _____ RECOMMENDATION: _____ SPECIALTY: _____ DATE: _____
NAME: _____ RECOMMENDATION: _____ SPECIALTY: _____ DATE: _____

PLEASE CHECK ANY OF THE FOLLOWING TREATMENTS YOU HAVE HAD FOR PAIN:

☐ Pain Clinic – Pain Improved? ☐Yes ☐No
☐ Epidurals – Pain Improved? ☐Yes ☐No
☐ Spinal Cord Stimulator – Pain Improved? ☐Yes ☐No
☐ Tens Unit – Pain Improved? ☐Yes ☐No
☐ Accupuncture – Pain Improved? ☐Yes ☐No
☐ Massage Therapy – Pain Improved? ☐Yes ☐No
☐ Nerve Blocks – Pain Improved? ☐Yes ☐No
☐ Radio-Frequency – Pain Improved? ☐Yes ☐No
☐ Pain Pump – Pain Improved? ☐Yes ☐No
☐ Physical Therapy – Pain Improved? ☐Yes ☐No
☐ Chiropractor – Pain Improved? ☐Yes ☐No
☐ Psychology – Pain Improved? ☐Yes ☐No
☐Other _____

WHAT DIAGNOSTIC TESTS/PROCEDURES HAVE YOU HAD FOR THIS PAIN? ☐MRI Scan ☐CT Myelogram ☐X-Ray ☐EMG/Nerve Study ☐Discogram ☐Bone Scan

PERSONAL HEALTH HISTORY (PAST MEDICAL HISTORY)

Conditions you have had in the past (check all that apply):

☐ AIDS/HIV +	☐ Bulimia	☐ Goiter	☐ Liver Disease	☐ Stroke
☐ Alcoholism	☐ Cancer	☐ Gonorrhea	☐ Migraine Headache	☐ Suicide Attempt
☐ Anemia	☐ Cataracts	☐ Gout	☐ Mononucleosis	☐ Thyroid Problems
☐ Anorexia	☐ Chemical Dependency	☐ Heart Disease	☐ Multiple Sclerosis	☐ TB
☐ Arthritis	☐ Chicken Pox	☐ Hepatitis	☐ Pneumonia	☐ Ulcers
☐ Asthma	☐ Diabetes	☐ Hernia	☐ Polio	LIST ANY OTHERS
☐ Bleeding Disorders	☐ Emphysema	☐ Herpes	☐ Prostate Problem	☐
☐ Breast Lump	☐ Epilepsy	☐ High Cholesterol	☐ Rheumatic Fever	☐
☐ Bronchitis	☐ Glaucoma	☐ Kidney Disease	☐ Scarlet Fever	☐

PATIENT NAME: _____ DOB: _____

Surgeries		
Year	Reason	Hospital

Other hospitalizations		
Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

Do you know your blood type? ☐ Yes ☐ No Type: _____

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Drug Name	Strength	Frequency Taken	Drug Name	Strength	Frequency Taken
1			9		
2			10		
3			11		
4			12		
5			13		
6			14		
7			15		
8			16		

Allergies to medications

Drug Name	Reaction You Had	Drug Name	Reaction You Had
1		3	
2		4	

HEALTH HABITS AND PERSONAL SAFETY (SOCIAL HISTORY)

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise) ☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)			
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
Diet	Are you dieting? ☐ Yes ☐ No			
	If yes, are you on a physician prescribed medical diet? ☐ Yes ☐ No			
	# of meals you eat in an average day?			
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola
	# of cups/cans per day?			
Alcohol	Do you drink alcohol? ☐ Yes ☐ No If yes, what kind? _____			
	How many drinks per week?			
Tobacco	Do you use tobacco? ☐ Yes ☐ No			
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
	☐ # of years	☐ Or year quit		

PATIENT NAME: _____ DOB: _____

Drugs	Do you currently use recreational or street drugs?	☐	Yes	☐	No
	Have you ever given yourself street drugs with a needle?	☐	Yes	☐	No
Personal Safety	Do you live alone?	☐	Yes	☐	No
	Do you have frequent falls?	☐	Yes	☐	No
	Do you have vision or hearing loss?	☐	Yes	☐	No
	Physical and/or mental abuse have become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your doctor or his staff?	☐	Yes	☐	No

FAMILY HEALTH HISTORY

Relation	AGE	AGE AT DEATH	SIGNIFICANT HEALTH PROBLEMS
Father			
Mother			
Brothers			
Sisters			

MENTAL HEALTH

Is stress a major problem for you?	☐	Yes	☐	No
Do you feel depressed?	☐	Yes	☐	No
Do you panic when stressed?	☐	Yes	☐	No
Do you have problems with eating or your appetite?	☐	Yes	☐	No
Do you cry frequently?	☐	Yes	☐	No
Have you ever seriously thought about hurting yourself?	☐	Yes	☐	No
Do you have trouble sleeping?	☐	Yes	☐	No
Have you ever been to a counselor?	☐	Yes	☐	No

SCREENINGS (please indicate most recent date)

Last Colonoscopy:	☐ Normal ☐ Abnormal	Cholesterol Screening:	☐ Normal ☐ Abnormal
Test for blood in stools:	☐ Normal ☐ Abnormal	Electrocardiogram:	☐ Normal ☐ Abnormal

Review Of Systems (check all that apply to you)

CONSTITUTIONAL
- ☐ Wt. loss or gain
- ☐ Fever
- ☐ Fatigue
- ☐ Chills

EYES
- ☐ Blurry vision
- ☐ Double vision
- ☐ Vision changes
- ☐ Cataracts
- ☐ Glaucoma

ENT/MOUTH
- ☐ Sinus problems
- ☐ Runny nose
- ☐ Tooth pain
- ☐ Hearing loss
- ☐ Ringing ears
- ☐ Gum pain
- ☐ Gum bleeding
- ☐ Swallowing difficulties
- ☐ Ear pain
- ☐ Ear discharge

ALLERGY/IMMUNO
- ☐ Rashes/hives/wealts
- ☐ Itchiness
- ☐ Allergic asthma/bronchitis

NEURO
- ☐ Dizziness
- ☐ Lightheadedness
- ☐ Headache
- ☐ Lack of coordination
- ☐ Balance problems
- ☐ Seizures
- ☐ Numbness

PSYCH
- ☐ Depression
- ☐ Mood swings
- ☐ Memory problems
- ☐ Anxiety

ENDO
- ☐ Excessive thirst
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Hair loss
- ☐ Nail changes
- ☐ Night sweats
- ☐ Hot flashes

SKIN
- ☐ Skin rashes
- ☐ Bruising
- ☐ Changes in skin lesions
- ☐ Wounds
- ☐ Ulcers

GENITOURINARY
- ☐ Burning urination
- ☐ Excessive urination
- ☐ Incontinence of urine
- ☐ Blood in urine
- ☐ Frequent bladder/kidney infections
- ☐ History of sexually transmitted disease

GASTROINTESTINAL
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Incontinence of bowels
- ☐ Blood in stools
- ☐ Bloating
- ☐ Poor appetite
- ☐ Hemorrhoids
- ☐ Nausea

HEM/LYMPH
- ☐ Bruising
- ☐ Nosebleeds
- ☐ Lack of energy

RESPIRATORY
- ☐ Frequent lung infections
- ☐ Shortness of breath
- ☐ Chest tightness
- ☐ Wheezing
- ☐ Sleeping problems
- ☐ Persistent cough
- ☐ Asthma

CARDIOVASCULAR
- ☐ History of Rheumatic fever
- ☐ Palpitations
- ☐ Chest pain
- ☐ Swelling hands
- ☐ Swelling feet
- ☐ Irregular heart beat
- ☐ High or low blood pressure

MUSC/SKELETAL
- ☐ Difficulty walking
- ☐ Joint stiffness
- ☐ Muscle pains
- ☐ Back pain
- ☐ Pain during walking

PATIENT NAME: _____ DOB: _____

WOMEN ONLY			
Age at menstruation:		Date of last PAP smear:	☐ Normal ☐ Abnormal
Number of pregnancies _____ Number of live births _____		Date of or age at last menstruation:	
Last Mammogram:	☐ Normal ☐ Abnormal	Bone Density Screening:	☐ Normal ☐ Abnormal
Experienced any recent breast tenderness, lumps, or nipple discharge?			☐ Yes ☐ No
Date of last rectal exam?		☐ Normal ☐ Abnormal	
MEN ONLY			
Do you usually get up to urinate during the night?			☐ Yes ☐ No
If yes, # of times _____			
Do you feel burning discharge from penis?			☐ Yes ☐ No
Has the force of your urination decreased?			☐ Yes ☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?			☐ Yes ☐ No
Do you have any problems emptying your bladder completely?			☐ Yes ☐ No
Any difficulty with erection or ejaculation?			☐ Yes ☐ No
Any testicle pain or swelling?			☐ Yes ☐ No
Date of last prostate and rectal exam?		☐ Normal ☐ Abnormal	
Date of last PSA test (If any):		☐ Normal ☐ Abnormal	

Is there anything else you would like to discuss with the doctor?

_____

_____

_____

_____ _____

Printed Name of Patient or Responsible Party Relationship to Patient

_____ _____

Signature of Patient or Responsible Party Date

I have reviewed this history with the patient for accuracy and completeness:

_____

Physician signature and date

Patient Name: _____ Date: ____/____/_____

Please answer each question as honestly as possible by putting the corresponding number in the box to the right (ie, if "Seldom" write "1", if "Sometimes" write "2", etc). There are no right or wrong answers.

SCORE	COLOR	Initials of Reviewer

SOAPP®-R

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?					
2. How often have you felt a need for higher doses of medication to treat your pain?					
3. How often have you felt impatient with your doctors?					
4. How often have you felt that things are just too overwhelming that you can't handle them?					
5. How often is there tension in your home?					
6. How often have you counted pain pills to see how many are remaining?					
7. How often have you been concerned that people will judge you for taking pain medication?					
8. How often do you feel bored?					
9. How often have you taken more pain medication than you were supposed to?					
10. How often have you worried about being left alone?					
11. How often have you felt a craving for medication?					
12. How often have others expressed concern over your use of medication?					
13. How often have any of your close friends had a problem with alcohol or drugs?					
14. How often have others told you that you had a bad temper?					
15. How often have you felt consumed by the need to get pain medication?					
16. How often have you run out of pain medication early?					
17. How often have others kept you from getting what you deserve?					
18. How often, in your lifetime, have you had legal problems or been arrested?					
19. How often have you attended an AA or NA meeting?					
20. How often have you been in an argument that was so out of control that someone got hurt?					
21. How often have you been sexually abused?					
22. How often have others suggested that you have a drug or alcohol problem?					
23. How often have you had to borrow pain medications from your family or friends?					
24. How often have you been treated for an alcohol or drug problem?					
Has any relative had a problem with: **(Please circle Y/N for each item below)** Alcohol: Y/N Addiction: Y/N Mental Illness: Y/N					

Green = less than 9	***Yellow = 10-21***	***Red = 22 and over***

Please include any additional information you wish about the above answers. Thank you.
STOP: Hand first 6 pages of packet to front desk if filling out paperwork in office

NEUROSPINE INSTITUTE

OPIOID CONSENT FORM

PATIENT INFORMED CONSENT AND AGREEMENT FOR LONG-TERM OPIOID/NARCOTIC THERAPY FOR TREATMENT OF CHRONIC PAIN

Name:_____ DOB:_____

You have agreed to or may potentially receive opioid/narcotic therapy for the treatment of chronic pain. You understand that these drugs are very useful but have a potential for misuse and are therefore closely controlled by local, state and federal governments. The goal of this treatment is to:

A) Reduce your pain; and
B) Improve your level of function in performing your activities of daily living. Our goal at Neurospine Institute is to not initiate or continue opioid therapy whenever possible, but sometimes this may be warranted for more effective pain management. Alternative therapies and medications have been explained and offered to you. You have chosen opioid/narcotic therapy as one component of treatment. The use of cigarettes demonstrates a dependence on nicotine. This complicates opioid therapy. If you are a smoker, you have agreed to a smoking cessation program. You must be aware of the potential side effects and risks of these medications. They are explained below. If you have any questions or concerns during the course of your treatment, you should contact your physician.

SIDE EFFECTS:

Side effects are normal physical reactions to medications. Common side effects of opioids/narcotics include mood changes, drowsiness, dizziness, constipation, nausea, and confusion. Many of these side effects will resolve over days or weeks. Constipation often persists and may require additional medication. If other side effects persist, different opioids may be tried or they may be discontinued.

Patient Name:_____ DOB:_____

YOU SHOULD NOT:

A) Operate a vehicle or machinery if the medication makes you drowsy;
B) Consume ANY alcohol while taking opioids/narcotic; or
C) Take any other non-prescribed sedative medication while taking opioids/narcotics. The effects of alcohol and sedatives are additive with those of opioids/narcotics. If you take these substances in combination with opioids/narcotics, a dangerous situation could result, such as coma, organ damage or even death. Driving while taking opioids for chronic pain is considered medically acceptable as long as you do not have side effects such as sedation or altered mental status. These side effects usually do not occur while taking opioids/narcotics chronically. However, it is **POSSIBLE** that you could be considered DUI if stopped by law enforcement while driving. Opioids have also been known to cause decreased sexual function and libido. This is due to their effects on suppression of certain hormones such as testosterone and DHEA which can cause these side effects. Your hormone levels can be monitored during your treatment. Constipation is a well-known side effect of opioid therapy and can usually be treated with stool softeners or gentle laxatives. Constipation is a side effect that usually does not go away and requires treatment.

RISKS:

DEPENDENCE: Physical dependence is an expected side effect of long-term opioid/narcotic therapy. This means that if you take opioids/narcotics continuously, and then stop them abruptly, you will experience a withdrawal syndrome. This syndrome often includes sweating, diarrhea, irritability, sleeplessness, runny nose, tearing, muscle and bone aching, gooseflesh, and dilated pupils. Withdrawal can be life-threatening. To prevent these symptoms, the opioids/narcotics should be taken regularly or, if discontinued, reduced gradually under the supervision of your physician.

TOLERANCE: Tolerance to the pain-relieving effect of opioids/narcotics is possible with continued use. This means that more medication is required to achieve the same level of pain control experienced when the opioid/narcotic therapy was initiated. This may occur even though there has been no change in your underlying painful condition. When tolerance does occur, sometimes it requires tapering or discontinuation of the opioid/narcotic. Sometimes tolerance can be treated by substituting a different opioid/narcotic. When initiated, doses of medications must be adjusted to achieve a therapeutic, pain-relieving effect; upward adjustments during this period are not viewed as tolerance.

PATIENT NAME:_____DOB:_____

INCREASED PAIN (Hyperalgesia): The long-term effects of opioids/narcotics on the body's own pain-fighting systems are unknown. Some evidence suggests that opioids/narcotics may interfere with pain modulation, resulting in an INCREASED sensitivity to pain. Sometimes individuals who have been on long-term opioids/narcotics, but who continue to have pain, actually note decreased pain after several weeks off of the medications.

ADDICTION: Addiction is a primary, chronic, neurobiological disease, with genetic, psychosocial, and environmental factors influencing the development and manifestations. I is characterized by behaviors that include one or more of the following:

- Impaired control over drug use;
- Compulsive use;
- Continued use despite harm; and/or
- Craving.

Most patients with chronic pain who use long-term opioids/narcotics are able to take medications on a scheduled basis as prescribed, do not seek other drugs when their pain is controlled, and experience improvement in their quality of life as the result of opioid therapy. Therefore, they are **NOT** addicted.

PHYSICAL DEPENDENCE is **NOT** the same as addiction.

RISK TO UNBORN CHILDREN: Children born to women who are taking opioids/narcotics on a regular basis will likely be physically dependent at birth. Women of childbearing age should maintain safe and effective birth control while on opioid/narcotic therapy. Should you become pregnant, immediately contact your physician and the medication will be tapered and stopped.

LONG_TERM SIDE EFFECTS: The long-term side effect of opioid/narcotic therapy is not fully known. Most of the long-term side effects have been listed above. If you have additional questions regarding the potential long-term effects of opioid/narcotic therapy, please speak with your physician.

PATIENT NAME:_____DOB:_____

PRESCRIPTIONS AND USE OF OPIOID/NARCOTIC MEDICATIONS: Your medication will be prescribed by your physician for control of pain. Based on your induvial needs, you will be provided with enough medication on a monthly basis, two-month basis, or three-month basis. New injuries or pain problems will require reevaluation. Prescriptions for opioids/narcotics will **NOT** be "called in" to the pharmacy. **YOU AGREE THAT YOU MUST BE SEEN BY YOUR PHYSICIAN AT A MINIMUM OF EVERY THREE MONTHS DURING THE COURSE OF YOUR THERAPY. YOU AGREE** and understand that increasing your dose without close supervision of your physician could lead to drug overdose, causing severe sedation, respiratory depression and/or death. **YOU AGREE** and understand that opioid/narcotic medication is strictly prescribed for you, and your opioid/narcotic medication should **NEVER** be given to others. **YOU AGREE** to secure your opioid/narcotic medications in a safe, locked source to prevent loss or theft. You are responsible for any loss or theft. **YOU AGREE** that lost, stolen or destroyed prescriptions or drugs **WILL NOT** be replaced, and may result in discontinuation of treatment. **YOU AGREE** to obtain opioid/narcotic medication from one prescribing physician or that physician's substitute if your prescribing physician is not available and your prescribing physician has authorized his or her substitute to provide treatment. **YOU AGREE** to submit to an initial examination and evaluation, to routine examination and evaluation on a monthly basis or regular basis (but no less than once every three months), and to examination and evaluation at the direction of your physician. **YOU AGREE** to submit to blood and/or urine testing to monitor the levels of medication or other drugs and any organ side effects. **YOU ALSO AGREE** that other doctors and law enforcement may be notified of the results. **YOU AGREE NOT** to call the physician for refills replacement medications during evening hours or on weekends/holidays. Medication refill and/or replacement requests will be addressed during regular business hours only. **YOU UNDERSTAND AND AGREE** that if you lose your medication or run out early due to overuse, you may experience and go through withdrawal from opioids/narcotics. **YOU FURTHER UNDERSTAND AND AGREE THA YOU ARE SOLELY RESPONSIBLE FOR YOUR OWN MEDICATIONS**. **YOU AGREE** to bring all prescription medication in their bottles or containers to the office during regularly scheduled visits. **YOU AGREE** to provide a list from your pharmacy detailing all medications received from that pharmacy and to provide updated lists as requested by your physician.

Patient Name:_____ DOB:_____

FOR PATIENTS TAKING METHADONE: Methadone has significant interactions with many other medications. Some of these medications may reduce your body's ability to metabolize methadone, thus **increasing** the methadone in your body, which could be dangerous. Therefore, you **MUST** notify this office of **ALL** medications prescribed for **ANY** condition while taking methadone.

OPOIOD/NARCOTIC THERAPY MAY BE DISCONTINUED IF YOU:

- Develop progressive tolerance which cannot be managed by changing medications;
- Experience unacceptable side effects which cannot be controlled;
- Experience diminishing function or poor pain control;
- Develop signs of addiction;
- Abuse any other controlled substance (this may be determined by random blood/urine testing);
- Obtain or use street drugs (this may be determined by random blood/urine testing);
- Increase your medication without the consent of your physician;
- Either refuse to stop or resume smoking;
- Obtain opiates/narcotics from other physicians or sources;
- Fill prescriptions at other pharmacies and evaluation on a monthly basis or regular basis (*but no less than once every three months) or as directed by your physician;
- Fail to bring your prescription medications to your regularly scheduled visits;
- Fail to submit to blood/urine testing as directed;
- Call for refills during evenings, weekends or holidays; or
- Violate any of the terms of this agreement. By signing below, Patient acknowledges and agrees that:

(i) I have read and fully understand the Physician/Patient informed Consent and Agreement for Long-Term Opioid/Narcotic Therapy for the Treatment of Chronic Pain;

(ii) I have been given the opportunity to ask questions about the proposed treatment (including no treatment), potential risks, complications, side effects, and benefits;

(iii) I knowingly accept and agree to assume the risks of the proposed treatment as presented; and

(iv) I agree to abide by the terms of this agreement.

SIGNATURES:

Print Name:_____

Patient Signature:_____ Date:_____

Print Name:_____

Witness Signature:_____ Date:_____

Print Name:_____

Physicians Signature:_____ Date:_____

NEUROSPINE INSTITUTE

DR. KAMRAN PARSA INC. DBA NEUROSPINE INSTITUTE

AGREEMENT AS TO RESOLUTION OF CONCERNS OF DISSATISFACTION
READ CAREFULLY

We take pride in our reputation for providing the highest levels of quality medical care to our patients. However, we realize there are times when some patients will not be satisfied with the outcomes of their treatments. We therefore recognize and respect a patient right to pursue legal action if he/ she feels we have been negligent in some way. While some health care legal claims are justified, there are also frivolous legal claims filed in our country, which drive up insurance rates and adversely impact court decisions for patients who deserve compensation. As such, we believe that an agreement early in the treatment process regarding the use of board-certified experts may help expedite resolution of concerns.

OUR COMMITMENT TO YOU: We commit to using only American Osteopathic Board of Surgeons, American Board of Medical Specialties, board certified expert witness(es) in any legal situation, who follow the code of ethics of our national specialty society. These steps ensure that expert medical witnesses we use have passed examinations, demonstrated expertise in their field and adhere to a solid code of ethics. We demonstrate this commitment to you with our signature on this form (which you may receive a copy of at any time after such signature is affixed) **WHAT WE ARE ASKING YOU TO DO:** We are asking you or any representative to commit to a process also, by using only American Osteopathic Board of Surgeons, American Board of Medical Specialties, board- certified physician expert medical witness(es) if you are dissatisfied with your medical care and decide on legal action. I understand that I am entering into a contractual relationship with the DR. KAMRAN PARSA INC. DBA NEUROSPINE INSTITUTE for professional services. I further understand that claims that are without merit or are frivolous have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided me by DR. KAMRAN PARSA INC. DBA NEUROSPINE INSTITUTE claims of medical malpractice against the providers within the DR. KAMRAN PARSA. DBA NEUROSPINE INSTITUTE should I initiate or pursue a medical malpractice claim against a provider within the DR. KAMRAN PARSA. DBA NEUROSPINE INSTITUTE, I agree to use as expert witness only physicians who are board certified by the American Osteopathic Board of Surgeons, , American Board of Medical Specialties in the same or similar specialty as the provider against whom the claim is being made. Further I agree that these physicians retained by me or on my behalf to be an expert witness will be a member in good standing of the medical specialty society to which the provider belongs. I agree an expert will be obligated to adhere to the guidelines or code of conduct defined by that physicians or providers specialty society. I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions.

In further consideration, DR. KAMRAN PARSA INC. DBA NEUROSPINE INSTITUTE also agree to exactly the same above referenced stipulations.

Each party agrees that his/her counsel shall have the right and be free to depose the other partys expert witness(es) at least 120 days before any scheduled trial date.

Each party agrees that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other defendants.

Each party agrees that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery or any other theory of recovery.

PRINT PATIENT NAME_____

PATIENT SIGNATURE_____ Date_____

PHYSICIAN SIGNATURE_____ Date_____

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient Information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient Files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restriction in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ date_____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Patient Signature:_____

NEUROSPINE INSTITUTE

Patient Record of Disclosures of Protected Health Information (PHI)

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be discussed:

☐ Appointment Dates/Times ☐ Diagnosis ☐ Imaging Results

☐ Medications ☐ Lab Tests/Results ☐ Medical Records

☐ Care Plan ☐ Other (specify)

Indicate Confidential Information:_____

_____

Patient Name: _____

Date of Birth: _____ Email Address:_____

Informed to be released to: _____

Name: _____

Relationship: _____

Address: _____

Phone: _____

This authorization shall remain in effect from the date signed below until (please check one):

☐ _____ (Specify expiration date or event)

☐ NO EXPIRATION

Signature: _____ Date: _____

Relationship to Patient (If signed by personal representative of Patient): _____

NEUROSPINE
INSTITUTE

SPECIAL NOTICE FROM NEUROSPINE INSTITUTE *(This notice is required by law. If you have any questions or concerns, please let us know before signing.)* I acknowledge that I have been given this separate written conspicuous notice by Dr. Kamran Parsa Inc. DBA NeuroSpine Institute Corp. that some or all of the care and treatment I receive will or may be provided by physicians who are employees and/or agents of NeuroSpine Institute, and liability, if any, that may arise from that care is limited as provided by law. I hereby certify that I am the patient or a person who is authorized to give consent for the patient.

_____

Signature of Patient or authorized Representative of Patien, Date

_____

Witness Signature

_____

Printed Name

_____

Relationship to Patient

NEUROSPINE INSTITUTE

INFORMATION ON NONOPIOID ALTERNATIVES FOR THE TREATMENT OF PAIN

ACKNOWLEDGEMENT PAGE

I have received the Pamphlet issued by NeuroSpine Institute, and my physician has reviewed with me the advantages and disadvantages of the use of non-opioid alternatives for the treatment of pain.

Patient Name: _____

Patient Signature: _____

Date: _____ Time: _____

Witness: _____

Physician Name: _____

CONSENT TO MEDICAL OR SURGICAL CARE AND TREATMENT

NOTE TO PATIENT: There are risks involved in any procedure or treatment. It is not possible to guarantee or give assurance of a successful result. It is important that you clearly understand and agree to the planned surgery or treatment.

I authorize Dr. _____ and such physicians, associates, assistants and other personnel or the hospital or medical facility chosen by him or her to perform the following (IN MEDICAL TERMS KNOWN AS):

_____

_____

_____

(IN COMMON TERMS KNOWN AS):

_____

_____

_____

and/or to do any other procedures that in their judgment may be advisable to my well-being, including such procedures as are considered medically advisable to remedy conditions discovered during the above procedure.

- **GENERAL RISKS AND COMPLICATIONS.** I am satisfied with my understanding of the more common risks and complications of the treatment or procedure which are described generally on the back of this form. These risks include the risk of bleeding, infection, pain, anesthesia risks and death.
- **SPECIFIC RISKS AND COMPLICATIONS.** I am satisfied with my understanding of specific risks of this procedure or treatment including (Doctor to describe specific risks where applicable):

_____

_____

_____

- **ALTERNATIVE METHODS OF TREATMENT.** I am satisfied with my understanding of alternative procedures or treatments and their possible benefits and risks including (Doctor to describe specific alternative procedures and complications where applicable):

_____

_____

_____

- **NO TREATMENT.** I am satisfied with my understanding of the possible consequences, outcomes or risks if no treatment is rendered.
- **SECOND OPINION.** I have been offered the opportunity to seek a second opinion concerning the proposed treatment or procedure.
- **ADDITIONAL OR DIFFERENT PROCEDURES DURING CARE AND TREATMENT.** I understand that conditions may arise which are unforeseen at this time and that it may be necessary and advisable to perform operations and procedures different from, or in addition to, the procedure described. I authorize and consent to the performance of such additional or different operations and procedures as are considered necessary and advisable.
- **OTHER SERVICES.** I consent to the performance of pathology and radiology services as needed and I further authorize the disposal of any severed tissue or member in accordance with customary hospital or medical facility practice.
- **PHOTOGRAPHY.** I consent to the photographing, filming or videotaping of the treatment or procedure for educational or diagnostic use .
- **NO GUARANTEES.** I understand there are risks involved in any procedure or treatment, and it is not possible to guarantee or give assurance of a successful result.
- **OTHER QUESTIONS.** I am satisfied with my understanding of the nature of the procedure or treatments and all of my additional questions about the treatment or procedure have been answered.

I have read and been given a copy of this form.

DATE: _____ TIME _____ AM/PM

PRINT PATIENT NAME: _____

SIGNATURE: _____

(PATIENT. PARENT OR LEGAL GUARDIAN)

TRANSLATED BY (IF APPLICABLE): _____

PHYSICIAN: _____

WITNESS: _____

PLEASE READ THE GENERAL INFORMATION ON BACK.

WHITE-Office Copy CANARY-Patient

A MESSAGE TO PATIENTS ABOUT MEDICAL/SURGICAL RISKS

Medicine and surgery are generally safe, helpful and often lifesaving. However, medical or surgical procedures of any type involve the taking of risks, ranging from minor to serious (including the risk of death). It is important to be aware of the following possible risks before receiving the treatment you and your physician are planning. The following may be the reactions of your body to medical/surgical operations or procedures:

1 **INFECTION:** Invasion of tissue by bacteria or other germs occurs to some degree whenever a cut, incision or puncture is made. In most instances, through the natural defense mechanisms of the body, healing of the affected area occurs without difficulty. In some instances antibiotic medicines are prescribed and at times additional surgical measures may be necessary to combat infection.

2 **HEMORRHAGE:** The cutting of blood vessels causes bleeding and this occurs in every surgical incision. This bleeding is usually controlled without difficulty. At times, blood transfusions are required to replace blood loss. If blood transfusions are given, there are additional risks of liver inflammation, hepatitis, and the possibility of receiving Acquired Immune Deficiency Syndrome (AIDS). There is no absolutely reliable way to predict these unwanted reactions, some of which may be quite serious and even lead to death.

3 **DRUG REACTIONS:** Unexpected allergies, lack of proper response to medications or illness caused by the prescribed drugs are possibilities. It is important for you to inform your physician and your anesthesiologist or certified registered nurse anesthetist of any problem you or your family have had with reactions to drugs and which medications you have taken in the past six months, including over-the-counter drugs, especially aspirin.

4 **ANESTHESIA REACTIONS:** There may be unusual or unexpected responses to the gases, drugs or methods used to anesthetize you which can lead to difficulties with lung, heart or nerve function. Eating or drinking before anesthesia increases the risks of vomiting which may cause significant complications. Inform your anesthesiologist or certified registered nurse anesthetist of problems you and your family have had with anesthesia.

5 **BLOOD VESSEL INFLAMMATION AND CLOTTING:** It is impossible to predict the occurrence of blood vessel inflammation and clotting problems. If blood clots form, they can move from where they formed to other areas of the body and cause injury.

6 **INJURY TO OTHER ORGANS:** Because of the closeness of other organs to the area being operated on, there may be injury to other organs. The stress of surgery or the procedure may also harm other organ systems of the body.

7 **OTHER RISKS:** It is not possible to list all the possible risks and complications, and their variations, that may arise in any surgical operation or medical procedure. Each situation depends upon the purpose and nature of the operation or procedures. Your physician is willing to discuss further with you various details about other risks.

ALTERNATIVES TO TREATMENT

Although you and your doctor have decided upon this procedure, do not hesitate to discuss the reasons for the choice and the alternatives available for treatment of your condition. In addition, be sure to ask your doctor any other questions that you may have about your treatment.

NEUROSPINE INSTITUTE

Information on Nonopioid Alternatives for the Treatment of Pain

A guide to working with your healthcare practitioner to manage pain

Prescription opioids are sometimes used to treat moderate-to-severe pain. Because prescription opioids have a number of serious side effects, it is important for you to ask questions and learn more about the benefits and risks of opioids. Make sure you're getting care that is safe, effective, and right for you.

This pamphlet provides information about nonopioid alternative treatments to manage pain. You and your healthcare practitioner can develop a course of treatment that uses multiple methods and modalities, including prescription medications such as opioids, and discuss the advantages and disadvantages of each approach.

Pain management requires attention to biological, psychological, and environmental factors. Before deciding with your healthcare practitioner about how to treat your pain, you should consider options so that your treatment provides the greatest benefit with the lowest risk.

Treatments provided by Licensed Healthcare Providers

Physical therapy (PT) and occupational therapy (OT). PT helps to increase flexibility and range of motion which can provide pain relief. PT can also restore or maintain your ability to move and walk. OT helps improve your ability to perform activities of daily living, such as dressing, bathing, and eating.

Massage therapy. Therapeutic massage may relieve pain by relaxing painful muscles, tendons, and joints; relieving stress and anxiety; and possibly impeding pain messages to and from the brain.

Acupuncture. Acupuncture is based on traditional Chinese medical concepts and modern medical techniques and provides pain relief with no side-effects by stimulation the body's pain-relieving endorphins. Techniques may include inserting extremely fine needles into the skin at specific points on the body.

Chiropractic care. Chiropractic physicians treat and rehabilitate pain, diseases and conditions using manual, mechanical, electrical, natural methods, physical therapy, nutrition and acupuncture. Chiropractors practice a hands-on, prescription drug-free approach to health care that includes patient examination, diagnosis and treatment.

Osteopathic, Manipulative Treatment (OMT). Osteopathic physicians (DO) are educated, trained, and licensed physicians, but also receive additional training in OMT. OMT is a set of hands-on techniques used by osteopathic physicians to diagnose, treat, and prevent illness or injury. OMT is often used to treat pain but also be used to promote healing, increase overall mobility, and treat other health problems.

Behavioral interventions. Mental health professionals can offer many avenues for pain relief and management. For example, they can help you reframe negative thinking patterns about your pain that may be interfering with your ability to function well in life, work, and relationships. Behavioral interventions can allow you to better manage your pain by changing behavior patterns.

Topical treatments and medications. Topical Agents, including Anesthetics, NSAIDs, Muscle Relaxers, and Neuropathic Agents, can be applied directly to the affected areas to provide needed pain relief and typically have a minimal risk of side-effects due to low absorption of the medication into the blood stream. Compounded topicals prepared by a pharmacist can be customized to the patient's specific needs.

Interventional pain management. "Interventional" procedures might include an injection of an anesthetic medicine or steroid around nerves, tendons, joints or muscles; spinal cord stimulation; insertion of a drug delivery system; or a procedure to stop a nerve from working for a long period of time.

Non-opioid anesthesia. Non-opioid anesthesia refers to the anesthetic technique of using medications to provide anesthesia and post-operative pain relief in a way that does not require opioids. Anesthetists can replace opioids with other medications selected for their ability to block surgical and post-surgical pain. By replacing opioids and incorporating the variety of anesthetic and analgesic medications that block the process of pain, anesthesia providers can provide a safer anesthetic that avoids the adverse effects of opioids.

Discuss these alternatives with your healthcare practitioner and talk about the advantages and disadvantages of the specific options being considered. Different approaches work better on different types of pain. Some treatments for pain can have undesirable side effects while other may provide benefits beyond pain relief. Depending on your insurance coverage, some options may not be covered, resulting in substantial out-of-pocket costs. Other options may require a significant time commitment due to the number of treatments or the time required for the treatment. Good communication between you and your healthcare practitioner is essential in building the best pain management plan for you.

Helpful Hints and Links

Natioinal Institutes of Health: https://nccih.nih.gov/health/pain/chronic.htm

Centers for Disease Control and Prevention: https://www.cdc.gov/drugoverdose/pdf/nonopioid_treatments-a.pdf

Cold and heat. Cold can be useful soon after an injury to relieve pain, decrease inflammation and muscle spasms, and help speed recovery. Heat raises your pain threshold and relaxes muscles.

Exercise. Staying physically active, despite some pain, can play a helpful role for people with some of the more common pain conditions, including low back pain, arthritis, and fibromyalgia.

Weight loss. Many painful health conditions are worsened by excess weight. It makes sense, then, that losing weight can help to relieve some kinds of pain.

Diet and nutrition. Chronic pain may be the result of chronic inflammation. Some foods can increase inflammation and contribute to pain levels. Reducing or eliminating foods that increase inflammation may provide pain relief.

Yoga and tai chi. These mind-body and exercise practices incorporate breath control, meditation, and movements to stretch and strengthen muscles. They may help with chronic pain conditions such as fibromyalgia, low back pain, arthritis, or headaches.

Transcutaneous electrical nerve stimulation (TENS). This technique employs a very mild electrical current to block pain signals going from the body to the brain

Over-the-counter-medications. Pain relievers that you can buy without a prescription, such as acetaminophen (Tylenol) or nonsteroidal anti-inflammatory drugs (NSAIDs) like aspirin, ibuprofen (Advil, Motrin), and naproxen (Aleve, Naprosyn) can help to relieve mild to moderate pain.