ADVANCED
PHYSICAL MEDICINE

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Dear Patient:

We would like to welcome you to our practice. Enclosed you will find registration and signature forms to be completed. Please take a moment to complete these forms PRIOR to your appointment.

On the date of your appointment please be sure to bring the following with you:

- Completed registration forms
- Health insurance cards (including primary, secondary, etc.)
- Photo I.D. (driver's license or state I.D.)
- Reports from diagnostic studies (MRI, EMG, x-rays, bone scans, etc.)
- Complete list of medications including dose and frequency
- Any copay or deductible as per your insurance

PLEASE READ CAREFULLY

IT IS YOUR RESPONSIBILITY TO FULLY UNDERSTAND YOUR INSURANCE BENEFITS. YOU ARE RESPONSIBLE FOR ALL CHARGES NOT PAID FOR BY YOUR INSURANCE COMPANY. ALL COPAY AND/OR DEDUCTIBLE AMOUNTS MUST BE PAID AT THE TIME OF SERVICE. IF YOU DO NOT HAVE INSURANCE ALL CHARGES MUST BE PAID AT THE TIME OF SERVICE.

HMO Insurances - If you have a HMO insurance that requires a referral your referral must be obtained prior to your appointment, otherwise we will have to reschedule your appointment.

Workers' Compensation or Automobile Insurances - You must provide us with a claim number, name of insurance adjuster, and complete billing address and phone number of your insurance carrier.

Again, we thank you and welcome you to our practice. If you have any questions please feel free to contact our office at **(586) 563-3300.**

Your appointment is scheduled for:

DATE: _____

TIME: _____

Advanced Physical Medicine – Office Policies & Signature on File

Thank you for choosing Advanced Physical Medicine.
We are committed to providing you with quality and affordable health care.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. We strive to maintain current information in regard to financial cost to you (co-pays, deductibles, coinsurance, etc.). ***Ultimately it is your responsibility to know your insurance benefits.*** Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid upon arrival. We reserve the right to reschedule appointments if payment is not made.

3. Non-covered services. Please be aware that some of the services you receive may be not covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. We will make every effort to make you aware of your responsibility **before** services are performed.

4. Proof of insurance. All patients must complete our patient information forms before seeing the doctor. We must obtain a copy of your driver's license and current insurance card. You must notify our office of any changes to your insurance.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with this request. *Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim*.

6. Non-payment. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

7. Returned checks. *There is a $30 non-sufficient fund (NSF) fee on all returned checks*. This amount must be paid prior to scheduling your next appointment.

8. Cancellations and no show. *There is a $25 fee for missed office visit appointments and $50 for procedure & new patient appointments not cancelled 24 hours prior to your scheduled time (48 hrs for new patient appointments).* These charges are your responsibility and billed directly to you and **MUST** be paid before your next appointment. Multiple no shows/late cancel may result in being removed from the schedule.

9. Forms. There are fees for completion of *all* forms. Staff will make you aware of the fees at the time the request is made, as the fees do vary. Payment is collected prior to completion.

10. Referral. Some HMO's require an "insurance referral". It is your responsibility to obtain this prior to the appointment or we will have to reschedule it. Please contact your primary care office for support in obtaining this referral.

Our office is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Should we have an change fees, you will be made aware.

All information that has been given thus far is accurate and true to the best of my knowledge. I understand that I am responsible for payment of services rendered, including reasonable attorney's fees and costs of collection in the event of default. I understand that Advanced Physical Medicine will bill my insurance company, but that I am ultimately responsible for any balance not covered by my insurance such as co-payments, deductibles, or uncovered services.

I request that payment of Medicare, Medigap, or other insurance carrier benefits be made on my behalf to Advanced Physical Medicine for services furnished to me.

BY SIGNING THIS FORM, I AGREE AND UNDERSTAND THE PAYMENT POLICY AND ABIDE BY ITS GUIDELINES.

_____ _____

Signature Patient/Responsible Party Date

NOTICE OF PRIVACY PRACTICES

This notice describes how medical/protected health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. *The right to inspect and copy your information.*
2. *The right to request corrections to your information.*
3. *The right to request that your information be restricted.*
4. *The right to request confidential communications.*
5. *The right to a report of disclosures of your information*
6. *The right to a paper copy of this Notice.*

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will ensure that your information remains private. This Notice is a summary only. ***A DETAILED NOTICE OF PRIVACY PRACTICES IS AVAILABLE UPON REQUEST.*** If you have any questions about this Notice, the name and phone number of our contact person is listed on this page.

Effective Date of this Notice	April 2003
Contact Person	Maria
Contact Phone	(586) 563-3300

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of this practice's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way.

_____
Patient or Representative Name (Please Print)

_____ _____
Patient or Representative Signature Date

☐ Patient refused to sign.

☐ Patient was unable to sign due to: _____

ADVANCED PHYSICAL MEDICINE

Date:_____

PERSONAL MEDICAL HISTORY

Note: This is a confidential report of your medical history.
Information contained here will be released only if you have authorized us to do so.

Last Name:_____ **First Name:**_____ **Middle Initial**: _____

Address:_____ City:_____ Zip:_____

Email:_____ **Cell Phone**:_____ **Home Phone**:_____

Date of Birth:___/___/___ **Sex**: ☐ Female ☐ Male **Marital Status**: Single/Married/Divorced/Widowed

Emergency Contact: _____ **Race/Ethnicity**: _____ Hispanic/Non-Hispanic

Preferred Pharmacy:_____ **Pharmacy Phone #:** _____

Injury Related to: ☐ Auto Accident ☐ Work ☐ Slip&Fall ☐ Other_____ **Date of Injury**:_____

Insurance Name:_____ **ID#:**_____ **Subscriber Name & DOB:**_____

Employer:_____ **Current Litigation or Attorney**: ☐ Yes ☐ No

PCP:_____ **Referring Doctor**: _____

Previous Pain Management Doctor: _____

Past Medical History:
Check any conditions you have

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anxiety/ ☐ Depression
- ☐ Asthma/ ☐ COPD
- ☐ Bipolar
- ☐ Blood disease
- ☐ Cancer Type:____
- ☐ Coronary Artery Disease
- ☐ Congestive Heart Failure
- ☐ Diabetes type_____
- ☐ Epilepsy
- ☐ Gout
- ☐ Headaches/☐Migraine
- ☐ Heart Disease
- ☐ Hepatitis / Type___ has it been treated? Y/N
- ☐ Any other not listed:_____
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Intestinal Disease type___
- ☐ Kidney Disease Stage____
- ☐ Liver Disease
- ☐ Lupus
- ☐ Multiple SclerosisType__
- ☐ Neurological Disorder
- ☐ Neuropathy
- ☐ Pacemaker
- ☐ Osteoarthritis
- ☐ Osteoperosis
- ☐ Rheumatoid Arthritis
- ☐ Schizophrenia
- ☐ Seizures
- ☐ Stroke when____
- ☐ Tuberculosis
- ☐ Vascular Disease

Allergies:
Are you allergic to:

Medications: ☐ Yes list:_____ ☐ No

Food: ☐ Yes list:_____ ☐ No

Latex: ☐ Yes ☐ No

Past Surgical History:
Have you ever had surgery? ☐ Yes ☐ No
*If yes, please list:**If Joint surgery specify Left or Right***

Type:_____Year:_____
Type:_____Year:_____
Type:_____Year:_____
Type:_____Year:_____
Type:_____Year:_____

Recent Hospitalizations:

Hospital:	Date:	Reason:

Current Medications: Name/How much/How often?

Family History:
Parents, Grandparents, Brothers, Sisters, Children, Aunts and Uncles

List Relative(s):

☐ Yes ☐ No Diabetes _____
☐ Yes ☐ No Hypertension _____
☐ Yes ☐ No Heart Disease _____
☐ Yes ☐ No Stroke_____
☐ Yes ☐ No Mental Illness _____
☐ Yes ☐ No Cancer _____
Type of Cancer:_____
☐ Yes ☐ No Rheumatoid Arthritis_____
☐ Yes ☐ No Osteoarthritis _____
Unknown_____
Other _____

Father: ☐ Living ☐ Deceased
Mother: ☐ Living ☐ Deceased
Brother ☐ Living ☐ Deceased
Sister: ☐ Living ☐ Deceased
Children: ☐ Living ☐ Deceased
Paternal Grandfather: ☐ Living ☐ Deceased
Paternal Grandmother: ☐ Living ☐ Deceased
Maternal Grandfather: ☐ Living ☐ Deceased
Maternal Grandmother: ☐ Living ☐ Deceased

How many siblings do you have? _____

How many children do you have? _____

Social History:
Have you ever smoked?

☐ Never ☐ Former ☐ Some Days ☐ Everyday

If yes, how many years have you smoked? _____

If former smoker, what year did you quit? _____

Packs per day? _____

Do you drink alcohol? ☐ Yes ☐ No

☐ Monthly or less
☐ 2-4 times per month
☐ 2-3 times per week
☐ More than 4 times per week

How many drinks on normal occasion?

_____

Do you use any illicit drugs? ☐ Yes ☐ No
If yes, what drugs : _____
Do you use Marijuana? ☐ Yes ☐ No
Have a Medical Marijuana Card? ☐ Yes ☐ No

Work Status
☐ Employed ☐ Part Time ☐ Full Time
Employer:_____ occupation? _____
Working with restrictions ☐ Yes ☐ No
☐ Retired ☐ Not currently employed
☐ Disabled year_____ Due to what condition_____
_____

Review of Symptoms: Please check the appropriate boxes indicating the symptoms you have had within the last year.

CONSTITUTIONAL
___Weight Gain
___Loss of Appetite
___Fever
___Weakness
___Weight Loss
___Fatigue
___Insomnia

MUSKULOSKELETAL
___Leg Cramps
___Joint Pain
___Joint Swelling
___Joint Stiffness
___Muscle Cramps

NEUROLOGIC
___Difficulty Swallowing
___Difficulty with Speech
___Loss of Balance
___Headaches
___Tingling
___Numbness
___Seizures
___Memory Loss
___Tremors
___Vertigo
___Weakness in Arms
___Weakness in Legs
___Loss of Smell

CARDIOVASCULAR
___Dizziness
___Chest Pain (angina)
___Irregular Heartbeat
___Leg Edema
___Shortness of Breath
___Orthopnea
___Cold extremities

ENDOCRINE
___Fatigue
___Excessive Sweating
___Excessive Thirst
___Excessive Urination
___Unexplained weight loss
___Cold Intolerance
___Heat Intolerance

Name:_____

Review of Symptoms: Please check the appropriate boxes indicating the symptoms you have had within the last year.

GASTROINTESTINAL
__Vomiting
__Difficulty Swallowing
__Abdominal Pain
__Diarrhea
__Constipation
__Change in Bowel Habits
__Blood in Stool
__Nausea
__Heartburn

ENT
__Cold
__Cough
__Hearing Loss
__Sore Throat
__Ringing in Ears
__Ear Pain

HEMT/LYMP
__Bruises Easily
__Bleeds Easily
__Varicose Veins
__Enlarged Lymph Nodes
__Ringing in Ears
__Ear Pain

PSYCHIATRIC
__Depression __ Anxiety
__ High Stress Level
__Sleep Disturbances
__Suicidal Ideation
__Eating Disorder
__Psychiatric Hospitalizations

RESPIRATORY
__Shortness of breath
__Difficulty Breathing
__Excessive sputum
__Wheezing
__Cough
__Coughing up Blood

- I consent to medical care including routine procedures, examinations, tests, immunizations, regional and local anesthesia, and other treatments by the physician.
- I consent to the testing and disposal of specimens, blood urine, and other bodily fluids and tissues.
- I understand that an HIV (human immunodeficiency virus) test may be done upon me without my further consent if a doctor, health care professional, or employee sustains a percutaneous mucous membrane or open wound exposure to my blood or other bodily fluids.
- I certify that the above information is correct and true to the best of my knowledge.
- I will not hold my doctor or any members of the staff responsible for any errors or omissions that I may have made in completion of this form

What phone number(s) do you want to be contacted by our office regarding appointments, test results, billing information, etc? _____cell/home

_____

If you are not available when called may we leave a message at the above number(s)?
☐ Yes, please leave voice message ☐ No, do not leave a voice message

If you are not available – who may we communicate with at the number you provided?
☐ SELF ONLY ☐ You may speak to the following people _____
For: ☐ Billing ☐ Treatment ☐ Test Results ☐ All of the above

Patient Printed Name & Signature Date

Name:_____ Date: _____

To successfully manage your pain, it is important to focus on your ability to function, not just your level of pain. This checklist can help you see where you are having difficulties with everyday activities. Check the appropriate activity with level of difficulty due to pain. If Activity doesn't apply mark N/A.

ACTIVITY	UNABLE	DIFFICULT	EXTRA EFFORT	SOME EFFORT	EASY TO DO
Sitting for more than 1 hour					
Driving					
Lifting more than 5 pounds					
Working at Computer					
Walking					
Light Yard/House Work					
Cooking					
Personal Hygiene					
Visiting w/ Family or Friends					
Shopping					
Attending Social Functions					
Child Care					
Sleep					
Job Responsibilities					
Sexual Intimacy					

Instructions: Mark these drawings according to where you hurt (if right side of your neck hurts, mark the drawing on the right side of the neck, etc.). Please indicate which sensations you feel by referring to the key below

KEY

/ / / / / / Stabbing
X X X X Burning
O O O O Pins & Needles
- - - - - - Numbness
+ + + + + Aching

PAIN LEVEL

0 No pain

1 Mild pain; you are aware of it but it does not bother you

2 Moderate pain that you can tolerate without medication

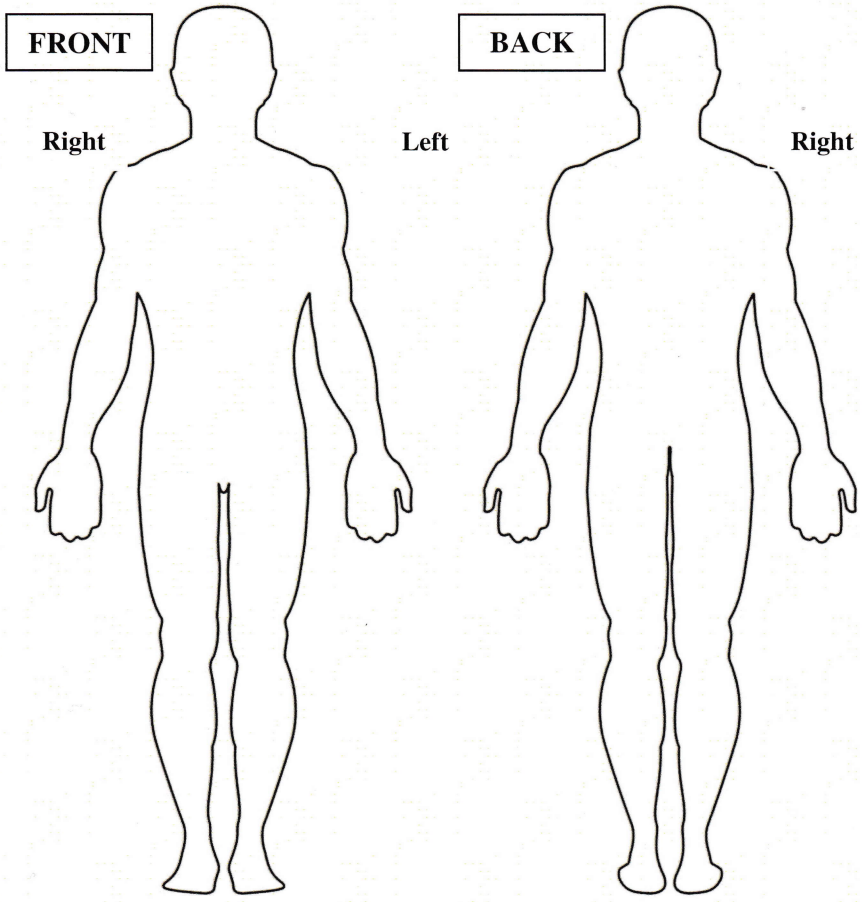
3 Moderate pain that requires medication to tolerate

4 -5 More severe pain; you feel antisocial

6 Severe pain

7-9 Intensely severe pain

10 Most severe; require ER or may contemplate suicide



Circle your current pain level 0 1 2 3 4 5 6 7 8 9 10

Patient Name:_____ **Date:**_____

Community Resource Screening (circle all that apply)

To better meet your needs, we are asking a series of questions to help connect you with resources in the community if you need help. Answering this questionnaire is voluntary. Please turn in to a staff member after completed. Thank you.

Domain	Question	Response	
Access	In the last 12 months, was there a time when you needed to see a doctor but could not because of cost?	Yes	No
Medications	In the last 12 months, did you skip medications to save money?	Yes	No
Transportation	In the last 6 months, have you ever had to go without health care because you didn't have a way to get there?	Yes	No
Personal Care	Do you need assistance with your personal care needs like bathing, making meals, housekeeping, setting up your medications?	Yes	No
Caregiver	Are you a caregiver to a loved one who needs help with personal care?	Yes	No
Housing	Do you need assistance to be able to stay in your current housing? Or do you need help to find a place to live that is safe and more stable than where you live now?	Yes	No
Utility	In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?	Yes	No
Food	In the last 12 months did you ever eat less than you felt you should because there wasn't enough money for food?	Yes	No
Clothing & Household Needs	Do you have the household supplies you need? Things like clothes, shoes, blankets, mattresses, diapers, toothpaste, and shampoo?	Yes	No
Child Care	Do problems getting child care make it difficult for you to work or study?	Yes	No
Intimate Partner Violence	Are you afraid you might be hurt in your apartment building or house?	Yes	No
	Would you like to receive assistance with any of these needs?	Yes	No
	Are any of your needs urgent?	Yes	No

Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Name:_____

Questionnaire developed by Lynn R. Webster, MD to asses risk of opioid addiction.

Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk too. Pain Med. 2005; 6 (6) : 432