Wellness Physical Medicine Center
43650 Garfield Rd.
Clinton Twp., MI 48038
(586) 263-0820

Name_____Age_____Hand you write with_____

Occupation_____Employer_____

Date of Injury_____Last Date Worked_____

Retired_____

Married_____Divorced_____Single_____

Race_____Ethnicity_____Primary Language_____

Chief Complaint: The reason for your office visit._____

_____

What are your symptoms?_____

_____

How severe and often are your symptoms? (Example: unbearable, every day 5-6 times a day, can't sleep, can't work.)_____

_____

When did it start? What were you doing? How long it last? Did it come again? How frequently? Is it better or worse now? When does it mostly happen?_____

_____

Aggravating and Alleviating Factors: What makes it better? What makes it worse?_____

_____

Treatment: What medications or treatments have been done? _____

_____

Special Tests: (Example: CT scan, EEG, Myelogram, EMG)._____

_____

I hereby certify that the above information is correct to the best of my knowledge.

_____ _____

Date Signature

Effect. 07/19/2018

RELEASE OF INFORMATION

Each time you are seen by a medical professional, a written report is generated detailing your visit and treatment recommendations. We need your signed authorization to release medical information. Please complete the information below.

1. Who sent/referred you to our office? Please note, if this area is completed, a written report MUST be sent.

   Name:_____

   Address:_____

   _____

   Phone:_____

2. Do you have a primary care (family) physician?

   Name:_____

   Address:_____

   _____

   Phone:_____

3. Can we speak to family members/other individuals regarding your medical condition? Yes_____
   No_____

   Name:_____Relationship:_____

   Name:_____Relationship:_____

4. By initialing here, you do NOT want medical information released to anyone_____

PLEASE NOTE: By law, we must send our reports to Workers Compensation or Auto insurance carriers if your care is related to a work or auto injury

I, confirm all information listed on this sheet is correct to the best of my knowledge. This authorization will stay in effect until revoked by myself.

_____ _____
Print Name Date

_____ _____
Patient Signature Date

_____ _____
Witness Date

Patient's Right to Privacy
The Neurosurgery Group. P.C.
Neurology Specialist
Sleep and Live Well Diagnostic Center
Wellness Physical Medicine

Healthcare Privacy

Each time you visit a hospital, physician or other healthcare provider, a written electronic record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. Protecting your privacy is very important to us. All of our patients have the right to considerate and respectful care.

Privacy Practices for Protective Health Information

The provision of high-quality healthcare requires the exchange of personal, often sensitive information between an individual and a skilled practitioner. Vital to that interaction is the patient's ability to trust that the information shared will be protected and kept confidential. Yet, many patients are concerned that their information is not protected.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner in the facility that complied it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of our information.
- Obtain a paper copy of this notice upon request.
- Inspect a copy of your health record.
- Request to amend your health record.
- Obtain an accounting of disclosures.
- Request communications of your health information by alternative locations
- Revoke your authorization to use or disclose health information except to the extent action has already been taken.
- Receive notification if ever there is a breach of unsecured public health information.

Consent Agreement

Providing "consent" allows for the use and disclosure of protected health information only for treatment, payment, and healthcare operations.

As part of your healthcare, we originate ad maintain health records describing your health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care or treatment.

This Information is a Basis For:

- Planning for future care or treatment.
- A means of communication among many health professionals who contribute to your care.
- A source of information for applying your diagnosis and medical information to your bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

Confidentiality

Expect that all aspects of your care will be confidential. Your medical records, both written and electronic, will not be released without your written permission, unless it is associated within our healthcare operations. These operations include but are not limited to; evaluation and review of healthcare professionals, quality reviews, assessments, improvement and training activities, licensing and credentialing activities, and certification and accreditation programs. Our office many use or disclose your healthcare information to a physician or other healthcare provider who is providing treatment to you. Your healthcare information will be used and disclosed by our office to obtain payment for services rendered to you.

You Have the Right to:

- Take part in decisions about your care. Before agreeing to any treatment, your doctor will tell you about your plan of care in terms you can understand.
- Refuse further medical care. If you make this decision, it is important that you understand the risks and how it can affect your health. If you refuse care, you become responsible for your future health outcome. If you and your doctor cannot agree about your care, which meets ethical and professional standards, you may be asked to seek treatment elsewhere.
- Pay out of pocket for a service and the right to require that we not submit PHI to your individual health plan.

This notice describes how medical information about you may be disclosed and how you obtain access to the information. Please review it carefully. It is the right of this office to change this policy any time as long as the changes are in accordance with applicable laws. If you receive this notice via our website or by e-mail, you are also entitled to receive this notice in written form from our office.

AKNOWLEDGEMENT OF RECIEPT OF PRIVACY NOTICE
HEALTHCARE INFORMATION DISCLOSURE
Wellness Physical Medicine

By signing below, I acknowledge that I have received a notice of the privacy practices of The Neurosurgery Group, Neurosurgery Specialist, Wellness Physical Medical Center and Sleep and Live Well Diagnostic Center located on the back of this sheet.

Patient Declined _____ Date _____ _____Initials

I understand once (the above named organizations) has disclosed the healthcare information I have authorized to be disclosed, (above named organizations) has no control over the information. The person or organization I have authorized to receive the information might also disclose the information, and it may no longer be protected by privacy laws. This request is effective until revoked by the beneficiary. By declining to sign you will be required to pay for treatment in full at time of service.

Patient Declined _____ Date _____ _____Initials

I consent (the above named organizations) to disclose and receive pharmacy clearinghouse healthcare information. This request is effective until revoked by the beneficiary.

_____Initials

I authorize any holder of medical or other information about me to release to the Social Security Administration and Healthcare Financing Administration or its intermediaries or carriers, as well as all insurance companies, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payments to medical insurance benefits to the party who accepts the assignment for services rendered by this provider. This request is effective until revoked by beneficiary. I HEREBY AGREE TO PAY ANY AND ALL CHARGES THAT EXCEED OR THAT ARE NOT COVERED BY INSURANCE.

The Neurosurgery Group, P.C, Neurosurgery Specialist, Wellness Physical Medical Center and Sleep and Live Well Diagnostic Center have my consent through routine use and disclosure of health records whether communicated electronically, on paper, or orally.

_____ _____

Signature (Patient or Authorized Representative) Date

_____ _____

Signature (Patient or Authorized Representative) Date

_____ _____

Witness (Staff Member) Date

PATIENT CONTRACT FOR TREATMENT OF CHRONIC PAIN AND USING A CONTROLLED SUBSTANCE MEDICATIONS

1. You are responsible for your medications. You are expected to take them only as prescribed by your provider. Please communicate any questions or concerns, such as side effects to your physician or physician extender.
2. You should not obtain medications from other doctors, or pharmacies unless you are a patient in the hospital. You should tell any hospital, or emergency room doctors as well as your dentist that you receive these pain medications from us. These guidelines are designed to protect you from the danger of receiving too much medication.
3. You may not change your medication dose without first getting your provider's permission. Changing the dose without permission may endanger your health. Your provider will give you instructions about what to do if the office is not open when you need advice.
4. You are expected to make sure that your prescriptions are filled on time. You will be given enough medication to last a fixed amount of time, usually 30 days. Refills can only be given during regular office hours, in person, during a scheduled visit. To avoid interruption in your medications, please schedule regular appointments for medication refill. Make sure that you schedule each appointment far enough in advance to avoid running out of medications. Prescriptions cannot be filled early. Prescriptions will not be sent by mail, faxed, or filled by telephone request.
5. Keep your pain medications in a safe and secure place. We advise that you keep them in a locked cabinet or safe. You are expected to protect your medications from loss or theft. Stolen medications should be reported to the police and to your provider immediately. If your medications are lost, misplaced, or stolen, your provider may choose to taper and discontinue the medications.
6. You may not given or sell your medications to any other person under any circumstances. If you do so, you may endanger that person's health. It is also against the law.
7. You should not use alcohol, or illegal drugs while taking these medications. You should not use sleeping pills, cold medicines, or other medications that might cause drowsiness, dizziness, or changes in thinking unless you first discuss them with your provider.
8. You should not drive or operate heavy machinery, or drive an automobile if you feel tired, mentally foggy, or are experiencing other side effects from your medications. It is your responsibility to keep yourself and others from harm.
9. It is sometimes necessary for your provider to check your medication levels, At such times, you may be asked to provide blood and/or urine specimens for testing.
10. Your medications are only a portion of a larger treatment plan. We ask that you participate fully in treatment and follow your providers' advice regarding physical therapy, psychotherapy, vocational rehabilitation, counseling, other medications, or other prescribed or recommended treatment.
11. So that your other doctors understand and can help with your treatment, we ask that you let your provider contact other providers and pharmacists about your use of medications.
12. These medications are very helpful to many patients, but are not right for everybody. It is sometimes necessary for a provider to stop prescribing these medications for a patient. Your provider might choose to taper and discontinue your medications if:
    - The treatment is not helpful
    - The treatment loses its effectiveness
    - You have serious side effects from the medication
    - You become less able to function physically, socially, or emotionally as a result of the treatment
    - You are unable to follow the other guidelines listed in this document
13. If your medication must be stopped for any reason, your provider will taper you off the medication (slowly decrease the dose) in a controlled fashion to avoid withdrawal symptoms. Suddenly stopping the medications can produce flu-like symptoms such as nausea, vomiting, diarrhea, aches, sweating and chills occurring within 24-48 hours of the last dose.
14. For Women Only: Your use of these medications may adversely affect a fetus if you are pregnant, or a child, if you are breast feeding. If you are pregnant, or breast feeding now, or if you are considering becoming pregnant, you should discuss your use of these (and any other) medications with your primary provider, or obstetrician.
15. I understand that there is a small risk that opioid addiction could occur. This means that I might become psychologically dependent on the medication, using it to change my mood, get high, or be unable to control my use of it. People with a past history of alcohol, or drug abuse problems are more susceptible to addiction. If this occurs, the medication will be discontinued and I will be referred to a drug treatment program for help with this problem.

Thank you. We look forward to working with you to help relieve your pain and improve your function.

The Neurosurgery Group
Wellness Physical Medicine Center

Patient Contract for Treatment of Chronic Pain
Using
Controlled Substance Medications

This document is about your use of controlled substance medications prescribed by your physician to help relieve pain and improve function. Most patients who use these drugs find them very helpful and use them without problems. These medications cannot completely relieve pain, but allow patients to become more functional and improve the quality of their life.

This document is to help you understand our medication policies (affected by state laws) and your part in the pain management team.

By signing below, you acknowledge that you have, read and understand the following guidelines on the revere side. For your best results and safety, you agree to follow the guidelines and understand that failure to follow these guidelines can result in discontinuance of medications. These guidelines apply to opioid pain medicines, some anti-anxiety medications and some tranquilizers.

_____ _____

Patient Signature Date/Time

_____ _____

Provider/Representative Signature Date/Time

PATIENT HISTORY QUESTIONAIRE

DATE:_____

NAME:_____ACCT:_____

CHIEF COMPLAINT:_____

OCCUPATION:_____

1. What medications are you currently taking?_____
2. Have you had any surgeries in the past?_____
3. Do you have any medical conditions (hypertension, diabetes)_____
4. Do you have allergies to any medications?What happens_____
5. Do you drink alcohol? How much/often?_____
6. Do you smoke or have you previously smoked?_____
7. Do you consume caffeine? How much?_____
8. Are you currently taking or previously taken any illicit drugs?_____

FAMILY HISTORY (First degree relatives parents, siblings only)

9. Are your parents living or deceased? If deceased what was the date of death and cause of death?_____

Illnesses

Check box if you or members of your family have the following illnesses or problems:

You	Your Family		You	Your Family		You	Your Family	
☐	☐	Alcoholism	☐	☐	Glaucoma	☐	☐	Rubella, German Measles
☐	☐	Anemia	☐	☐	Heart Disease	☐	☐	Stroke
☐	☐	Asthma	☐	☐	High Blood Pressure	☐	☐	Thyroid Disease
☐	☐	Bowel/Bladder Problems	☐	☐	Kidney Disease	☐	☐	Ulcer in Stomach/Duodenum
☐	☐	Cancer, Tumor	☐	☐	Liver Disease, Hepatitis	☐	☐	Uncontrolled Bleeding
☐	☐	Diabetes	☐	☐	Yellow Jaundice	☐	☐	Vascular Disease
☐	☐	Drug Abuse	☐	☐	Lung Disease, Tuberculosis	☐	☐	Venereal Disease
☐	☐	Depression	☐	☐	Mumps, Measles, Chicken Pox	☐	☐	Other Illnesses:
☐	☐	Eczema, Hives, Rashes	☐	☐	Nervous Breakdown/Mental Illness	☐	☐	_____
☐	☐	Epilepsy	☐	☐	Phlebitis	☐	☐	_____
☐	☐	Eye Problems	☐	☐	Rheumatic Fever	☐	☐	_____