



## New Patient Form Packet

**Instructions:** Please bring your completed and signed forms to your first appointment. Additionally, please be sure to bring medical records, labs, imaging, insurance information, and other relevant materials.

Please call with any questions: (847) 289-8822

### Illinois Pain and Spine Institute New Patient Locations

#### Elgin

431 Summit Street  
Elgin, IL 60120-3861

Fax: (847) 289-0815

#### St. Charles

2455 Dean Street  
Suite 3G

St. Charles, Illinois 60175

Fax: (847) 289-0815

#### McHenry

4309 Medical Center Drive  
Suite B103

McHenry, IL 60050

Fax: (847)-381-0882

#### Itasca

650 East Devon Ave  
Suite 152

Itasca, IL 60143

Fax: (630) 250-4933

#### Barrington

600 Hart Road  
Suite 320

Barrington, IL 60010

Fax: (847) 381-0882

#### Libertyville

755 S Milwaukee Ave  
Suite 175

Libertyville, IL 60048

Fax: (847) 381-0882

## ILLINOIS PAIN & SPINE INSTITUTE.

### Patient Consent for Use and Disclosure of Protected Health Information (PHI)

I consent that Illinois Pain & Spine Institute may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Illinois Pain & Spine Institute "Assignment of Insurance Benefits and Statement of Service (AIBSS) " for a more complete description of such uses and disclosures.

I have the right to review the AIBSS prior to signing this consent. Illinois Pain & Spine Institute reserves the right to revise its AIBSS at any time. A revised AIBSS may be obtained by forwarding a written request to Illinois Pain & Spine Institute, 431 Summit Street, Elgin, IL 60120 (Attn: Privacy/Compliance Officer).

I consent that Illinois Pain & Spine Institute may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminder, insurance items and any call pertaining to my clinical care, including laboratory results among others.

I consent that Illinois Pain & Spine Institute may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I consent that Illinois Pain & Spine Institute may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that Illinois Pain & Spine Institute restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Illinois Pain & Spine Institute's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Illinois Pain & Spine Institute may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

\_\_\_\_\_  
Witnessed

\_\_\_\_\_  
Date

ILLINOIS PAIN & SPINE INSTITUTE  
ASSIGNMENT OF INSURANCE BENEFITS AND STATEMENT OF SERVICE

I hereby assign and authorize payment to Illinois Pain & Spine Institute of the covered insurance benefits, including major medical benefits, whether payable to me by BlueCross/Blueshield, Medicare, Medigap, worker's compensation carrier, and/or commercial insurance companies. I fully understand that I am financially responsible for and agree to pay all charges not paid by my health coverage, including deductibles, co-insurance and payments from insurance companies sent directly to me. In consideration of the medical service furnished to me, I hereby agree to pay Illinois Pain & Spine Institute any balance due. If my account should become delinquent and collection efforts become necessary, I agree to pay any reasonable collection or attorney's fees incurred.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and /or employee health care plan with respect of medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law for to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and /or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and /or employee health care plan in my name but at such doctor and clinic's expense.

Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonable expected to be effective and such anti-assignment is waived.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement. This assignment shall apply to all services now rendered and to be rendered in the future until it is revoked.

I have disclosed the names of all my health insurance providers including tie-in-coverage, and I represent that such health care coverage is in full force and effect at this time. If prior authorization or certification for medical services is required under my health care coverage, I agree to obtain and furnish such authorization or certification.

I authorize the release of medical information as may be required to process the claims for payment of the medical service rendered, which may include medical records pertaining to mental health and /or substance abuse. Any account not paid in full by 45 days after the date it becomes patient responsibility, will be assessed a \$10.00 rebilling fee for each month that the balance remains unpaid..

Drs. John Prunskis and Terri Dallas-Prunskis have an ownership interest in Pinnacle Anesthesia Ltd.

**MISSED APPOINTMENT/PROCEDURES**

Unless cancelled at least 48 hours in advance, we may charge you \$50.00. For any procedure not canceled at least 48 hours in advance, we may charge you \$100.00. Please help us serve you better by keeping your scheduled appointments.

**PRESCRIPTION REFILL POLICY**

Prescription refills will only be made at the time of your visit.

I have had an opportunity to discuss with the physician or his staff, to my satisfaction, the nature of the services provided. I acknowledge that no guarantees have been made to me as to the results.

I am satisfied that I fully understand this agreement and assignment and its significance.

I agree to promptly notify your office of any changes of address or change of health insurance providers or changes of worker's compensation carrier.

A copy of this assignment shall be considered as valid as original.

X \_\_\_\_\_  
Patient Name Printed

X \_\_\_\_\_  
Signature of Patient

X \_\_\_\_\_  
Date

Social Security# \_\_\_\_\_

Employer \_\_\_\_\_

Insurance Co. \_\_\_\_\_  
(Primary)

X \_\_\_\_\_  
Signature of Insured(If Applicable)

X \_\_\_\_\_  
Date

Social Security# \_\_\_\_\_

Employer \_\_\_\_\_

Insurance Co. \_\_\_\_\_  
(Secondary)

SIGN BELOW IF YOU HAVE MEDIGAP INSURANCE POLICY  
MEDICARE LIFETIME MEDIGAP ASSIGNMENT

I assign and authorize payment of Medigap benefits to Illinois Pain & Spine Institute for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agency any information needed to determine these benefits payable for related services.

X \_\_\_\_\_ Date \_\_\_\_\_

12.18.2020 cmh

Medigap Company \_\_\_\_\_



## Communications Waiver

I, \_\_\_\_\_, \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_,  
(Name of Patient or Authorized Agent) (Date of Birth: xx/xx/xxxx)

Hereby request Illinois Pain and Spine Institute to keep communication regarding my health information confidential by adhering to the following communication requests:

Between the hours of 8:30 a.m. and 4:30 p.m.:

Try this phone number 1<sup>st</sup>: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ Ext: \_\_\_\_\_, which is my: Home ☐ Work ☐ Cell ☐

Try this phone number 2<sup>nd</sup>: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ Ext: \_\_\_\_\_, which is my: Home ☐ Work ☐ Cell ☐

Try this phone number 3<sup>rd</sup>: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ Ext: \_\_\_\_\_, which is my: Home ☐ Work ☐ Cell ☐

Before 8:30 a.m., call my: Home ☐ Work ☐ Cell ☐

After 4:30 p.m., call my: Home ☐ Work ☐ Cell ☐

In case of emergency, please provide the name of a contact we may call to provide your medical information:

Emergency Contact Name: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

You can leave a message or medical information on my answering machine or voicemail:

Home: Yes ☐ No ☐

Work: Yes ☐ No ☐

Cell: Yes ☐ No ☐

You can leave a message or medical information with the following people

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient or Authorized Agent)

## AGREEMENT FOR PAYMENT

The undersigned patient and/or guarantor authorizes Illinois Pain & Spine Institute to submit credit card slips using any of the cards listed below to collect unpaid amounts due for services rendered. Charges will be placed on cards thirty days after a balance becomes the patient's responsibility.

I have read and understand the above statements concerning my responsibility in paying my bill.

Credit Card: ☐ MasterCard ☐ Visa ☐ Discover

\_\_\_\_\_  
Card Number

\_\_\_\_\_  
Expiration

\_\_\_\_\_  
Name as it appears on card

\_\_\_\_\_  
Security code

\_\_\_\_\_  
Credit card billing address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip code

\_\_\_\_\_  
Card Holder Signature

# ILLINOIS PAIN & SPINE INSTITUTE

## HIPAA NOTICE OF PRIVACY PRACTICES (“NOTICE”)

**THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. IT FURTHER DETAILS HOW YOU OR YOUR PERSONAL REPRESENTATIVE MAY GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.**

This Notice describes how our practice and our health care professionals, employees, volunteers, trainees and staff may use and disclose your medical information to carry out treatment, payment or health care operations and for other purposes that are described in this Notice. We understand that medical information about you and your health is personal and we are committed to protecting medical information about you. This Notice applies to all records of your care generated by this practice.

This Notice also describes your right to access and control your medical information. This information about you includes demographic information that may identify you and that relates to your past, present and future physical or mental health or condition and related health care services. Typically, your medical information will include symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment.

We are required by law to protect the privacy of your medical information and to follow the terms of this Notice. We may change the terms of this Notice at any time. The new Notice will then be effective for all medical information that we maintain at that time and thereafter. We will provide you with any revised Notice if you request a revised copy be sent to you in the mail or if you ask for one when you are in the office.

- I. **Uses and Disclosures of Protected Health Information.** Your medical information may be used and disclosed for purposes of treatment, payment and health care operations. The following are examples of different ways we use and disclose medical information. **These are examples only.**
- (a) **Treatment.** We may use and disclose medical information about you to provide, coordinate, or manage your medical treatment or any related services. This includes the coordination of management of your health care with a third party that has already obtained your permission to have access to your medical information. For example, we could disclose your medical information to a home health agency that provides care to you. We may also disclose medical information to other physicians who may be treating you, such as a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your medical information to another physician or health care provider, such as a laboratory.
  - (b) **Payment.** We may use and disclose medical information about you to obtain payment for the treatment and services you receive from us. For example, we may need to provide your health insurance plan information about your treatment plan so that they can make a determination of eligibility or to obtain prior approval for planned treatment, such as disclosing relevant medical information to the health plan to obtain approval for hospital admission.
  - (c) **Healthcare Operations.** We may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your medical information to remind you of your next appointment. We may share your medical information with third party “business associates” that perform activities on our behalf, such as billing or transcription for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your medical information, we will have a written contract that contains terms that asks the “business associate” to protect the privacy of your medical information. We may use or disclose your medical information to provide you with information about treatment alternatives, case management or other health-related benefits and services that may be of interest to you. We may also use and disclose your medical information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer, or a prescription refill reminder may be sent to you for a prescription you are currently prescribed or its generic equivalent. We may also send you information about products or services that we believe may be beneficial to you. You may contact our **Privacy Contact** to request that these materials not be sent to you. We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our **Privacy Contact** to request that these fundraising materials not be sent to you.
  - (d) **Health Information Exchange.** We along with certain other health care providers and practice groups in the area, may participate in a health information exchange (“Exchange”). An Exchange facilitates electronic sharing and exchange of medical and other individually identifiable health information regarding patients among health care providers that participate in the Exchange. Through the Exchange, we may electronically disclose demographic, medical, billing and other

health-related information about you to other health care providers that participate in the Exchange and request such information for purposes of facilitating or providing treatment, payment or health care operations.

## **II. Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent. Authorization of Opportunity to**

**Object.** We may use and disclose your medical information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your medical information. If you are not present or able to agree or object to the use or disclosure of the medical information, then your physician may, using professional judgement, determine whether the disclosure is in your best interest. In this case, only the medical information that is relevant to your health care will be disclosed.

- (a) **Others Involved in Your Healthcare.** Unless you object, we may disclose to a member of your family, a relative or close friend your medical information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information if we determine that it is in your best interest based on our professional judgment. We may use or disclose medical information to notify or assist in notifying a family member or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your medical information to an entity assisting in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.
- (b) **Emergencies.** We may use or disclose your medical information for emergency treatment. If this happens, we shall try to obtain your consent as soon as reasonable after the delivery of treatment. If the practice is required by law to treat you and has attempted to obtain your consent but is unable to do so, the practice may still use or disclose your medical information to treat you.
- (c) **Communication Barriers.** We may use and disclose your medical information if the practice attempts to obtain consent from you but, is unable to do so due to substantial communication barriers and, in our professional judgment, you intended to consent to use or disclosure under the circumstances

## **III. Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity**

**to Object.** We may use or disclose your medical information in the following situations without your consent or authorization. These situations include:

- (a) **Required By Law.** We may use or disclose your medical information when federal, state or local law requires disclosure. You will be notified of any such uses or disclosure.
- (b) **Public Health.** We may disclose your medical information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. This disclosure will be made for the purpose of controlling disease, injury or disability.
- (c) **Communicable Diseases.** We may disclose your medical information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
- (d) **Health Oversight.** We may disclose medical information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure. These activities are necessary for the government agencies to oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- (e) **Abuse or Neglect.** We may disclose your medical information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your medical information to the government entity authorized to receive such information if we believe that you have been a victim of abuse, neglect or domestic violence as is consistent with the requirements of applicable federal and state laws.
- (f) **Food and Drug Administration.** We may disclose your medical information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.
- (g) **Legal Proceeding.** We may disclose medical information in the course of any judicial or administrative proceeding, when required by a court order or administrative tribunal, and in certain conditions in response to a subpoena, discovery request or other lawful process.
- (h) **Law Enforcement.** We may disclose medical information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include: (i) responding to a court order, subpoena, warrant, summons or otherwise required by law; (ii) identifying or locating a suspect, fugitive, material witness or missing person; (iii) pertaining to victims of a crime; (iv) suspecting that death has occurred as a result of criminal conduct; (v) in the event that a crime occurs on the premises of the practice; and (vi) responding to a medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.
- (i) **Coroner, Funeral Directors and Organ Donors.** We may disclose medical information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose medical information to funeral directors as necessary to carry out their duties.
- (j) **Research.** We may use and disclose your medical information for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Internal Review Board ("IRB") or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure

involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate, written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would be otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

- (k) **Criminal Activity.** Consistent with applicable federal and state laws, we may disclose your medical information, if we believe that the use or disclosures is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose medical information if it is necessary for law enforcement authorities to identify or apprehend an individual.
- (l) **Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- (m) **Military Activity and National Security.** If you are a member of the armed forces, we may use or disclose medical information, (i) as required by military command authorities; (ii) for the purpose of determining by the Department of Veterans Affairs of your eligibility for benefits; or (iii) for foreign military personnel to the appropriate foreign military authority. We may also disclose your medical information to authorized federal officials for conducting national security and intelligence activities, including for the protective services to the President or other legally authorized.
- (n) **Workers' Compensation.** We may disclose your medical information as authorized to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illness.
- (o) **Inmate.** We may use or disclose your medical information if you are an inmate of a correctional facility and our practice created or received your health information in the course of providing care to you.
- (p) **Required Uses and Disclosures.** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500, et seq.

#### **IV. The Following Is a Statement of Your Rights with Respect to Your Medical Information and a Brief Description of How You May Exercise These Rights.**

- (a) **You have the right to inspect and copy your medical information.** This means you may inspect and obtain a copy of medical information about you that has originated in our practice. We may charge you a reasonable fee for copying and mailing records. To the extent we maintain any portion of your PHI in electronic format, you have the right to receive such PHI from us in an electronic format. We will charge no more than actual labor cost to provide you electronic versions of your PHI that we maintain in electronic format. After you have made a written request to our Privacy Contact at the following address: 431 Summit Street, Elgin, IL 60120, we will have thirty (30) days to satisfy your request. If we deny your request to inspect or copy your medical information, we will provide you with a written explanation of the denial. You may not have a right to inspect or copy psychotherapy notes. In some circumstances, you may have a right to have the decision to deny you access reviewed. Please contact the Privacy Contact if you have any questions about access to your medical record.
- (b) **You have the right to request a restriction of your medical information.** You may ask us not to use or disclose part of your medical information for the purposes of treatment, payment or healthcare operations. You may also request that part of your medical information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. You must state in writing the specific restriction requested and to whom you want the restriction to apply. You have the right to restrict information sent to your health plan or insurer for products or services that you paid for solely out-of-pocket and for which no claim was made to your health plan or insurer.
- (c) **We are not required to agree to your request.** If we believe it is in your best interest to permit the use and disclosure of your medical information, your medical information will not be restricted; provided, however, we must agree to your request to restrict disclosure of your medical information if: (i) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (ii) the information pertains solely to a health care item or service for which you (and not your health plan) have paid us in full. If we do agree to the requested restriction, we may not use or disclose your medical information in violation of that restriction unless it is needed to provide emergency treatment. Your written request must be specific in what information you want to limit and to whom you want the limits to apply. The request should be sent, in writing, to our Privacy Contact.
- (d) **You have the right to request to receive confidential communications from us at a location other than your primary address.** We will try to accommodate reasonable requests. Please make this request in writing to our Privacy Contact.
- (e) **You may have the right to have us amend your medical information.** If you feel that medical information, we have about you is incorrect or incomplete, you may request we amend the information. If you wish to request an amendment to your medical information, please contact our Privacy Contact, in writing to request our form *Request to Amend Health*



*Information.* In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us.

- (f) **You have the right to receive an accounting of disclosures we have made, if any, of your medical information.** This applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, family members or friends involved in your care, or for notification purposes. To receive information regarding disclosures made for a specific time period no longer than six (6) years and after April 14, 2003, please submit your request in writing to our Privacy Contact. We will notify you in writing of the cost involved in preparing this list. To the extent we maintain your PHI in electronic format, you may request an accounting of all electronic disclosures of your PHI for treatment, payment, or healthcare operations for the preceding three (3) years prior to such request.
- (g) **Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization.** Other uses and disclosures of your medical information not covered by this Notice or required by law will be made only with written authorization. For example, the following uses and disclosures require your authorization: (1) Most uses and disclosures of psychotherapy notes; (2) Uses and disclosures of PHI for marketing purposes unless (i) the communication occurs face-to-face; (ii) consists of marketing gifts of nominal value; (iii) is regarding a prescription refill reminder that is for a prescription currently prescribed or a generic equivalent; and/or (v) communication from us to recommend or direct alternative treatments, therapies, healthcare providers or settings of care when we do not receive any financial remuneration for making the communication; and (3) Disclosures that constitute a sale of PHI and other than those described in this Notice, require authorization. You may revoke this authorization at any time, except to the extent that our practice has taken an action in reliance on the use or disclosure indicated in the prior authorization.
- (h) **Right to be Notified of a Breach.** You have the right to be notified in the event that our practice (or a Business Associate of ours) discovers a breach of unsecured protected health information.
- (i) **Complaints:** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by obtaining a *Complaint Form* from our Privacy Contact. All complaints must be in writing. We will not retaliate against you for filing a complaint.
- (j) **To Contact Us:** You may contact us through our Privacy Contact as follows:

Illinois Pain & SpineInstitute  
Attn: Privacy/ Compliance Officer  
431 Summit Street  
Elgin, IL 60120  
847-298-8822 (telephone) 847-289-0815 (facsimile)

By signing this form, you acknowledge receiving this Notice and that you were afforded an opportunity to ask questions related to the content herein.

Signature of Patient \_\_\_\_\_

Date \_\_\_\_\_

Print Name of Patient \_\_\_\_\_

# Illinois Pain & Spine Institute

## Contract (Agreement) for Controlled Substance Medication Prescriptions

We are committed to doing all we can to treat your pain condition. In some cases, opioids and other controlled substances are used as a therapeutic option in the management of pain and related conditions, all of which are strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and the physician by establishing guidelines, within the laws, for proper controlled substance use.

1. All controlled substances have a potential for dependency and abuse.
2. All controlled substances must come from the Illinois Pain & Spine Institute physician whose signature appears below or, during his absence, by the covering health care provider, unless specific authorization is obtained for an exception. If controlled substances are obtained from an unauthorized health care provider, the incident may be reported to primary physician and other authorities.
3. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies our office must be informed. The Pharmacy that I have selected is:

Phone

4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide my health care for the purpose of maintaining accountability.
5. I may not share, sell, or otherwise permit others including spouse or family members to have access to these medications.
6. Unannounced urine or serum toxicology screens may be requested, and my cooperation is required. Presence of unauthorized substances may result in my discharge from our practice.
7. I will only consume minimal or no amounts of alcohol in conjunction with narcotics, nor will I use, purchase, or otherwise obtain any illegal drugs. I agree to help myself by trying to change my behavior to include a healthier lifestyle including: stopping smoking, diet, weight control and exercise.
8. Medication may not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, etc. If my medication has been stolen it will not be replaced unless explicit proof is provided with direct evidence from authorities. My report narrating what happened is not enough.
9. If the responsible legal authorities have questions concerning my treatment, as might occur, for example, if I were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substance administration.
10. Medications are to be taken as directed. I will not increase medication myself. Early refills will not be given. Renewals are based on keeping scheduled appointments. I will not phone for prescription refills, however, I will call to schedule an appointment for that refill.
11. In the event I am arrested or incarcerated related to legal or illegal drugs, refills on controlled substances will not be given.
12. It is understood that failure to adhere to these policies may result in immediate cessation of therapy with controlled substance prescribing by this physician and our practice.
13. I affirm that I have full right and power to sign and be bound by this agreement, and that I have read, understand, and accept all of its terms.

Patient's full name

Patient's signature

Date

Physician's signature

Date



## TREATING PHYSICIAN SUMMARY

DATE: \_\_\_\_\_ PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

Please list the NAME, LOCATION and PHONE NUMBER of any of physicians that are currently involved with your healthcare.

**PLEASE CHECK OFF WHICH DOCTOR REFERRED YOU TO OUR PRACTICE.**

Specialty	Name of Physician	Location	Phone Number
<input type="checkbox"/> Primary Care:	_____	_____	_____
<input type="checkbox"/> Cardiologist:	_____	_____	_____
<input type="checkbox"/> Orthopedic:	_____	_____	_____
<input type="checkbox"/> Neurology:	_____	_____	_____
<input type="checkbox"/> Psychiatry/Psychology:	_____	_____	_____
<input type="checkbox"/> Hematology/Oncology:	_____	_____	_____
<input type="checkbox"/> Rheumatology:	_____	_____	_____
<input type="checkbox"/> OB/GYN:	_____	_____	_____
<input type="checkbox"/> Physical Therapy:	_____	_____	_____
<input type="checkbox"/> Other: _____	_____	_____	_____
<input type="checkbox"/> Other: _____	_____	_____	_____

Last Name: \_\_\_\_\_

First Name : \_\_\_\_\_

Age \_\_\_\_\_

City you live in: \_\_\_\_\_

Insurance Provider: \_\_\_\_\_

Male ☐ Female ☐

Today's Date \_\_\_\_\_

Referring Provider: \_\_\_\_\_

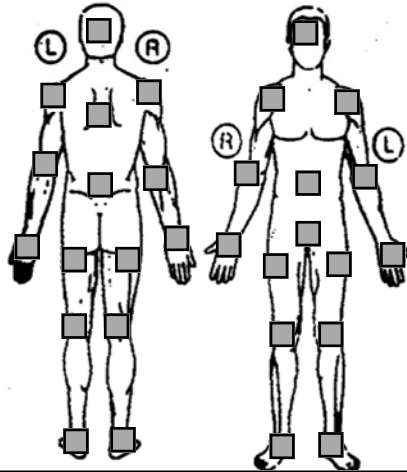
List Doctors you have seen & city:

\_\_\_\_\_  
\_\_\_\_\_

### Circle words that describe your pain

- ☐ Burning ☐ Stabbing ☐ Depressing ☐ Constant Freezing  
☐ Shooting ☐ Comes and Goes ☐ Electric Shock ☐ Dull Ache  
☐ Tightness ☐ Unbearable ☐ Entire Body Throbbing ☐ Muscle Spasm

Shade in where you have pain  
Or describe in the box below



\_\_\_\_\_

What started the pain?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe any accidents you have had related to this pain:

\_\_\_\_\_  
\_\_\_\_\_

What was the date of injury?: \_\_\_\_\_

What makes the pain better? \_\_\_\_\_

\_\_\_\_\_

What makes the pain worse? \_\_\_\_\_

\_\_\_\_\_

**Pain Level:** Place an X along this line to indicate how severe your pain is today.

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

☐ Worst pain possible.

How many minutes can you walk until you must stop due to pain? \_\_\_\_\_

What **specific activities** is the pain preventing you from doing? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### Please check any of the following treatments you have had:

- ☐ Pool Therapy ☐ Biofeedback ☐ Tens Unit ☐ Acupuncture ☐ Nerve Blocks ☐ Trigger Point Injections  
☐ Epidural Steroids ☐ Back Surgery ☐ Chiropractic Manipulation ☐ Psychological Counseling for Pain  
☐ Physical Therapy, Dates: \_\_\_\_\_ Other: \_\_\_\_\_

Please list all **surgeries** you have had \_\_\_\_\_  
\_\_\_\_\_

Are you working now? Y ☐ N ☐ What kind of work do you do? \_\_\_\_\_

What was your last date of work? \_\_\_\_\_ Is this a work related injury? Y ☐ N ☐

Was there ever a law suit regarding your pain? Y ☐ N ☐ Have you ever been on disability? Y ☐ N ☐

Your attorney's name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone number: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## Intake Information

Who do you live with at home? \_\_\_\_\_

Are you: ☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

Please check any medical problems that you have had and the approximate year when you first had it. Place a check in the "Family" column next to it if one of your family members has or had the problem.

You	Family	Year		You	Family	Year	
<input type="checkbox"/>	<input type="checkbox"/>	_____	Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	_____	Asthma/Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Irregular Heart Beats
<input type="checkbox"/>	<input type="checkbox"/>	_____	Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease/Heart Attack
<input type="checkbox"/>	<input type="checkbox"/>	_____	Decreased Appetite	<input type="checkbox"/>	<input type="checkbox"/>	_____	Shortness of Breath
<input type="checkbox"/>	<input type="checkbox"/>	_____	Treatment by a Psychiatrist	<input type="checkbox"/>	<input type="checkbox"/>	_____	Loud Snoring
<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Difficulty Sleeping
<input type="checkbox"/>	<input type="checkbox"/>	_____	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	_____	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	_____	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	_____	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Problems
<input type="checkbox"/>	<input type="checkbox"/>	_____	Decreased Concentration	<input type="checkbox"/>	<input type="checkbox"/>	_____	Night Sweats, Fever
<input type="checkbox"/>	<input type="checkbox"/>	_____	Unexplained Crying	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	_____	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	_____	Numbness
<input type="checkbox"/>	<input type="checkbox"/>	_____	Liver Problems/Yellow Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____	Weakness
<input type="checkbox"/>	<input type="checkbox"/>	_____	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____	Change in Bowel, Bladder or Sexual Function

Please list any other medical problems you have \_\_\_\_\_

Have you ever smoked? **Y**☐ **N**☐ What year did you stop? \_\_\_\_\_ Do you smoke now? How much? \_\_\_\_\_

Were you ever a heavy drinker of alcohol? **Y**☐ **N**☐ When did you stop? \_\_\_\_\_

How much do you drink now? \_\_\_\_\_

Have you ever used street drugs? **Y**☐ **N**☐ If so, please list: \_\_\_\_\_

Please circle if you have had any of the following:

**TESTS**    **Approx date**    **Which Hospital**

X-Ray: \_\_\_\_\_

MRI: \_\_\_\_\_

CT-Scan: \_\_\_\_\_

Nerve test: \_\_\_\_\_

Please list all medications you are taking (including over the counter such as Tylenol), or give your list to our staff to copy for your records.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Are you allergic to any medication?**

**Please list:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medications used in past?**

**Any problems you had?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_