



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).

Patient's Initials: _____



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 Plans
- First Health – **Dr. Ruiz only**
- HAP – **Dr. Bleiberg, Dr. Firsten**
- HCAP
- Health Plus – **Dr. Bleiberg and Dr. Barrett**
- Medicare
- Medicaid
- McLaren
- 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: _____

Patient's Initials: _____

Treatment Agreement

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.

Patient's Initials: _____

Treatment Agreement

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 \$100.00 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