



AUTHORIZATION AND CONSENT
TO OBTAIN AND RELEASE INFORMATION

Patient Name: _____ **Date of Birth:** _____

I hereby authorize my Medical Records to be released to/from Michigan Spine & Pain. This information to be released is to be used only for the following authorized purpose:

- **Planning and Management of Medical Care**
- **Payment of Services by a Third Party Payor**

I understand I may withdraw this authorization at any time. Revocation of this authorization will not affect any information already released. I understand in order for a third party payor to pay for services, Michigan Spine & Pain must send reports and proof of services.

I hereby certify that I am:

- The parent of a minor child
- The legally appointed guardian of the above named individual
- The patient and legally empowered to sign this consent

Please list responsible parties who may receive your health information. (Spouse, mother, child, Nurse Case Manager, etc.) Please provide name and relationship below:

By signing this you also give permission to leave non-specific healthcare messages on a machine or with family (Appointment reminders, messages to call our office, lab results, etc.)

I have read and understand this consent. I am signing this release voluntarily.

Signature

Date

Witness

Date

Information may be withheld if it is not relevant to the authorized purpose claimed. Any subsequent disclosure of medical information by the recipient is prohibited without express written authorization from the above named individual.

Witness is responsible to assure that if the individual signs, he/she was competent to give the informed consent (R330.7003 and R300.6031 (5) (a)-(c) Michigan Department of Mental Health Emergency Rules) or if guardian signs, documentation is on file indicating that the court has empowered the guardian with the authority. If the witness does not feel that the individual is competent, refer to R330.6011 (3)-(4).

Initial: _____

NEW PATIENT INFORMATION

First: _____ Middle Initial: _____ Last: _____

Date of Birth: ____/____/____ Age: _____ Social Security No.: ____/____/____

Home Phone No.: () _____ Alternative Phone No.: () _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

E-mail Address: _____

Height: _____ Weight: _____ Sex: _____ Right or Left Handed?: _____

Emergency Contact Person: _____ Relationship to you: _____

Home Phone No.: () _____ Alternative Phone No.: () _____

Family Physician / Primary Care Provider: _____

Other physicians you have seen in the past year: _____

Whom can we thank for referring you to Michigan Spine & Pain? _____

INSURANCE INFORMATION

No Insurance, I will privately pay for my treatment.

Primary Insurance: _____

Name of Subscriber: _____ Date of Birth of Subscriber: ____/____/____

Subscriber's Social Security No.: _____

Policy No.: _____ Group No.: _____

Secondary Insurance: _____

Name of Subscriber: _____ Date of Birth of Subscriber: ____/____/____

Subscriber's Social Security No.: _____

Policy No.: _____ Group No.: _____

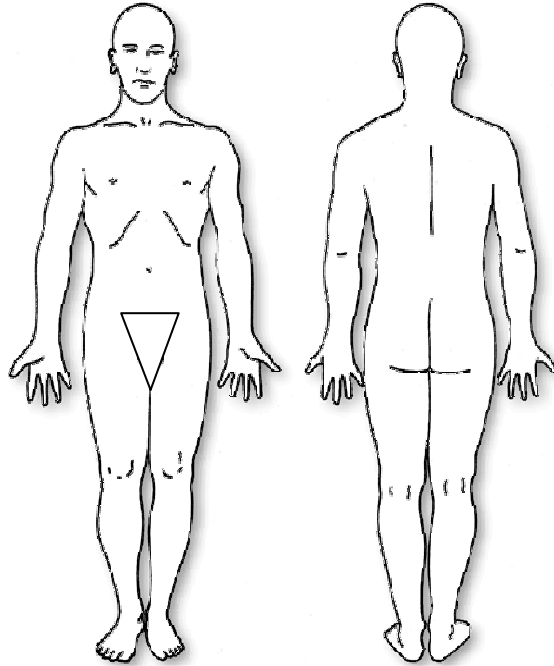
Workers' Comp **Auto** **Date of Accident / Incident / Injury:** _____

Claim No: _____

Name of Adjuster: _____ Phone No.: () _____

Insurance Billing Address: _____

Where is your pain located? On the diagrams below, please shade in the areas where your pain is located. P = Pain T = Tingling N = Numbness



Date of Injury: _____

What makes your pain better? Rest Medication Bending Forward Sitting
 Other: _____

What makes your pain worse? Activity Weight Bearing Other: _____

Please check the appropriate words that best describe your pain.

- | | | | |
|------------------------------------|-------------------------------------|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Aching | <input type="checkbox"/> Severe | <input type="checkbox"/> Constant | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Radiating | <input type="checkbox"/> Unbearable | <input type="checkbox"/> Heavy | <input type="checkbox"/> Numbing |
| <input type="checkbox"/> Intense | <input type="checkbox"/> Dull | <input type="checkbox"/> Stinging | <input type="checkbox"/> Sharp |
| <input type="checkbox"/> Transient | <input type="checkbox"/> Hot | <input type="checkbox"/> Burning | <input type="checkbox"/> Tight |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Sore | <input type="checkbox"/> Annoying | <input type="checkbox"/> Excruciating |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Cold | <input type="checkbox"/> Brief | <input type="checkbox"/> Stabbing |

On a scale of 0 to 10, with 0 being no pain at all and 10 being the worst possible pain, how would you rate your pain **right now**?

0 1 2 3 4 5 6 7 8 9 10
no pain worst
at all possible pain

How would you rate your pain, on **average**, during this **last week**?

0 1 2 3 4 5 6 7 8 9 10
no pain worst
at all possible pain

MEDICATIONS – PLEASE FILL OUT COMPLETELY AND ACCURATELY PLEASE REFER TO YOUR MEDICATION BOTTLE(S) IF ADDITIONAL SPACE IS NEEDED – PLEASE USE ADDITIONAL SHEET			
Name of Medication	Dose (mg)	How Often	How Many Pills Per Day

PAST MEDICAL HISTORY

Please check any of the following health problems with which you have been diagnosed:

- | | | |
|--|---|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Emphysema / COPD | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gastric Reflux Disease | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Gout | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer of _____ | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Vascular Disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> History of Pain or, |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Injury in Same Area |
| <input type="checkbox"/> Other: _____ | | |

Medication Allergies: _____

Other Allergies: _____

PAST SURGICAL HISTORY

Type of Surgery	Date

Initial: _____

FAMILY HISTORY

Are there any diseases that run in your family? Yes No If yes, please list below:

Are there any close family members who are disabled? Yes No If yes, please list below:

Father: Alive Deceased Medical Problems: _____

Mother: Alive Deceased Medical Problems: _____

Grandparents: Alive Deceased Medical Problems: _____

Your Children: Alive Deceased Medical Problems: _____

NOTES: _____

SOCIAL HISTORY

Marital Status: Married Single Separated Divorced Widowed

Children: How Many?: _____ How old are they?: _____

Do you smoke cigarettes? Yes No How many packs per day? _____ Years? _____

Did you quit smoking? Yes No When? _____

Do you drink alcohol? Yes No How many drinks per day? _____ Years? _____

Did you quit drinking? Yes No When? _____

Have you used street drugs? Yes No What kind? _____

Do you currently use drugs? Yes No What kind? _____

Education: High School Graduate College Graduate GED

Other: _____

Grade Completed (Circle): 6 7 8 9 10 11 12

What are you expecting from today's visit? _____

Hobbies/Activities affected by pain: _____

Does your pain affect your self-esteem or self-worth?

0 1 2 3 4 5 6 7 8 9 10
not at all *all the time*

How would you rate your feelings of depression?

0 1 2 3 4 5 6 7 8 9 10
not depressed at all *extremely depressed*

How would you rate your overall energy?

0 1 2 3 4 5 6 7 8 9 10
totally worn out *most energy ever*

How much do you worry about re-injuring yourself if you are more active?

0 1 2 3 4 5 6 7 8 9 10
not at all *all the time*

How would you rate your feelings of anxiety?

0 1 2 3 4 5 6 7 8 9 10
not anxious at all *extremely anxious*

Do you have problems concentrating on things?

0 1 2 3 4 5 6 7 8 9 10
not at all *all the time*

WORK HISTORY

Are you currently working? Yes No Retired Homemaker

**PLEASE COMPLETE THE FOLLOWING USING YOUR MOST RECENT EMPLOYER –
EVEN IF YOU ARE NOT CURRENTLY WORKING**

Date Last Worked: _____ Date of Hire: _____

Place of Employment: _____

Job Title: _____ Are you currently under work restrictions: Yes No

If yes, who placed you on work restrictions?: _____

If yes, please list your restrictions: _____

Do you perform repetitive activity? : Yes No

If yes, please list these repetitive activities: _____

Maximum number of pounds lifted: _____ Parts processed per hour: _____

Hours worked per day: _____ Days worked per week: _____ Shift: _____

Describe your job in detail _____

Have you ever been injured at work? Yes No If yes, please explain:

Type of injury: _____ Date: _____

Type of Injury: _____ Date: _____

How many days have you lost from work due to this injury/illness? None _____ Days

Michigan Spine & Pain
New Patient Information

FUNCTION	Please check (✓) the level you are able to complete the following functions
SIT	<input type="checkbox"/> Able to Sit <input type="checkbox"/> Able to Sit with Assistance Sit Duration? _____ Minutes / Hours <input type="checkbox"/> Unable to Sit
STAND	<input type="checkbox"/> Able to Stand <input type="checkbox"/> Able to Stand with Assistance Stand Duration? _____ Minutes / Hours <input type="checkbox"/> Unable to Stand
WALK	<input type="checkbox"/> Walks Independently without Assistance or Equipment <input type="checkbox"/> Walks with Some Help/Assist Device Walk Duration? _____ Minutes / Hours / Blocks / Miles <input type="checkbox"/> Unable to Walk
LIFT	<input type="checkbox"/> Able to Lift 50+ lbs <input type="checkbox"/> Able to Lift 25 – 50 lbs <input type="checkbox"/> Able to Lift 10 – 25 lbs <input type="checkbox"/> Able to Lift < 10 lbs <input type="checkbox"/> Unable to Lift
PUSH / PULL	<input type="checkbox"/> Able to Push/Pull 50+ lbs <input type="checkbox"/> Able to Push/Pull 25 – 50 lbs <input type="checkbox"/> Able to Push/Pull 10 – 25 lbs <input type="checkbox"/> Able to Push/Pull < 10 lbs <input type="checkbox"/> Unable to Push/Pull
BATHES	<input type="checkbox"/> Bathes Self Independently <input type="checkbox"/> Bathes Self with Some Help <input type="checkbox"/> Unable to Bathe Self
BEND / TWIST	<input type="checkbox"/> Able to Bend/Twist without Difficulty <input type="checkbox"/> Able to Bend/Twist with Pain (Direction) _____ <input type="checkbox"/> Unable to Bend/Twist
CARE FOR FAMILY	<input type="checkbox"/> Able to Care for Family <input type="checkbox"/> Able to Care for Family with Assistance <input type="checkbox"/> Unable to Care for Family
CLEAN HOUSE	<input type="checkbox"/> Able to Clean House <input type="checkbox"/> Able to Clean House with Assistance <input type="checkbox"/> Unable to Clean House
COOK	<input type="checkbox"/> Able to Cook <input type="checkbox"/> Able to Cook with Assistance <input type="checkbox"/> Unable to Cook
DRESS SELF	<input type="checkbox"/> Able to Dress Self <input type="checkbox"/> Able to Dress Self with Assistance <input type="checkbox"/> Unable to Dress Self
DRIVE	<input type="checkbox"/> Able to Drive <input type="checkbox"/> Able to Drive with Assistance <input type="checkbox"/> Unable to Drive
FEEDS SELF	<input type="checkbox"/> Able to Feed Self <input type="checkbox"/> Able to Feed Self with Assistance <input type="checkbox"/> Unable to Feed Self
GROOM	<input type="checkbox"/> Able to Groom Self at Head/Face Level (Brush Teeth/Comb Hair) <input type="checkbox"/> Able to Groom Self at Head/Face Level (Brush Teeth/Comb Hair) with Assistance <input type="checkbox"/> Unable to Groom Self at Head/Face Level (Brush Teeth/Comb Hair)
DO LAUNDRY	<input type="checkbox"/> Able to Do Laundry <input type="checkbox"/> Able to Do Laundry with Assistance <input type="checkbox"/> Unable to Do Laundry
LAY ON BACK	<input type="checkbox"/> Able to Lay on Back <input type="checkbox"/> Able to Lay on Back with Assistance or for a Short Period of Time <input type="checkbox"/> Unable to Lay on Back
LAY ON STOMACH	<input type="checkbox"/> Able to Lay on Stomach <input type="checkbox"/> Able to Lay on Stomach with Assistance or for a Short Period of Time <input type="checkbox"/> Unable to Lay on Stomach
SEXUAL ACTIVITY	<input type="checkbox"/> Able to Engage in Sexual Activity <input type="checkbox"/> Able to Engage with Assistance <input type="checkbox"/> Unable to Engage in Sexual Activity
TRANSFER SELF	<input type="checkbox"/> Able to Transfer Self <input type="checkbox"/> Able to Transfer Self with Assistance <input type="checkbox"/> Unable to Transfer Self
VACUUM	<input type="checkbox"/> Able to Vacuum <input type="checkbox"/> Able to Vacuum with Assistance <input type="checkbox"/> Unable to Vacuum
WORK	<input type="checkbox"/> Currently Working <input type="checkbox"/> Currently Not Working <input type="checkbox"/> Able to Work <input type="checkbox"/> Unable to Work <input type="checkbox"/> Able to Work with Restrictions <input type="checkbox"/> Currently Working with Restrictions <input type="checkbox"/> Currently Working without Restrictions



TREATMENT AGREEMENT

It is important for you to know **what your insurance policy covers**. Your insurance is a contract between you, your insurance company and/or your employer. Michigan Spine & Pain employs Registered Medical Coders and Certified Professional Coders to bill your insurance.

If you do not have insurance, you will be expected to pay for your appointment in full at the time of your appointment.

In order to comply with your insurance company requirements, **all deductibles and co-pays are due at the time your appointment.**

Our office participates with the following insurance companies:

- Blue Care Network
- Blue Cross and Blue Shield
- Connect Care - **Dr. Bleiberg only**
- County Health Plan
- First Health – **Dr. Ruiz only**
- HAP – **Dr. Bleiberg / Dr. Shapiro**
- HCAP
- Health Plus – **Dr. Bleiberg only**
- Medicare
- Multiplan – PHCS – **Dr. Bleiberg / Dr. Ruiz / Dr. Shapiro**
- Physicians Care – **Dr. Bleiberg only**
- Priority Health

We will likely be referring you to physical therapy and/or psychological services. Upon referral, we ask that you seek the first available appointment with these providers. Since these therapies play a very important role in your pain management program, attendance is monitored.

The purpose of this portion of the agreement is to protect your access to controlled substances and to protect our ability to prescribe for you. The long-term use of such substances is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain. Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of our clinic to consider the initial and/or continued prescription of controlled substances to treat your pain.

1. All controlled substances must come from a provider at Michigan Spine & Pain or, in the event of his/her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment).
2. All controlled substances must be obtained at the same pharmacy. The pharmacy you have selected is: _____ Phone: _____

3. You are expected to inform our office of any new medications or medical conditions and, of any adverse effects you experience from any of the medications you take.
4. The prescribing physician has permission to **discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care** for purposes of maintaining accountability. This also allows us to perform a pharmacy “sweep” when we feel it is necessary.
5. You may not share, sell or otherwise permit others to have access to these medications.
6. These drugs should not be stopped abruptly as an abstinence syndrome will likely develop.
7. **UNANNOUNCED URINE SCREENS WILL BE REQUESTED.** You must comply with the request **immediately**. Failure to do so may result in immediate discharge.
8. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected you will take the highest possible degree of care with your medication and prescription. Your medication should not be left where others might see or otherwise have access to them.
9. Medications **WILL NOT** be replaced if they are lost, get wet, are destroyed, left on an airplane, stolen, etc, even if you have a police report.
10. **EARLY REFILLS WILL NOT BE GIVEN.** Do not call for prescriptions after hours or on weekends. Our medication policy states that you must be seen prior to any change in medication and refills may be called in within a 72-hour period.
11. If you fail to comply with **ANY** of the prescribed treatments, lab orders, diagnostic tests, etc, you may be discharged from the clinic. This includes non-compliance with physical therapy or chiropractic (i.e., missing or canceling 3 or more appointments) as well as failure to follow through with appointments with a pain psychologist or for lab/X-ray tests. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you 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.
12. The risks and potential benefits of these therapies are explained elsewhere (*and you acknowledge that you have received such explanation*).
13. You affirm that you have full right and power to sign and be bound by this agreement and you have read, understand and accept all of its terms.
14. It is understood that any medical treatment is initially a trial and continued prescriptions are contingent on evidence of benefit.
15. You have been advised that you should have a primary care physician while being treated at Michigan Spine & Pain.

At Michigan Spine & Pain, we have adopted a **Zero Tolerance** policy with regard to abuse in the workplace. At no time will foul or abusive language or behavior directed toward our staff be tolerated. These actions are grounds for immediate dismissal from our practice.

Patients will be charged a fee of \$35.00 per check for checks returned to our office for non-sufficient funds.

Patients will be charged a fee of \$25.00 for failure to cancel their appointment within 24 hours prior to the appointment and/or not showing for their appointment.

In all instances, our office will work with patients having difficulties paying for their care. We understand that extenuating circumstances occur with injuries and accidents and we would like to help you navigate the issues that arise. If you would like to speak with someone regarding payments, please contact our Patient Accounts Department, at 989-772-1609.

I understand that I am responsible for any and all treatments that may not be covered by my insurance.

IT IS UNDERSTOOD THAT FAILURE TO ADHERE TO THESE POLICIES WILL RESULT IN CESSATION OF TREATMENT WITH OUR OFFICE.

I have answered all of the questions in full and to the best of my ability. I certify the information I have provided is true. I do understand any false information or information left out could affect my medical care and rehabilitation. I promise to notify the office of Michigan Spine & Pain immediately should there be any changes or new information. I hereby authorize Michigan Spine & Pain to furnish the requested diagnostic services and or treatment. I authorize payment of insurance benefits be made directly to Michigan Spine & Pain for those services. I authorize the office of Michigan Spine & Pain to release to the insurer such case record documentation about any insured under the below mentioned policy, which may be necessary for any claim to be processed for payment. If female, I am aware that I may be placed on medications or undergo procedures that could be potentially harmful to an unborn baby. If female, I agree to notify the office of Michigan Spine & Pain immediately if I suspect I may be pregnant.

Signature of Patient

Date

Printed Name of Patient



MICHIGAN SPINE & PAIN

Real People. Real Relief. Since 1999.

Our multidisciplinary pain clinic is unique in the fact we have Board Certified, Fellowship Trained Pain Physicians dedicated to providing relief for those who suffer from acute and chronic pain. We want you to be informed healthcare consumers and compare our services and prices with other multidisciplinary pain clinics.

Our Billing Department will bill your insurance company - we participate with most major insurers.

For patients without insurance or for those with Health Saving Accounts and Flexible Spending Accounts, our general prices are listed below. This is not a complete listing and prices are subject to change without notice. Please contact our office for more information.

New Patient Appointment
\$75 - \$700

Follow Up Appointment
\$40 - \$195

Chiropractic Visit
\$55 - \$90

Acupuncture
\$50 per session

Pain Psychology/Counseling
\$180 - \$250 per session

Physical Therapy
\$50 - \$260

Epidural Injection
\$1,201 - \$1,301

Medial Branch Block Injection
\$1,266 - \$2,401

Radiofrequency Ablation
\$2,026 - \$2,226

Major Joint Injection (Hip, Knee, Shoulder)
\$112 - \$500

EMG
\$1,037 - \$1,109

BioFreeze
\$10 - \$45

Kool-N-Fit
\$10.00 - Spray

Vitamins
\$16 - \$70

Forms
\$50 - First two pages
\$15 - Each additional page



Treatment Plan and Orders

This form is for your use as a guide during your first visit.
 Please complete this form with your provider and keep it for your reference.

Diagnosis(es):

- | | |
|----------|-----------|
| 1. _____ | 7. _____ |
| 2. _____ | 8. _____ |
| 3. _____ | 9. _____ |
| 4. _____ | 10. _____ |
| 5. _____ | 11. _____ |
| 6. _____ | 12. _____ |

RECOMMENDED TESTING

- Standard X-Rays of: _____

- CT Scans of: _____

- MRI of: _____
With / Without Contrast _____
- Digital Motion X-ray of: _____

- Electrodiagnostic Study (EMG):
Upper / Lower Extremity _____
- Functional Capacity Evaluation _____

RECOMMENDED TREATMENT

- | | |
|--|---|
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Discogram |
| <input type="checkbox"/> Epidural | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> Home E-Stim Unit | <input type="checkbox"/> Injection |
| <input type="checkbox"/> Medial Branch Nerve Block | <input type="checkbox"/> Pain Psychology for Pain Coping Techniques |
| <input type="checkbox"/> Chiropractic Care | |
| <input type="checkbox"/> Other _____ | |