9502 Lima Road Suite 103
Fort Wayne, IN 46818
Office: (260) 459-7313
Fax: (260) 436-6229

Welcome to the STAR Team!

Want to find out more about where your pain is potentially coming from and possible treatment options before your new patient consultation?
Visit our website **STARHealthTeam.com** and click on "Where does it hurt?"

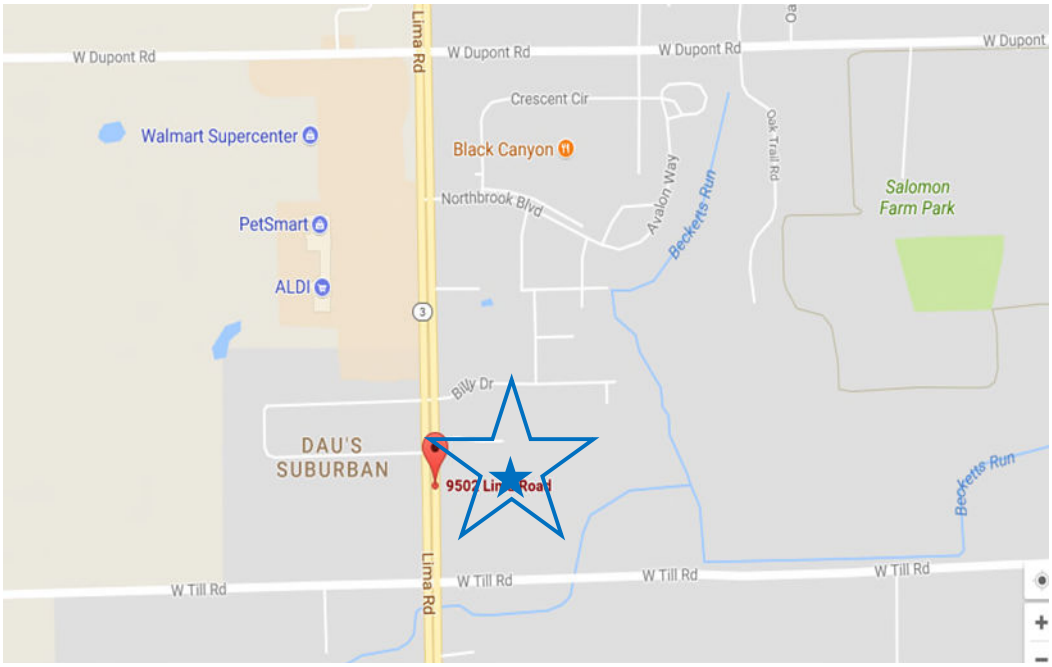
We look forward to meeting you and taking care of your needs. Proper preparation is critical to the success of your appointment. **Please take the following steps:**

❶ **Complete this new patient paperwork and return it,** once it has been processed our office will contact you to schedule your consultation. Completed packets may be dropped off or faxed to our office, or emailed to frontdesk@spine-technology.com

❷ **If you have been examined by another physician, physical therapist, or chiropractor**, contact them and request a copy of your most recent visit notes to be faxed to our office.

❸ **If you have had any X-Rays or MRIs done**, contact the imaging facility and request a copy of the reports to be faxed to our office, as well arrange to pick up a physical copy.

❹ **Please make sure to bring the following** to your appointment:
►Insurance Card(s) ►Driver's License ►Imaging Discs/Films



Our office is located at **9502 Lima Road Suite 103, Ft. Wayne, IN 46818**. We are conveniently ½ mile south from Dupont Road, immediately north of Till Road in the Hyde Park Office Center (on the east side of the road).

Please call us at 260-459-7313 with any questions.

Interventional Pain Management and Spinal Diagnostic Specialists

STAR HEALTH

O NEW O CHANGE Effective date: ____/_____/_____

PATIENT DEMOGRAPHIC INFORMATION

Personal Information:

Last Name First Name Middle Initial

O Male O Female DOB (mm/dd/yyyy): _____ SSN: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home# _____ O Preferred Work# _____ O Preferred

Mobile# _____ O Preferred E-mail: _____

Employer: _____ Address: _____

Spouse's Name: _____ Spouse's Employer: _____

Emergency Contact: _____ Phone# _____

Referral Information:

Who referred you to our office? _____

We like to personally thank our referral sources, can you provide their current mailing address?

_____

Family Doctor: _____ Phone# _____

I agree to provide to my physician accurate and complete information, including, but not limited to, insurance information, cause of injury, medical history, etc. I understand that not providing accurate and complete information will result in the physician not receiving correct reimbursement from the appropriate insurance company and I agree to be responsible for all charges for services rendered.

_____ _____

Signature Date

In accordance with HIPAA regulations, I authorize STAR to disclose my protected health information (PHI) to other healthcare providers as well as to the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Patient's Signature Date

STAR HEALTH

O NEW O CHANGE Effective date: ____/_____/_____

PATIENT INSURANCE INFORMATION

We will need to make a copy of your insurance card(s)

Patient Name:

Last Name First Name Middle Initial

Is this injury: O Work-Related? O Auto-injury?

If so, **please be aware that we do not bill worker's compensation or auto insurance.** You will be responsible for all visit costs up front, but you can request receipts after your visits have been processed to submit for reimbursement.

Primary Insurance Information:

Insurance Company: _____ Phone #_____

Address: _____

Member/Subscriber ID# _____ Group# _____ Effective Date _____

Subscriber's Legal Name: _____ DOB (mm/dd/yyyy): _____

SSN: _____ Subscriber's Relationship to patient: _____

Subscriber's Employer: _____ Phone# _____

Secondary Insurance Information:

Insurance Company: _____ Phone# _____

Address: _____

Member/Subscriber ID# _____ Group# _____ Effective Date _____

Subscriber's Legal Name: _____ DOB (mm/dd/yyyy): _____

SSN: _____ Subscriber's Relationship to patient: _____

Subscriber's Employer: _____ Phone# _____

STAR HEALTH

O NEW O CHANGE Effective date: ____/_____/_____

PATIENT HISTORY ASSESSMENT

Patient Name:

Last Name First Name Middle Initial

Section A:

What is your primary complaint? _____

Category of pain (choose one): O A gradual onset without trauma, injury, or change in activity.
O An abrupt onset without trauma, injury or change in activity.
O An abrupt onset with trauma, injury or change in activity.
Date of onset (mm/dd/yyyy): _____

This injury is a…O Personal Injury (Continue to Section B)
O Worker's Compensation Injury (Continue to Section C)
O Automobile Injury (Continue to Section D)
O None of the Above (Continue to Section E)

Section B: Personal Injury

Date of Injury (mm/dd/yyyy): _____ Location (Ex. home, parking lot, etc.): _____

What happened? (Ex. fell of ladder, etc.): _____

Where have you been treated for your injury? _____

Has any legal action been taken? O Yes O No If yes, is the litigation still pending? O Yes O No
If yes, who is your attorney? _____

Please be aware all billing will go through your insurance.

PLEASE CONTINUE TO **SECTION E.**

SECTION C: Workman's Compensation (WC) - Please be aware that we do not bill worker's compensation.

Date of Injury (mm/dd/yyyy): _____

Has your employer filled the claim? O Yes O No State where claim was filled: _____

Briefly explain the cause of your injury: _____

Is the WC claim still open? O Yes O No If no, date closed (mm/dd/yyyy): _____

If yes, do you have an attorney? O Yes O No If yes, who is your attorney? _____

PLEASE CONTINUE TO **SECTION E.**

SECTION D: Automobile Injury (AA) - Please be aware that we do not bill auto insurance.

Date of accident (mm/dd/yyyy): _____ Do you have an open auto claim? O Yes O No

If yes, do you have an attorney? O Yes O No If yes, who is your attorney? _____

Any open litigation? O Yes O No If yes, please explain: _____

Mark all that apply: O Driver O Passenger O Pedestrian O Wearing Seat Belt O Not Wearing Seat Belt
O Rear-ended O Head-On O Side-swiped O T-boned O Single Auto-accident

PLEASE CONTINUE TO **SECTION E.**

STAR HEALTH

O NEW O CHANGE Effective date: ____/_____/_____

SECTION E: Disability

Are you on Social Security Disability? O Yes O No If yes, do you have Medicare Part D? O Yes O No

Are you on Short Term (Sick Leave) Disability through your employer? O Yes O No

If yes, state the last day you worked: _____ Doctor that authorized it: _____

Are you on Long Term (Sick Leave) Disability through your employer? O Yes O No

If yes, state the last day you worked: _____ Doctor that authorized it: _____

A Functional Capacity Evaluation (FCE) is an assessment tool utilized for those who have suffered an injury that may affect employment. It is a standardized way to collect information regarding physical abilities to determine whether or not you can return to your previous job duties. You may be asked to have an FCE if off work for an extended period of time.

Have you had an FCE? O Yes O No If yes, state the date and place: _____

SECTION F: Education and Employment Status

What is the highest grade you have completed in education? _____

Employment Status: O Employed O Unemployed O Disability O Sick Leave O Retired

If employed, what is your occupation? _____ For how many years? _____

If retired, what was your occupation? _____ For how many years? _____

If you are currently unemployed, on disability or on sick leave, please describe briefly why you are unable to work:

_____

SECTION G: Social History

Marital Status: _____ # of children: _____ Household Occupancy: _____

SECTION H: Family History

Please list any condition that your family members have or have been treated for:

Family Member	Condition
_____	_____
_____	_____
_____	_____

Is there any family history of osteoporosis (brittle bone)? O Yes O No

SECTION I: Past Medical History I (check yes or no)

SKIN	YES	NO	EYES, EARS, NOSE AND THROAT	YES	NO
Skin Infections	___	___	Foreign object in eyes	___	___
Decubitus Ulcer	___	___	Visual Disturbances	___	___
Skin Ulcers	___	___	Ringing in ears	___	___
Scars	___	___	Mouth Sores	___	___
Incisions	___	___	Nose Drainage	___	___
Rashes	___	___	Hearing Loss	___	___
			Double Vision	___	___

STAR HEALTH

O NEW O CHANGE Effective date: ____/_____/_____

SECTION J: Past Medical History II (mark all that apply)

CARDIO	RENAL	URO/ GYN	PULMONARY
O Coronary Artery Disease	O Kidney Stones	O Endometriosis	O COPD/ Emphysema
O Congestive Heart Failure	O Kidney Cysts	O Tubal Pregnancy	O Asthma
O High Blood Pressure	O Kidney Failure	O Pelvic Inflammatory Disease	O Sleep Apnea
O Peripheral Vascular Disease	O Kidney Transplant	O History of Ovarian Cancer	O Recurrent Pneumonia
O Heart Murmur	O Kidney Disease	O History of Testicular Cancer	O History of Pulmonary Embolism
O History of Heart Attack	O History of Kidney Cancer	O Erectile Dysfunction	**GASTROENTEROLOGY**
ENDOCRINOLOGY		**PSYCHIATRIC**	O Heartburn/ Reflux
O Diabetes (w/ insulin)	**HEMATOLOGY**	O Depression	O Systemic Lupus
O Diabetes (w/ o insulin)	O Anemia	O Bipolar Disease	O Colitis
O Hypothyroidism	O Leukemia	O Anxiety	O Chronic Diarrhea
O Low Testosterone	O Lymphoma	O Social Phobia	O Chronic Constipation
O Addison's Disease	O Bleeding Disorder	O History of Suicide Attempt	O Irritable Bowel Syndrome
DERMATOLOGY	O History of Blood Clotting	O Psychosis	O Celiac Disease- Gluten Sensitive
O Skin Lupus			O Crohn's Disease
O Eczema	**RHEUMATOLOGY/ ORTHO**	**NEUROLOGY**	O Ulcers
O Psoriasis	O Rheumatoid Arthritis	O Seizure Disorder	O Bleeding Ulcers
O History of Skin Cancer	O Systemic Lupus	O Multiple Sclerosis	O History of Colon Cancer
INFECTIOUS DISEASES	O Osteoarthritis	O Neuropathy	O Barrett's Esophagus
O Shingles	O Psoriatic Arthritis	O Myasthenia Gravis	OTHER CONDITIONS
O Lyme Disease	O Osteoporosis	O Polymyositis	
O HIV/ Aids	O Osteopenia	O Carpal Tunnel Syndrome	
	O Fibromyalgia		

SECTION K: Previous Medication (mark all that apply)

O Amerge	O Frova	O Norgesic Forte	O Soma
O Amrix	O Gabitril	O Neurontin	O Talwin
O Arthrotec	O Ibuprofen	O Opana ER	O Topamax
O Avinza	O Imitrex	O Oxycodone	O Trazadone
O Axert	O Indocin	O OxyContin	O Treximet
O Celebrex	O Kadian	O Pamelor	O Tylenol
O Celexa	O Keppra	O Panlor SS	O Tylox
O Cymbalta	O Klonopin	O Parafon	O Ultracet
O Darvocet	O Lexapro	O Paxel	O Ultram ER
O Darvon	O Lodine	O Pennsaid	O Valium
O Daypro	O Lortab	O Percocet	O Vicodin
O Depakote	O Luvox	O Prestiq	O Voltaren
O Dilaudid	O Lyrica	O Prozac	O Wellbutrin
O Duragesic	O Maxalt	O Relafen	O Zanaflex
O Effexor	O Methadone	O Relpax	O Zoloft
O Elavil	O Mirapex	O Remeron	O Zomig
O Embeda	O MS-Contin	O Requip	O Zonegran
O Exalgo	O MSIR (morphine)	O Robaxin	O _____
O Fentora	O Naprosyn	O Ryzolt	O _____
O Flexeril	O Norflex	O Senokot	O _____

STAR HEALTH

O NEW O CHANGE Effective date: ____/_____/_____

SECTION L: Current Medication

MEDICATION	DOSE	FREQUENCY	EFFECTIVENESS (high, medium, low)

SECTION M: Allergies (mark all that apply)

O No Known Drug Allergies O Dye/Contrast Allergy O Iodine Allergy O Seafood/Shell Fish Allergy

ALLERGEN	REACTION

STAR HEALTH

O NEW O CHANGE Effective date: ____/_____/_____

SECTION N: Nature of Symptoms: RATE the affective areas according to severity (1st being highest priority)

____ Neck	____ Right Elbow	____ Right Ankle
____ Mid-Back	____ Left Elbow	____ Left Ankle
____ Low Back	____ Right Wrist	____ Right Foot
____ Buttock	____ Left Wrist	____ Left Foot
____ Right Arm	____ Right Hand	____ Chest Wall
____ Left Arm	____ Left Hand	____ Abdominal
____ Right Leg	____ Right Hip	____ Pelvis
____ Left Leg	____ Left Hip	____ Headaches
____ Right Shoulder	____ Right Knee	____ Tail Bone
____ Left Shoulder	____ Left Knee	____ Other: _____

SECTION O: Review of Symptoms (choose all that apply)

O Weakness	Where? _____	O Numbness	Where? _____
O Tingling	Where? _____	O Burning Pain	Where? _____
O Shooting Pain	Where? _____	O Stabbing Pain	Where? _____
O Achy Pain	Where? _____	O Muscle Spasms	Where? _____

O Loss of Bladder O Loss of Bowels O Pain disrupts sleep O Pain disrupts housework

O Pain disrupts my job O Pain disrupts my ability to care for myself/family

Pertaining to Headaches (choose all that apply)

O Left-Sided	O Head and Eyes	O Double vision	O Worse when lying down
O Right-Sided	O Nausea	O Runny Nose	O Better when lying down
O Behind the head	O Vomiting	O Eyes Watering	O Awaken by headache
O Forehead	O Sensitive to light	O Ear Drainage	O History of TMJ
O Facial Pain	O Sensitive to sound	O Nasal Congestion	O Grinding Teeth
O Sides of head	O Dizziness	O Metallic taste in mouth	O Other: _____
O Top of head	O Blurred vision	O Worse when standing/sitting	

SECTION P: Review of Symptoms II

ACTION	PAIN LEVEL		
When I first get out of bed	O Worsens Pain	O Relieves Pain	O No change
Sitting	O Worsens Pain	O Relieves Pain	O No change
Leaning forward	O Worsens Pain	O Relieves Pain	O No change
Lying on side	O Worsens Pain	O Relieves Pain	O No change
Lying on back	O Worsens Pain	O Relieves Pain	O No change
Lying on stomach	O Worsens Pain	O Relieves Pain	O No change
Lifting	O Worsens Pain	O Relieves Pain	O No change
Bending backwards	O Worsens Pain	O Relieves Pain	O No change
Getting up	O Worsens Pain	O Relieves Pain	O No change
Standing	O Worsens Pain	O Relieves Pain	O No change
Walking	O Worsens Pain	O Relieves Pain	O No change
Driving	O Worsens Pain	O Relieves Pain	O No change
Coughing	O Worsens Pain	O Relieves Pain	O No change
Stooping	O Worsens Pain	O Relieves Pain	O No change
Twisting	O Worsens Pain	O Relieves Pain	O No change
Other: _____	O Worsens Pain	O Relieves Pain	O No change

STAR HEALTH

O NEW O CHANGE Effective date: ____/_____/_____

SECTION Q: Diagnostic Testing (choose all that apply)

O X-RAY	Region: _____	Date : _____
O MRI	Region: _____	Date : _____
O Myelogram	Region: _____	Date : _____
O Discography	Region: _____	Date : _____
O Bone Scan	Region: _____	Date : _____
O Spinal Tap	Region: _____	Date : _____
O EMG	Region: _____	Date : _____
O Arthrogram	Region: _____	Date : _____
O Other: _____	Region: _____	Date : _____

SECTION R: Previous Treatments (choose all that apply)

TREATMENTS	DATES (mm/dd/yyyy-mm/dd/yyyy)	RESPONSE (+ or -)	
O Massage Therapy	_____	_____	
O Medications	_____	_____	
O Chiropractic Care	_____	_____	
O Acupuncture	_____	_____	
O Traction	_____	_____	
O Tens Unit	_____	_____	
O Facet Injections	_____	_____	
O Sacroiliac Joint Injection	_____	_____	
O Joint Injections	_____	_____	# of times: _____
O Epidurals	_____	_____	Type: _____
O Home Exercise	_____	_____	# per week: _____
O Physical Therapy	_____	_____	# of sessions: _____
O Back School	_____	_____	# of sessions: _____
O Brace/Splint	_____	_____	# of sessions: _____
O Radiofrequency Ablation	_____	_____	

SECTION S: Previous Surgeries (choose all that apply)

SURGERIES	YEAR	RESPONSE	
O Spinal Cord Stimulator	_____	_____	# of times: _____
O Low Back Surgery	_____	_____	Type/Levels: _____
O Neck Surgery	_____	_____	Type/Levels: _____
O Extremity Surgery	_____	_____	Type: _____
O Vertebroplasty/Kyphoplasty	_____	_____	Type/Levels: _____
O Other: _____	_____	_____	Type: _____
O Other: _____	_____	_____	Type: _____
O Other: _____	_____	_____	Type: _____

STAR HEALTH

O NEW O CHANGE Effective date: ____/_____/_____

SECTION T: Tobacco, Alcohol and Illicit Drug Use

Tobacco Use:

O Never
O Chewing Tobacco # times a day: _____ Age you started: _____
O Cigarettes # of packs a day: _____ Age you started: _____
O Cigars How many a day? _____ Age you started: _____
O Quit How long ago? _____

Alcohol Use: O Never O Drinks per day? _____ O Drinks per week? _____

O Currently attending AA O History of rehab

Do you have any history of alcohol abuse? O Yes O No if yes, when? _____

Do you have any past or current legal issues with alcohol usage? O Yes O No

If yes, please explain: _____

Illicit/Illegal Drug Use:

	Currently Using	Past regular use	Tried it	Never
Marijuana	O	O	O	O
Cocaine	O	O	O	O
Methamphetamine	O	O	O	O
Heroin	O	O	O	O
PCP	O	O	O	O
LSD	O	O	O	O

Prescription drugs (not prescribed): _____

Other: _____

Do you have any past or current legal issues with drug usage? O Yes O No

If yes, please explain: _____

_____

As a patient at STAR, what is your goal?

_____

_____

_____

_____

Please mark an **X** along the line from 0% to 100% to express the degree that your pain has affected your life:

Opioid Risk Tool:

The Opioid Risk Tool (ORT) addresses the need to predict who is at risk for opioid abuse before opioid therapy is initiated. This gives physicians a better opportunity to monitor moderate to high risk patients rather than waiting until treatment has begun to check for abuse. Dr. Lynn R. Webster designed the ORT to be used as a point of care tool for providers prescribing opioids during the initial visit for pain treatment. The ORT is a five-question, self-administered assessment that takes fewer than five minutes to complete and can accurately predict which patients are at the highest and lowest risk for displaying aberrant drug-related behaviors associated with abuse or addiction.

Mark Each Box That Applies		Female	Male
Family History Of Substance Abuse	• Alcohol	O	O
	• Illegal Drugs	O	O
	• Prescription Drugs	O	O
Personal History Of Substance Abuse	• Alcohol	O	O
	• Illegal Drugs	O	O
	• Prescription Drugs	O	O
Age (Mark Box If 16-45 Years Old)		O	O
History Of Preadolescent Sexual Abuse		O	O
Psychological Disease	• ADD, OCD, bipolar disorder, schizophrenia	O	O
	• Depression	O	O
None of the above apply to me		O	
	TOTAL		

Reference: Webster LR. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. *Pain Medicine*. 2005; 6(6): 432-442.

STAR HEALTH

AGREEMENT TO PAY FOR SERVICES

Welcome to Spine Technology and Rehabilitation, PC (**STAR**). It is important our patients are informed of the financial policies of STAR. Should you have any questions regarding any of these policies, we encourage you to discuss them with us.

APPOINTMENT FEES:

- If a referral is required, it is **your responsibility** to obtain the referral from your primary care or referring physician **prior to the scheduled appointment.** If a referral is not obtained, the appointment will need to be rescheduled or **you will be required to pay** for the entire visit at the time of service.
- Not arriving to your appointment without prior cancellation or arriving late may be considered a **NO SHOW**. You are responsible for paying any no show fees before being able to schedule another appointment. Fees are as follows:
  - $40 for office or rehabilitation visits
  - $200 for all missed procedures

INSURANCE PAYMENTS:

- Patients will not be seen without presenting a current insurance card at each appointment.
- STAR will bill your primary (and secondary) insurance plan(s) for all charges related to services rendered. **You will be responsible at the time of service for any co-payment and/or charges for non-covered services.** You will also be responsible for any deductible associated with your plan.
- In the event there may be a charge for services not covered by your plan, we will ask you to sign an **Advanced Beneficiary Notice** that indicates the approximate cost for services not covered by your insurance carrier and for which you will be financially responsible.
- If your insurance carrier holds a claim for "review" longer than 90 days, delaying payment, or your third party payor does not make payment in a timely manner, as described by the Employee Retirement Income Security Act of 1974 (ERISA law), STAR reserves the right to require the contractually agreed upon reimbursement from the patient. It will then be your responsibility to obtain payment from your insurance carrier or third party payor.
- If your **primary** insurance coverage is through a carrier with whom STAR is not contracted, you will be responsible for payment in full at the time services are rendered. It will be your responsibility to file with your primary and secondary insurance carrier(s) as necessary.

PAYMENT POLICIES:

- **Any account more than ninety (90) days past due will be forwarded to our attorney.** The undersigned shall pay reasonable attorney fees and collection expenses. If litigation results, the amount of attorney fees shall be set by the court and not by the jury.

CHECK RETURN FOR NON-SUFFICIENT FUNDS:

- If a check is returned to STAR for non-sufficient funds, we will contact you directly and request a cash payment for the amount of the check. STAR reserves the right to convert any "non-sufficient fund" checks to electronic payment, thereby automatically deducting the amount from your checking account. **STAR will not accept personal checks toward any future payment(s) on your account.** Due to the additional handling and charges made to STAR by the bank, an added fee of $25.00 will also be due for each returned check.

WORKMAN'S COMPENSATION CLAIMS:

- If you are seeking care under a workman's compensation claim, you shall indicate such no later than at the time of your **first appointment, prior to being seen.** STAR does not bill workman's compensation, and you will be responsible for payment in full prior to each visit.

I agree that I am financially responsible for payment to Spine Technology and Rehabilitation, PC even though I may have insurance coverage. **I, therefore, agree to pay for all medical charges my insurance carrier does not cover either at the time of services or as soon as I receive notice.** I further agree that if my insurance carrier or third party payer fails to make payment within the time frame contractually obligated as described by ERISA Law, I shall be responsible for all costs incurred at Spine Technology and Rehabilitation, PC in collecting such charges, including attorney fees, court costs and/or collection fees.

Signature: _____ Date: _____

STAR HEALTH

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been in our practice for years. This form is a "friendly" version. A more complete text is posted in the office.
What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your protected health information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services, www.hhs.gov.

We have adopted the following policies:

1. PHI will be kept confidential allowing for the provision of services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, and health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public records. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.
2. It is a courtesy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send other communications informing you of changes to office policies and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduction of business. These vendors may have access to your PHI, but must agree to abide by the confidentiality rules of HIPAA holding them equally liable to any breach of information.
4. You understand and agree to inspections of the office and review of documents, which may include PHI, by government agencies or insurance payers in the normal performance of their duties.
5. You agree to take any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goals, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws. You are entitled to access your medical records within 30 days of your request, with one 30-day extension provided to the medical records department.
8. You have the right to request restriction of access to your PHI by your insurance payor related to services for which you have personally paid in full.
9. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.
10. You have the right to request restrictions in the use of your PHI and to request changes in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to you request.

I, _____, on this date _____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes in office policies. I understand that this consent shall remain in force from this time forward.

STAR HEALTH

OUR SERVICES

Pain management is a specialty of medicine providing numerous treatment approaches to diminish pain and improve function. STAR Health provides interventional pain management solutions. We conduct a comprehensive evaluation to determine the root cause of your chronic pain, then we build a personalized treatment plan that doesn't involve addictive pain medication. Treatment measures at our office may include navigation-guided anti-inflammatory injections, stem cell therapy, rehabilitation, infrared therapy, home exercise programs, or a combination of these various modalities. **While medications may be prescribed for a brief period following certain procedures to aid in recovery, our office does not provide medication management as a primary means of managing pain.**

By signing below, you are acknowledging the above statement and indicating that you understand drug-seeking or drug diverting behavior is grounds for termination of the provider-patient relationship.

Signature: _____ Date: _____

APPOINTMENT ETIQUETTE

Punctual attendance of scheduled appointments is key to your treatment. Arriving tardy to your appointment may result in being rescheduled. **Frequent tardiness or failure to show without prior cancelation may result in termination of the provider-patient relationship.** This behavior disrupts the healthcare delivery system, impacting the treatment of other patients.

Undoubtedly, you are seeking help for a condition requiring intense focus and scrutiny by the STAR Health team. Audible ringing, beeping, or buzzing during appointments is a distraction. **Please turn off or silence any electronics in the exam room.**

We understand having another set of ears can be beneficial and welcome you to bring a spouse, family member, or friend to your appointments. As space and seating in the exam room is limited, **please be aware we can only accommodate one additional person during your appointment.**

While we love seeing children be active and play, our office is not an appropriate location for them to expend energy. Our patients are here due to chronic pain; vibrations and noise can exacerbate these symptoms. **Disruptive children will result in your appointment being rescheduled** to a day and time when you are able to secure childcare for them.

By signing below, you are acknowledging and agreeing to the above statements.

Signature: _____ Date: _____

STAR HEALTH

COMPLIANCE AGREEMENT

This agreement is between the "patient" and Spine Technology and Rehabilitation, PC the "provider for the purpose of establishing an agreement between the provider and patient on clear conditions for the prescription use of pain controlling medications (when appropriate and at the provider's discretion) and treatment prescribed by the provider for the patient. Controlled medications are very useful, but they have a high potential for misuse and therefore are closely monitored by local, state and federal government. Pain medications are intended to relieve pain, improve function and/or the ability to work and are not used simply just to "feel good."

I am aware that the use of such medication(s) has certain risks associated with it, including but not limited to: sleepiness, drowsiness, constipation, nausea, vomiting, itching, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and possibility that the medicine will not provide complete pain relief.

Provider and patient agree that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship. My provider will now undertake the responsibility of treating me based on my voluntary signature of this agreement.

I agree to and accept the following conditions for the management of pain medication (if provider agrees that my conditions require medication(s)) and treatment prescribed as provided to me by the provider.

- I understand that a reduction in the intensity of my pain and improvement in my quality of life are the goals of this program. I will communicate fully about the character and intensity of my pain, the effect the pain has on my daily life, and how well medications are helping to relieve the pain.
- As a condition of my care, I will commit to keeping appointments with Spine Technology and Rehabilitation, PC, referral appointments, diagnostic and therapeutic appointments as agreed upon. Medication refills (if needed) will be approved on the basis of my compliance with keeping scheduled appointments.

- I realize that all medication has potential side effects, and I agree to have the recommended lab studies required to keep the regimen as safe as possible.
- I agree and understand that I will submit to a blood or urine test if requested by my provider to determine my compliance with this agreement and my regimen of pain control medication. Refusal or alteration of a sample of any of these tests, Spine Technology and Rehabilitation, PC will terminate my treatment.
- I will report all drug side effects and concerns to my provider.
- I realize that it is my responsibility to keep others and myself from harm, including the safety of my driving. I shall not drive nor operate heavy machinery until medication drowsiness has cleared. If there is any question of impairment or my ability to safely perform any activity; I agree that I shall not attempt to perform such activity until my ability has been evaluated or I have not used medication for at least four days.
- I shall safeguard my medication from loss or theft and agree that the consequence of my failure to do so is that I will not receive a replacement to cover the loss. This includes if my medication(s) get wet, are destroyed, stolen, left on an airplane, etc.
- I understand that if my provider determines that I am not responsible for my medication(s), future prescriptions will not be given.
- I will not use any alcohol or illegal controlled substances, including marijuana, cocaine, etc.
- I shall not horde, share, sell or trade my medication(s) for money, goods or services.
- I shall report all medication amount changes or discrepancies to the provider immediately.
- I shall not attempt to obtain or accept any pain medications from any other healthcare provider without telling them that I am taking pain medications prescribed by the provider and reporting such to Spine Technology and Rehabilitation, PC. I understand it is against the law to do so. If my referring physician is willing to prescribe my medication(s), my provider must approve the arrangement to ensure there is no duplication. **I will discontinue all previously used pain medications, unless told to continue them by my prescribing physician.** The only exception is if medications are prescribed should I be admitted to a hospital. I will ask that Spine Technology and Rehabilitation, PC be notified of my admission.
- I will inform Spine Technology and Rehabilitation, PC of any new medical conditions or medication prescribed to me at my next scheduled appointment or sooner if necessary.
- I am aware that certain other medications, such as **Nalbuphine (Nubain), Pentazocine (Talwin), Buprenophine (Buprenex), and Butorphanol (Stadol)**, may reverse the action of the medicine I am using for pain control. I agree not to take any of these medicines and to tell any other physicians that I am taking an opioid as my pain medicine and cannot take any of the medicines listed.
- I will be limited to disbursement from the following two pharmacies for all my pain medication(s):

  Primary: _____ Location: _____

  Secondary: _____ Location: _____
- If I change pharmacy for any reason, I shall notify the provider at the time I receive a prescription, and advise my new pharmacy of my prior pharmacy's address and telephone number.

STAR HEALTH

COMPLIANCE AGREEMENT

- I waive my applicable privilege or right to privacy or confidentiality with respect to the prescribing of my pain medication(s) and I authorize the provider any my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including the Indiana Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medication(s). I authorize the provider to provide a copy of this agreement to my pharmacy.
- I authorize the provider to share information with other providers regarding my treatment.
- I will bring in the containers of medication(s) prescribed by Spine Technology and Rehabilitation, PC at each clinic visit even if there is no medication remaining in the bottle(s).
- I shall keep each medication in its original container from the pharmacy to prevent law enforcement issues.
- I agree that I shall use my medication(s) at a rate no greater than the prescribed rate. If I use medication(s) at a greater rate, I understand it will result in being without medication(s) for a period of time or it may end in my termination from Spine Technology and Rehabilitation, PC.

I understand that the following guidelines must be adhered to for any refills of a controlled substance medication(s):

1. Refills will be made only during regular office hours each month during a scheduled office visit.
2. No refills will be made if medication(s) "run out early." I am responsible for taking medication(s) in the dose prescribed and keeping track of the amount remaining.
3. No refills will be made during evening, night hours, holidays or weekends.
4. No refills will be made in an "emergency," such as Friday afternoons because I realized my medication(s) will "run out tomorrow." I will call at least twenty-four (24) hours ahead if I need assistance with a controlled substance medication prescription(s).

- I understand that this medication regimen will be continued for a period of six (6) months. If there is no evidence that I am improving or no progress is being made to improve my function or my quality of life, the regimen will be tapered to my pre-trial medications and my care will be referred back to my primary care physician.
- I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine used is markedly decreased, stopped or reversed by some the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all of the following: Runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, or aches throughout the body and flu-like symptoms. I am aware that opioid withdrawal is uncomfortable, but not life threatening.
- I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a problem for most patients with chronic pain. I realize I may or may not experience drug tolerance or failure to respond well to opioids may cause my provider to choose another form of treatment.
- In the event it is determined that I will no longer be prescribed pain medication(s), my provider will taper off the medicine(s) over a period of several days, as necessary, to avoid withdrawal symptoms. Also a drug dependence treatment program may be recommended.
    - **(Males only)** I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and sexual performance. I understand that my provider may request a lab study to see if my testosterone level is normal.
    - **(Female only)** If I plan to become pregnant or believe that I have become pregnant while taking pain medicine(s), I will immediately call my primary care physician or obstetric physician and Spine Technology and Rehabilitation, PC to inform them. I am aware that, should I carry a baby to delivery while taking these medicine(s), the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects, however, birth defects can occur whether or not the mother is taking medicines and there is always the possibility that my child will have a birth defect while I am taking opioids.

Lifestyle

I understand that the main goal of treatment is improved function, I shall help myself by following better health habits: exercise, weight control, and the non use of tobacco and alcohol. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treatment.

- I have read this agreement and my questions have been answered to my satisfaction by a member of Spine Technology and Rehabilitation, PC staff. By signing this agreement voluntarily, I indicate that I shall agree to comply with the terms of this agreement. I further agree that any violation of this agreement will be reported to my primary care physician, local medical facilities, local, state and federal law enforcement agencies and my insurance carrier.
- If I fail to abide by the terms of this agreement, it shall result in the withdrawal of all prescribed medication(s) by the provider and the termination of the provider-patient relationship.

Patient Signature: _____ Date: _____