Northwest Suburban Pain Center

PATIENT DEMOGRAPHICS:

Patient Name:_____ Sex: M__ F__
Home Address:_____
City:_____Zip Code:_____
Date of Birth:_____Age_____
Email:_____
Home Phone #:_____Cell #:_____
Work #:_____ Employer Name:_____

Emergency Contact Person:_____

Relationship to Patient:_____
Contact Phone #:_____Cell #:_____
If patient is UNDER 18 Parent/Guardian Name:_____
Parent/Guardian Phone #:_____Social Security #:_____

PRIMARY CARE DOCTOR:_____

Address:_____
Office Phone #:_____

REFERRING DOCTOR:_____

Address:_____
Office Phone #:_____

INSURANCE:

Primary:_____
Policy holder's name:_____Policy holder's DOB:_____
Secondary:_____
Policy holder's name:_____Policy holder's DOB:_____

PHARMACY:_____

ADDRESS:_____
PHONE #:_____

Northwest Suburban Pain Associates
880 W. Central Rd. #3800 Arlington Heigths, IL 60005
Phone: (847) 255-0900
Fax: (847) 255-4344

Name of Pain Physician: **Dr. Ahsan** **Dr. Bukhalo** **Dr. Bhave** **Dr. Badiee**
Appointment Date: _____ / _____ / _____

PATIENT INFORMATION- PLEASE PRINT

Please describe your current status by checking the appropriate category:

____ Working full-time
____ Retired
____ Semi Retired
_____ Working part-time
_____ Unable to work due to painful condition

My previous or current employment is: _____

Do you live alone? _____Yes ____No If 'No', with whom do you live with? _____

What is your marital status? ___Single ___Married ___Widowed ____Divorced _____Other

Have you had any of the following tests done within the last 3 years?

____ X-Rays ____ EMG ____CT Scan _____MRI _____Bone Scan

Other diagnostic tests/procedures _____

Please describe the location of your pain:_____

_____

When did the pain first seem to be a problem? (Check appropriate category with the date pain started if possible)

___On-the-job injury date ____/____/_____ ___Car accident date _____/_____/_____

___Related to cancer date ____/____/_____ ___No exact date time when pain first began

Please use this section to provide other information on your pain including circumstances of accident if work related. It is also helpful to know what you feel makes the pain better or worse.

_____
_____
_____
_____

PATIENT INFORMATION - PAIN ASSESSMENT

- Please indicate on the line below, the level of pain that you feel **TODAY.** Your average pain score can be anywhere between the two extremes shown on the line. Circle the number score which most closely matches how your pain feels **today**.

No pain_____ Pain feels as bad as it can be. ("10" is considered
0 1 2 3 4 5 6 7 8 9 10 hospitalization type of pain)

- Please indicate on the line below the average pain level you have felt in the past week. Your average pain score can be anywhere between the same two (2) extremes.

No pain_____ Pain feels as bad as it can be. ("10" is considered
0 1 2 3 4 5 6 7 8 9 10 hospitalization type of pain)

WHERE IS YOUR PAIN?

Please look carefully at the pain distribution diagram which follows this questionnaire. Use the diagram to help us understand more about the pain you have been experiencing. **Mark on the diagram where your pain is**.

HEALTH HISTORY & FAMILY HISTORY

Do you have any medical problems the doctor should know about? _____NO _____YES
If your answer is 'YES', please list conditions you have been diagnosed or treated for in the past.

_____
_____
_____
_____

Have you had any surgeries or operations? ____NO _____YES
If your answer is "YES", please list all surgeries or operations performed and dates when they were performed.

_____
_____
_____
_____

Please check any of the following conditions that are part of your **family's medical history.**

___Depression ___Neck/Back problems ____Neck/Back surgeries or operations
___Chronic Pain ____Fibromyalgia ___Migraine Headaches
___Heart Disease ____Cancer ___Arthritis or joint replacement surgery

Is there any other family history you feel we should be aware of? (If yes, please explain).

_____
_____

What time do you go to bed? _____ How many hours of sleep do you get per night? _____

How would you rate your sleeping pattern now? ____Poor ____Fair ____Good ____ Very good

How would you rate your appetite now? ____Poor ____Fair ____Good ____ Very good

List all medications that you are currently taking, both prescription and non-prescription types. If you have a listing of medications please provide us with it so we can make a copy.

Medication:_____ Dosage:_____ How often: _____

Medication: _____ Dosage:_____ How often: _____

Medication:_____ Dosage:_____ How often: _____

Medication:_____ Dosage:_____ How often: _____

Medication:_____ Dosage:_____ How often: _____

Do you have and **KNOWN ALLERGIES** or sensitivities to any medications, drugs?

NO_____ YES_____ If 'YES', please list:

_____

Do you smoke? NO_____ YES_____ Packs per day_____ Are you a former smoker? NO_____YES_____

If so, when did you quit? _____

Do you drink alcohol? Daily_____Occasionally_____Rarely_____Never_____

Have you **EVER** had a history of any alcohol or drug abuse problem? NO_____ YES____ If 'YES', please explain:

_____

If your condition is the result of an injury, please complete the section below:

Date of injury _____/_____/_____

Do you receive disability compensation of any kind? NO_____YES_____ (Please check all that apply)

_____Social Security Disability
_____Applied for Disability -application pending
_____Lawsuit pending settlement
_____Welfare, food stamps
_____Workers' Compensation
_____Other_____

Name of attorney that is on your case or pending disability:_____
Telephone No. _____
Fax No.

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize Northwest Suburban Pain Center and its physicians, to release any medical records or other information concerning this treatment for reimbursement to my insurance companies, employer insurance groups, and other agents or intermediaries, my referring physician, and other physicians participating in the delivery of my pain evaluation, assessment, treatment and care delivery. I understand co-payments, deductibles or amounts not covered by my group health insurance are my responsibility as part of the physician-patient relationship I am establishing with this private physicians group.

Patient Signature _____ Date _____/_____/_____

Parent or Guardian Signature _____ Date _____/_____/_____
(If patient is a minor)

Northwest Suburban PainCenter

Mohammad Ahsan, MD, AQPM, DABPM, DAAPM

Yuriy Bukhalo, MD, AQPM

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have read the Notice of Privacy Practices from the above named practice. In addition, I want the following information to become part of my permanent record. I understand that I can make changes to this document at any time. I also understand that I can request a copy of this document at any time.

I want to authorize leaving messages on my answering machine.

Home: _____Yes _____ No Work: _____Yes _____ No

The staff of Northwest Suburban Pain Center may leave appointment reminder messages with the following people who may answer my home/work phone.

Name: _____

Relationship: _____

I authorize the staff of Northwest Suburban Pain Center to discuss my protected health care information with the following people:

Spouse (name)or Significant Other:

_____

Other Family Members (names):

_____

PATIENT NAME: _____

PARENT OR GUARDIAN (if under age 18): _____

RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____ **DATE:** _____

880 West Central Road, Suite 3600 • Arlington Heights, IL 60005 • 847.255.0900 • fax 847 255.4344

www.nwpaincenter.com

Northwest Suburban
Pain Center

Mohammad Ahsan, *MD, AQPM, DABPM, DAAPM*
Yuriy Bukhalo, *MD, AQPM*
Meghan Bhave, MD

PATIENT CONSENT - TREATMENT & RELEASE OF MEDICAL INFORMATION

(2/21/06)

Patient's Name _____

General Consent for Treatment

I consent to and authorize the administration and performance of all tests and treatments by members of the pain management, general medical staff, and personnel affiliated with Northwest Suburban Pain Center and Northwest Community Hospital, which in the judgment of my physician(s) and Emergency Dept. or other attending physicians at this institution, may be considered necessary or advisable for the diagnosis and treatment for the condition for which I am presenting myself at this time. I understand that the practice of medicine is not an exact science, and acknowledge that no guarantees have been made to me as a patient.

Disclosure Statement

My care will be managed by my personal pain physician or other physicians who are affiliated with Northwest Suburban Pain Center, who are not employed by the hospital, but who have privileges to care for patients at this institution. My physician may also decide to call in consultants who practice in other specialties who may also be involved in my care. Like my physician, those consultants have privileges to care for patients at the hospital, but are not employed by Northwest Community. To provide specialized services such as emergency medicine, radiology, pathology, and anesthesiology, I understand the hospital has entered into agreements with independent physician groups. The members of these groups are not employees of the hospital, or its Day Surgery Center, but have privileges to practice at these facilities.

Release of Responsibility for Valuables

Patients are requested to make use of the safe at the hospital for any valuables in their possession, or to leave such valuables home when receiving treatment from Northwest Suburban Pain Center. I acknowledge the hospital and the pain center will not be liable for any loss or theft of any personal property of mine, other than that which I deposit in the institution's safe, whether such loss of theft is occasioned by any patient, visitor, guest, agent, or employee of the institution, the Day Surgery Center, or Northwest Suburban Pain Center.

Assignment of Insurance Benefits & Payment Guarantee

I represent that I currently maintain insurance coverage which will reimburse the charges submitted by Northwest Suburban Pain Center and my treating physician for medical or surgical care which is being provided to me. In consideration of those professional physician services, I assign, transfer, and agree to have such physicians reimbursed directly by my insurance company, managed care organization, or health plan through my assignment of such payments to Northwest Suburban Pain Center for all amounts they are entitled to collect from such payers as reimbursement. I assume responsibility and agree to pay all costs, charges, and expenses of every description for services which are given to me by my treating physicians, whether such care is provided on an inpatient, outpatient, office, or emergency basis. If my medical insurance is not sufficient to satisfy such costs, charges, and expenses in full, I understand that the resulting balance not covered by my assignment of insurance benefits, is my personal responsibility. I agree to pay such established rates for all physician services, procedures, supplies, and medications used for my diagnosis, assessment, treatment, and recovery. If external collection services become necessary to obtain payment from me, I agree to pay all collection agency and attorney fees, as well as court costs associated with such collection efforts. I agree that all attorney and collection agency fees that do not exceed one third of the full account balance I owe, are reasonable, and I therefore agree to pay the same. I understand that Northwest Suburban Pain Center is only contracted with BCBS for in network benefits. We accept Medicare ,Public Aid, and United Healthcare.

Release of Medical / Surgical Information

I authorize Northwest Suburban Pain Center to release to my (or the patient's) insurance companies, employer insurance groups, health plans, Medicare / Medicaid program, its insurance carrier, intermediaries or agents, any and all medical records or other information concerning my treatment to obtain reimbursement on my (or the patient's) behalf provided by physicians in this pain group. If appropriate, I authorize the Social Security Administration to release information about my (or the patient's) entitlement to Medicare to Northwest Suburban Pain Center. I also authorize this physicians' group to release and disclose medical records or other information to third parties with which Northwest Suburban Pain Center has contracted for purposes of reimbursement. I understand I may revoke this consent to release information to third parties at any time, and that the provision of services is not conditioned on my agreement to disclose information to third parties. However, I further acknowledge that if I revoke my consent, and a third party payer denies payment in whole or part to Northwest Suburban Pain Center, as a result of my refusal to release information, I will be responsible for paying for any all services rendered by this physicians' group and its employees. This authorization is not intended to allow release of records regarding my treatment for services requiring a restricted release under federal or state law.

Acknowledgement

By signing this agreement, I acknowledge that I have read and understand information contained in this consent and release of medical information form, and that I accept its terms. Any parts in this consent form to which I do not agree, have been crossed off and initialed by me. Any exceptions to this form, have been entered and initialed by me.

Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Form

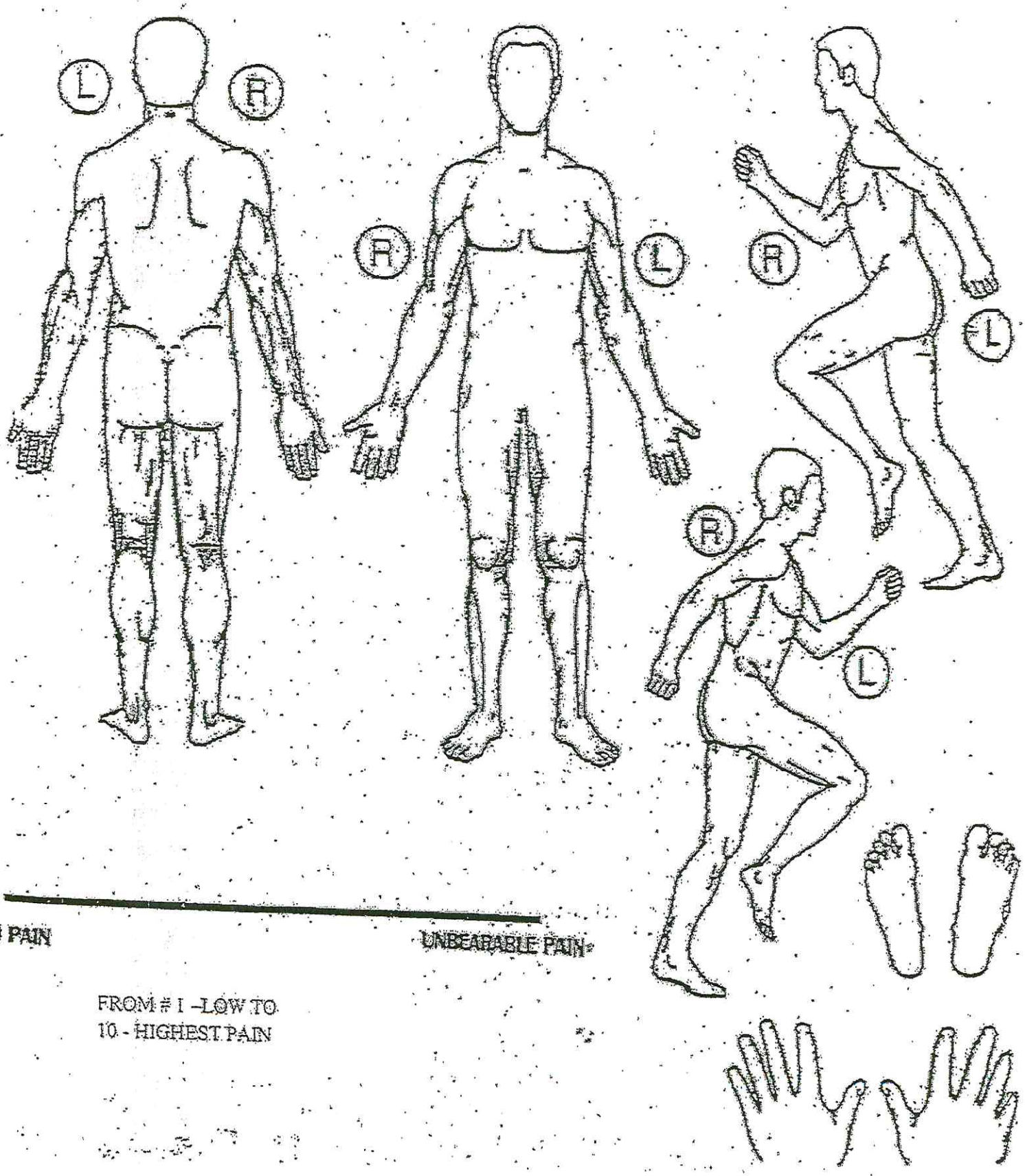
I, hereby give my consent to the Northwest Suburban Pain center to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in my patient record. I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information. I understand that the physician has reserved a right to change his or her privacy practices that are described in the notice. I also understand that a copy of any Revised Notice will be provided to me or made available upon request beginning on the revision's effective date. I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signed: _____ Date _____ / _____ / _____
(Name of Patient or Authorized Agent)

If you are not the patient, please specify your relationship to the patient _____.

PAIN DISTRIBUTION DIAGRAM

CIRCLE WHERE PAIN IS



0 PAIN

UNBEARABLE PAIN

FROM # 1 –LOW TO
10 - HIGHEST PAIN

NORTHWEST SUBURBAN PAIN CENTER POLICIES

Welcome !

Dear Patient,

Thank you for the trust you have placed in our practice. We are committed to providing quality healthcare to you and your family. So that we are sure to meet your expectations consistently, we have prepared a summary of our office policies to answer the most typical questions.

1. Appointments- We will confirm appointments 48 hours prior to the visit. If your scheduled time is not convenient, please notify us at least 48 hours in advance so that we may make this appointment time available to another patient. We make every effort to stay on schedule throughout the day. Unfortunately, because medicine in not an exact science some patients may require more time than others. We will notify you of any extended delays.

2. Missed Appointments- We understand that things happen that may interfere with your daily schedule from time to time. We do track missed appointments and may charge a no-show fee for repeated incidents. Please give us at least 48 hour notice if you will not be able to keep your appointment.

3. Prescriptions- Your provider will write for an appropriate number of refills for chronic medications as allowed by DEA rules. Typically, when these refills expire you are expected to return to the office for a recheck. A new prescription will not be initiated without a face-to-face visit with a provider.

4. Telephone Messages- Every effort will be made to return calls within 24 hours. If there is a medical emergency, please contact 911 or go to the nearest emergency facility. Please refrain from repeat calls regarding the same concerns so we can have focus on all patient messages and return your call asap.

5. Insurance- We participate on most of the insurance plans, including Medicare. If you need help finding out if we are in your insurance plan, just ask us. If you are not insured by a plan that we accept we will check your benefits and depending on your deductible we will make every effort to work with you to provide payment option plans. If you have questions about that, please contact your insurance carrier directly.

6. Claim Submissions- As a courtesy, we will submit an insurance claim for the services provided in our office. If your insurance fails to pay their portion of your charges in a timely manner, we may look to you for payment for those services. Though we may have a contract to participate with your insurance, your individual benefit structure is a contract between you and the carrier.

7. Proof of Insurance- We will request proof of insurance at each visit. If your insurance has recently changed, please notify us at check-in.

8. Copays and deductibles -All co-pays will be collected at check-in.

9. Outstanding Balances- We will notify you on a monthly basis about outstanding balances. At 90 days, any outstanding balance will be referred to an outside collection agency. Any associated collection fees will be added to your balance.

10. Dismissal From the Practice- There are several scenarios that may result in dismissal from our practice.

    a. If a balance remains unpaid, even after the collection agency has exhausted their efforts

    b. Verbal abuse of the staff or aggressive behavior will not be tolerated

    c. Repeated missed appointments/no shows

    d. Failure to comply with medical treatment

    e. Falsification of any medical or personal information

Our practice is committed to treating you and your family with care and respect. If you have any questions about these or any other office policies please feel free to contact us during regular office hours.

Sign:_____ Date:_____

Northwest Suburban Pain Center

A personal approach to pain management.

880 West Central Road, Suite 3600 Arlington Heights, IL 60005

Phone: (847)255-0900 Fax: (847)255-4344