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PATIENT REGISTRATION

LAST NAME	FIRST NAME	MIDDLE INITIAL

DATE OF BIRTH	MALE/FEMALE	SOCIAL SECURITY NUMBER	EMAIL

STREET ADDRESS

CITY	STATE	ZIP

WORK PHONE	HOME PHONE	CELL PHONE	PREFERRED CONTACT PHONE

CURRENT MARITAL STATUS SINGLE MARRIED DIVORCED WIDOWED	SPOUSE NAME	SPOUSE DATE OF BIRTH

PRIMARY INSURANCE COMPANY	EMPLOYER PROVIDING PRIMARY INSURANCE

PRIMARY INSURANCE SUBSCRIBER NAME	PRIMARY INSURANCE SUBSCRIBER SOC SEC NUMBER

SECONDARY INSURANCE COMPANY	EMPLOYER PROVIDING SECONDARY INSURANCE

SECONDARYINSURANCE SUBSCRIBER NAME	SECONDARY INSURANCE SUBSCRIBER SOC SEC NUMBER

SECONDARY SUBSCRIBER'S RELATIONSHIP TO PATIENT

IF NOT REFERRED BY A PHYSICIAN, HOW DID YOU LEARN OF PAIN RECOVERY SOLUTIONS?

PHYSICIAN/MEDICAL PROFESSIONAL WHO REFERRED ME TO PAIN RECOVERY SOLUTIONS

ADDRESS (IF KNOWN) OR CITY/STATE OF REFERRING MEDICAL OFFICE

EMERGENCY CONTACT #1	PHONE	EMERGENCY CONTACT #2	PHONE

DATE COMPLETED	PERSON COMPLETING THIS FORM

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New Patient Medical History

Name: _____ Date of Birth: ___/___/ 19___ Age: ____ Sex: ____

How did you hear about our practice? Date:

Please briefly state in the space below the reason for your visit

Past Medical History			
Condition / Disease	***Year Began***	***Condition / Disease***	***Year Began***
❑ Hypertension		Other(s):	
❑ High Cholesterol			
❑ Hypothyroidism (low thyroid)			
❑ COPD, Emphysema or Asthma			
❑ Diabetes			
❑ GERD			
❑ Depression or Anxiety			
❑ Heart Problems -			

Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures			
Operation / Hospitalization / Injury	***Month / Yr***	***Operation / Hospitalization / Injury***	***Month / Yr***

Other Physicians and Specialists *List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc)*

Allergies or Intolerances

List below medications causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)

Medication	*Reaction*	*Medication*	*Reaction*

Medications, Vitamins and Herbal Supplements

Medication	*Strength*	*Number of pills taken & frequency*	*Medication*	*Strength*	*Number of pills taken & frequency*

Social, Educational and Work History

Marital Status:	Age of children, if any:	
Work Status (circle one): Employed Unemployed / Retired / Disabled	Current or Prior Occupation:	Hours worked per week:
Highest Level of Education:	Completed at which institution / school:	

What type of exercises do you perform, duration & frequency?

In what type of residence do you live (i.e., house, assisted living, nursing home)?

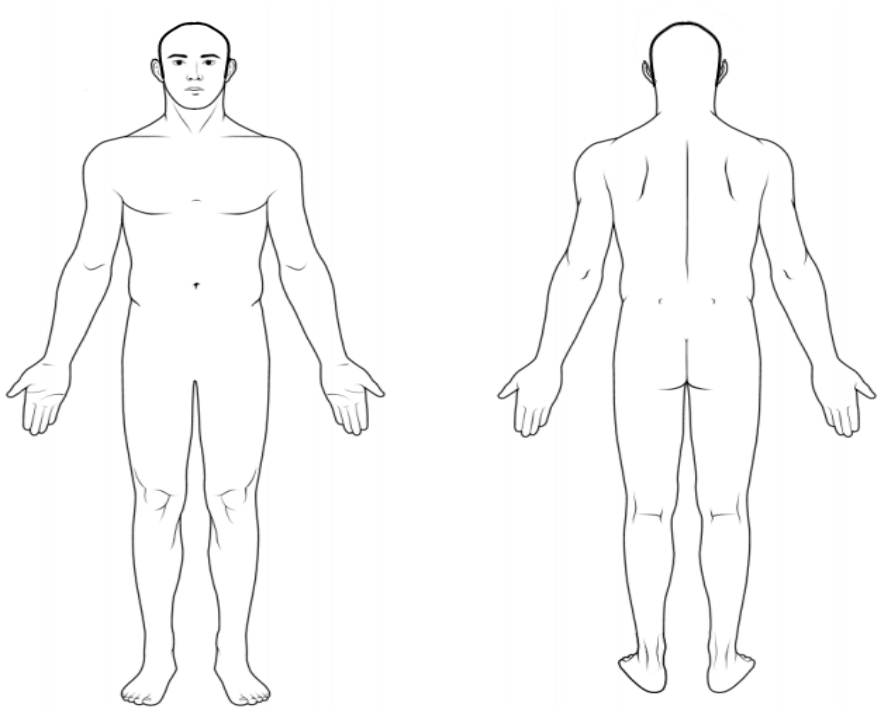
What are your hobbies?

Do you drink alcohol?	What type of alcohol?	No. of drinks per week?
Are you a current smoker?	If you smoke, how many packs per day?	
Are you a former smoker?	If so, what year did you quit?	No. of years you smoked?
On average, how much did you smoke per day?		
Are you sexually active: Yes / No	Do you have sex with: Men / Women / Both	How many partners have you had during the past 12 months?
Are you concerned that you may have been exposed to HIV? Yes / No		

Family Health History				
Relative	***Living or Deceased***	***Current age or age at death***	***Cause of Death***	***Health Problems***
Father:				
Mother:				
Brother(s):				
Sister(s):				

Review of Systems *Please circle those items below that are a problem for you*				
Vision problems	Wheezing	Lumps in breast	Frequent Urination	Excessive hunger
Hearing problems	Asthma / COPD	Breast discharge	Incontinence	Excessive thirst
Sinus trouble	Emphysema	Trouble swallowing	Blood in Urine	Weakness
Hay fever	Bronchitis	Nausea	History of STD's	Fatigue
Nosebleeds	TB exposure	Vomiting	Anemia	Fever / Sweating
Sore throat	Chest pain	Abdominal pain	Easy bruising	Fainting
Hoarseness	Chest discomfort	Hepatitis / Jaundice	Pain in legs	Seizures / Tremor
Lumps in neck	Shortness of breath	Gallstones	Joint pain / stiffness	Headaches
Tooth problems	High blood pressure	Diarrhea	Blood clot	Numbness/tingling
Cough	Diabetes	Constipation	Weight loss / gain	Anxiety/Depression
Coughing blood	High cholesterol	Blood in stool	Heat/cold intolerance	Difficulty sleeping

Mark the areas of your pain on the body diagram below.
Please use these pain indicators to show the different types of pain sensations you may have.



Pins and Needles: **X**
Numbness: **N**
Shooting: **S**
Burning: **B**
Stabbing: **+**
Aching: **A**

Mark where you are on the pain scales. (on average)
Best_0___1____2___3___4___5____6___7____8____9___10_ Worst

Ability to do things
I can do anything _0___1____2___3___4___5____6___7____8____9___10_ I do absolutely nothing

Pain level needed to return to work
Best _0___1____2___3___4___5____6___7____8____9___10_ Worst

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ **DATE:** _____

Over the *last 2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
add columns:		+	+	
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) **TOTAL:**				

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- **Not difficult at all** _____
- **Somewhat difficult** _____
- **Very difficult** _____
- **Extremely difficult** _____

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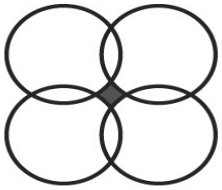

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4870 West Clark Road, Suite 205 Ypsilanti, Michigan 48197 Phone: (734)434-6600 Fax: (734)434-6684

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, _____request and authorize Pain Recovery Solutions
or _____to release healthcare information pertaining to me.

Example: *Primary care/ Referring doctor/ Family member*

Physician name: _____ **Phone**: _____
Address: _____ **Fax**: _____

Physician name: _____ **Phone**: _____
Address: _____ **Fax**: _____

Case Nurse Manager name: _____ **Case Nurse Manager name**: _____
Phone: _____ **Phone**: _____
Fax: _____ **Fax**: _____

Name: _____ **Fax**: _____
Phone: _____

Name: _____ **Fax**: _____
Phone: _____

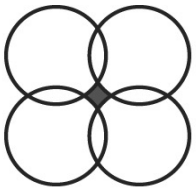
Type of Information to Be Disclosed

- All types
- History & Physical
- Laboratory Results
- Urgent Care/ Emergency Room notes
- Hospital Reports
- Doctor/Nurse Practitioner office visit notes
- Verbal communication regarding care

Signature of Patient_____ Date_____

Signature of Witness _____ Date_____

THIS AUTHORIZATION EXPIRES 4 YEARS AFTER IT IS SIGNED



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IMPORTANT INFORMATION

We reserve a specific time for each of our patients so that we can provide exceptional patient care.

We require 24-hour cancellation notice.

A fee of $50 will be charged for all late cancellation or no show appointments. This fee will be charged to the credit card or debit card we have on file. If there is no card on file the fee must be paid before you can schedule an appointment

To reduce error and provide higher quality of care you will receive prescriptions with the adequate number of refills to make it until your next appointment. **Please review all prescriptions before you leave the office.** If you should have any questions, please inform the office staff.

If an urgent situation arises where you need to contact us for a prescription. Please note it will take **3 business days to process.** No prescriptions will be filled after hours or on the weekends.

If for any reason your follow up appointment needs to be rescheduled please ensure that your rescheduled appointment is before the expected time you would run out of medication.

If this is an emergency, please proceed to the nearest emergency room.

Name: _____
Date of birth: _____
Signature: _____ **Date:** _____

Please circle one

MasterCard/ Visa/ Discover Expiration date: _____ Zip code_____

Card#_____ 3-digit security code (on back of card): _____

- ***Financial Policies***

1. Pain Recovery Solutions will bill on your behalf to insurance companies with which we participate. We have provided you with information about limitations your insurance coverage may have and encouraged you to work with your insurer to understand your coverage completely.

2. We will require you bring your account current each time you are in our office for care. For us to continue to book your appointments, we must have some payment on your account (from you, or from your insurance company) every 30 days. We accept VISA, MasterCard, check or cash.

3. If you expect to pay cash for some/all of your care, we may also ask you to execute a payment agreement with us.

4. Unless your payment agreement states otherwise, whenever your account balance exceeds $100 for 60 days or more we will decline to book further appointments until your account is brought up to date.

5. Please mark your appointments on your calendar. If you miss an appointment without notifying us, or if you cancel or reschedule an appointment fewer than 24 hours in advance, a $50 “no show” fee will be posted to your account.

- ***Consent to Care***

I hereby consent to medical/surgical/behavioral health treatment rendered to me/my family member by medical care professionals associated with Pain Recovery Solutions, P.C.

- ***Authorization for Billing***

I hereby authorize Pain Recovery Solutions, P.C. and the staff/laboratory to bill my insurance company for services rendered and to release medical records to any third party payer as required to receive reimbursement. I authorize payment for covered services directly to Pain Recovery Solutions, P.C.

I understand that I am financially responsible for any co-payments, deductibles and/or non covered services rendered to me or on my behalf. Some insurances (including Medicare) do not pay for preventive services or physical exams. I have reviewed and understand the Financial Policies of this office.

In accordance with the Michigan Public Health Code, if a health professional or other office personnel experiences an exposure to your blood or other body fluids, you may be tested for evidence of the HIV virus. The cost of the test will not be charged to you or your insurance company. The performance and results of this test are confidential. This information will not be released without your written consent, except to those individuals or organizations that have been given access by law, who are also required to keep your records confidential.

Patient Name- Printed _____
Patient/Guardian Signature _____
Date Signed_____
Pain Recovery Solutions, P.C. 4870 W. Clark Rd. Suite 205, Ypsilanti, MI 48197

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Prescription Policy

Prescriptions are written for a specified period of time. Our patients are expected to schedule a follow-up appointment with our office prior to your prescription expiring. In order to provide quality care, our physicians need to monitor your condition and ensure your compliance with prescribed medications. This is only accomplished if you are seen on a regular basis. We reserve the right to deny any prescription that is not in the best medical interest of the patient.

Please know that with each refill request we may need to pull your chart, verify current treatments, verify dates, and make physician decisions, all before being able to safely prepare your prescription and submit it to the pharmacy of your choice /mail out or call you to pick up the prescription. At that point we are often asked to authorize changes by the pharmacy or, more commonly, your insurance. This is why it's a 3-day process.

- All medication refill request must be left on the refill line. You may access this line by calling our office at 734.434.6600 and pushing option 2.

- Prescriptions take 3 business days to be processed and refilled. Plan ahead if the prescription is due on a weekend or holiday, and give us enough time to prepare the prescription.

- Requests for same day or walk-in refills (requested by walking into the clinic)

will not be honored. You must give the staff 3 business days to prepare the prescription. Please do not keep calling to check when we will refill as that is not necessary.

- There will be no refills on weekends or after hours by any of our on-call physicians or providers for any reason. The on-call providers are to be called for emergencies only.

- Any changes to your medication/treatment plan (increasing or changing medications) will require a office visit for re-evaluation.

- If your prescription runs out early for any reason you will need to be seen in the office by any available provider.

- If you need medicine in an emergency, you will have to go to a local emergency room/ urgent care if you are unable to come in the office and be seen.

- If your prescription is stolen/lost. You must be seen in the office. A police report is required the same day as you schedule appointment. In this case we may consider refilling your medication. Do not file false reports to obtain medications.

Patient name_____ Dob: _____

Date: _____